THE MEDICAL HUMANITIES JOURNAL OF BOSTON COLLEGE

VOLUME 11 · ISSUE 1

The Medical Humanities Journal of Boston College seeks to:

- Initiate and engage in conversation with 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 and genres
- Critically and creatively examine and represent ideas of health, illness, caregiving, and medicine
- Connect students with alumni, professionals, and other Medical Humanities programs to extend and engage in conversation beyond Boston College

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Josephine Edgar and Jesse Julian, *Undergraduate Interns for The Medical Humanities, Health, and Culture Minor*

Cover Art

“Heartbeat”

Emma Su, ’26

Logo

Emma Su, ’26

Thanks & Additional Information

We would like to thank Boston College, The Institute for the Liberal Arts at Boston College, and The Center for Centers at Boston College for the financial support that made this publication possible. Special thanks to Susan Dunn, Cameron Williams, and Rebekah Waalkes.

To read the journal online and find more information, visit us at www.bcmhj.com. Please direct any questions regarding the journal to bc.mhj.1@gmail.com. Submissions are collected via Google Form each semester.

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The Medical Humanities Journal of Boston College, Volume 11, Issue 1, Spring 2026.

Mailing Address: 10 Stone Avenue, Chestnut Hill, MA 02467

Before You Read...

Hey there—a quick note before you dive in.

The Medical Humanities Journal of Boston College explores the messy, beautiful intersection of bodies, minds, and meaning. Sometimes that means confronting the uncomfortable. Some pieces in this issue touch on heavy themes like:

- Illness, death, or grief,
- Trauma or loss
- Mental health struggles
- Inequity, identity, or systemic harm

We trust our readers to approach these stories with empathy, and to step back if something feels too close. Take a walk, drink some water, talk to someone you trust. We invite you to read slowly, and to rest when the work asks too much.

If you need someone to reach out to:

- University Counseling Services: (617) 552-3310
- Murray Center for Student Wellness: (617) 552-9900
- 24/7 Crisis Text Line: Text *HOME* to 741741
- National Suicide Prevention Lifeline (US): 988

Our mission is to foster dialogue around the human dimensions of medicine and health. We recognize that such conversations can be both illuminating and emotionally challenging. The inclusion of these works does not reflect endorsement of all views expressed, but rather our commitment to giving voice to diverse and often difficult human experiences.

Thanks for reading bravely.

With care,
The Editorial Team

The Medical Humanities Journal of Boston College

Editor's Note

JESSE JULIAN, EDITOR-IN-CHIEF

I've been thinking about the things we can control versus the chaos we fall victim to.

As I reach the end of my academic career at BC, I've realized that the bounds of knowledge only go so far. I carry my education with me, and so do the fellow members of my graduating class. But in this changing world, there's so much uncertainty to step into. How do we live with this? Where do we even start?

Experiences with medicine, health, and illness often exemplify that tension between relinquishing control and diving into uncertainty. It is an inevitable encounter that all come to face with time. The goal of this journal is to amplify those experiences, give voice and autonomy to those living through uncertainty, and create a space that can encourage wisdom and sympathy through writing and art.

The pieces presented certainly agree on one thing: survival is not straightforward. Malia Robinson's "Trypanophobia" poetically exemplifies discomfort in the spaces that are supposed to sustain us. Traumatic memories follow us with the piercing scent of antiseptic or the blinding overhead lights. Our authors question the authority of providers whose biases inhibit social justice, especially in the realm of gender and race. Some pieces, like Charlotte Caine's "Bolting the Frame," navigate the road to recovery: an unclear, imprecise path that runs askew.

How do we process uncertainty? One takeaway, intuitive to the art of scientific inquiry, would be to investigate and question that which we do not fully understand. For instance, Nick Huempfner's "Etiology" looks up from lab specimens to examine the bigger picture. We can also zoom in and pick apart the minute details, drawing attention to concepts we *think* we understand, as showcased by Domenic Ciampa's epistemological analysis of mental health in "On The Other End of Suffering."

Then there's the other takeaway: radical acceptance. Perhaps there are explanations we will constantly ask for but never reach, and that's okay. We might witness a loved one, who was once so lively, suddenly spiral into deterioration. We might watch a stranger reach their final moments, not knowing how to act or whether to act at all. We might fear the future of our own health, questioning what illness we might inherit—or if there's anything we can do about what we might call *fate*.

Perhaps we can try to accept the unknown and choose to live regardless. Perhaps we can keep asking questions to navigate that windy road of survival. Through the stories shared here, we find a community of people searching for connection and meaning despite the struggles and hardships faced. It is the effort to live in the face of uncertainty that defines us—not the diagnosis, but our humanity rising to the challenge.

I would like to thank our editorial team, who dedicate their time to revising and proofreading these works. In particular, thank you to our Lead Editors: Jessica, who curated the layout and order in which these pieces speak to each other; Angela and Tay, who spearhead the publicity and reach of this journal; Malia, whose expertise guides the revision process, shaping the pieces to be publication-ready; and Emma, my fellow senior who maintains the professional and perfect layout of our website and journal archive. Thank you to the remainder of the Executive Board, who are receptive to the knowledge shared by the Lead Editors.

I'd also like to extend an immense amount of gratitude to Vincent Salamone, our Deputy Editor who will inherit my role for future issues. I can safely say that this journal will continue to grow under his organization, passion, and leadership.

This issue would not be possible without the impressive list of authors and artists who chose to share their art with us. There's a lot at stake when exposing your vulnerability to the unknown "reader" on the other side of the page. Still, there's comfort in knowing that this stranger might relate to your story. If we can control one thing—the way we express ourselves and the way we are understood—then that's worth the risk.

I am thankful for all those who have engaged with the journal, as a reader, supporter, or otherwise. This final issue marks my departure from the publication itself, but not from the overall mission. I offer my greatest gratitude to you for reading the Spring 2026 edition of *The Medical Humanities Journal of Boston College*.

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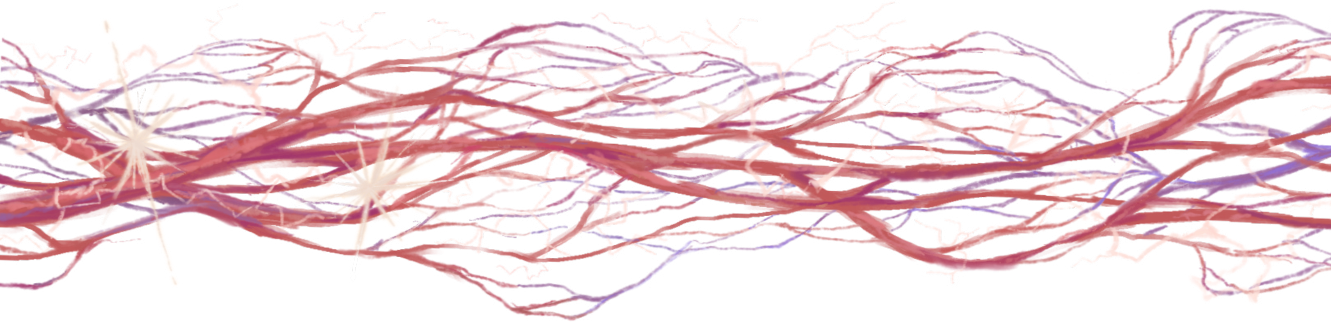

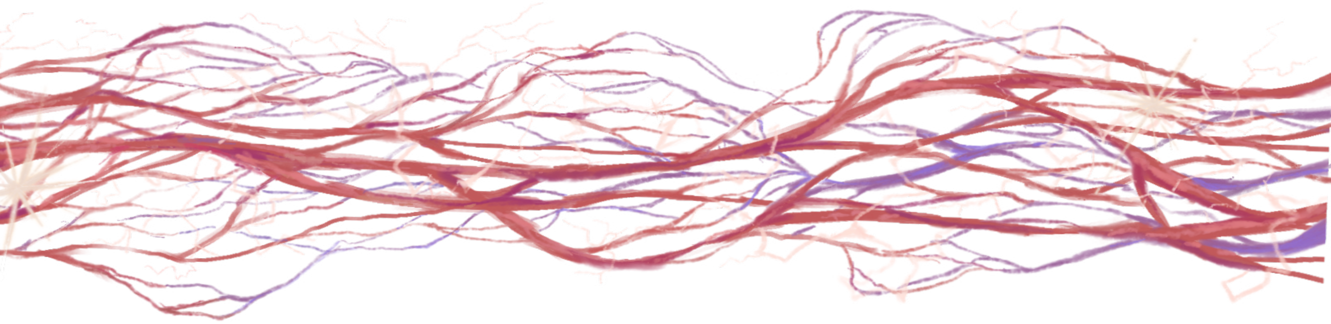

Countdown

JESSE JULIAN

Jan. 2nd.
Counting down ’till
liftoff no room
no air he’s strugg-
ling to squeeze thr-
ough the claustroph-
obic aisle betwe-
en such a tight fit
row upon row upon row
of sweating sardines his bo-
dy pinched pulled
pushed and pushed
past chairs and arm rests mea-
suring his worth
I’m sorry. I’m so sorry,
he apologizes
for taking up space,
I need to catch my breath.
His last words to his son, hands on his back
forcing him through the aisle until he nosedives and crashes.
The crowd erupts: *Is he actually dying? What’s going on?*
Under blinding pearl lights, a sterility ironic for anywhere-but-the-hospital,
we've become a shooting star to wish upon in the 1 a.m. sky of Columbus, OH.
Do we have a doctor on this plane? A nurse? Anyone know CPR? We need volunteers!
One two three four five six seven eight nine ten eleven twelve thirteen fourteen fifteen sixteen seventeen eighteen nineteen twenty twenty-one twenty-two twenty-three twenty-four twenty-five twenty-six twenty-seven twenty-eight twenty-nine thirty—thirty minutes of CPR.
Did he really die?
I ask my mom.
She answers.
I watch them hoist
his body, up, off
His family in chaos,
pacing,
their screams still
frozen in my head
Their flight home or away
a day after New Year’s
Now no years, days, hours, minutes, seconds remain.
The grief stands by on the runway, delaying departure. I haven’t left
that runway. I still hear the cruel counting
compressed in his chest where they
pushed, and pushed,

Bolting the Frame

CHARLOTTE CAINE

I spent the car ride lying sideways, different doses of hydroxyzine and gabapentin slowing the ride. It was fourteen hours between Maryland and Wisconsin. My whole body felt knotted under my sternum, loopy and tight. It was the first time I had ever really been unbuckled in a car, head on my bag, shuddering from stop-and-go traffic. I remembered my parents' stories about squeezing in the back of a van in the '80s, card tables between them, seatbeltless. The night before, I had loaded up my dad's old iPod nano with music, a roundabout rejection of the hospital's no-technology rule.

We got there an hour early and circled around the lake twice before stopping at a Kwik Trip. I practiced the name of the town under my breath, exhaling "Oconomowoc." For the weeks before, lying alone in my bed felt like being smited: lightning hissing from collarbone to ankle. Then my parents told me the OCD and Anxiety Residential Treatment at Roger's Behavioral Health Hospital had a bed for me in three days.

"I can't possibly make it to Wisconsin. I can't even make it down the driveway without having a panic attack."

My parents sat at one end of the bed. My face was pressed into the mattress. I'm surprised I was intelligible.

"That's the whole reason we think you need to go. This is really the only place that specializes in anxiety."

"That cannot possibly be true. There's no way the *only* place is in Wisconsin."

I heard my dad exhale.

"You'll have to call an ambulance if you want me to go to a hospital. I'm being practical, Dad. I can't make it to Wisconsin."

"This is the only option. This is what you've been recommended by doctors, and frankly, Charlotte, it's our recommendation, too. This is what we think is right—"

"You don't know what's right! You don't know how this *feels*! I—I can't even *stand* I'm so sick, I—"

My mom sat up. I felt the bed shift.

"You're right. We don't know, we can't know, we just have to trust what we *think* is best. You need to trust that, too."

I realized I had no choice. I realized I had no fight. I cried until my eyes and lips swelled to three taciturn lines. I'm still not sure how I made it there, but I know I did it silently, unforgiving.

I thought my time at the hospital would be an extended collapse. I could picture my dad's foot rolling me across the threshold, falling into a bed and emerging months later. Really, most of the arrival was logistics. Clipboards and pens on strings. Even after I was admitted, the stay was shockingly bureaucratic: mostly paperwork and waiting. I was either answering a questionnaire or getting my vitals taken.

Saying goodbye to my parents was sudden and bloodless. My mom only became frantic when she realized she had misplaced the bag with all of my toiletries. I walked forward, shampoo and conditioner-less. HIPAA prevented them from following further, so they turned around.

Danny, a mental health technician (MHT), took me straight to the more clinical section of the facility. He had on two-toned yellow Converse and a pastel striped shirt. As I answered questions, I noticed the Converse charm attached to his badge, a shoe that could fit in my palm.

“Ankle or wrist?” asked Stella, the MHT who took over my intake when Danny was called away. I hadn’t heard of a beacon until she held it up.

“It’s not a tracker. I mean, it logs where you are, but only if you’re in a certain range. Only like, from here to the lake.”

I didn’t know how far the lake was. I asked: “What do people normally do?”

“Oh, it depends on the patient. Some people think it bothers them less when it's on their ankle. But it’s really whatever.”

“I’ll just do my wrist. Thank you.”

I learned that every fifteen minutes, one of the MHTs would have to log visual confirmation of my safety into their iPad. As my stay progressed, this window would turn into thirty minutes, then an hour. I would soon grow used to an hourly click of the door throughout the night, a shadow padding over, peering at me.

The bed was low to the ground, heavy like it was already bearing weight. Stella put my suitcase onto the mattress.

“I have to make sure you’re not smuggling anything in here. Ha. Um, you can just show me everything, shake it out a little. I don’t want to put my hands all over your clothes.”

I took out each piece of clothing carefully, unfolding each tank top and t-shirt, holding it up like I was selling it. I grabbed my underwear last, loosening each balled up pair. The new band on my wrist shimmied, the too-long tail cutting through air. The small tracker was thick and plastic, like an anti-theft tag. She took my bag of “sharps”—chargers, nail clippers, and my notebook with its wire spiral. She told me we could trim the wristband later; the scissors were with the rest of the sharps. When the door closed, I slid the pile of clothes off the mattress, dropping them into the shallow drawers at the foot of the bed. Each surface was smooth and inflexible. From the window, over the second bed, I could see the corner of the lake, a fire pit on a chalky patio, and a hill. The sky was coated in smoke. It was July of 2023 and wildfires choked the air, the sun a red puncture wound in the grey. The air conditioning was sterile and sharp, blowing persistently from a vent near the ceiling. I walked through creaking hallways, and it felt like each footstep was in sand, leaving an impression.

I noticed that all of the picture frames were askew at different, random angles. I pushed one with the tip of my finger and it didn’t budge.

That first night, I squeezed the travel-sized body wash Stella had found into quarter size dollops. There was a smattering of single bathrooms, with a shower, toilet, mirror, and sink. There were no hooks on the wall and there was no lock on the door. I wrote my name on the whiteboard outside. I rested my towel on the sink counter. I rested my head in my hands in front of the mirror.

When I returned to my room, I curled into the peeling wall, pressing the thin comforter into my damp hair, covering my eyes with the blanket. My roommate, Lena, was silent. She had turned on the LED lamp attached to her bed towards the ceiling, training a spotlight on the curtains. The bright circle allowed me to consider what it might be like if she started performing shadow puppets. I had overheard that she was having trouble with her insurance. I soon learned that most people were having trouble with their insurance. There were about twenty-four patients at any given time, with turnover every week. Insurance tended to dictate the length of most stays: some people would be kicked long before their recommended discharge date.

Group D, when I arrived, was made up of Maddie, Bryson, Dylan, and Max. Maddie had been there for four months and seemed to be in a slightly different category than the rest of us. She was in her late thirties, she often ate alone, usually yogurt, and was allowed to scream and be late in a way we weren't. Bryson had been to the hospital three times over the course of his childhood. This time, he had been there for about a month. He referenced his stays at the hospital, especially as a kid, like it had been a sort of summer camp. Bryson loved the art therapy room and was distressed by profanity. He might've been twenty-four. Dylan had been there for about three weeks. He cycled between two graphic t-shirts, both related to Mario Kart (which he deemed his favorite form of vehicular manslaughter). The custodian had a soft spot for Dylan, which was surprising considering the way his stuff slumped into the hallway. Dylan was eighteen—the youngest you could be—and from Ohio. Max, who was in his late twenties, had driven himself from Washington about three weeks ago. He lamented the limited access to social media: he had two Snapchat accounts, "one for the hos, and one for the bros." We all met every morning and evening, then cycled through daily activities together. Each day was some combination of group therapy, individual therapy, psychiatry, exposure therapy with a behavioral specialist, art therapy, and experiential therapy. Once deemed low-risk, you could go on community outings.

My first evening, Stella was the MHT facilitating our group. She wore all black, down to her combat boots. Selena Gomez winked at me from her t-shirt.

"Okay. Who wants to start?"

Max raised his arm, swinging it up from his body. The gesture that made me feel like he was the type of guy to refer to a teacher as "teach."

"Anxiety 5, Depression 2."

Max went on, telling us about his day, and reading tallies out from a tiny black journal, called a Ban Book. Inside were the behaviors that he was prohibited from performing. Each patient had to mark down each time they had either "resisted" or "submitted" to the urge to perform the behavior. These behaviors ranged from hand washing to apologizing. He then read out the numbers he gave to each trial for his assigned exposures, which were rated before, during, and after.

"Blood, 6, 5, 3. Meat, 4, 3, 1. Um, the fake diagnosis didn't really work for me. And I didn't have time for the name calling."

I was both curious and entirely disinterested. I was too caught up with my anxiety, and too confused by the terminology, to really invest in what was going on. But, I still cared about my first impression—and I've always hated not knowing things.

After Max finished, with Stella writing notes as he spoke, the rest of the group went.

"Okay, Charlotte," Stella started, "your turn. Start off by rating your anxiety and depression on a scale of one to seven."

"One to seven? Not like, ten?"

"No, we do seven. Seven is the worst."

I looked at her. "Why?"

"The scale is on a handout in your binder."

"Oh, okay. I'm sorry."

"Just say whatever feels right."

"Um. Okay. Hi guys." I paused. I looked at the TV on the wall. Roku City strolled by. "I guess because it's my first day, anxiety is like, probably, a six? And depression is like, um, a four."

Stella scribbled as we sat, waiting. "Okay! Great!"

The first days were a weird mix of highly processed and vaguely unstructured: I had been woken up at 6am with urgency, taken to get my blood work, to do drug and pregnancy tests. I filled out online quizzes, paper forms, and spoke to every sort of employee. It was only 11am by the end of it. The rest of the day I sat on the back porch, my eyes stinging from the smoke.

Putting together a bunch of people with the same relative severity in their mental illnesses is a dangerous game. Some particularly narcissistic men treated it like a dating pool. The treatment team was allowed to "ban" people from being in the same room unless it was a room everyone had to be in; close relationships, even friendships, were prohibited. I witnessed some screaming, dangerous breakdowns. Within three days, there were two code yellows. I was told secrets that I still don't have a place for; disastrously traumatic stories so private I feel guilty for remembering them. The treatment itself was painful, too. Exposure response prevention took up most of the time. My task was essentially to trigger as many panic attacks as possible. Some exercises were physical, like sprinting down a trail, spinning in a desk chair, or forcing myself to hyperventilate. I had a plastic timer and a spreadsheet to track every exhale.

After I had settled at the hospital, maybe four weeks in, an MHT would tap my shoulder and I would follow them to the red van, sliding open the back door. My phone, wallet, and water bottle would remain in the main office, and I would sit in the backseat, blindfolded. After driving, cutting through backroads, around roundabouts, or merging onto the highway, the old car would jerk into park. It was a relief to be released from the stale sound of air conditioning and passing pavement. I would have no sense of how far I was, or when the car would return. I was left by grocery stores, rest stops, and small clusters of town centers. Sometimes an MHT would be back ten minutes later, and the drive I thought was twenty minutes was more like five. Other times, I would cup the curb with my hands for forty minutes, sitting on the side of the road, thirty minutes away from the hospital. I would walk through the grocery store and consider stealing a plum. I knew I was too anxious to eat, but I appreciated the novelty, the image of sliding back into the car purpled and grinning.

They targeted our specific fears with such creativity that it neared mockery. Walking through the hallway, I would see Max with his fist in a package of raw meat or pressing his face to the floor. Kallie, a patient with social anxiety, would have to prank call restaurants. Hearing Max complain that all he wanted was Applebee's, she called every restaurant of the chain in a fifty-mile radius. After cautioning each employee against letting a man named "Max" in, she was asked if he was a safety concern.

It was troubling to articulate the humor of our circumstances to our families and friends. We *were* safety concerns, but there was a particular absurdity to it all. We would go fishing most nights, guided down to the dock at the edge of the hill. Under the sweep of trees shrugging towards the smooth-rocked river, I had to hook all of the bait. I was one of the few patients without contamination OCD; sometimes, people had to touch the worms as exposures, but more often, I was up to my elbows in dirt and Styrofoam. It was a strange picture. Me, in one of the few t-shirts I had brought, ankles off the dock, splitting worms on the hook and passing out rods. We organized talent shows, where Calvin crooned an a capella version of "Hallelujah". It was delightful to clap for Tom's "Danse Macabre", or Jack's precise bird whistles. At the weekly bonfire, Steven showed up with a DJ set one day, pumping out techno while we stared silently at the flickering between us. Those in SURGE (the group therapy for substance abuse) had an unspoken social capital: the popular kids within our small group. When I asked my "psych ward bestie," Catie, if she thought we would be friends outside of these circumstances, she answered:

"Maybe if you did a line."

When she left, she gave me her bottle of ketchup and her big soft towel.

For most of my life, going almost anywhere left me sunken into myself. Heat would roll down my body in torrents, thick, sweating palms would twine around my throat, my stomach, hands over my eyes, fingers tapping. The walls would swell, tiles tessellating into reaching patterns, everything too close, every person too far away. Torpid and frantic. All I could see were exit maps and excuses.

It was difficult for me to get support because I had trouble displaying my emotions. Here, you got the most help the more visibly you were hurting. With the constant turnover and the looming threat of insurance dipping out, time was vulnerable. You had to be vulnerable within that time. Those who cried in the hallway or screamed before entering the car often had more hands-on support. When I ran into a Starbucks bathroom sobbing during my first time off-unit, I felt like I had to walk out with a sheepish smile. Even though I had wiped my tears, it was shocking to see the MHT, Tess, ordering a latte. I felt like I could only ask certain people to take me on exposures. When some of the more arrogant MHTs were working, I knew I couldn't get much done. The MHTs who thought of themselves as more serious, as more central, saved their time for those with public outbursts. Over the course of my stay, I was told that many of the MHTs had been patients at some point. I learned this in whispers, like it was gossip, but by the end of my treatment many of them had told me directly. At first, I wondered if they were looking for themselves when they waited for a sudden release of emotion.

So much was dependent on individual personalities. I felt dismissed and desperate to somehow bridge the gap between what I was feeling and what I was showing. My behavioral specialist, Dylan, wanted the same; I began having to mark down every time I was masking in my Ban Book. Scrawled and sharp, I would streak black tallies into the palm-sized composition book whenever I wasn't genuinely presenting the emotion I felt. I read this out each morning to Group D.

Being told I had to do something worked for me. Dylan, with her tight curls and set jaw, would tell me that she didn't care whether or not I felt ready to try a new exposure. I sat in the passenger seat of the Ford. She sat in the driver's seat, impassive and unimpressed. I tried to smile, chatter, to nudge her with a joke. She said: "I'm not sure what you're trying to accomplish right now."

At first, I thought, maybe, people weren't helping me because they didn't like me. It took me six weeks and many tallies to grasp why Jordan really looked at me with such flat disapproval.

One of my days there, I walked the trail, leaves matting into the tread of sneakers. As I moved forward, three cranes approached, triangulating straight towards me. They bobbed forward, small lunges, until we faced each other. In a tight line, they stepped to the side, returning when I passed. It was startling; it felt like social convention, uncommunicated roles. How did they know what to do? How did they know how to tell me?

By the time I returned to the backseat of my parents' car, with all the other patients by the rounded oak entryway, waving until the car pulled out of sight, I understood. Each patient looked to each other to negotiate the limits of themselves. What did we have in common? Our scale was each other; every time one of us fell into a distressed rambling, into a solemn shut-down, we compared, we evaluated our progress, we hoped for difference. At the same time, my pain had to be exceptional to be possible. I convinced myself: I could not feel this awful if it wasn't some sort of maximum. It took many quiet moments of kindness to realize all of us felt this way.

I remember running into Jack, another patient, at the end of the trail. I was jogging around the mile long path, down to the thin land bridge between the two shallow lakes. Jack was sitting at the sunken bench where the path turned. We both had a safety clearance high enough to let us be on the trail alone: signing out, telling an MHT, and returning within the hour. Even still, no one was supposed to be together without supervision. Cautiously sitting on opposite ends of the teal bench, absently tearing strips of paint off the metal with our fidgety hands, we told each other about how a panic attack felt for us. We staggered our walk back to the unit, but for the first time, I felt like I was truly with someone else.

Catie, who had arrived about two weeks before me, had suffered the Target trip first. The unit split: half of us went on the supply run on Tuesday, the others on Thursday. As an exposure, Catie and I were required to go on both trips. Before I was considered safe enough to go, I had watched the groups leave and return to be metal-detected and bag-checked. On Tuesday, the first time I was supposed to get into the van that was spilling with patients and snack lists, I could barely get myself to leave the lobby. I found some shadow to sulk in, hiding, knowing they wouldn't wait for me. Then, Thursday, I sat, buckled into the passenger seat of the van. Catie, who usually called shotgun, sat right behind me. She reached forward, arm pushing the seatbelt to the side, and put her hand on my wrist. For us, the automatic doors sliding open weren't a freedom. Patients spread out across the superstore, gripping the cutting plastic connecting soda bottles, arms overflowing with overinflated bags of chips, ready to stuff their corner of the communal fridge. Catie and I moved cautiously, separately, like we were learning to walk.

It was in these moments, on two edges of a bench, a hand under the seat belt, that I realized their comfort wasn't just kindness—it was recognition. There was a lot of loneliness. Being there meant absence from work, from family, from routines of self-preservation. It was a hard choice. A clinical incision over the throbbing of our lives. Our diseases tended to separate us from the world, from other people.

There was a lot that felt contradictory about the hospital. I had to cause myself pain to believe I could survive it. Pressing the outlines of my fears, testing the contours, I had to learn where my panic disorder ended and I began. All of us had to learn to bolt our frames crooked; to sit with our uncentered selves.

Time of the Month

BENJAMIN HURLEY

Not feeling great,
Dragged down by my mood;
Could try to see him,
But I think I would intrude;
Could talk about the pain,
But my words aren't really valued.

Every time I see him,
He silences my symptoms;
"Darling, you are fine,
It's just that time of the month."
But as the pain intensifies,
I can't bring myself to visit again.

The next thing I know,
I am falling into his arms:
My face as pale as powder,
As I lose my womanly charm.
My vitals are declining;
The Doctor can no longer silence my
alarms.

Now that I have reached the
imperative, I finally found the answer:
To all of my friends and daughters,
My time of the month was cancer.

Caffeine Abuse

BRADFORD CONNER

Alcohol Markers on Paper

DNR

NICK HUEMPFNER

Not hesitating exactly, but standing there,
with gloves on my hands, my hands
already sweating, the sweat
making it harder to trust
what my hands know
to do.

I am standing over
a man lying dead
on the floor—not maybe
dead or mostly
dead, I mean done,
I mean the kind of stillness
that doesn't need
confirmation, the kind
you feel in the air
the moment you enter
the room. The kind
I am programmed to fix—

except I am not
fixing it yet,
because fixing
starts something, and starting
is the part that can't be
undone.

Behind me, the family tears
the house apart. The clock
ticks. The man
stays dead.
They are looking for a paper
that says he wants
to stay
this way.

The wife swears
it exists, and I believe her.
I do. But belief
doesn't matter
unless it’s written
down.

With every passing
second, the man becomes
more dead—an irreversible
dead that my compressions
won’t fix. I know
this. What I am choosing
by not acting. Still
I wait.

The family begs me
for more time. The son swears
at the drawers he empties,
cold sweat slipping
from his brow
onto old magazines,
forgotten birthday cards
spilling
onto the floor.

The daughter shuffles
papers on the bureau.
His name
caught on her lips,
as if the search itself
is keeping him
here.

I check a pulse
again, my fingers grazing
the hollow
of his neck—
buying time,
giving my hands
something to do,
an excuse to believe
there is still a decision
waiting,
while a man lies dead,
very dead,
and I have no proof
this is what he wanted.

And why not say it plainly:
I could break
his ribs right now.
I could do
what I was trained
to do.
I could turn
this living room
into a scene that looks
like effort,
like care,
like hope—
even if it ends
the same way.

Or I could wait,
because what if the paper
exists,
folded wrong inside a book
no one's opened in years.
What if starting
is the real
violation.
What if the only thing
he asked of us
was this—
to let him stay
like this.

So there I am,
standing over a dead man.
My training telling me to act.
My conscience telling me to pause.
The family telling me to wait.
The man telling me
nothing at all.

All that’s left
is to watch the man
his body cooling on the floor
while everyone panics
over ink and signatures,
while years of training
sit itching
in my hands,
counting the seconds
I was trained to steal back,
growing more uncertain,
as the man grows more dead,
knowing that whatever
my hands do next
will shape the silence
that follows
me home.

Trypanophobia

MALIA ROBINSON

The intrusive scent of alcohol,
the nauseating metallic disinfectant
that hangs permanently in the air
and pierces me as if
it is already wiping down my skin
and chilling my arms
in preparation for the slicing of metal,
the prodding of a needle,
the instantaneous bite
that holds my mind as a helpless captive.
The air waits,
with an unpleasant cleanliness
as I pretend I'm feeling fine.
Is it too hot in here,
or too cold?
Am I shaking?
Am I sweating?
I'm not five years old anymore,
so I pretend
I'm feeling fine.
If I cover my nose
I won't be able to smell it
but I'll still be able to
feel it.

you said,

JESSICA HWANG

it's like an egg—
my head.

not round,
more like something cupped in two hands.
something delicate you're supposed to carry carefully
down hospital corridors
that smell like bleach and warmed plastic.

you grinned when you said it.
like it was a joke you'd already practiced.

if it cracks,
does it leak?

the monitor answered instead—
the thin green line
stitching you to the present.

earlier that day,
a doctor closed the door
with too much gentleness.

four months.

the phrase floated between us
like dust in sunlight.
visible, yet
untouchable.

outside, traffic kept moving.
a bus sighed at the curb.
somewhere a dog barked
at something it couldn't see.

four months
is long enough for seasons to shift.
long enough for hair to loosen in the shower drain
long enough for a boy
to memorise the ceiling tiles above his bed.

you pressed your fingers to your scalp.

if it's an egg,
then something's growing, right?

I didn't know
whether you meant the tumour
or yourself.

Doxorubicin drips in quietly—
blooming red beneath your skin,
passing its own verdict.

it moves through you
searching for what shouldn't be there.

it doesn't ask permission.
it takes what it finds.

some of it is wrong,
some of it is you.

you close your eyes
when the nausea comes.
open them again
like someone testing a door.

I once learned
that an egg only breaks from the outside
if it's the end.

from the inside—
it's a beginning.

they said four months to live.

you tilted your head.
and went still.

or four months
to hatch.

you don't say it loudly.
you don't need to.

there is something fierce about
the way you hold still
while the medicine enters you.

something stubborn
in the small pulse at your throat.

the shell is thin.
we both know that.
but so is the line
between prognosis
and defiance.

later, when the lights dim
and the hallway quiets
to a soft mechanical breath,

you whisper it—

watch me.

and for the first time,
I realise—
eggs don't choose to be fragile.
they split
because something inside
refuses
to stay small.

Eating Disorders Anonymous

ANONYMOUS

It has been four years since I walked out of the eating disorder unit at UCSF Benioff, but on a hard day, I still crave skipping breakfast like some crave scotch on the rocks.

The lie about eating disorder "recovery" is that you never fully recover. I am far better, evidenced by my full sugar lattes (yes to whole milk—*no one* can convince me almond tastes better) and ample snacks I always have on hand. My friends know I am the go-to person when they want an enabler for their Tonight Dough addiction, and I *have* been known to shamelessly take down half a pint in a night. But recovery, like most things in life, is not a perfect black-and-white label. Oftentimes, I still go to bed, haggling like a tourist purchasing an "authentic" Peruvian sweater from an American street vendor: I'll just skip breakfast, I just won't eat after dinner, no, *just* my morning coffee, desperately searching for the 20% off that demands far more effort than it is worth.

I have come to terms with the fact that stray thoughts will always push for my attention. The temptation to skip a meal follows me on my walk to dining halls, reminding me of all I have to lose—pun intended. Which actually brings me to my other point. Recovery gave me, in my opinion, prime joke material, though I will concede that it takes the right audience.

In the hospital, my dad left on *My 600-Pound Life* for twenty seconds when he was changing channels on the TV. My mom, appalled, quickly made us turn it off: "My *gosh*, Jon, they're going to think we are *encouraging her*." Her horrified face, mixed with my dad's attempt at an innocent expression, and my knowledge that my parents were the last people to play a role in my disorder, had me falling over in bed, cackling. It was the hardest I had laughed in weeks.

At risk of making this a psychoanalysis of my past, present, and future mental state, I want to linger briefly on what led to my decision to cut out some of the best foods modern humans have invented. For six months, I went entirely vegetarian, ate dry, mayonnaise-free sandwiches, and accumulated a depressingly repetitive list of Google searches, including, but not limited to, "one only m&m calories" (Seriously? Who was this person, and what did she do with the girl that preceded her?). Thanks to thousands of dollars of therapy, because insurance doesn't always have its priorities straight, I have concluded a cause: I am a perfectionist. I *love* for things to look perfect. Because, if they look perfect—if *I* look perfect—I must have the perfect life too, right?

In April of my sophomore year of high school, I decided to download MyFitnessPal and restrict my calories to a plan that allowed me to lose two pounds a week, a 1000-calorie deficit. I have always been at the heavier end of my age group, and though I was considered healthy at every doctor's appointment I went to, I had a goal: lose 15 pounds. If all went well, which it seemed to at the beginning, I would be able to revert back to ice cream and pulled pork sandwiches by the end of June.

After three weeks, I was sitting downstairs with my brother while he played Madden, in a rare twenty minutes of peace between him frustratingly arguing with the TV and a hollered reminder from a parent that it was late, he had homework, and we *needed* to enforce rules about "that thing."

Eyes glued to the screen, he said, “Mom’s worried about you.” It was the first I had heard of the matter. It was also the first time the thought that this could be something to worry about had crossed my mind.

“Why?” I replied.

“You’re trying to lose weight. You don’t need to lose weight.”

I have replayed the moment that follows this in my head countless times. In the depths of my eating disorder, during recovery, and in the years since, I have been angry with myself—was it ignorance that led me to the point I ended at? But it has also helped me sympathize with the people in my life who didn’t understand the magnitude of what I was grappling with.

I turned toward my brother, scoffed, and said, “I’m not gonna get an eating disorder, Charlie, I’m not *stupid*.”

Okay. Pause. I no longer think this, obviously, as I believe that my intelligence (along with my humility) is incredibly high. However, I include this anecdote because there is a prevailing belief that anorexia is fundamentally an issue of a person’s vanity overriding their desire to eat. In other words, I knew that I did not want to be skinny badly enough that I would put my life at risk for it. But, at a certain point, it is not about your desire to eat in the same way that it is not about a smoker’s desire to spend less money on Marlboros, or an alcoholic’s desire to enjoy a sober night. Which brings me to the other thing they don’t tell you about recovery: anorexia is an addiction.

In an effort to understand more about eating disorders after I recovered, I spoke with Dr. Haleh Kashani, a psychiatrist who has been working with eating disorders through one-on-one counseling since the early 2000s. In an attempt to disentangle the social narratives, the clinical diagnosis, and my own personal experiences, the first question I asked her was: “What is anorexia?”

She explained that anorexia is a severe restriction of caloric intake in an individual, often as an emotional coping style in those who already have a predisposition to this type of extreme-control emotional regulation. Anorexia thrives off of perfectionism and the routines and rules someone sets for themselves regarding food and exercise. It is, in other words, a disease that develops out of the very things we praise each other for in our society. It’s the girl with straight A’s who goes from being “well-disciplined” in school to “motivational” in her exercise routine. It’s the guy who wants to eat healthy in the new year, so he decides to impose a strict, one-dessert-a-week rule that slowly becomes an anxiety-ridden mandate.

After that, the details get more gruesome, so I will spare you most of those. However, to exemplify the humility I just spoke of, I will include some of my less flattering moments. Consider this like step 5 of AA: I’m admitting to another human being “the exact nature of my wrongs.”

Once, on a vacation, I yelled at my grandma because she accidentally brought home a chai latte rather than a regular one. Ah, the lovely actions that come out of being hangry and deeply insecure.

I ran ten miles despite the fact that I had three-inch blisters from the ball of my foot to the heel, on both feet.

On my birthday, I cried in my room after my parents surprised me with a Jimmy John's sandwich, one of my favorite meals, because I hadn't accounted for that being part of my birthday dinner, and I didn't know how I was going to eat that *and* a salad (don't even get me started on the bundt cake that followed).

And, the worst sin of all: in an effort to pack small lunches, I used to be that girl in the cafeteria who brought a hard-boiled egg to school. You know the one. Where you're sitting at lunch, enjoying a conversation, and all of a sudden you're hit with an absolutely unmistakable smell, and *gosh*, what *is* that, and oh, you turn around, and there she is. Unassumingly, unashamedly, eating a hard-boiled egg in public. I know, but I had to save the worst for last.

Eventually, my saga had to end. I went to my annual physical to get cleared for fall sports, and the doctor did a double-take when she saw my heart rate. She thought the machine was broken, so she tried again. Then, she ordered me an EKG.

When you're severely under-eating, your body begins to adapt to the lower energy intake as it tries to preserve calories and doesn't need to work as hard to burn them. My resting heart rate, for months, had been slowly dropping, but until that appointment, I hadn't put much thought into it. A few days later, my EKG results came in. My mom drove me to the hospital that night.

The first thing the nurses did when I arrived at the hospital was give me a chalky, vanilla Boost shake (they were sorry, as they were out of chocolate). They then said that I would have to drink those every day for every meal unless I ate real food. They did not have to tell me twice. With that, my recovery started.

I was in the hospital for eight days. Every day, I woke up for the first time at 6 a.m., when a nurse checked my vitals, then again around 7:30, when I was given breakfast. At 10:30, I got my morning snack. At 12:30, I was given lunch. At 3:30, an afternoon snack; 6:30, dinner; and 9:30, an evening snack. Each meal, I got a beverage, usually juice, but occasionally I got vanilla-flavored milk, which was always a treat. I had 20 minutes to eat meals and 15 minutes to eat snacks, supervised by a staff member on duty. I was given no say in what I would eat each day, which I actually kind of enjoyed because they brought out my tray with one of those silver coverings that you see in Tom and Jerry, and I would always be like: *ooh, what's this gonna be?* I felt like a rich Victorian woman delivered an ornately presented plate of French toast.

I also found out, to my great horror, that I was not allowed to drink coffee while I was in the hospital, as it could falsely inflate my heart rate. My caffeine addiction has a greater chokehold on me than the anorexia, clearly, and this actually probably factored in a great deal with my speed and commitment in leaving the hospital. They couldn't even give me decaf! Believe me, I asked.

I got to leave the hospital when my heart rate stayed above 45 bpm for a full 24 hours. This is the legal requirement, and I'm sure my mom was thankful not to have to sleep another night on a hospital cot next to me, awakened every time my heart rate monitor fell off as I slept.

However, despite the infinite coffee that awaited me at home, I had conflicted feelings about leaving the hospital. UCSF had become a sort of rehab for me. The stressors of life were nonexistent; I had no autonomy to choose my drug of choice, even if I wanted to, and the reality waiting for me outside the doors was too overwhelming to think about. I walked out with my mom into her Volvo and crossed the Golden Gate with a pit in my stomach—along with a whole lot of food.

At home, I got to skip school to continue my full-time job (eating) and my part-time hobby (reading any book that I had not already finished). I ate thousands of calories every day. The perk of this was that I was at the peak of my recovery at Thanksgiving time. Now, I normally throw down quite a bit at our Thanksgiving dinners, but I will have you know that the sweet potato casserole had officially met its match that year.

And then, that was it. I had gained back all of my weight. My heart was in a healthy range. I went to see a therapist every week. Eventually, slowly, I started to be allowed to go on walks, then bike rides, and finally runs. I even started to eat meat again, which was probably the best thing to come out of all of this. Re: Thanksgiving turkey.

And yet, I still craved it. I knew that it was ridiculous, I saw where it had gotten me, but I also knew how good, albeit brief, the high was when I would enter my day's calories into MyFitnessPal, and my little blue circle had not yet been completed, and it would tell me in three innocent numbers how many calories I *hadn't* yet eaten. I loved it. And sometimes, most times, the Thanksgiving turkey simply didn't taste good enough for those thoughts to go away.

In my conversation with Dr. Kashani, she told me that an "eating disorder is a condition with a tendency for relapse," often triggered by major life changes. In her work, she sees college, children, menopause, moving to a new place, or making friends often triggering those with histories of eating disorders to relapse. The lurking threat of anorexia—or bulimia, binge, or any other eating disorder, for that matter—as a condition with a tendency to strike a second time is far from a comforting thought. Like, are you kidding me? Amongst the other things I'm told I will face from the post-partum and menopause horror stories, I now *also* have to make sure I'm not relapsing? Is the whole pushing-out-a-baby part not hard enough on its own?

As I distanced myself from the emotional pulls of anorexia, I became more interested in its neuroscience. My mom had coped with my time in the hospital by reading my dad and me articles about anorexia, attempting to understand my irrational fear of weight gain that was literally eating me alive.

It's addictive, she told me, l*ike self-harm. Not eating is addictive.*

In the years since I recovered, I've also spent a fair amount of time researching this phenomenon. I was—and still am—fascinated by the way the disorder took over my life, and it was validating to discover that not only was this not unique to me, but it was also something that scientists have been looking into as having a possible neurological basis. A 2015 article in *Current Drug Abuse Reviews* emphasizes how anorexia both behaviorally mimics and is linked to substance addictions.

"The relentlessness with which individuals with anorexia nervosa pursue starvation despite profound negative physical, emotional, and social consequences is similar to the maladaptive cycle seen in individuals with addiction," and there are other parallels too. Both anorexia and substance abuse emerge during adolescence, "a period of vulnerability for the development of addictive behaviors," and those with anorexia report a compulsive need to pursue the behavior, just like a drug. Like drug abuse, individuals with anorexia will narrow "their behavioral repertoire so that weight loss, restricting food intake, and excessive exercise interfere with other activities," much the same as how individuals with addiction forgo other responsibilities in order to obtain and use drugs.

There is also an interesting linkage between substance addictions and anorexia. Comorbidity between eating disorders and substance abuse falls at 27%, and the extent of restriction has been found to be an indicator of psychostimulant use. In the lab, numerous studies that varied in species, drug, and administration all revealed that food restriction also increases the reinforcing effects of drugs of abuse.

We are at a point in society where we talk openly about addictions. Alcoholism runs in my family, and I grew up knowing relatives who struggled with drinking and got sober. I understood, at least to a certain extent, that the fight with alcohol never truly ends. We talk about the age of excessive dopamine hits we are in, in which a 5x2-inch phone has the power of a Vegas casino; Instagram posts, an ante; notifications, a payout. Yet eating disorders remain taboo and tragically common.

I've had numerous conversations with my mom about her experiences and perceptions of eating throughout her life. My mom is from rural Indiana, where she went to a public school in a class of 54 kids. My mom knew of people from her hometown who had lost their lives to anorexia, and she, like many of us, knew of the disorder only from hushed voices and tragic Facebook posts. But I was curious if our vastly different experiences with eating disorders came from our different childhood locations—I was raised in California, after all, and aren't we all supposed to be hot and blonde?—or the times in which we grew up.

I asked Dr. Kashani how she has seen the prevalence of eating disorders change in the 25 years she has been working with them. She said, undoubtedly, their prevalence has increased. Disturbingly, she is also seeing it affect different populations. Younger and younger people, as well as older individuals with no previous history, are developing eating disorders in recent decades. She's also seeing more boys and men in her practice, in an often-overlooked community whose eating disorders are too frequently dismissed as an extreme commitment to the gym and chicken-and-rice.

So, why? How come my mom didn't even notice that fast-food restaurants list calories on their menus, while my friends and I find ourselves basing our orders on that number? Dr. Kashani points to a few reasons. COVID led to a rise in eating disorders among middle- and high-schoolers and created pressure to use the *shelter-in-place* to improve oneself. At the same time, everyone had an opportunity to emerge in a few months and blow everyone away by the new, better person they were. Dr. Kashani said this exacerbated, especially, restrictive eating disorders over bulimia.

Predictably, social media plays a key role. Especially during COVID, our constant online presence allows negative comparison based almost entirely on physical looks. Additionally, our recent societal emphasis on thinness, not only as a sign of beauty but as an indicator of character and personality, has worsened the rates of eating disorders. Think of the widespread association of fat with being lazy, unmotivated, unsuccessful, and our association of skinny with being fit, disciplined, on top of things. We exist in a period of comparison, in a chronically online world, in which the size of our bodies carries a moral weight.

My conversation with Dr. Kashani left me, if I'm being completely honest, feeling a little bit hopeless. It's easy to point to reasons. I could set a line on the number of times my older relatives will say "It's that damn phone" at our holiday dinners, and I will *always* hit the over. And then, just like that, the blame is transferred, and we don't do anything about the actual issue.

People, young people especially, are losing their lives to anorexia. I can—and do—joke, but the reality is that this disease sucks the fun out of life, and then the life out of people. It is not enough to have a week stint in a hospital, pour a few thousand dollars into therapy, and then only mention the fight for my life in the whispered intimacy of a late-night dorm room conversation.

I asked Dr. Kashani about the similarities between anorexia and addiction after I noticed them in my own experiences and read the growing bulk of scientific literature about it. The compulsive aspects of eating disorders, she acknowledged, *are* very similar to drug addiction. However, when someone's addicted to substances, there is a "whole community of 12-steps where people can go say, 'Hi, I'm Joe, I'm an alcoholic,' and everyone claps." With eating disorders, Dr. Kashani said, that doesn't exist. Instead, the judgment and shame that those with eating disorders are met with only cause more suffering, as they fear speaking up about the obsessive thoughts that have a chokehold on their lives.

I'm interested to see what the world would look like if we treated anorexia like alcoholism. I'm interested to see if we could get to a point where the sentence, "I don't make rules around food," is met with the same nod of understanding as "I don't drink anymore." *It's a slippery slope*, I can imagine a mother saying to her children on the way home, who overheard the conversation. *You just have to be careful.*

I have a friend who struggled with various drug addictions and abused alcohol throughout high school. She has been to rehabs all over the West Coast: residential, out-patients, and one in the wilderness of Idaho. She is now sober, in college, despite the desire she has every Friday night for a shot of cheap vodka and a line of coke.

I have a great aunt who, throughout my entire childhood, always carried the scent of cigarettes on her infinity scarves and striped T-shirts. I would lean my head on her shoulder while sitting on her lap in her living room, and would smell the bitter, woody scent that meant I was with my Aunt Clare. She would quietly excuse herself from family reunions and holidays to smoke outside. Now, she ritualistically puts on a nicotine patch every morning, in the same way I ritualistically check my hunger cues throughout the day.

I still struggle with confidence. I still question if gaining weight was *really* worth it. Sometimes, in my lower moments, I try to convince myself I never really even had anorexia, that I have a naturally low heart rate, that I just lost weight too fast. And then I remind myself that *very little* is worth crying over a Jimmy John's #6 Little John or eating a hard-boiled egg in public.

Like any recovered addict, I have a mental list of all the experiences I've had since and because of recovering; I've run half and full marathons, aced exams, gone out to eat at amazing restaurants, bonded over baking with my mom, and cried laughing over Chipotle bowls with my roommates. In an effort not to find the eating disorder part of my life horribly depressing, I try to look at it with gratitude. It taught me to lean on others, and it taught me to let others lean on me. And hey, maybe I'll even start an EDA one day—Eating Disorders Anonymous. I'll stand up in front of a bunch of people sitting in a circle of chairs in a church basement, hands gripping subpar coffee in white cups, and say, "Hi, I'm Anna, and I have anorexia." And maybe, everyone will clap.

References

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On The Other End of Suffering

DOMENIC J. CIAMPA

On the other end of suffering is a world that few will know. As a mental health provider, I hold humans suffering through grief, despair, and disillusionment as part of my daily existence. Whether a young girl with OCD riddled by rituals, an elderly man suffering through the slow death of his life partner, or a depressed student slowly losing their will to carry on, all will share a vague yet universal desire to *stop feeling something*. Something that is undoubtedly uncomfortable, morose, and perhaps threatening to our very existence. Though its specific manifestations are idiosyncratic to each human spirit, its penchant for inspiring distaste and loathing remains universal. We all get the same sense, but if it were not for this most-unwanted feeling, we would somehow be more complete, our lives far richer. At the very least, we might be happy. If you find yourself nodding to this sentiment, then here is where our agreements might end. I have come to term this process as *mental health through exorcism*: the idea that removing unwanted feelings or states of being (symptoms, if you must) is the proper path toward a prosperous existence. Though intuitively agreeable and logically valid, we are struck by the most dissatisfying sense of its incompleteness. In a post-pandemic existence, we are inundated with calls to attend to our health. From corporate campaigns to subway slogans, one is bombarded with reminders (at times even bordering on threats) to attend to our wellbeing; to indulge in a me-first experience and prioritize our mental health. But what do we even mean by *mental health*? To eschew a dry, academic approach, I ask that you pause to reflect on your own assumptions here: how has culture programmed you to think about mental health? Returning to the concept of the exorcism, most of us are inclined to understand mental health as some type of perfected balance between positive and negative; a felt sense that one ought to diminish *bad* feelings and prioritize happiness; a paradigm that seduces one into believing that life is something to be optimized, something that might be achieved through the fine balance of chemical neurotransmitters. While undoubtedly attractive in its simplicity, this model guarantees our collective failure as it diverts our gaze from matters of ultimate importance. If you need proof of this failure, you might be disheartened (or validated) to know that 90% of Americans believe that we are experiencing a *mental health crisis*. Our youth are exceptionally harmed as more than four out of ten high schoolers suffer persistent feelings of hopelessness, and a staggering 22% have seriously considered suicide (Insel, 2023). You might be further discouraged to discover that these changes have occurred in a decade where mental health funding has *doubled* (Statista, 2024).

It is self-evident that a paradigm shift is necessary. I posit here that the Buddha was correct in his assertion that "life is suffering." This sentiment was so profoundly felt that it came to occupy the very first of the four noble truths, suggesting that nothing could be more self-evident. If one looks honestly, it is rather difficult to challenge this given of existence; you and everyone you know will die, tragedy will befall us all with routine frequency, and periods of respite are ubiquitously interspersed by collapse and chaos. These givens of existence urged the existentialists to ask not how one might fall to madness, but how anyone could remain sane under such conditions.

We must recognize, however, that the Buddha did not assert that life is *nothing but suffering*; rather, suffering is the fundamental substrate upon which human experience is formed. So, what are we to do about this? What is it that lies on the other end of suffering? The answer is as old as culture, and perhaps time itself—we have forgotten the ancient cure of meaning as an antidote to suffering. Though undoubtedly leading much more difficult lives than we do today, members of antiquity were buttressed by a meaning that was purposefully integrated into their societies through religious devotion, communal, generational living, and economies structured on service and connection. Once givens of a healthy society, these forces have been supplanted by isolation, nihilism, the worship of technology, and the pathological defenses evoked in their wake. But much like the end of a loving reunion weekend, we are struck with the saddening realization that we cannot simply revert to better times of the past. Here we are reminded of Nietzsche's poignant proclamation: "God is dead… and we have killed him." Far from a triumphant pronouncement, he warned that the scientific endeavor's toppling of the spiritual foundation of all prior cultures would leave us nihilistic and subject to ideological possession with devastating effect. How right he was.

So where does meaning live in a post-God world? Though the answer to this question is undoubtedly more difficult to ascertain, we might turn to biology: the oft-neglected wellspring of knowledge. Swiss psychoanalyst Carl Jung posited that beyond the primitive drives for survival and reproduction, human beings also possess an instinct for meaning and religious experience. This hypothesis was founded on the observation that from shamans to saints, all cultures throughout recorded history have upheld spiritual customs, often elevating spiritual practitioners to the pinnacle of their societies' hierarchies. Stranger yet, we all possess a conscience that attunes us to something like a course of proper action. Though we cannot go into the fittingness of religious truths within a secular frame here (that will have to be a later essay), I think it is necessary to impart Jung's injunction on interest. Jung posited that the path toward meaning and self-actualization is made manifest through our interests. Far from a whim or "follow your bliss" approach, Jung beckons us to cultivate an awareness of the forces that compel us forward, the ideas and problems that command our attention, and the ways of being in the world that make us feel as though the suffering of existence were worthwhile for the adventure. Here, I suggest we might come to know meaning not as a noun but as a verb, a continual act of seeking and attuning oneself to the calling that brings purpose to life. This is simply not optional. In my clinical work with young adults, it is rare that any of them have ever been asked to put serious thought into what their life should mean, who they would like to become if given the chance. This fatal position leaves only the negative meaning of life: the suffering intrinsic to being, without any positive meaning to offset it. The least imaginative among us can envision how this gives way to nihilism, despair, and a bitterness toward existence. So, how far can we take this? The pervasive materialist viewpoint might have you imagine that meaning is a rare treasure afforded to a privileged few, something only available to those with lives of relative ease (we did learn about Maslow's hierarchy after all). But this is simply not the case, for hope lived in Auschwitz after all. History contains no shortage of humans engaging in ethical conduct under the most depraved and appalling conditions imaginable, yet meaning still lives through these dark nights of the soul. Maslow himself never intended for his hierarchy to be a linear process; the popular pyramid depiction came only after business leaders co-opted his ideas. Further yet, we all know this to be true in our own lives, for the specter of nihilism does not discriminate in its arch; those with the greatest material advantage are often the most spiritually dispossessed and devoid of purpose.

Though there is much to be explored in this respect, I fear that I have overstayed my welcome here, and this must happen at another time. But before leaving you, I encourage you to reflect on the ineffable importance of *meaning* the next time you find yourself discussing mental health.

I close our conversation here with a case of a patient I had treated while working with the homeless population of Boston. A suave, charismatic man of before middle age, S presented to our addiction clinic with a near-terminal diagnosis: stage four liver failure. A brilliant bank robber, S had made a name for himself in the underworld, priding himself on being a central player in his community by procuring *top tier* heroin—he himself being a lifelong user. Their identity and framework for meaning became inextricably linked with substance use and the social strata that came with this life. Prior to our encounter, he was called off the waiting list for a liver transplant, an incredibly rare opportunity, but ultimately refused the operation as he was committed to live and die by his lifestyle. Years later, during our work together, a connection of his afforded him another opportunity for a liver transplant—an exceptionally rare second chance. This life-saving operation was contingent on him passing only a single drug test, the surgeons remaining tentatively agnostic as to whether he would resume substance use post-operatively. Yet much to my surprise, S again refused the procedure, effectively consigning himself to death's reach. A man of considerable financial means, social standing (within the hierarchy he chose), access to treatment, and possessing the opportunity to save his own life, S resigned himself to destruction. Is this but a matter of material security, a chemical imbalance, or something more? I leave this for you to decide. Until next time...

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Heartbeat

EMMA SU

Digital Illustration

The Black Maternal Health Crisis: How the Roots of Slavery Haunt our Healthcare System

ANNA HELMAN

As of 2023, the United States government spends $4.9 trillion on healthcare each year, ranking first in healthcare expenditures compared to Japan, the U.K., the Netherlands, and Canada.[1] Despite this, the U.S. ranks among the lowest of the developed countries in maternal health outcomes, a statistic that is only exacerbated for Black women.[2] While the 2023 Maternal Mortality Report showed a decrease in overall maternal death rates in the United States, the disparity only widened between Black and White women.[3] The historical perception of Black women's birth as fundamentally different and extensive victim-blaming has led to the disproportionately high rates of Black maternal deaths seen in the United States today. Physicians and citizens need a comprehensive historical analysis of Black maternal care before the country can truly understand and eliminate this disparity.

The roots of the Black maternal health crisis can be traced back throughout American history to the original perception of Black reproduction in the United States. Medicine, and especially the field of obstetrics, evolved as a system that served the interests of slave owners over enslaved patients. Slaves, seen as commodities, were treated medically as a means to preserve and increase the financial prosperity of their owners. When the transatlantic slave trade was banned in 1807 and 1808, slaveholders became especially reliant on the fertility of Black women. Women were overworked both pre- and post-partum and were often blamed for miscarriages, still births, or infertility when their humanity stood in the way of a slave owner's financial interests.[4]

High rates of maternal mortality were evident during American slavery, though maternal healthcare looked different than it does today. Enslaved midwives and nurses did much of the daily care for pregnant women, but slave owners still relied on White physicians to assist with difficult births and examine cases of infertility and infant mortality. Infant mortality itself was high; 50% of enslaved infants were stillborn or died within the first year. For many of these deaths, enslaved mothers and midwives were blamed.[5] This victim-blaming shifted the onus away from the quality of White physicians' care and the moral weight of slave owners who adamantly favored Black reproduction.

Throughout this time, the myth that Black women did not experience pain also carried a strong legacy. Black women were often operated on without anesthesia to advance obstetric and gynecological experimental procedures at the demand of their owners, further enforcing the idea that their experience with birth was fundamentally

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[1] "Historical," National Health Expenditure Data, CMS.gov.

[2] "World Health Systems Facts," Real Reporting Foundation.

[3] "Maternal Mortality in the U.S. Declined, Though Disparities in the Black Population Persist," Policy Center for Maternal Mental Health.

[4] Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery."

[5] Ibid.

different than that of White women.[6] There were also numerous instances of women dying shortly after they gave birth because they were forced to return to labor due to the widespread idea that Black women did not need as much time to recover from giving birth as White women.[7]

In the postbellum era, a lack of trust in White physicians lingered long after slavery was abolished. During the Jim Crow era, Black midwives extensively provided maternal and infant care, delivering more than half of all Black babies and 80% of those born in the rural South.[8] Black women were encouraged to turn to physicians if they wanted to avoid maternal and infant deaths, though even when they did so, they still faced alarmingly high death and interventionary procedure rates. A study from 1937 showed that physicians made errors with 50% more frequency when caring for Black mothers. Physicians would also often claim that biological differences demanded that Black women required "radical interference much more frequently than whites." When the disparity in maternal and infant mortalities was drawn to their attention, physicians defaulted back to blaming midwives as the cause.[9]

Tragically, the Black maternal health crisis has only worsened in recent years. The same interventionary procedures can still be seen; since the 1990s, Black women have had significantly higher rates of C-sections, supposedly due to pre-existing conditions such as obesity or labor circumstances.[10] However, even controlling for health status, Black women remain more likely to receive the operation. Black women are also more than three times as likely as White women to suffer a pregnancy-related death and are more likely to have birth risk factors that contribute to infant mortality or detrimental effects on the physical and cognitive health of their children.[11] Additionally, the disparity between Black and White infant death rates is *larger* than under *antebellum slavery*—2.3 times higher compared to 1.6.[12]

Different organizations and groups have pointed to varying reasons for the high Black maternal death rates in the United States. The Black Mamas Matter Alliance argues that Black mothers find their reports of pain symptoms both ignored and minimized.[13] In fact, 22% of Black women who have been pregnant or given birth report they were refused pain medication they felt they needed.[14]

As demonstrated, this narrative—that Black women experience pain differently than White women—can be traced back centuries in American history. Originating from the demarcation of Black mothers as physically and culturally different, continuing as a justification for chattel slavery and overworking women both pre- and post-partum, and as a justification for experimental gynecological procedures, the misconceptions of Black women's experience with pain have undoubtedly affected Black maternal care.

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[6] "Black Subjectivity and the Origins of American Gynecology," Black Perspectives, African American Intellectual History Society.

[7] Owens and Fett, "Black Women's Experiences in Slavery and Medicine."

[8] Wangui Muigai, "Framing Black Infant and Maternal Mortality," The Journal of Law, Medicine, and Ethics.

[9] Ibid.

[10] Ibid.

[11] KFF, "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

[12] Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery."

[13] Ibid.

[14] KFF, "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

But attention also needs to extend beyond the delivery room. More than half of pregnancy-related deaths, of which Black people are more than three times as likely as White people to experience, occur one week to one year after delivery, exhibiting the importance of quality access to healthcare beyond pregnancy.[15]

However, Black women are simply not getting access to care in these crucial periods. The Kaiser Family Foundation argues that differing levels of access to health insurance and care, due to social and economic factors, are the main drivers for maternal health disparities between races. People of color are more likely to be uninsured and face barriers to the care needed to support health pregnancies, and other barriers to care, such as access to culturally and linguistically appropriate physicians, present roadblocks. Linked to this, Black women are twice as likely to receive pregnancy-related care starting only in their third trimester or not at all, leading to the very pre-existing conditions that physicians cite as the cause of high Black maternal mortality.[16]

Among women who do have access to care, racism persists in their healthcare settings, perpetuating the feelings of distrust for healthcare professionals that originated centuries ago. In 2020, a report determined that discrimination contributed to 30% of pregnancy-related deaths.[17]

The centuries-long legacy of poor Black maternal care and high infant and maternal death rates is not, however, a hopeless reality of healthcare in the United States. The reform must begin with an acceptance and understanding of the deep historical embeddedness of victim-blaming and the narrative that Black deliveries are fundamentally different, on a physiological, cultural, and pain level, than White deliveries. Numerous groups have already attempted to fight the distrust of, and inequality within, White healthcare systems.

The People's Free Medical Clinics were founded by the Black Panther Party, which used clinics to explain medical procedures in an effective attempt to bridge the gap of medical authority between patients and their physicians, heightening trust and the patient's ability to advocate for quality care.[18] In 2018, New York City proposed an investment of 12.8 million dollars over three years into implicit bias training for healthcare providers, data tracking, and a partnership with community-based organizations to spread information about maternal health in response to the statistic that Black and Brown women are eight times more likely to die in childbirth than Whites.[19] This plan allows an examination of the faults within the healthcare system, shifting the victim-blaming mentality that physicians have held for centuries, and attempting to eliminate the narrative of difference.

Lastly, cultural competency is crucial in addressing the disparity in maternal mortality rates. State licenses and certifications should require proficiency in cultural competence and bias recognition for medical providers and midwives. In a study at the University of Virginia Medical School in 2016, 222 White medical students were asked about their levels of agreement with various comparative statements about White and Black people's physiologies. Half of the students held false beliefs about Black physiology; 60% thought that Black skin was thicker than white, and 12% thought the nerve endings of Black people were less sensitive. Furthermore, there was a strong

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[15] KFF, "Racial Disparities in Maternal and Infant Health: Current Status and Key Issues."

[16] Ibid.

[17] Ibid.

[18] Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery."

[19] Owens and Fett, "Black Maternal and Infant Health: Historical Legacies of Slavery."

correlation between those who agreed with false beliefs about Black physiology and those who rated and medically treated the pain of Black patients as less severe than that of White patients.[20]

These concerning results underscore what Black patients have been arguing for centuries. Women's pain is being minimized and undertreated, leading to an accumulation of distrust in the healthcare system and causing unnecessary distress in the delivery process, all of which can contribute to increased maternal mortality rates. Cultural competency and bias tests hold the potential to address and eliminate these misconceptions that have proven themselves to be barriers to ethical and effective healthcare.

Last month, in November of 2025, a video went viral that captured a Black woman in labor at Dallas Regional Medical Center. Screaming and writhing in pain, Kiara Jones can be seen pleading for a space to give birth while in the waiting room. Hospital staff members, shown in the video, appeared unbothered and did not assist her, despite her cries for help. Shortly after, still in the waiting room, she gave birth to her son. The video quickly gained traction as viewers became both concerned and confused about the quality and lack of care the woman was receiving.[21] Kiara Jones' story disturbingly echoes the outright denial of care for Black patients in the Jim Crow era, which forced many women to desperately seek safe and comfortable places to deliver their children. Clearly, despite the centuries put between the twenty-first century and colonial America, the bias and blatant disregard for Black healthcare remain a prominent feature in the United States' medical system.

Today, Black women remain more than three times as likely to experience a pregnancy-related death than White women, a statistic that is both disturbing and tragically reflective of the racism that rooted itself in America centuries ago. However, with a proper understanding of this disparity's historical foundations and its subsequent modern-day implications, maternal mortality can and should be decreased. It is time to put an end to the racism that has haunted the American healthcare system, from chattel slavery to Kiara Jones. It is time to put an end to the Black maternal healthcare crisis.

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Etiology

NICK HUEMPFNER

We bend over brittle bodies,
eyes like searchlights
combing skin,
our careful fingers
mapping every hollow.

We lift small samples
to the glass—
pale constellations blooming
in our petri dishes.

There it is, we say—
hands already reaching
for the amber bottles,
as if our synthetic answers
and Latin names
could drive the illness away.

But what exactly are we treating?

The tiny microbe
threading through the gut,
or the river
the color of old coins
our patients drink from?

The fever
burning behind the eyes,
or the unpatched roof
that lets the winter in?

Do we ever stop to consider
the patient's confusion
when the prescription reads:

Take twice daily with meals.

What meals?

We have become masters
of the small—
measuring the cause
in millimeters,
tracing its shadow
through cultures
and cell counts.

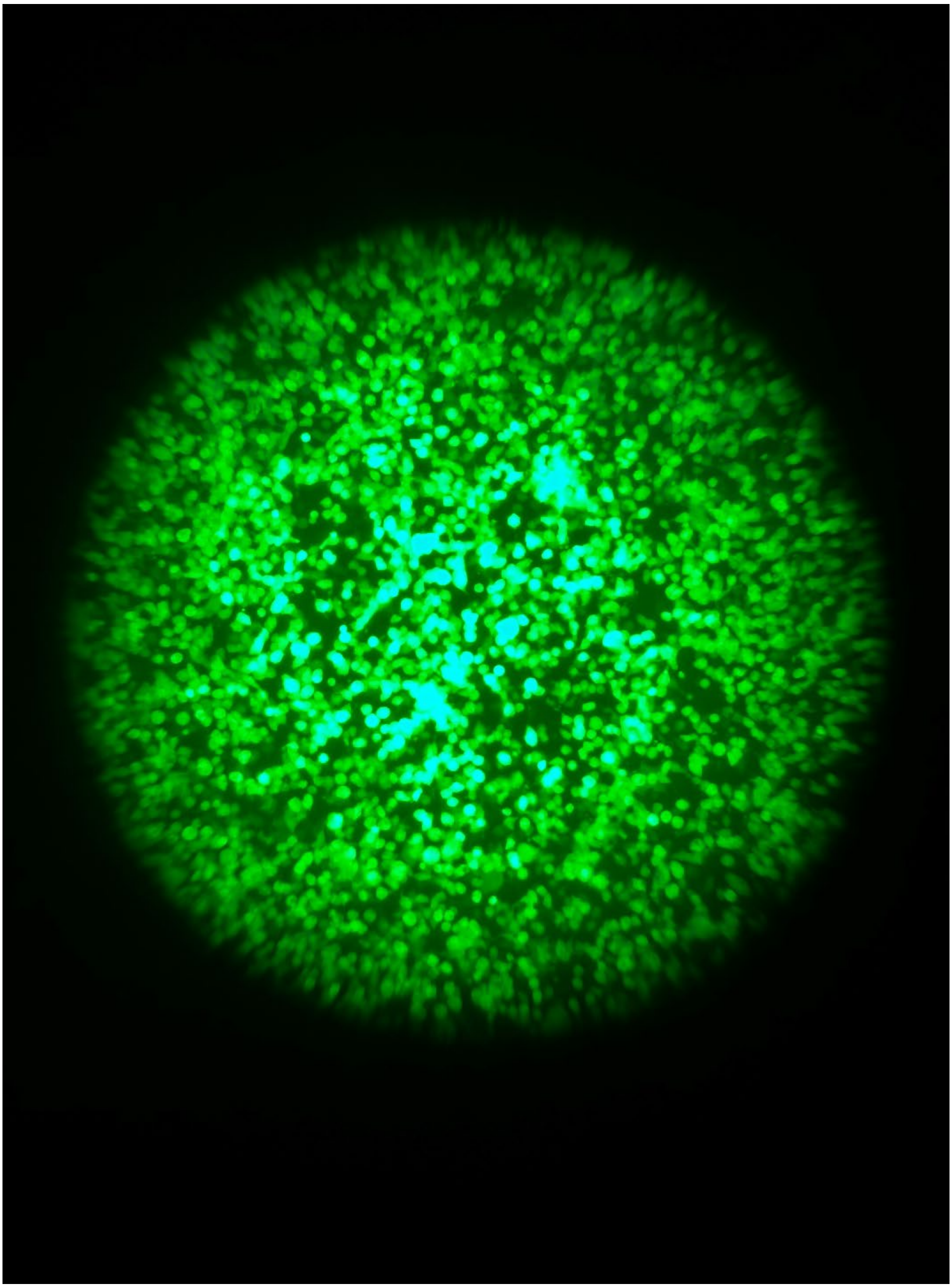
Our eyes fixed so tightly
on the invisible
we forget

to look up—

The Glow Within

VINCENT SALAMONE

Fluorescence Microscopy



Crusting

LUCAS BURACHIO

Blood-red carpet, familiar once to care,
now dries from accreted canine urine;
the sculptor's hands, once kneaded dough, remain
like sap of a pruned pine against the air.
Fish scales on her eyelid, an ensnarement.
Adapting, or conforming—thus ordained:
this braille Bog Queen is now detained;
her painted china waits, heir to silence.
This Maiden, Mother, and Crone are to blame!
And yet, they prolong, and she must contend.
"Who," "What"—Medusa lures her loops, immured
in her skull's sutures; nothing stays the same.
Her portraits traced the self that attended;
in verse, her delicious being endures.

Crusting is a Petrarchan sonnet that details the metaphysical condition of a woman (my grandma) after her stroke and with her advancing dementia. The poem observes a subject who has unwillingly taken on a new identity defined by status, repetition, and dependence, while still suggesting that something persists beneath that confinement. It explains the terrors of recursive cognition that most individuals with dementia face: questioning only to arrive at the same questions.

The majority of the poem's imagery—such as Medusa and the painted china—is based on aspects that made up my grandma's identity and can be used in verse to elucidate the tension between bodily entrapment and metaphysical endurance. My grandma was a strong Sicilian woman who loved to cook and paint, owning an art shop at one point.

The Maiden, Mother, and Crone, as well as Medusa, all refer to the Sicilian Trinacria, representing the stages of life (youth, fertility, decline) and the cyclic passage of time.

The Uncertain State of My Amygdala

NICK HUEMPFNER

Current down the axon. A circuit breaks in the burning brain. Somewhere
wires crossed, while cortisol soils the blood with ash.

Or was it the amygdala, shriveled and sunken—atrophying by its own design?
A time bomb buried in folds of gray matter. Ticking.

Still they portioned your pills to quiet your starving synapses, eyes
dimmed by the artificial calm of chemical restraint. I watched your edges

erode, day by day—I imagined your pain, a parasite
that wore your face, borrowed your voice, swallowed your thoughts.

Were you still there when it consumed you?   I ask myself
with my nose pressed to the mirror, tired brown eyes peering back.

I can almost see past my pupils, my brain a pale animal trapped in its airless
cage. It stares back at me, a secret folded deep in its soft furrows.

                                                                Is it already too late?

I imagine your genes threading into my mother's, coiled strands locking
that blueprint of self-destruction inside my cells. Will I feel the quiet construction

of that time bomb tangled among my neurons, its fuse slowly burning
vertebra by vertebra up the dark ladder of my spine—

The Right Pieces

İREMSU SAK

Couldn’t tell by looking
Took it to the repair shop to fix,
Did not fit in the binaries
Could not fit into its skin
There had to be something broken
Repairmen started to examine
10, 11, 12 of them
Looked at and touched the rusty wheels,
between its thighs
brown skin—peeling,
between its thighs

The robot *had* to produce other robots
For the sake of family
For the sake of society
Yet, it had a handle,
Or a keyhole with gears,
Or both,
Or all.

The committee of repairmen, gathered
The committee of repairmen, decided
The Intervention was inevitable
They had to *cure*,
Turn the brown extension of threat
Into golden metal,
Work ethic.
Three of the repairmen started melting the wheel
With solder, did they get rid of the extension
Then, did they weld the right pieces into it
Never questioned if those pieces would fit.
They did what they did
To *save* the family,
To *save* society
From a machine
A “terminator” to be

Right after the repair
The machine was oiled and fueled
Just to pretend to be a real human being
With a plastic button of norms

Who cares about
What’s beneath the golden skin.

The Blank Stare

VINCENT SALAMONE

It was a hospital room. The day before, my father called me on the verge of tears. *The doctors don't think she has long*. That night I booked a train ticket home like it could buy me time. I didn't go to the house first. I went straight to the hospital. Down an all-too-familiar hallway that smelled like antiseptic and warmed-over air, and into her room.

The vancomycin drip hung over the bed like a silent clock, its slow, steady rhythm measuring out something none of us wanted to name. The tubing looped down her arm toward the hand I tightly clenched. The room was too quiet for how much it meant. She was still there in whatever way a body could be, but everything I loved about her felt out of reach—like it had already started to leave.

I was the only one in the room who knew what *vancomycin* really meant. Not from experience, but from a biochemistry lecture that suddenly felt unbearably real. I tried to explain it to my family as evenly as I could. The last-ditch antibiotic. Something you don't reach for unless the situation is serious. Halfway through the sentence my throat tightened. The words wobbled. The room sank as if it had heard the same thing I had.

I squeezed her hand while I said it, trying to keep my voice and face steady, but to no avail. I stepped closer anyway, close enough to search her eyes for something that would pull me back into place. They say the eyes are the windows to the soul. But what happens when all that remains is a blurred silhouette of the soul that once was—not completely void, but gone nonetheless? What does it mean to lose someone twice?

I kept trying to replace that room with the ones I knew her in. The kitchen first. Then the sidewalks where we walked. Then the aisles of the mall and the card table—hands moving, voices overlapping, her laugh arriving without effort as she cleaned us out in a game of thirty-one.

In her kitchen, dinner always felt like more than just a meal. She would cook pasta for the whole family while Frank Sinatra's "Luck Be a Lady" or "Fly Me to the Moon" played, and she would move between the stove and the counter like she had done it her whole life. Because she had. She didn't just cook well. She cooked like it was a way of taking care of everyone at once. If the music hit a certain way, she'd pull you in for a few steps, laughing, and then go right back to stirring as if dancing belonged there, too.

And every Christmas there was *giuggiualena*—an Italian Christmas candy which made any afternoon feel like its own holiday. She'd arrive with pots and pans and her old trusty rolling pin like she was gearing up for a mission, and our kitchen would turn into beautiful chaos: sugar, sesame, heat, laughter, someone always in the way. It was intense in the way only family traditions are. Messy, loud, and completely worth it. She ran it all with the confidence of someone who had done it a hundred times.

That was who she was: the strong Italian matriarch who held our family together, sharp and quick-witted, a loving grandmother in the most uncomplicated sense of the word. She was always ready for something, whether it was mini golf at the Saybrook Point Inn by the shore, a shopping trip after she got her paycheck, or a walk around the neighborhood when she'd ask about school or tell stories from her long tenure in the Middletown Health Department. She remembered details. She noticed things. She made you feel known.

For a while, it was hard to pinpoint when that began to change. In our family, we trace it back to her first hospital stay—one of those moments that feels temporary at the time, something you assume someone strong will simply recover from. But after that, the visits started to add up. Appointments turned into follow-ups, follow-ups turned into return-visits, and slowly the rhythm of her life shifted from home to waiting rooms. And all the while, we could tell her mind and memory were going.

At first it was subtle: a name missed here and there, a story repeated, a question asked twice. Then it became the kind of forgetting that changes the shape of a room. You walk in and you can't tell what your presence will mean. Sometimes she'd smile, but it felt like the smile came from habit more than recognition. Sometimes there would be a pause just long enough to make your stomach drop before she decided how to respond.

I was lucky, for a time. When I came home from college and walked into her room, she usually lit up, even when she was exhausted. It felt like proof that she was still there, still reachable. But over time, even that changed. Some days she couldn't keep her eyes open for more than a few seconds, and the smile I used to count on became something I hoped for—something I wasn't always sure would come.

Near the end, there was one day that still feels unreal. Her sister flew up from South Carolina to visit one last time, and by some miracle it was like she surfaced. She was awake. She sat up in bed. We had pizza. We talked and laughed, and for a few hours it felt almost normal again. Like the disease had loosened its grip just enough to give us one last glimpse of her. It was the last time she saw both of her living sisters together, and it's one of the strongest memories I have of her: not the decline, not the quiet, but her—present, animated, back in the room with us.

Watching someone so strong fight something like this, when you can't help, is its own kind of helplessness. You try anyway. You bring stories. You remind them of where they worked, what they loved, who they raised. You do it not because you think you can fix anything, but because you don't know what else love is supposed to do.

And then there is the stare. The moment you look into the eyes of someone you love and they don't look back. Not because they're refusing you, but because they can't reach you. There can be a faint smile that looks like recognition from a distance, but nothing that calls you by name. Nothing that makes you feel, unmistakably, seen. The strange part is that it doesn't feel like losing them all at once. It feels like being erased slowly while you're standing right there.

Alzheimer's teaches you a kind of anticipatory grief. You mourn someone while they're still alive. You mourn them and then you go back to class, go back to work, go back to whatever your life demands, and the mourning follows you anyway. It brings guilt with it: guilt for feeling frustrated, guilt for dreading visits, guilt for the moments you feel numb because sadness has become too constant to carry. It brings anger, too—not at them, but at the unfairness of it all, at the way an illness can dismantle a person who once held everyone else up.

When she died, it hurt. But the grief was complicated, because by then we had already been losing her for years. We had been saying goodbye in fragments. The second loss came with finality and rituals and a date on a calendar. The first loss did not. The first came quietly, in pauses and misrecognitions and the gradual disappearance of the version of her who knew you.

Sometimes it feels shameful to admit that the first loss can be the harder one. Death is devastating, but other people readily understand and sympathize. With dementia, you're asked to grieve without closure while continuing to show up. You're asked to keep loving someone who can't always return you to yourself. You learn to measure connection in seconds.

A year and half later, grief still catches me in ordinary moments. After the one-year anniversary of her death, two days before my twenty-first birthday, I was cleaning out my phone and found several old voicemails from her. One of them was her singing happy birthday to me from years prior, and I broke down immediately. Not quietly. Completely.

There were others too, and they all started the same way—bright and enthusiastic: *Mr. Vincent*! Her favorite nickname for me. She'd check in, ask about school, ask about my brother, and then ask if we were free for another round of mini golf by the beach. Listening to them, I could see her again so clearly I felt knocked over by it. Her voice didn't hesitate. It didn't search. It didn't pause. It just knew.

I thought about her kitchen, about pasta simmering while Sinatra played, about the way we used to cook and dance without making anything of it. I thought about how easy it used to be to know someone.

Maybe that's what remains. Not that she knows me now, but that I knew her fully then—and that I still do. That love doesn't disappear just because recognition does. That even after the blank stare, even after the silence, her voice can still find me, years later, and make me feel like her grandson again.

Alone Together

SABINA MEHDI

Photography

Claimed Inheritance

JESSICA HWANG

they tell me at 4:12 a.m.
but I am asleep—
somewhere under the anesthesia
where time has no edges.

when I wake,
there is a weight in my chest
that is not pain,
not exactly.

more like a door
that has been closed for years
standing slightly ajar.

the nurse says,
“take a deep breath.”

I do—

and the air goes all the way down.

it feels illegal.

for months, my lungs were small rooms
with windows painted shut.
every inhale a negotiation,
every exhale a loss.

now the air rushes in
like it has been waiting for me.

they say someone died.
they don’t say when.
they don’t say where.
just that I should rest,
that the numbers look good.

numbers.

I watch them blink green.
steady. obedient.
as if they have always belonged to me.

there is a scar beneath the bandage.
beneath that, a rhythm
I do not recognise.

it startles me at night—
this strong, insistent thudding.
not the tired flutter I memorised,
but something fuller,
impatient.

sometimes I press my hand to my chest
and wonder whose breath
once matched this beat.

I don't know their name.
I don't know who sat in a parking lot
with fog on the glass
waiting for an echo.

I only know
that when I walk outside now,
the street lights hum softly
and the cold air burns in the best way,

and for the first time in years
I am afraid
of wasting it.

THE MEDICAL HUMANITIES JOURNAL
OF BOSTON COLLEGE

CHESTNUT HILL, MA 02467