COLLEGE-SPONSORED MENTAL HEALTH CLUBS: MAXIMIZING SUCCESS AND REDUCING RISKS

O. Nere Ayu, Howard University
Linda Berg-Cross, Howard University

Abstract

College-sponsored Mental Health Clubs (MHCs) are a 21st-century phenomenon, helping to reduce mental health stigma at colleges across the country. MHCs take many shapes, but most focus on psychoeducation, reducing stigma, advocacy, and peer-to-peer support. These clubs are especially attractive to groups like LGBTQ students and students of color who come to college with additional traumas and identity issues. Trends in training club leaders and members are discussed, and the role of the counseling center as a sponsoring organization is highlighted. Issues of liability are presented, particularly those having to do with: a) the responsibilities of mental health club advisors, b) duty to warn issues, c) dual relationship issues, and d) brave space paradigms and triggering situations. The need and utility of peer-to-peer support groups have been well-documented for decades. Still, the successful transition to mental health clubs under the auspicious of the college requires special vigilance to protect both students and the college.

In December 2021, the Surgeon General, Dr. Vivek Murthy, recognized the ongoing mental health crisis among youth and young adults and issued the Surgeon General's Advisory on *Protecting Youth Mental Health* (2021). The statistics are both convincing and cause for alarm. Even before the pandemic, mental health issues were the leading cause of poor life outcomes in young people. Twenty percent of youth ages 3-17 have a mental, emotional, developmental, or behavioral disorder. One in three students reports persistent feelings of sadness (Whitney & Patterson, 2019). While persistent feelings of sadness do not qualify for a specific DSM diagnosis, it does speak loudly about the quality of life among today's youth.

Most startling, between 2007 and 2018, there was a 57% increase in the suicide rate among youth ages 10-24 (Curtin, 2020). In 2020, it was estimated that there were more than 6,600 suicide deaths in this age group (Curtin et al., 2021). While the 2021 Surgeon General's report is focused on the 17 and under, the vulnerable youth referenced in the report have now experienced two-plus years of covid restrictions, trauma, loss, and isolation and are current undergraduates in our universities and colleges. College data confirm the downward trajectory. Thirty-nine percent of college students state they are coping with a serious mental health issue while in college, yet, over two-thirds will never seek professional help (Liu, 2019).

Over the past decade, student-led *mental health clubs* (MHCs) have been founded and are making a significant positive impact on college campuses across the country (Nutt, 2018; Bauer-Wolf, 2018; Sontag-Padilla et al., 2018). For example, in 2019, a University of Rhode Island student started the "r u ok" club, which now has over 200 students signed up. In 2021, a Howard University student started the Phoenix mental health club to support students who have experienced trauma. Active Minds, a national nonprofit mental health organization, has a chapter founded in 2016 at Mount Mary University (Walther, Abelson, & Malmon, 2014). As student-led organizations have been steadily increasing, college counseling centers have seen an increase in student utilization

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of services. According to the Center for Collegiate Mental Health (2021) annual report, there is a high demand for counseling services. Still, the capacity to treat based on the clinical load index for the campus center varies, and treatment is becoming increasingly less effective and sustainable. Most college counseling centers that have a high clinical load index struggle to provide services to all students and often will need to refer students to external sources to receive treatment. Hence, students have mobilized themselves to get help by forming college-sanctioned clubs, which allows them to raise funds, get physical meeting space, have access to faculty sponsors, and offer services and support to students that are difficult to access elsewhere, while colleges attempt to address the mental health crisis on their campuses. It is important to note that these clubs are not designed to be a substitute for services that counseling centers should provide. Instead, these mental health clubs offer peer support, community, and connection among students that cannot be easily duplicated or created within the walls of a counseling center.

Mental Health Clubs (MHCs) is the umbrella term we will use in this article to refer to all college clubs whose primary goal is healing dysphoric effect and stigma via education, advocacy, and the total spectrum of peer-to-peer support activities. Theoretically, MHCs should have many curative components: they provide students with same-age peers that they can rely on, reduce social and physical isolation, provide role models of successful coping in difficult situations, and allows the helping relationship to be more reciprocal with members giving and receiving support and advice. Additionally, peer-to-peer support groups do not carry the stigma, embarrassment, or cost of using formal mental health services. Most students feel less judged and more easily understood by their classmates than by an unfamiliar adult.

MHCs take many different forms, but two of the most widespread are Active Minds (Walther, Abelson, & Malmon, 2014) and NAMI on Campus (Cook, 2007). Active Minds has chapters on over 600 campuses. They provide a variety of services, such as community outreach and education, a speaker's bureau, a suicide prevention traveling display, and peer support. The peer outreach program is based on a three-step procedure VAR (Validate, Appreciate, and Refer) that helps create healthy boundaries between peers and involves one-hour training session that includes videos, Q & A, and group discussions (Walther, Abelson, & Malmon, 2014). The goal is to teach students how to respond to friends that may approach them with their feelings of distress. Active Minds does not officially promote any organized peer-to-peer support groups.

On the other hand, NAMI on Campus uses student-led groups to educate the student body about mental health challenges and reduce stigma (Cook, 2007). NAMI has developed many campus materials, including toolkits, templates, and ideas for club meetings. NAMI on campus specifically states on its website that it is not a support group nor a therapy group but instead focuses on walks, fairs, speakers, student panels, and advocacy for improved mental health services and policies on campus.

Another growing organization is To Write Love On Her Arms (TWLOHA), a national mental health advocacy organization with 65 student-led college chapters (*TWLOHA,* 2011). Focused on suicide prevention and awareness, they prepare yearly campus events for a Suicide Prevention Day campaign in September each year. They encourage each campus to make the events culturally attuned to their campus. One campus, for example, asked students to respond to the prompt "tomorrow needs me because…". The note cards were then displayed all around campus.

These franchised groups serve a critical function, providing campus communities with well-developed resources and organizational backup. At least one study shows that Active Minds is achieving its goals, reducing the stigma of mental health struggles, and seeking help when needed. In this study, 1000 students at California colleges ranked their engagement with Active Minds on their campus as "low," "medium," or "high." At year's end, those who increased their engagement with Active Minds had significantly better knowledge of mental health issues, were less likely to stigmatize mental health problems, and, most importantly, were significantly more likely to help other students experiencing a mental health crisis (Sontag-Padilla et al., 2018). This is the first large-scale intervention to show that MHCs on campus can reduce stigma and increase empathic support. These goals are in line with what students say are needed on campus. Elbulok-Charcape et al. (2021) recently reported a survey

of over 1200 geographically diverse students. They found students felt the greatest need for a) education (21% of responses), b) awareness of mental health problems and stigma, and c) a positive atmosphere (17% of responses). However, students diagnosed or treated for a mental health disorder were more likely than other students to want to see structural changes, including curriculum innovation and reconceptualization of mental health themes.

Change is currently being met on college campuses in various ways that contribute to failures and improvement in student mental health. Counseling center directors are aware of the demand for services, and in their attempt to meet the demand (AUCCCD, 2019), centers have moved to provide short-term support treatment, referring students to off-campus services, and reducing campus outreach which reduces the quality of care and awareness on campus. Although there are challenges to meeting the needs of all students, counseling centers are increasing their clinician training and services to meet the needs of the LGBQ campus community and those who identify as Transgender and Gender Expansive (Couture, 2017; Swanbrow et al., 2017). Additionally, Coley and Das (2020) identified over 62% of colleges and universities have LGBTQ student groups. However, there is an urgent need for all institutions with LGBTQ groups. Organizations such as the Campus Pride in Faith coalition work nationally and on individual campuses to protest a lack of equity, affirmation, and safety on religious-affiliated campuses (Campus Pride, 2022). Campus Pride clubs are activists for the LGBTQ community and want to restructure faith-based colleges so that "faith, sexuality, and gender identity are not mutually exclusive" (Campus Pride, 2022). Changes promoted include student recruitment and retention, targeted counseling services, course majors, course offerings, and promoting inclusive readings and/or lectures. A web-based international group, CenterLink's LGBTQ Community Center Member Directory, provides a worldwide guide to LGBTQ community centers, many of which are housed on college campuses (Centerlink, n.d.). CenterLink helps these clubs communicate with each other, share ideas and strategies for change, and mobilize across campuses.

College Choice has empowered students to make informed college choice decisions by offering an alternative top-school ranking system for LGBTQ students (*Best LGBTQ Schools,* 2021). When ranking the most supportive colleges for LGBTQ youth, each college was ranked using criteria designed to assess inclusion and access for its LGBTQ youth. The following are examples of questions used for ranking: Does the school have gender-neutral restrooms and showers? Does the school have LGBTQ-specific scholarships? Does the school have LGBTQ-specific counseling services? Using these additional criteria, the top 5 colleges were the University of Pennsylvania, Ohio State University, UCLA, Washington University in St. Louis, and the Massachusetts Institute of Technology (*Best LGBTQ Schools,* 2021). The presence of organizations, such as Campus Pride and College Choice, creates an environment where LGBTQ students can find helpful resources to navigate their college experience. More importantly, when a college campus climate of acceptance and solidarity is present, students are more likely to engage in the campus community and mental health-seeking behaviors (Heiden-Rootes et al., 2020; Kosyluk et al., 2015). Hence, the work of these organizations and student-led MHCs is especially relevant because LGBTQ students tend to have higher levels of substance abuse, depression, and suicide ideation (Cole & Das, 2020; Jacques, 2020; Pryor, 2015).

It should come as no surprise that the avalanche of mental health problems and crises on college campuses (Oswalt et al., 2020; Kruisselbrink, 2013; Kirsch, 2014) has mobilized students to organize for more intimate, disclosing peer support groups in the form of university-sponsored clubs. These clubs provide peer-to-peer support, resources, and activities, and even help reduce stigma by changing the campus climate to support mental health among student populations. Although the mission statements of such clubs preclude "psychotherapy," they offer a safe environment for healing and dialogue. Student-led MHCs run the gamut from wellness clubs with an activity focus to peer support clubs with a self-disclosure component to all types of hybrids in between. For example, Duke's student government sponsors a physical space where students can "relax, re-energize and recharge" with holistic offerings such as drum circles, guided meditations, Koru mindfulness, paint night, tai chi, and tea ceremonies. It is directed toward the typical "stressed student." On the peer support end, Ithaca College's Active Minds holds "Speak Your Mind" panels where students share their stories or the stories of family and friends. At the University of Davis, NAMI on Campus hosts "In Your Own Voice," where the community invites students with mental health challenges to share their experiences. Although these mental health clubs offer var

ious activities with safeguards in place for possible triggering events, they should be explored at a deeper level. Still, it should be clear that these safeguards, as well as clear guidelines, do not serve as a replacement for students who may need clinical intervention.

CULTURAL RESPONSIVITY IN PEER-TO-PEER MENTAL HEALTH CLUBS

For HBCUs and students of color at PWIs, peer-to-peer groups are an important component of a holistic education. Walker (2015) surveyed 2000 students; unfortunately, only 227 completed the survey. Using open-ended questions, Walker reported that over a third of students reported traumas, from natural disasters to interpersonal violence (IPV) to death. This is in accord with the large-scale Kaiser Permanente study, which found that Adverse Childhood Events (ACEs) were unevenly distributed among racial groups, with 61% of black children and 51% of Hispanic children experiencing at least one ACE, compared to 40% of white children. While there were significant demographic differences, in most areas, black children were most at risk. We know that ACES affect many life outcomes, including health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones), behaviors (smoking, alcoholism, drug use), and life potential (graduation rates, academic achievement, lost time from work). When students of color come to college with these additional stressors, peer-to-peer support can be invaluable. Several articles in recent years corroborate the positive impact of peer-to-peer support on the academic and social forefront for African Americans at HBCUs and PWIs (Watkins & Mensah, 2019). Peer support has been credited as a primary reason for how African American STEM students can finish their undergraduate and graduate training. Same-race peer support for African Americans at PWIs has been shown to help students cope with the negative impacts of race-related issues, lack of diversity, and exclusion.

At the University of Virginia, a group of African American undergraduate students formed a peer counseling organization to promote mental wellness called Project RISE, Resolving Issues through Support and Education (Nearly, 2007). Oriented towards attracting Black students, peer counselors aim to create a positive atmosphere where students can receive help and information and have someone to talk to about their problems. What is distinctive about this organization is that it is housed between the Office of African American Affairs and the Counseling and Psychological Services department (*Project Rise,* n.d.). Project RISE participants can get counseling from their peers and have access to a licensed professional if their needs exceed what a peer counselor can handle. Furthermore, student counselors must complete a 3-credit Peer Counseling Theory and Skills course. The relevance of having peer support groups that specifically target minority students cannot be overemphasized, given that African Americans report higher rates of trauma exposure and experiences with discrimination and racism (Watkins & Mensah, 2016; Boyraz et al., 2013).

TYPE OF TRAINING AND SUPERVISION PROVIDED IN PEER-TO-PEER GROUPS

Peer-to-peer support should not be a competitor to the college counseling center or other formal mental health services off campus. Rather a best practices model may be to have peer-to-peer support as an auxiliary service of the Counseling Center. College Counseling Centers are best prepared to train student supporters and their club work.

Groups with a staff member from the Counseling Center can safely take on a more self-disclosing, explorative style. Project RISE at UVA has succeeded at peer counseling, partly due to its connection with its counseling center and course offerings. Another good example is Harvard University's Student Mental Health Liaisons (SMHL) which was created as a partnership between students and the university's Counseling and Mental Health Services. The group, which is supervised by clinicians, have an orientation session where member share stories about their own mental health journey and prepare for challenging college situations that may arise during the year. The group also offers workshops to upper-level students on how to support a friend. Linking the mental health group directly with the college counseling center provides invaluable support to the club and the student.

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Although the clubs mentioned thus far received support from either national organizations such as SAMSA and/or their campus counseling center. The degree, frequency, and type of supervision are specifically discussed. Although the outcome data on supervision, in general, is an evolving field, research does indicate that from the supervisor's perspective, assuring "safe practices" is the most important component of supervision. At the same time, for the supervisee, "trust" and "having a safe place to bring problems" is the most important component (Pack, 2012). Britt and Gleaves (2011) also found that collaboration and mutual understanding were most important to clinical psychology trainees, but again there was no examination of the impact of the supervision on services. The most needed data contribution would be to show which type of supervision, with which type of supervisee, treating which type of problems, in which type of context leads to the most successful outcomes for the student (or client) seeking help. Currently, we are a long way from being able to describe that taxonomy. There is general agreement that the best supervision is tied to assessing the supervisees' skills, attitudes, and relationship competencies (Gonsalvez & Crowe, 2014).

Acknowledging the need for training among mental health clubs, Mental Health First Aid offers a crisis-response training program geared toward higher-education environments. It can be accessed by all universities (*ABOUT MHFA,* n.d.). The cost of training is reasonable ($150 per certificate), and the curricula are excellent. The topics covered include depression and mood disorders, anxiety disorders, trauma, psychosis, and substance use disorders. Their first aid action kit is fivefold and involves assessing for risk of suicide or harm, listening nonjudgmentally, giving reassurance and information, encouraging appropriate professional help, and encouraging self-help and other support strategies. They then learn how to apply these skills in the most common scenarios to help a peer with panic attacks, suicidal thoughts or behaviors, non-suicidal self-injury, active psychosis, overdose or withdrawal from alcohol or drugs, and reaction to a traumatic event. While large-scale evidence-based outcome studies have yet to be done, several case reports from colleges that have adopted the program report that the demand is very high and that RAs who receive the training feel better prepared. The authors believe Mental Health First Aid provides stellar leadership in this area and will hopefully be adopted and expanded upon by more campuses.

At Uncle Joe's Peer Counseling and Resource Center (n.d.) at Washington University in St. Louis, 60 student counselors—each with more than 100 hours of training—hold one-on-one sessions at the program's office or by phone to help students cope with anxiety, depression, and campus-life issues. Their extensive curricula mirror much of what is found in the Mental Health First Aid training. It is important to note that the Uncle Joes (student counselors) are not mandatory reporters, although they can and will report if they deem the student is in immediate harm or danger to themselves or someone else. Additionally, in an effort not to be a substitute for psychotherapy, Uncle Joes has a "one time per issue" policy. Students may visit their office as often as they would like, provided they talk about different issues each visit. In short ongoing counseling is not the mission of Uncle Joe. Instead, they are available to provide support and resources to fellow students in need.

Like Uncle Joe's Peer Counseling and Resource Center, mental health clubs with the least liability restrict their activities to community education, advocacy, structured support, and referral for needy students. Mental health clubs that go beyond offering a physical space for healing and offer a healing peer community where intimate thoughts and feelings are shared in a safe space are open to possible liability risks.

To maximize the success of MHCs on campus and minimize their exposure to potential litigation, each club needs to develop strategies to navigate common ethical quandaries and reporting standards for when a member may be in immediate danger to themselves or others. In so doing, they will be able to provide better services and, hopefully, reduce the incidence of negative events. It is important to note that very few student suicide cases on a college campus have led to litigation (Lapp, 2010). For example, the Iowa Supreme Court's 2000 decision in Jain v. Iowa did not hold the University of Iowa liable for not preventing the suicide of Sanjay Jain. Although the university was aware of the student's risk and previous attempts, the court found the university did not have a duty to protect another individual from self-harm because the university did not have a "special relationship" with the student. It is recognized by the courts that "special relationships" exist under custodial care, i.e., prisons and hospitals (Lapp, 2010; Gray, 2007). However, due to the rise in suicides on college campuses, amendments

such as the "Restatement (Third) of Torts section 40…specifically list a "school with its students" as one of the "special relations" giving rise to "a duty of reasonable care…" (Lake & Tribbensee, 2002, p. 631).

Counseling centers are the most appropriate branch of the college to develop mental health club guidelines. These guidelines can be used to train campus leaders (faculty sponsors and student leaders) and codify the counseling center's role. This organizational/oversight role can build a bridge between peer-to-peer support groups and responsible university oversight. Several models are possible, and each institution must craft its own guidelines. However, the following four areas should be covered in all guidelines: responsibilities of mental health club advisors, duty to warn issues, dual relationship issues, brave space paradigms, and handling triggering situations.

UNIQUE REQUIREMENTS OF MENTAL HEALTH FACULTY SPONSORS

The notion of students forming clubs to work on personal traumas, distressed affect, and emotional coping has been rising in light of counseling centers being overwhelmed by demand (Kirsch, 2014; Kruisselbrink, 2013). Most college clubs have historically been focused on shared hobbies, skills, political ideologies, social issues, or other extra-curricular passions (Montelongo, 2002). Self-help/advocacy groups, on the other hand, are about intrapsychic pain, breaking down stigma and shame, and exposing trauma as well as painful, intimate relationships in a raw, vulnerable manner. If most groups are about sublimated defenses, MHCs that focus on peer-to-peer support are about naked anxieties associated with the pain and trauma of the human condition. Some of the most vulnerable students on campus will invariably be drawn to these clubs, and the students are more at risk of facing ethical quandaries and mental health emergencies.

Therefore, the first rule of preventative liability for campus mental health clubs should be to recruit a licensed mental health professional. This professional could serve as a faculty advisor or group mentor. Recruitment efforts should focus on forming relationships with staff members from the Counseling Center. Having a licensed mental health professional partnered with the MHC will allow for more efficient and appropriate referrals when needed. Hopefully, doing so will help the club meetings focus on advocacy, education, and structured peer support (e.g., listening and validating). If a non-licensed faculty member sponsors the mental health club, there should be a clear liaison relationship with some point person at the Counseling Center.

In most campus clubs, faculty sponsors do not attend many of the club meetings, if at all. They are available to facilitate activities that the club cannot do on its own (e.g., procuring printing vouchers for posters) or don't know the proper procedures to execute (e.g., opening an account for their fundraisers). All faculty sponsors should be available when a club has problems of any kind. However, if the club's purpose is mental health, the problems likely to arise may stretch into unknown, uncomfortable, or crisis-oriented territory. Faculty sponsors need to be aware of such possibilities when they accept such a position.

DUTY TO WARN ISSUES OF FACULTY CLUB ADVISORS

The first potential land mine for MHCs involves duty-to-warn issues. In virtually all states, a club advisor's legally mandated and professionally responsible actions are the same whether the faculty club advisor is a licensed mental health worker or a faculty advisor without any mental health experience. Both would have a "duty to warn" if they have direct knowledge that a student(s) clearly intends to hurt themselves, another member, or a nonmember. It has generally been agreed that college faculty and administrators have a duty to warn if an identifiable person is potentially being harmed and if the university can protect the student against the foreseeable risk. This is an expansion of the original Tarasoff vs. the Board of Regents California Supreme Court case that ruled that a psychiatrist has a duty to warn potential victims of harm if their client has disclosed a specific intent to harm a specific person(s). In addition to warning about imminent or potential danger, under Title IX, responsible employees (e.g., faculty advisors) must report incidences that constitute sexual assault, harassment, stalking, or dating violence (Holland & Cortina, 2017). The university bears this duty to warn because the student(s) relies on the university to provide a safe environment for their growth and well-being, much like a client relies on the therapist. When a college or university has responsibly discharged its duty to warn and protect, they

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have upheld its legal and ethical responsibilities (Lake & Tribbensee, 2002; Lapp, 2010).

It is a more difficult call if the club advisor has firsthand knowledge, but the facts are fuzzier or less direct. For example, UCLA was sued because a faculty member had a paranoid schizophrenic student who complained that comments by other students were interfering with his thinking. Later this student stabbed a fellow student in the chest. The student survived but sued the university for "failure to warn" (Dolan, 2018). While the ill student did not indicate a specific person he was going to harm, he was projecting irrational abilities onto his classmates and was incapable of reality-testing about his peers. The issue becomes even more complicated because the ADA protects student's privacy and discriminatory college actions based on unreasonable fears and prejudices, which might well be apropos in the case mentioned above since the vast majority of those with mental illness, including paranoid schizophrenics, do not commit violent crimes (Goren, 2018).

Goren believes universities should be liable for the violent actions of students with known mental health problems because students depend on their colleges for a safe environment. Colleges can help maximize safety with respect to the activities they sponsor and the facilities they control. The ADA protections that all people should have a right to engage in community activities is a competing policy based on competing values and would lean towards protecting the privacy of the disabled student unless there is a clear and present danger.

So, if a club member hears that another student is ruminating about suicide or plans to harm someone else, how should the support student respond? Beyond the training offered by the colleges within their student affairs departments, faculty advisors and club members should recreate guidelines for handling these situations within a club context. A protocol might include an orientation session for all potential club members where the duty to warn policy of the university is reviewed, and the steps required of peer supporters are understood and doable. There may be signed agreements attesting that club members have been told and understand how to contact the faculty club sponsor if they are worried that a club member has threatened to harm themselves or another person. Students should also attest that they understand the peer support protocols to be followed when a club member is in distress.

For the faculty mentor, hearing that a club member is in distress puts them in a delicate situation. Do they have a moral obligation to reach out to the student to see if they want to meet? Should they notify the Counseling Center of the incident? What other University officials or offices should be notified? How should they advise the student coming to them with this information? What type of follow-up is needed? Colleges should develop case-based discussion sessions for club advisors based on these problematic scenarios and have policies that follow best practices.

DUAL RELATIONSHIP ISSUES WITH FACULTY ADVISORS

Whenever an academic professional enters a relationship other than the one preconditioned by contractual obligation, they enter the domain of dual relationships (Gross, 2005a; Moleski & Kiselica, 2005). Dual relationships can happen during or after the contractual relationship has ended and are dangerous to both parties. The student/advisor status differential is a power differential where the student is the vulnerable party and at risk for exploitation.

Dual relationships can emerge when a faculty advisor has a club member as a student in a class. If the club advisor has been privy to personal information in their role as club advisor, they may give the student preferential treatment or discriminate against the student. Dual relationships are more likely to elicit ethical and moral dilemmas for the faculty advisors to mental health clubs than other clubs because of the intimate nature of the club. The advisor may feel that their counsel can help the student, particularly if they refuse to go to the Counseling Center. This advisement may go beyond academic counseling, career counseling, or normal advisement functions. Vulnerable students may misinterpret caring cues of the advisor as inappropriate, sexually suggestive, or unwanted. Despite these pitfalls, there are times when dual relationships are helpful or even lifesaving. The club advisor is best protected by a) being warned of such conflicts as a club advisor, b) sharing concerns as soon as a dual relationship is recognized, c) seeking all possible options for the student that would not involve the

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advisor, and documenting these efforts, and, d) consult with their department chair if uncomfortable situations arise and triage a solution that protects both parties.

TRIGGERING SITUATIONS AND THE ROLE OF THE FACULTY CLUB SPONSOR

The main goal of mental health clubs is to reduce stigma and shame and facilitate healing. However, it is essential to acknowledge mental health clubs are not without risks because they are likely to expose their members to traumatic triggers. The type of situations that trigger students are highly individualized but can include microaggressions, humiliating comments, harsh tones, topics that touch on IPV, aggression, mass murders, shameful behaviors, and judging. For example, Dolman (2018) presents the case of a medical student who complained that a case-based discussion of the bias against giving opioids in the ER to a young man with many tattoos was "triggering" for him. Within a club context, students may be triggered by various issues at club meetings or events. Whether it be a film viewing or peer disclosures, the nature of trauma can be both predictable and unpredictable. The high intensity of emotional stimuli can trigger a physiological shutdown response where individuals "freeze" and begin to experience any or all the symptoms associated with their own trauma. For example, a student hearing about an incident of sexual abuse may begin to have flashbacks about their own sexual abuse history, feel panic, and put themselves in a flight-or-fight mode where they are focused on their own emotional safety instead of the reality at hand. In these situations where the trigger has a negative impact, there should be procedures to help alleviate the situation.

Mental health clubs can best approach triggering situations by explicitly wrapping club activities around a brave space framework instead of a safe space framework. Brave spaces are not necessarily free of discomfort but use the following five guidelines to facilitate growth instead of panic: a) all opinions are accepted as valid for discussion; b) participants must own their intentions but also own the impact that their statements have on others; c) all participants are free to exit challenging conversations and the room where they are occurring; d) all members express respect for each other's personhood and e) everyone vows not to inflict harm on another intentionally (Wasserman, 2021). It might be argued that the club context is, ipso facto, a safe space since all members have experienced or are in tune with the burden of mental health challenges. It may be naively assumed that statements made in the peer support context would not be as triggering as those same comments made in other settings. However, atop the usual college angst, potentially traumatic disclosures and triggering situations seem unavoidable in today's culture. A safe place can instantly become unsafe if the appropriate trigger appears at the appropriate time.

Preventative strategies to reduce negative instances of triggering should focus on brave space frameworks and ensure all faculty sponsors are comfortable helping students enact that framework. It might be useful for club leaders to begin each meeting by reminding participants that if the conversation gets too intense or uncomfortable, they should feel free to leave and/or go to a designated alternative place until they want to return.

In summary, as MHCs continue to grow in large numbers on college campuses across the US, the positive impact of peer-to-peer support provided by students cannot be understated. Research continues to link positive outcomes such as improved academic performance and better physical, mental, and emotional health as benefits from peer-to-peer support groups (Gruber, 2008; Hirsch & Barton, 2011; Hefner & Eisenberg, 2009). Specifically, Bissonette and Szymanski (2019) report that peer groups offer identity validation, community, and acceptance for LGBTQ students. MHCs offer ongoing peer-to-peer support centered on providing healing spaces and resources. Nevertheless, it is important for the MHCs to establish and follow university protocols that maintain a level of professionalism and care and protect students and faculty from negative incidents, such as liability and unintentional harm. Regardless of the good intentions of these groups, adverse effects among members can occur without proper oversight and supervision. College counseling centers must take on an active role in the guidance and supervision of these clubs. There is no substitute for psychotherapy, nor is there a substitute for community and connection created among peers who address mental health. Mental health stakeholders are needed on all fronts to promote wellness and wholeness on college campuses.

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