CAPTVRE Imagination
Fall 2019

CAPTVRE IMAGINATION: A NEWSLETTER ON CHILDREN, PLAY, AND MENTAL HEALTH

Welcome from the editor

Welcome, everyone, to the third issue of the CAPTVRE newsletter. This edition marks the first since Dr. Steadman's transition away from academia and into a full-time clinical role. As a result, the format is slightly changed in that there is no longer a dedicated CAPTVRE research lab. Still, the articles follow a similar format and target a similar audience. The CAPTVRE lab's name stands for Child Advancement, Play Therapy, and Virtual Reality Environments. Our name represents our three main focuses, 1) Raising healthy children, 2) Enhancing play to maximize its therapeutic effects, and 3) Understanding digital play (videogames, virtual reality, etc.) and its impact on today's society.

Given our focus, our newsletters are perfect for a diverse audience of parents, youth, mental health professionals, teachers, and anyone else who may spend time with youth in their daily lives, including other pediatric healthcare professionals.

To the right, you will see an "IN THIS ISSUE" column, where you can see a highlighted table of contents for each newsletter. Each newsletter follows a similar format.

For information about Dr. Steadman's recent professional development activities, check out the "*Updates*" section. The "*Hot topics*" section reviews a hot topic currently trending in the popular media and what it means for you and/or for your child(ren)'s mental health. The "*Professional spotlight*" section contains a guest article written by a pediatric healthcare professional, on invitation from the editor. In this issue, Dr. Natasha Gouge encourages us to consider a different type of "grading system" for your school-aged child.

In the "*Students' Column*" we feature articles written by students for students. Some authors may be graduate or college students, while others can be high school, middle school, or even elementary school students. If you or someone you know would like to write an article for consideration in this section, please contact the editor.

Each newsletter also contains a "*Play in Review*," where we review some sort of play-based topic relevant to our work. We also include "*Storytime,"* which incorporates storytelling to promote positive mental health.

I hope you will all enjoy this issue. Subscription instructions are included at the end of the newsletter.

IN THIS ISSUE

Updates

For any of you that missed it, the official CAPTVRE lab at ETSU closed in August 2018, when Dr. Steadman left his position at ETSU, following his wife to her new job at UT-Chattanooga. Thus, we now live in Chattanooga, where Dr. Steadman practices full time as a pediatric and clinical child psychologist at Chattanooga Pediatrics. Dr. Steadman has thus spent the majority of the past year in building up his clinical caseload and integrating into the Chattanooga healthcare community.

Most recently, Dr. Steadman became board certified in Clinical Child and Adolescent Psychology through the American Board of Professional Psychology. This is a unique distinction in the field that helps provide assurance to the public about Dr. Steadman's clinical skills and general professional competence. Currently, including Dr. Steadman, there are only 4 psychologists in the state of TN who are board certified in Clinical Child and Adolescent Psychology. Dr. Steadman will write more about this experience in a later section of this report.

Dr. Steadman has started a blog, where these newsletters will now be housed, along with other content Dr. Steadman produces, mainly for his patients. You can access this blog by clicking here.

Dr. Steadman also continues some research activity, primarily focusing on analysis and publication of previously collected data at this time. There are no studies currently collecting data. Most recently, Dr. Steadman published an article on using motivational factors in videogaming to assist with treatment planning in people with problematic gaming behaviors.

Dr. Steadman is still available to provide consultation and continuing education to students, residents, or established healthcare providers. To inquire about such trainings, please contact Dr. Steadman using the information below.

CONTACT

To contact Dr. Steadman, you mail email jsteadman@hushmail.com or you may call his business phone at 423-254-0899 or 423-825-4040.

This poem, of course, isn't really about eels. It's about fear, and it focuses on 4 skills kid can use to fight fear: 1) positive thinking, 2) choosing to be brave, 3) remembering they aren't alone, and 4) remembering fear can't change who you are!

Eels

by Jason Steadman, Psy.D.

There's something lurking deep inside,
you know how it feels
A rumbly in your tumbly
A slithering of eels.

You hate them more than anything,
they make you want to spew
but one thing that you may not know
they're more afraid of you

Because you've got this power,
coursing through your veins
The strength of many million men
Hidden in your brains.

See you can change those eels
To anything you like
A beautiful savannah
A brand new yellow bike

Bravery has never meant
that you are not afraid
it's taking deeper breathes
and fighting through the fray

And knowing you are not alone,
No matter what you do
That eels are only eels,
But you are always you!

PROFESSIONAL SPOTLIGHT

Guest contributor

In this edition, our guest contributor is Dr. Natasha Gouge. Dr. Gouge is the director of the ETSU Behavioral Health and Wellness Clinic. She is also an Assistant Professor in the ETSU Dept of Psychology and the Assistant Director of Clinical Training. She specializes in Pediatrics, Integrated Primary Care Psychology, Brief Interventions, and Interdisciplinary Consultation. She is also the Owner of Grow on the Go with Dr. Gouge, a program designed to provide behavioral health coaching for physicians.

A for effort, and other "grades" that really matter

by Natasha Gouge, Ph.D.

FAST FACTS

56%

Percentage of students in one study (of CA communities) who consider homework to be a primary source of stress.

44%

Estimated percentage of a 24-hour day (10.56 hours) students spend, on average, completing schoolwork.

26%

The percent of variance in 12th grade GPA explained by psychosocial and behavioral factors. This is a **large** effect size.

50%

Percentage of students in one study who were assigned an F for a course, even though they passed competency assessments for that course.

Imagine this scenario:

Two students bring home their grade cards. "Billy" has earned all As on everything. "Johnny's" card reads straight Cs. Who would you say is the best student? Who would you predict to be the most successful in future grades of school or later in adulthood? It's Billy, right?

But consider some additional information. Billy's As come easy to him. Billy is described by his parents like this: "He is so smart. Honestly, we've never even seen him crack a book to study. We've never had to assist him on homework. In fact, he barely ever has homework. He finishes it all at school. It just all comes so easily to him. He's such a great student and really loves school. He's never stressed about it." Billy beams with pride as his parents say this about him.

And what about Johnny? Johnny is described by his parents like this: "School is such a struggle. Sometimes we spend hours every day on his homework and studying. It is such a challenge for him. He's done tutoring, stayed after school, has a study buddy, watches online tutorials, and I swear it's still like pulling teeth to keep a C average even with exhaustive effort." Johnny hangs his head down in defeat as his parents describe him this way.

Now who's the more successful student? It's still Billy right? By every measure of school success, Billy comes out on top. But I'm here to challenge that idea with you, and I hope those of you who are parents with kids who've just started a new school year will keep these things in mind as you coach your child through their next year of learning.

As a psychologist, I'm here to say that the grades your child gets in academics are less important in the long run than they may seem. If making high marks involves very little to no effort, they may as well be the same as being born with the "right" skin color or inheriting millions of dollars at birth. Now, don't get me wrong, being born with privilege is not inherently bad. It's what you do with your privilege that matters. So, I'm **way** more interested in the kids who learn and apply fundamental skills and perseverance to learn something that is hard, something that isn't just given to them, but for which they work hard to earn. For Johnny, school grades are hard. He's had to learn and use all kinds of skills to figure out how to keep his head up and push, even if it's hard. For Billy, for whom school is easy, it may matter more to find other challenges in his life, so he can build those same skills.

Researchers who study wildly successful adults never highlight the high grades those people made growing up. You don't hear about their GPAs or ACT scores, unless they happen to be low. In fact, more frequently you might instead hear about how this said person flunked out of school or was rejected by such and such school, or was at a significant academic, social, or other type of disadvantage in some way, yet here they are being studied as among the most successful members of society. So, what do researchers say are the more important attributes of a successful person? Guess what, they have nothing to do with which level you're on for AR, how many math problems you've mastered in IXL, or which tier you've been grouped in for RTI.

Below, I include a list of 28 attributes (in no particular order) that do matter, grouped roughly into 4 categories.

Work-Related Attributes

1. Willingness to try, to learn, to take risks, and to seek help
2. Resilience
3. Persistence
4. Focus on effort vs evaluation
5. Discipline
6. Patience
7. A "Growth" mindset - passion for improvement, willingness to learn from failure, set goals based on growth, rather than achievement

Social Attributes

1. Kindness
2. Connectedness with others
3. Dependability
4. Friendliness
5. Ability to Cooperate
6. Gratefulness
7. Advocating for Others
8. Desire to give back / community involvement
9. Respectfulness
10. Diversity

Motivational Attributes

1. Drive
2. Aspiration
3. Self-Reliance
4. Will Power

Other attributes

1. Creativity
2. Optimism
3. Self-Control
4. Emotional Awareness / Emotional IQ
5. Flexibility
6. Authenticity
7. Integrity

If you could pick even a handful of these things and increase your focus on these with your child, you will likely have less stress and less of a headache when it comes to school stuff, *and* you will be fostering fundamental successful skills that are linked to successful futures, rather than arbitrary scores that are not. Again, there are no life-long skills gained getting something without effort – advantages, yes, but skills, no. Being the "smartest person in the room" and getting good grades only go so far. Eventually, all humans will be faced with challenges, and it's best for humans to face those challenges as children, when there are supports and backups to guide them through failures and stimulate growth. I trust we can all think of adults who seem to have tremendous gifts, but who squander those gifts when faced with a challenge. Now imagine an adult who may not be ultra "gifted," but who steps up to challenges and comes through when you need them. Which would you have work for you? Which would you rather have as a friend?

So as you enter the new school year, consider rewarding your child not for what grade they bring home, but for what they do every day to face the challenges of growing up. When Johnny brings home Cs, try recognizing how he got there: "We are so proud of the work ethic that Johnny shows with his schoolwork. Honestly, I don't know how he persists like he does. He is like a little homework machine. And he's so good about asking for help when he needs it and willing to try any techniques that have been suggested. We are really proud of the study skills and critical thinking skills he is developing this year. I don't even understand some of the work he's doing!"

You might even consider creating a different kind of report card – one that gives your child "grades" for some (or all) of the attributes I mentioned above. But, even though it's tempting to do so, don't just go across that alternative report card and arbitrarily assign As a show of your love/pride– maybe, instead, let your children choose their grades, in conversation with you. Let them rate themselves, and have discussions about how they can improve or grow in other areas. Set goals together for the new year and track them on your card. And remember, let's go into this upcoming school year with a fresh focus and resist the urge to let that traditional grade card define success for you or your student.

"No matter your ability, effort is what ignites that ability and turns it into accomplishment."

Carol Dweck, author of *Mindset*

Board Certification in Child and Adolescent Psychology

by Jason L. Steadman, Psy.D., ABPP

Over the past 14 months or so, I have been going through the process of acquiring board certification in child and adolescent psychology (ABCCAP) through the American Board of Professional Psychology (ABPP). For those that don't know, board certification is an "above and beyond" distinction for healthcare professionals. It is a voluntary credential that many professionals pursue in addition to licensure in their field. Board certification demonstrates "exceptional expertise in a particular specialty and/or subspecialty field." For psychologists, the process for board certification differs slightly from that of our MD/DO colleagues. Most notably, physicians become board-eligible immediately at the end of their traditional training program, including residency. Psychologists, on the other hand, for most boards, become board-eligible after at least 3-years of *independent* practice. Now, because of differences in training models (MD/DO residency is 3-7 years; psychologist residency is 1-2 years), both physicians and psychologists still become board-eligible at about the same time – approximately 4 years after completion of schooling. And so the eligibility requirements are still fairly similar.

Another key difference is in the number of professionals that get board certification. According to data from the American Board of Medical Specialties (ABMS), for physicians, >880,000 physicians are currently certified in at least one of 24 specialty boards, which accounts for 80% to 90% of all physicians in the US, depending on how physicians are counted. According to data collected on June 30, 2018, 102,830 physicians are board certified in Pediatrics, which is the 2nd most common certification, second only to Internal Medicine (232,759). In TN, there are 1,963 physicians board certified in Pediatrics. Also, from a practical standpoint, board certification is considered by many to be a necessity for medical practice today, required for privileges at most hospitals and for credentialing by most insurers. It is said that few practices will hire physicians who aren't board certified.

For psychologists, on the other hand, board certification is quite rare. According to a 2017 report, approximately 3900, or 4%, of all psychologists were board certified in at least one specialty. Within clinical child and adolescent psychology, only 234 were board certified in 2017, which is equivalent to about 1% of all psychologists who report a primary or secondary area of specialty in child and adolescent clinical psychology. When I become board certified on 7/12/2019, I was one of only 4 psychologists in the state of TN with a board certification in clinical child and adolescent psychology.

One of the reasons that board certification is so rare for psychologists is that it not considered necessary for practice in the field. Unlike physicians, it is quite common for skilled and competent psychologists to practice without board certification, and it is easy for us to get jobs when we don't have the ABPP credential behind our names. As a result, almost no one pursues it, even though they have the qualifications (and competence) to do so. So, while the general public is usually somewhat "suspicious" if a physician is not board certified, the same suspicion should not necessarily be held for a non-certified psychologist. At the same time, if you can find a board-certified psychologist (denoted by them having ABPP behind their name), this extra certification provides an extra level of assurance about their quality in a specialty field.

What did the ABCCAP certification process involve?

As I indicated previously, I became eligible for ABCCAP after 3 years of independent licensure and practice as a clinical child psychologist. The first step of the application process involved a basic credentials review, where an independent committee reviews your training background to ensure you have the requisite experiences to earn a specialty in clinical child and adolescent psychology. The second step of the application involves submission of Practice Samples to the committee for review, along with a written statement outlining competence across a variety of critical practice areas (e.g. assessment, intervention, consultation, supervision, research, etc.). Applicants have 1-year after completion of credentials review to submit/complete practice samples. Practice Samples also include recordings of your clinical work with real clients (who have signed releases to allow recording and usage of recordings for the boards process), along with submission of supporting written materials, all anonymized to protect confidentiality.

Step 3 of ABCCAP involves an in-person oral exam, administered by a team of 3 psychologists already credentialed with ABCCAP. Because there are so few ABCCAP-credentialed psychologists in the US currently, most applicants will need to plan to travel for this exam. In my case, I took my exam at the University of Kansas. The oral exam is a three-hour exam designed to measure an applicant's competence in all of the key areas of clinical practice in child and adolescent psychology. However, overall, the oral exam is also designed to be collegial. Personally, I was very pleased with my exam. My team was kind throughout and the exam felt mostly like a group of colleagues discussing my work and the key ideas that influence what I do.

There is some cost to the exam. Altogether, I paid approximately $1500 out of pocket for my exam, which included exam fees and travel and lodging. Still, for me the cost was

well worth it. The pride I felt after learning I passed my exam was honestly a feeling that has not been matched in my professional career so far. And, I was awarded 40 continuing education credits for passing the exam, which in TN is enough to cover the full requirement of CEUs for every 2-year license renewal cycle. Thus, overall, the cost is not much greater than any other continuing education endeavor (such as conference registration fees and travel).

Why should other psychologists seek board certification?

First, I think, like it or not, and fair or not, having board certification allow psychologists to be taken more seriously as healthcare professionals. As noted above, among our physician colleagues, almost all are board certified in something, which leads many to the conclusion that not having board certification means you have "failed" at something and thus are less competent. Again, even if this may be a false conclusion, it still happens. So, if nothing else, board certification moves psychologists into a realm where medical colleagues, and the general public too, have higher assurance of competence.

Another reason to seek board certification is that the process grows you appreciably as a clinician. Many psychologists share an experience similar to mine. Throughout our training we are closely monitored, held accountable for our actions, and challenged to think deeply about everything we do. We meet at least weekly with our supervisors to discuss our cases, forcing us to reflect upon our practice in meaningful ways. However, when we become independent practitioners, we often lose these ready-made opportunities for self-reflection, falling instead into a routine of providing clinical care within our "comfort zones" established through training. We have to create our own opportunities for growth, which is easier for some than others, often depending on your work setting. Still, that same vulnerability we had as students and trainees is rarely achieved again.

The ABPP application process, then, pushes us as established practitioners to become vulnerable once again – to put ourselves out there under the scrutiny of experts. It's also a time to appreciate just how much we have grown since our last clinical practice "test" (which for many of us occurred before graduation). In my training at Baylor, we all completed a Clinical Practice Exam during our final year before internship. Our CPE was an oral exam, very similar to that used in the ABCCAP exam. I was given random cases and had to demonstrate my competence in evaluating and treating those cases in front of a panel of examiners. I remember my CPE being quite anxiety-provoking and difficult. I passed, but not without making a few mistakes, as all students do (no one is perfect). My ABCCAP exam, however, felt simpler. It wasn't because the test was simpler. Instead, the difference was that I had grown in my competence and confidence as a clinician. Seeing this difference was extremely gratifying for me. It showed me just how far I've come, and it renewed my focus on appreciating continual growth throughout my career.

Lastly, achieving ABPP left me with an immense sense of pride! I will admit openly that in a lot of ways it feels like a "bragging right," a distinction that doesn't make me better than anyone else, but definitely makes me feel very good about myself. And why pass up an opportunity to feel great about yourself!

American Board of Professional Psychology

For more information about the American Board of Professional Psychology, you can visit their website at https://abpp.org. Here, the general public can search for ABPP-certified psychologists in their area. Psychologists can also use the website to get more information about their specific board requirements and can apply for certification through the website.

Social Media for Tweens and Teens: Influencers, Likes, and Addiction

by Jason L. Steadman, Psy.D., ABPP

HOT TOPICS

In this section, we review a hot topic currently trending in the media. We present our thoughts on the topic and provide some research background to inform you about what the topic means for you and/or for your child(ren)'s mental health. In this edition, Dr. Steadman discusses trends in social media use among tweens.

In the inaugural issue of CAPTVRE IMAGINATION (Fall 2017), I wrote an article on the Netflix show *13 Reasons Why,* and I provided guidelines on why teens are watching it and what parents can do when then they learn their children are accessing mature content in media. Much of the material covered in that article also applies here, so I encourage you to check it out for some additional useful insights I won't cover again here. In this article, though, I focus on social media for Tweens and Teens. The article is designed for review by parents to understand trends and effects in social media and to provide guidance on how parents can introduce their children to social media.

Here's the truth, nearly everyone uses social media. Figure 2 below shows the percentage of US adults who used social media, according to a 2019 Pew Research Center study. What is not shown in the chart is that among young adults (ages 18-24) social media use is even higher, with ~75% of reporting use in each of Snapchat, Instagram, and Facebook, 90% using YouTube, and 44% using Twitter. Furthermore, most adults use these platforms daily. In a 2018 study of US teen social media use, teens ages 13-17 reported most heavily using YouTube, Instagram, and Snapchat (see Figure 1). **So, what you should notice here is that teens report heavier social media use than most adults.**

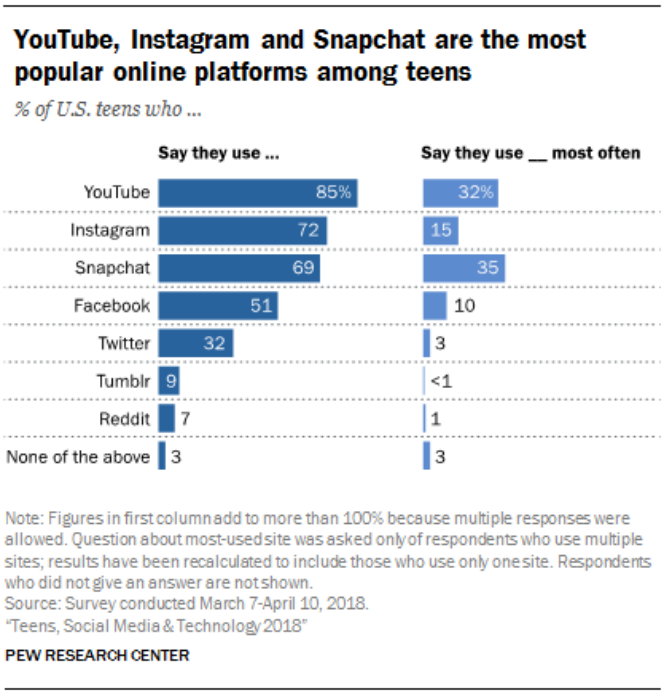


Figure 1

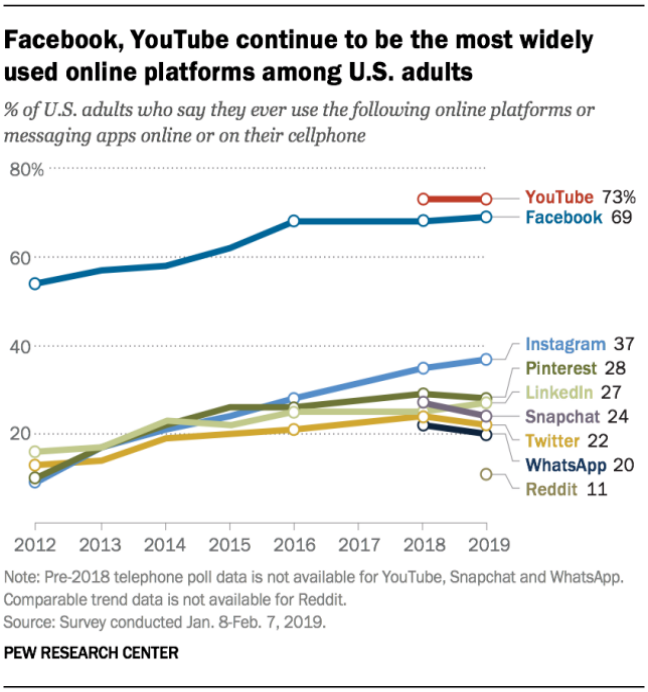


Figure 2

There are also interesting data about what teens perceive are the effects of social media on people their age. Figure 3 on the page 7 shows teens various perceptions about these effects. Three in ten teens reported a "mostly positive" effect of social media, with the majority there reporting that it facilitates connection with friends and family. About one in four teens reported a "mostly negative" effect, citing online bullying/rumor spreading as the most common negative outcome. Of course, hard data on whether social media actually accounts for negative outcomes in teens and tweens is harder to come by. The main reason for such lack of data is methodological. Because social media is so heavily used by teens, it is extremely difficult to design a study that compares teens who use social media with those who don't. As a result, we can't always tell if there are any actual differences. **Still, there are sufficient data now to suggest that at least a significant portion of teens do experience some negative effects from social media. So, it is important for parents to be equipped with tools help our children manage these potentially negative effects of social medias.**

Sidebar: What do people post to social media?

A few years ago, I conducted a study on what young adults actually post on social media. In my data, I specifically examined anonymous social media (YikYak, at the time). Our data revealed some interesting insights into the types of things young people tend to post on an anonymous social media website, which are outlined below. We examined a subset of posts from young adults attending a regional public university in TN (our full dataset, though included over 115,000 posts from colleges across the US). We found that the most common type of post to anonymous social media involved a non-specific complaint or some other unspecified negative content, making up just under 15% of posts. The next most common types included a non-sexual relationship content, school-related complaints, school-related questions, entertainment-related topics, and posts about the self.

Theme Frequencies

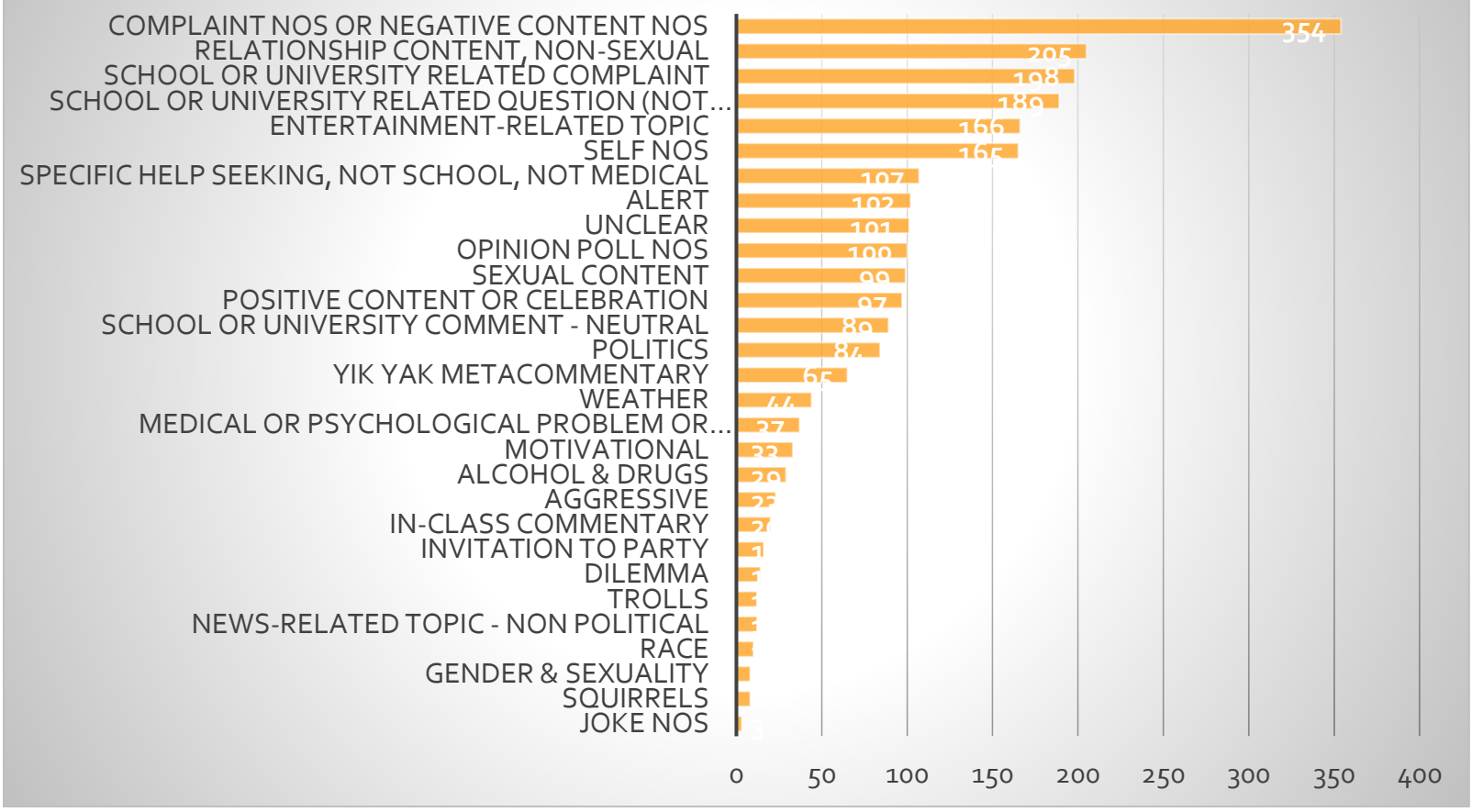
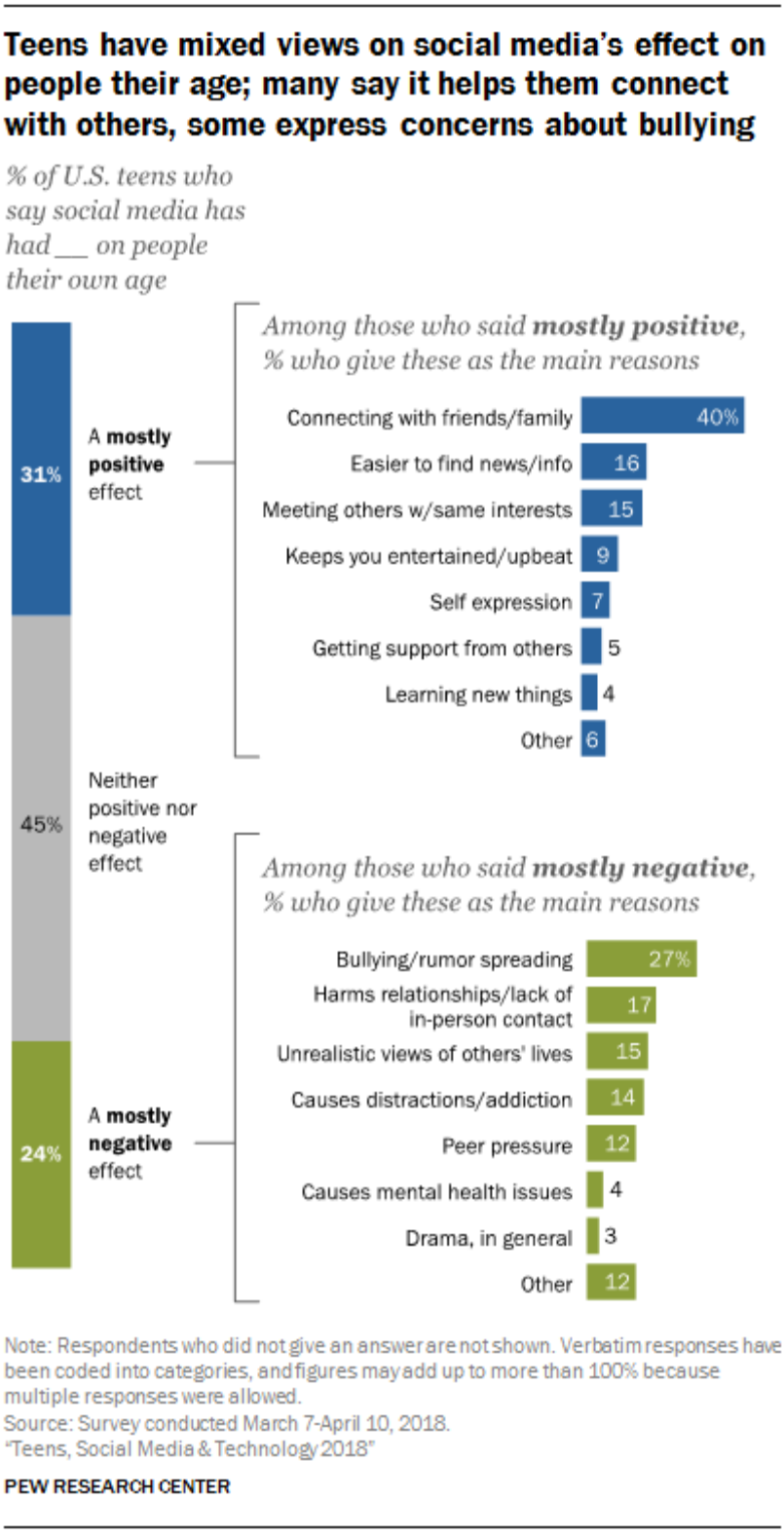


Figure 3



In addition to all of the above reasons teens give for using social media, there is also something addicting about social media. Most teens have constant access to social media through a smartphone. Across all demographics, between 93 and 97 percent of teens have a smart phone, with a growing number (89%) saying they access social media at least several times a day and 45% saying they access it "almost constantly." I have conducted other studies on addiction as well, and the number one answer I get from research participants when I ask them to name something they feel they are addicted to is "social media."

There is so much about social media that draws us in and latches hold. First, humans are inherently social creatures. We are biologically designed to live in groups and to make close social connections with other members of our group. Social media allows us a sense of constant connection with others while requiring relatively little work to make it happen. We can feel connected without having to "meet up." Therein lies the second reason social media draws us in. Humans are genius in our ability to invent tools to make our lives easier. It's what sets us apart as a species, and we're really good at it. Unfortunately, some inventions work so well that they begin to completely erase the "old ways" of doing things. The drive to make life "easier" sometimes means that we sacrifice quality for facility – in other words, we'll often (though not always) take the easy way over the "best" way. Social media feels like easy social connection, so we use it, even if most of us acknowledge that it's not quite as good as an in-person meeting.

Another social benefit of social media is that it allows users to "connect" even with people they have never met in person. By connecting with celebrities, political figures, and other people that feel "important," we, by connection, also feel more important. This feeling of importance also feels good.

But social media is now far more than social. In fact, social media is now an actual career, and a lucrative one. I read a recent news report that Kylie Jenner makes an average of $1.27 million dollars per sponsored Instagram post! In other words, companies pay her a ton to promote their product on her Instagram page. To teens, being a "Social Influencer" feels like a pretty glorious job, with pretty easy requirements. Step 1, get followers; step 2, make money!

Thus, getting followers on social media feels to many youth like a pathway to a glamorous career. However, getting likes and followers is addicting in and of itself, even if it's not a career. Likes and follows are immediate rewards, and who doesn't like to be rewarded? And, because different friends like and follow different posts at different times, the rewards can keep coming, sometimes for days to weeks, all for a single post. What's more, you can get these rewards sometimes for very mundane posts – having McDonald's, smiling pretty, your cute cousin learned to tie his shoe. All of these are everyday occurrences that can feel extra special because of the likes they get on social media. Social media, then, makes boring, everyday life into something more!

What all these Likes create is something we in Behaviorism refer to as a "Variable Reward Schedule." Decades of studies in behaviorism show clearly that a variable reward schedule is the most reliable way to stimulate a target behavior. If you teach a rat that it can press a lever and get some caffeine, for example, you can have the caffeine come out every time it presses the lever (a continuous reward schedule) or every 5th time (or 10th time, or 100th time, all additional examples of a continuous reward schedule). This method is pretty effective at getting rats to press the lever, but the rats eventually figure it out and learn to just press the lever the appropriate number of times only when they need or want the caffeine. Then, the rat will stop pressing until the next time it feels ready for caffeine. But what if you just wanted to get the rat to press the lever as much and as often as

possible? The best way to do that is to change up the interval. So, sometimes it gets caffeine with every lever press, sometimes they have to do it 5 times, sometimes 100 times. You change the interval randomly, to make it unpredictable. This unpredictable reward actually makes the rat press the lever like crazy, and randomly, throughout the day. You can enhance this effect even more by changing the amount of caffeine too. Sometimes they get the "right" amount, sometimes they get less. This unpredictability is where the principle of a variable reward schedule comes from. **Unpredictable frequency and intensity of rewards drive sharp increases in behaviors.**

So, this same principle applies in social media. When a person posts to social media, they never know how many Likes they're going to get. They may get zero, or they may get hundreds. They also don't know when a Like is going to come. Some may come right away, but others might be delayed. This unpredictable schedule of rewards drives the addiction of using and checking social media through the roof. And social media developers know this principle very well, and they capitalize on it!

With all of these factors in play – constant connection to friends and family, linking with celebrities and other "important" people, lucrative earnings possibilities, and variable rewards through Likes and Follows – everyone is susceptible to becoming over-engrossed in social media. But all of these benefits also come at a cost, and the costs of constant social media use are potentially quite great.

The costs of social media

1) **Narcissism is on the rise.** A particularly interesting finding that has been noted in research is a clear rise in the personality trait of *narcissism* that is associated with social media. This finding has been documented in numerous studies now, and this makes sense, if you think about it. Social media makes us feel important. In fact, it makes us feel like people care about every little thing we do. It gives us a stage to "perform" and a constant audience to watch. When people (especially youth) feel like they have a constant audience, they also tend to feel like they are "important." When all of this happens through the key developmental years of adolescence, that trait of importance and narcissism can become "hardwired" into the brain, and become hard to extricate during adulthood. It should be noted, though, that the trait of narcissism is not all bad. There is such a thing as toxic narcissism, and this toxic narcissism isn't necessarily on the rise. There are good parts to narcissistic traits – confidence, pride, charisma – and most people learn to balance their narcissism in a healthy way. Still, the majority of balancing happens through traditional social contacts encountered in youth. As social media encounters replace more and more traditional, face-to-face encounters, there is a real fear amongst psychologists that unhealthy narcissism may continue to rise.
2) **Social distance increases social aggression.** Humans are more likely to attack other humans if they don't have to look them in the eye, and so, yes, bullying can happen on social media. Some people even take pride in "Internet trolling," insulting others and wreaking havoc on the internet as a fun weekend activity, while hiding behind the safety of their computer screen. Fortunately, trolling is actually less common than most of us think. In fact, in my data cited on page 6, trolling made up only 0.5% of all posts, and that was on a totally anonymous social media site, where one could get away with trolling without being identified. Still, when it does happen, it hurts just as much as if it happens in person. Some youth even perceive it as worse, because the bullying is now out there for everyone to see.
3) **Smartphones impair attention span.** Another interesting finding emerging in a number of research studies is that a smartphone reduces attention span. In fact, several studies have shown that just having a smartphone out on the table, rather than in the pocket, impairs focus, even if that phone doesn't actually "go off" (ring, ping, etc.) at any time. Similarly, another recent study found that older adults actually have longer-lasting and more resilient attention spans than younger brains. Again, this finding was attributed to smartphones. Although we can't prove it (it's too late for the kind of studies that can prove such a connection), the general theory is that the ubiquity of smartphones has trained developing brains over the past 15 years or so to process information faster, but at the cost of sustained attention, patience, and complex problem solving. So, while younger brains are quicker at processing and quite skilled at shifting from task-to-task, they are not so good at thinking deeply, for long periods of time, about a problem, at least when compared to older adults who did not grow up with smartphones.
4) **Constant stimulation reduces tolerance for boredom.** Related to #3, above, studies have also found a reduced tolerance for boredom among young adults who have grown up in the era of smartphones. Some may say, in fact, that millennials "have zero tolerance for boredom." While I disagree with the intensity of that axiom, there is solid research, when compared to older adults, that younger people in the modern era become bored more quickly and rate boredom more negatively than their elders. In fact, though I haven't conducted research to back it up, I have noticed anecdotally over the years that youth, much more so than the adults I work with, often confuse boredom with anxiety. When they feel bored or undistracted, many youth today report anxiety! So when did boredom turn into anxiety? I think it has a lot to do with smartphones, again. For many youth, being bored means being removed from technology, and without their technology, many teens experience a very real sense of withdrawal-related anxiety (see #7 below). Over time, youth start being unable to tell the difference between the two feelings. But being bored is actually good for our brains. Boredom actually enhances creativity. Also, in an interesting British study published in 2011, researchers found that, when bored, people tend to engage in unpleasant, but meaningful, prosocial activities (such as blood donation). Boredom seems to turn the mind inward and encourage reflection.
5) **Screens interfere with sleep and other circadian rhythms.** In scientific terms, a circadian rhythm means a daily rhythm, something that follows a predictable pattern from day to day. Biologically, our bodies have an interesting and brilliant way to program circadian rhythms. Our brains have a region (called the suprachiasmatic nucleus (SCN), if you're curious) with the sole responsibility of programming circadian rhythms. That region is located right on top of the spot where your optic nerves meet in your brain. This location is important because it's actually through our eyes that our SCN knows how often and when to change our rhythm from day to night. So, during the day, when our

eyes take in UV light, the light activates our SCN to regulate our daytime rhythms. When the light dies down, our brains know it's time to quiet down and prepare for sleep. So, in short, our brains rely on light to program important daily rhythms. Screens, however, expose our brains to light when our brains don't expect it, and this confuses our brain into thinking it's time to be awake, when it really isn't. That's why it is advised to turn your phone on nighttime mode at least 2 hours before you go to bed each night.

But smartphones don't just interfere with sleep because of light. Even if you do turn on nighttime mode, sleep is a removal from the constant connection we otherwise have with our phones. For many people, this withdrawal psychologically interferes with sleep. For those people, putting the phone away at night actually causes anxiety.

6) **Social media opens a child's social realm to that of adults.** Throughout the vast majority of human history, kids have spent at least half of their day with other kids (most often in school/education or at play). These exposures are important for their social development, but it also protects children somewhat from being too encapsulated by adult ideas and responsibilities before they are prepared to handle it. Before social media, we could all rest easily during the day knowing where our kids were and who they were spending time with. Now that kids have smartphones and social media, their world is opened to infinity. They can connect with anyone, anywhere, and at anytime. Although in most cases this is harmless and although most youth actually know not to interact with strangers on social media, it is still possible for them to be influenced in myriad ways by this new, vastly more opened world.
7) **There is evidence of tolerance and withdrawal symptoms in a small subset of social media users.** As I mentioned above, I've conducted research previously about "digital addictions." In my research, I have found that a small minority (about 5% of people in my studies) actually report feeling symptoms of tolerance and withdrawal from digital content (including smartphones and social media). If you aren't familiar, the terms tolerance and withdrawal were once used in the clinical world to decide if someone had a substance dependence (e.g. alcohol dependence). Tolerance means having to take more of a substance to experience its effects, and withdrawal means that your body undergoes a physiological reaction when the substance is removed from your system for too long. Although we don't know much about a physiological reaction that occurs in our bodies due to tolerance or withdrawal from digital content, there is some evidence that suggests a psychological tolerance and withdrawal. In other words, people report needing more and more digital content to feel satisfied. They also experience anxiety, irritability, sadness, restlessness, and many other negative psychological states when they are prevented from accessing digital media for too long! These indicators suggest there may really be such a thing as "digital dependence."
8) **Some articles have tracked other new psychiatric disorders that have arisen because of social media.** I once read an article that documented cases of "selfitis," which was defined as a unique presentation of obsessive-compulsive disorder around taking Selfies. In these cases, people engaged in compulsive selfie-taking, driven by a heavy, obsessive anxiety that if they did not post a selfie, something bad would happen. Furthermore, they regularly took hundreds of selfies before landing on one that felt "just right." In a similar vein, paranoid schizophrenics can now be found with intense paranoia about what people are saying about them on social media, or about who is "watching" them on social media. The point is that we are seeing a social media influence in real psychiatric disorders now. This doesn't necessarily mean that social media *caused* the disturbance. In fact, in all cases I've seen, the disturbance would have occurred without social media. Instead, it only means that social media creates new ways for psychiatric disorders that are already there to present differently.

What can I do as a parent to protect my child from all of this?

Have an open discussion with your child early on (4th or 5th grade) about the responsible use of social media.

The first step to protecting your child is acknowledging the risk of social media. Have an open discussion with your child early on (4th or 5th grade) about the responsible use of social media. This discussion can include more and more information as your child ages, according to their developmental level. For younger children (4th or 5th grade), stick to the basics:

1) **Outline social media as a form of entertainment that has a beginning and an end.** It is not something that should last all day or to which someone needs to maintain a constant connection. As your child begins to use social media, be sure there is a limited time of day that they use it – maybe 30-60 minutes per day, at most. I encourage chunking this into a single session, rather than spreading it out in small increments throughout the day. The reason for this is that these small increments are what interfere with sustained attention. They also promote that variable reward schedule I mentioned above. Instead, keep it predictable!
2) **Have your child log in and log out each time.** First, logging in and out is annoying and time consuming, so it might make them just avoid checking all together. At the very least, logging out when finished facilitates having that well-defined end. If they're logged out, they won't get constant notifications tempting them to check outside their allotted time.
3) **Use parental controls to turn off Wifi at least 1 hour before bedtime.** Most modern wireless internet routers now have parent controls that allow you to selectively turn the Wifi off of your children's devices at programmed times of the day. Also, have younger children leave their phones outside of their room at night.
4) **Importantly, be sure to have replacement activities to fill the day.** It doesn't work to restrict access to social media if you don't have alternative ideas of things for your children to do. Help them get involved in their community through extracurricular activities. Teach them

a new skill such as gardening, woodwork, autoshop, cooking, laundry, sports, etc. You may be surprised, but most kids actually love that stuff. They'll love spending time with you too, as you teach it to them. If you can't teach it to them, find a class after school for them. Lots of times, you can find such stuff for free.

5) **Talk to them about responsible social media use.** As you create all of these "rules" above, tell them about responsible social media use and the things they can encounter when they do use it. Have a short conversation with them regularly about what they see on social media. You don't have to nag or pry to get this info, and don't do it every time, or else it will feel like nagging. But a gentle prod here and there – "See anything interesting today on Instagram?" can open up doors for them to talk. You can also open the doors by sharing about your own exposures and how you handle them.
6) **Practice what you preach.** Okay, here's the hard one! A lot of us parents have just as much of a problematic relationship with our smartphones as our kids do – sometimes, our problem is worse! It won't work for you to set boundaries for your child if you don't follow them yourself. So, check your own social media usage and set limits for yourself. On my phone, for example, I set an alert to block out my social media apps after I've used them for 30 minutes. Of course, I can override this when I want (and, in the intertest of full disclosure, I often do – my own social media use is a "work in progress"), but the reminder is useful for me to track my own use, and it helps me notice when I've been looking for too long. You can also monitor your usage weekly on your phone through a weekly status report. My phone pops up a notification every Sunday morning around 9:00 to tell me how much "screen time" I've had. Again, this is useful information to tell me how I'm doing, and it was all very easy to set up.
7) **Understand that your child will eventually break your social media rules, and don't be harsh when they do.** Kids are kids, and kids will do kid things. One thing that tweens and teens lack is the ability to think ahead about the consequences of their actions. As a result, they also don't appreciate the dangerousness of some behaviors. Sure it's frustrating when your kid makes mistakes you've told them not to do, but a lot of times they genuinely can't help it. They aren't being defiant; their brains just aren't always capable of remembering in the moment whether the "rule" applies in this situation or not. They can also easily convince themselves the rules don't apply or really aren't all that important. When this happens, and it will happen, be firm and give reasonable consequences (e.g. no Wifi for the rest of the day), but also be understanding and remind them why the rules are there in the first place. Tell them about some of the things in this article and ask them what they think about it. When doing this, remember to "Teach. Don't Judge." In other words, think about your word choice and how you can get your point across without being judgmental. Also, related to #6 above, your child will notice if you regularly break the rules, and they may point it out. If they do, try to take the information in stride. It's easy to get defensive and say "I'm the adult – you can't tell me what to do!" but it's probably more helpful if you take a moment to listen to your child's feedback on your own use. In most cases, they are telling you something meaningful. Make a pact to work on it together!
8) **As your kids grow older, allow them more independence, but encourage continued, open communication.** Someday, we all have to teach our kids to set their own boundaries. If we start them early, they can usually do this more easily than if they started later, but at some point, preferably before they leave the house, our kids need a chance to demonstrate that they can set their own boundaries in healthy ways without us looking over their every move. This means removing some of the rules you set when they were younger, while also giving them additional tools to set their own rules. This may mean giving them choice in how much time they want to allow themselves on social media each day, as well as ways to track when they may be using it too much. They also need to learn how to track problematic use. (see #9)
9) **Know the signs of problematic social media use. And teach your child to notice them too!**
    i. Social media is the first thing you do in the morning and /or the last thing you do at night.
    ii. You waste your time looking at things you don't care about.
    iii. You check notifications all the time
    iv. You contact and talk to friends through social media more than in person
    v. You check or use social media nearly every time you have down time
    vi. You constantly monitor how many likes, shares, or follows you receive
    vii. You search for an internet connection everywhere you go
    viii. You feel a need to post or share most or all of your photos
    ix. You feel tense or anxious whenever away from your phone or from social media
10) **Report bullying when it happens.** Kids don't realize it, but most US states actually have laws specific to cyberbullying, and bullying can be illegal in all states, depending on the nature of the bullying. A review of bullying laws across the US can be found here: https://cyberbullying.org/bullying-laws. Although cyberbullying can sometimes be treated as criminal behavior (and thus managed by police), in most cases, schools handle cyberbullying. If your child is being bullied online, I recommend the following steps:
    i. Provide emotional support to your child
    ii. Attempt to alert the bully's parents, if possible.
    iii. Inform your school principal about the bullying. All states except Montana are required by law to have a formal policy on cyberbullying. Ask to see the policy and work to make sure your child's school is following it.
    iv. If the cyberbullying crosses over into criminal behavior (e.g. assault, criminal harassment, stalking), alert the local police.

STUDENT'S COLUMN

This is a column for students, by students. In this edition, we completed a Facebook poll where we asked kids to respond to three questions. Each question, and a selection of responses, are included below. Try asking your own kids!

From the mouths of babes

By Kids

What stresses you out most?

In this section, we see trends that such as lack of independence (being told what to do; not getting your way), feeling overwhelmed with responsibilities, social rejection, and general fear of pain.

"Being grounded, when I don't get what I want, and when we run out of my favorite juice." (H, age 6)

"Having too much to do at once." (A, age 8)

"People annoying me and being mean to me." (L, age 7)

"School work and sports." (K, age 15).

"Getting the flu shot." (C, age 6)

"Whenever I have a quiz on a test, and I haven't studied very well." (B, age 12).

"That they won't share with me." (C, age 6)

"When they yell at me." (S, age 6).

"When another team beats my team." (R, age 8)

"Not having enough time to do something." (M, age 14).

"Getting bullied, not getting my way, and too much homework." (H, age 13)

"The neighbors always telling me what to do." (K, age 7).

"When I'm in trouble with dad." (A, age 7)

"When I have new "first time ever" days." (D, age 5).

"Fear of failure." (V, age 7)

"Distractions." (K, age 8)

"Having to clean my room." (M, age 8).

What advice do you give kids who are going into the grade you most recently completed?

In this section, trends include general words of encouragement, but a lot of advice centered around kids noticing workload and work demands increasing, so kids advised listening and paying close attention. Some kids offered practical advice about behavior at school (don't shout out, don't stomp on the top floor, eat all your lunch).

"Be good, be nice, be respectful, don't say anyone died or do anything bad or inappropriate." (H, age 6).

"Keep trying and do your best, even when it's really hard." (A, age 8)

"Do your best and have fun." (L, age 7)

"Get ready for multiplication and division and the beginning of hardness." (L, age 9).

"Get your homework done because if you don't you'll get behind really fast" (K, age 15).

"A lot of things might seem hard, but when you really look at it, it's not necessarily quite as hard as it seems." (B, age 12).

"Great job!" (S, age 6).

"Keep up the good work." (C, age 6).

"Pay attention and listen, the work will be a lot easier." (T, age 10)

"Listen," (R, age 5).

"Don't stomp on the top floor." (K, age 7).

"Just listen and you'll be safe. And don't shout out." (A, age 7).

"Just try." (J, age 13).

"Recess is the best, so eat all of your lunch or they won't let you go outside." (D, age 5).

"Help each other," (K, age 8).

What is the most important thing in life?

In response to this question, by far the most common response was "family," but other common answers included "God," "Being alive," and "Being happy." Because individual responses are quite repetitive, we don't include quotes from respondents here. There were only two variant responses from family, God, living, and happiness. These were 1) helping people, and 2) picking your friends. Clearly, kids fairly universally agree on what is most important in life, and these are all things we could each perhaps do better at remembering on a daily basis.

Healthcare for transgender youth: A primer

by Jason Steadman, Psy.D., ABPP

If you work in healthcare, there is a good chance that someday you will encounter transgenderism. In my fellowship in Community Health and Integrated Primary Care, I received some specialty training in providing mental and physical healthcare to transgender persons. In this article, I share insights from that training, as well as some best practice guidelines to assist other healthcare workers with growing more comfortable in working with transgender youth.

Transgender youth present with unique healthcare needs, but few professionals have experience and training specific to these needs. It is hard enough, often, for transgender adults to find competent healthcare workers to provide for their needs. However, it is often even more difficult for youth. This is especially true in rural areas, where there are usually fewer healthcare providers in general and fewer specialists too. Transgender mental healthcare should be considered specialist care. In other words, therapy with transgender youth is very rarely included in general training curricula for therapists. In most cases, therapists obtain specialized training in transgender care, which they then implement in their practice. Thus, if you or someone you know is looking for mental health support for transgender issues, it is advised to find someone with specialty training in this area, rather than a "general" therapist. Though general therapists can provide some help, specialists will typically have more knowledge about unique issues in transgender youth, including unique medical issues. Specialists will also have a better understanding of developmental issues relevant to transgender youth.

Developmental considerations in transgender youth

In typical child development, gender identity begins to develop around 3 or 4 years of age, usually toward the later end of that range. It is during this period that children often begin to truly "discover" their private parts and learn how these private parts are used to differentiate boys from girls in culture. It's also during this time that they begin to understand other ways a culture differentiates boys from girls – through clothing, interests, demeanor, and general behaviors. Make no mistake, though, the majority of these differences are culturally defined and are not biological differences. In other words, although biology defines sex, it does not define gender. In current terminology, gender is defined as the way a particular culture represents differences in sex, whereas sex is defined as the biological differences that occur as a result of exposure to sex hormones.

It's also important to understand that neither gender nor sex are dichotomous – there is far more variety than just "male" and "female," and it's not as simple as just looking at whether or not someone has a Y chromosome. This is easier to understand if you know how sexual development occurs. The "default" sex in humans is female. In other words, an embryo will develop female biological characteristics unless it is exposed to androgens. Androgens, by definition, are hormones that produce male characteristics. It's only through exposure to androgens that an embryo "becomes" male. The Y chromosome is responsible for telling the body to produce these androgens in humans.

It's possible though, for example, to have androgen insensitivities, where a person has a Y chromosome, but they don't have any of the receptor proteins for androgens to have any effect. As a result, these individuals have a Y chromosome but externally develop female characteristics. There is another interesting genetic anomaly found in a group of people from the Dominican Republic. This group, called *guevedoces* (which roughly translates to "eggs at 12"), are born with female eternal genitalia, and are thus raised as females. However, when they turn 12, their external female genitalia changes to male genitalia (yes, really!). This occurs because at puberty we release different hormones than we released prenatally. So, the *guevedoces* people have an insensitivity to prenatal androgens but not to pubertal androgens. As a result, when they hit puberty, the sex hormones finally take effect.

These are only two of myriad examples of the complicated definition of sex and gender. What sex are androgen insensitive females? What about the *guevedoces*? What is their sex? What is their gender? These examples are why binary coding for sex and gender doesn't work. There is simply more diversity than man and woman.

So, one important feature of working with transgender youth is a thorough understanding of how sexuality and gender identity develop in various people, in various groups, across various cultures. Though most of us would freak out if we suddenly started developing a penis at 12 years old, the Dominican tribe where this anomaly occurs simply accepts it as a different biological variation of their people. So, when these children begin to change, they are able to accept these changes as normal. They just understand that they are a *guevedoces*, and it's no different than any of the other changes that occur in puberty. In this culture, *guevedoces* is just one of several acceptable cultural variations of gender in youth. Thus, **one key factor for any therapist or other healthcare professional working with youth is to understand how variations in gender are understood within the local culture and how these understandings impact psychological development.**

When do youth develop gender identity?

Gender identity emerges in children around age 3 or 4. It is during this time that children begin to understand there are differences between males and females. They also begin during this time to align themselves with the various features of male versus female, as defined by a culture. So, gender dysphoria can occur as early as 3 or 4 years, but, importantly, *it does not have to emerge that early to be genuine.* There are many transgender youth who do not realize their gender dysphoria until later in life, perhaps until puberty or even adulthood. Many children who form a transgender identity

later in life, though, have a notable history of either internal or external feelings of gender dysphoria. For many youth (and adults), they just do not realize that the way they feel is normal and can be defined by a meaningful term – transgender. Once they realize transgender is a thing, most transgender youth can tell you a clear story about how they've "always felt different," but just didn't know what to call it. So, an important developmental process for youth of all gender identities is learning about all the possible variations of gender identity there are. After learning about them, most youth come to find which one describes them best.

However, it should be noted that a mature gender identity is one that takes time to process and formulate. Even cisgender individuals change our understanding of our own gender identity over time. It has taken me a lifetime, and many years of education and self-reflection to figure out what it means, to me, to be a man. As a child, I had very basic ideas of manhood, and I saw many variations of manhood in my everyday life, but there is no way I could have, at any point in my childhood, have developed as nuanced a view of manhood as I have now. No, my definition of manhood has changed with my maturity. All humans go through a similar process. We deepen our understanding of various gender identities as we age. But this process is perhaps more complicated for transgender youth, because these youth do not as often see clear depictions of their identity in everyday life (although that is changing, as more transgender individuals come out in the public eye). Still, the process is the same, fully matured transgenderism will not be achieved during youth. **It will take years of self-reflection and pensive interpersonal exploration for a youth to grow into a transgender adult. Along the way, they may explore multiple identities, or multiple forms of transgender identity, before they find one that fits best. This is normal, and no different than a young boy or young girl "trying on" different variations of manhood or womanhood as they age.**

However, knowing that gender identity will not fully mature in youth does NOT mean that it is best not to administer transgender medical interventions in youth. In fact, numerous studies support that such medical interventions actually decrease overall risk of psychological complications as youth age. Furthermore, almost all youth who undergo transgender medical interventions state later in adulthood that they do not regret it and are happy with the ultimate outcomes.

Medical interventions for transgender youth: A cursory overview

Around the onset of puberty, youth may start taking hormone blockers, to block the onset of secondary sex characteristics associated with puberty. The specific medications used and the specific changes that are being blocked are different depending on the medication being used and on whether the youth is a transgender male or transgender female. Males transitioning to female are given drugs that block the effects of testosterone, thus preventing changes such as testicular enlargement, deepening the voice, growth of facial hair, thickening of body hair, thickening of skin, and distribution of weight to the "male" prototype, where weight is predominantly carried in the shoulders. Blocking testosterone also decreases muscle development. Females transitioning to male will take drugs that block estrogen and/or progesterone, thus preventing secondary female sex characteristics, including menstruation, development of breasts, and pubic hair growth. It is important to note that hormone blockers are reversible. If a youth stops taking these blockers, they will develop the secondary sex characteristics associated with natural hormone exposure.

There are side effects associated with hormone blockers, and so it is important that administration of such blockers is monitored by a licensed physician with experience in prescribing such medications in youth. In most cases, pediatric endocrinologists manage these interventions. Still, because hormone blockers are reversible, these are considered the lowest level of care for transgender youth.

Once youth reach the age of 16 (at least), they become eligible for hormone replacement therapy (HRT). HRT does not just continue blocking naturally-produced hormones, it supplements the body by adding the hormones of the desired sex. For males transitioning to female, HRT introduces estrogen/progesterone. For females transitioning to male, HRT introduces testosterone. HRT is only a *partially reversible* intervention. In other words, there are some physical changes that can result from HRT that cannot be reversed. For example, once testosterone causes the growth of facial hair and a deepened voice, those processes do not stop. Similarly, once breasts grow, they do not go away when estrogen/progesterone is stopped. Because HRT is only partially reversible, there is a higher standard for meeting eligibility criteria for HRT. Youth who desire and ultimately undergo HRT may be required by their physician to have been in therapy for at least 1 year with a therapist who also has experience in transgenderism in youth. Some physicians even require the therapist to provide a letter stating a child is ready for HRT. At the very least, such youth have to demonstrate a fairly long-standing history of living or at least wanting to live as their desired gender. Most physicians will not prescribe HRT if there is not a clear history of transgender identity.

The final category of medical interventions includes gender-confirmation surgery (GCS), which, as the name implies, involves surgical procedures to allow the body to match a person's internal gender identity. Sometimes, GCS involves surgeries that are not specific to transgenderism, such as breast reduction or augmentation, shoulder implants to increase appearance of musculature, and other plastic surgery procedures involving the face. Other times, GCS may involve surgeries that are specific to transgenderism, including a vaginoplasty or phalloplasty. Not all transgender individuals choose to undergo GCS, though. GCS is expensive and rarely covered by insurance companies. Also, not everyone wants to have GCS. Importantly, whether or not someone chooses GCS does not make someone more or less transgender.

What are the psychological considerations in deciding whether or not to move forward with medical interventions?

The decision to delay puberty in a developing child is not without controversy. Blocking sex

hormones has some medical side effects. Most commonly, bone mineralization relies on the presence of sex steroids, so one side effect of suppressing them is possible lower-than-normal bone density. Physicians who prescribe these medications will closely monitor bone density. Other common side effects include weight gain, irregular vaginal bleeding (for FtM patients), and emotional lability. So, psychologically, a patient undergoing puberty suppression should be prepared to manage these side effects and should be able to keep regular medical appointments.

Medical treatments are also imperfect, and, even with puberty suppression, subtle signs of puberty can still "slip through" (for example, menstruation can re-emerge). Youth will need to be psychologically prepared for these factors that can be inconsistent with their desired goals.

Importantly, delaying puberty can have psychosocial effects on youth. Specifically, they do not undergo puberty at the same time as their peers, which risks contributing to further psychosocial stress due to differential development. However, general professional consensus is that the distress from gender dysphoria is greater than stress of delayed puberty, and so delaying puberty creates a lesser psychosocial risk overall.

Lastly, the most frequent concern among parents and clinicians is that pubertal children are too young to decide on whether or not to undergo a conceptually "optional" medical intervention. Fortunately, there are emerging data to address this concern. Specifically, in published research studies, the extreme majority (virtually all) of children 12 or older who undergo puberty suppression continue with a trans gender identity through adulthood. Long term follow-ups show no incidence of "regret." In fact, it has been suggested by some that a desire for puberty suppression after age 12 can be considered diagnostic of true gender dysphoria, because such a presentation almost never reverses. Thus, the current available data strongly suggest that pubescent transgender adolescents do make reliable decisions about puberty suppression and that supporting this decision for puberty suppression has far better outcomes than denying it, as those who are denied gender-affirming healthcare are placed at much higher risk for mental health problems.

What mental health interventions are recommended for transgender youth?

Contrary to popular tradition, not all transgender youth need professional mental health support. Mental health support is not designed to treat transgenderism itself. In fact, transgenderism should not be considered an illness that needs treatment. Rather, mental health support is designed to treat the *sequelae* of transgenderism. Having a transgender identity places a person at great risk for *minority stress*, an umbrella term used to describe social discrimination and cultural prejudice that minorities are often subjected to. One national survey found that 78% of trans students were harassed or assaulted within the past year. Some youth are able to cope quite well with minority stress, without professional support, but others may develop symptoms of depressive, anxiety, and/or trauma-related disorders. It is these latter youth that benefit most from formal mental health intervention.

Common interventions include individual and/or group therapy. Group therapy seems to be especially beneficial, as it introduces transgender teens to others who are like them. Ideally, a therapy group consists of youth who are in different stages of transition, to allow those who are further along to provide mentorship to those who are just beginning. Thus, another common intervention uses a mentorship model. Because open transgenderism is relatively rare, youth often have great difficulty locating mentors in their communities, especially if they live in small, less diverse communities. So, many youth turn to online resources for support. Of course, as with any online source, there is a risk that youth may be given incorrect information online, and so it is important for mental health professionals and parents to be aware of high-quality online sources to recommend to youth. I especially like http://genderspectrum.org, which is rich with high quality, accurate information for youth. Youth can also access online mentorship through the website. Still, parents are encouraged to monitor online interactions, and it is often useful for therapists to focus at least some time in sessions discussing online safety with their young clients.

Another focus of mental health support is to keep clients centered on a realistic depiction of what they can expect with their transition. Many patients, in their excitement to transition, develop unrealistic expectations about how quickly and how "successfully" their bodies will change as a response to treatment. There is a fair risk of body dysmorphism in gender dysphoria, where youth may perceive something as being "wrong" with their body that, objectively, is perfectly normal. For example, a MtF youth may have ideas about the "feminine ideal" and how their body does not match that. The same is true for FtM youth. Therapists can help youth learn to manage body dysmorphism by helping youth appreciate the great variety of bodies that fall within the normal range of healthy human functioning. For example, therapists may acknowledge that not all women have breasts or that many women have deeper voices. Similarly, they can acknowledge that most men do not have an ultramuscular physique and not all have square jaws. At the same time, therapists have to exercise caution that in doing so they do not also inadvertently take a non-affirming stance and should refrain from making such statements before a secure relationship is established with the transgender youth in which the youth knows the therapist is "on their side." Saying things such as "You're perfect just as you are!" can be perceived as non-affirming and a passive-aggressive means to suggest the child should not transition at all.

Other resources

UCSF transgender care guidelines
https://transcare.ucsf.edu/guidelines

Gender Spectrum
https://www.genderspectrum.org/

WPATH https://wpath.org/

Play in Review with Cindy Butor

This column features a discussion of the therapeutic benefits of *Dungeons and Dragons,* the classic tabletop role-playing game enjoyed by millions of people all over the world. This "Play in Review" uses a question and answer format, where Dr. Steadman briefly interviews a friend from college, Cindy Butor, about her own experiences with D&D. Cindy is currently a fulltime librarian living and working in Kentucky. She has previously published *In Purr-suit of Happiness,* a D&D 5th edition adventure, and other D&D products, currently available online.

*"Role-play…*is *absolutely essential to our human psyche."*

Dungeons & Dragons (D&D) has been around for so many years, and has permeated our culture so much, that almost everyone has at least heard of the game. Many may have even seen the game played on TV or somewhere else. For those of you that don't know, here is the basic premise. Gameplay consists of a Dungeon Master (DM) and a team of other players/adventurers, whose goal is basically to explore the dungeon created by the DM. The DM describes his or her created dungeon to the players, and then the players take turns responding to the environment. A game dice (most commonly, a 20-sided dice) is used to help decisions about certain parts of gameplay (e.g. whether or not a player's sword swing hits an enemy or bounces off). Generally, though, gameplay is open, fluid, and flexible, with players having to "think on their toes" to solve problems laid out in front of them. Of course, the actual rules of gameplay are more complex. For interested readers, the full basic rules are available for free online here. They are 180 pages long, but to truly understand the richness of D&D, it helps to peruse these rules and/or watch a few games. Many groups now stream their games online, and so games can be viewed at home. If you want to view a game in person, local gaming stores usually host groups routinely and are often eager to welcome new players.

At its heart, D&D is about role-playing, and role-playing has been key to psychotherapy for over 100 years. Even Sigmund Freud, the original psychotherapist, regularly used role-play in his methods, and for good reason. Through role-playing, humans are able to explore different aspects of themselves – personality traits they usually keep dormant, behaviors they may be too shy to display in daily life – and of relationships with others – specifically, how others respond to different parts of the self. As psychologist, and as researcher of the Self, I (JS) believe that a well-developed Self is extremely important to optimal mental health functioning. But, interestingly, the Self is complex. First, it does not exist or develop in isolation. Rather, the Self is clearly and intricately related to our experiences with others throughout our life. Object-relations theory is my favorite exploration of this process, but a full description of object-relations theory is beyond the scope of this article. For readers interested in the theory, I refer readers to the works of Harry Stack Sullivan, Melanie Klein, Donald Winnicot, Ronald Fairbairn, Margaret Mahler, Anna Freud, and Heinz Kohut. Second, the Self has been found in multiple studies to be key to optimal personality functioning across the lifespan. For a comprehensive review of how the Self develops over time and of what happens when its development is derailed by adverse experiences, Susan Harter's *The Construction of the Self (2nd edition),* is excellent. The major takeaway from all of the above, though, if I could *oversummarize* for the sake of brevity, is that humans construct key features of their self-identity, and consequently key building blocks of their overall mental health, through regular engagement of role-play, starting in childhood and continuing throughout the lifespan. Role-play, then, I would argue, is *absolutely essential* to our human psyche.

So, as an object-relations theorist, when I look at D&D, and as I think about its use as a therapeutic tool, I focus most heavily on what the role-playing features of D&D do for improving our Self-Identity. However, it should also be noted that D&D has *many other* psychological benefits in addition to its effect on the Self. Briefly, D&D (and other, similar games) have been shown through research to have beneficial effects on cognition, with players building skills at creativity and problem-solving. Players also often learn about economics (i.e. exchange of goods). Perhaps as much as anything, D&D groups build social skills. Role-playing games also tend to increase a person's "openness" to new experiences. For a more thorough review of how role-playing games influence our psychology, I recommend *The Proteus Paradox,* by Nick Yee (although Yee focuses on video-game RPGs in his book, the lessons also apply to D&D).

So, with all of the above as an introduction, let's start our interview with Cindy:

JS: How long have you played D&D? When did you start playing it? How did you get into it?

When I was in high school, my sister and her friends would play infrequently and, if I was lucky, they might let me sit in on a session or do some light exploration, but I spent most of my time focusing on character creation. I would write up horribly complicated backstories and draw intricate portraits while they hashed out the details of the encounter. It was rare that I rolled the dice or paid attention.

However, a few years ago a friend asked if I and some other women wanted to start a party and play together. I said yes, and it quickly became one of my favorite activities. I started to follow streams like Dice, Camera, Action from Wizards of the Coast and Critical Role from Geek and Sundry, bought the Player's Handbook and other basic books, and delved into the rules, lore, and community. Since then, I've only gotten more involved, especially as I've gotten to know more members of the community and started to DM my own games.

JS: Thinking back over all the time you've played D&D, how have you changed since when you began? What role did D&D play in facilitating those changes?

When I first started seriously playing, I was pretty selfish. DnD is a collaborative game, and while you **can** do things solo, you really shouldn't. It's important to back up your party members, lend your skills judiciously, pay attention, and make sure that the DM is having a good time too. Initially, I fell into the trap that a lot of amateur players do, which is to think it was a solo adventure all about my character's motivations and desires. Now I try harder to make choices that make the game more fun for the DM and that give my fellow party members the support they need. As a DM, I reward players for working together and work with them on the narrative beats of our campaign so they don't feel bored or blindsided.

I've also tried to incorporate these skills into real life too. I've never been enthusiastic about collaboration or group work, but playing DnD has helped me see the value in other people's contributions. It's also given me the opportunity to practice compromise, non-aggressive confrontation, and dealing with people offering criticism or going against my plans. I don't think I'm perfect at these skills yet, but DnD has honestly helped me get better at them. People actually call me a team-player now!

JS: What is one of your most positive memories involving D&D?

I have so many good memories that it's honestly difficult to choose! I'm going to cheat and choose one from being a player and one from being a DM.

As a player, my most positive memory is the time my character, a high elf paladin, died. I was playing a one-shot charity game with some amazing people, and I took point on trying to kill the big baddie. I managed to get him down to about a quarter health when he sent all of his minions (four beholders) after me. I died, but the DM let me narrate the moment, and my party members used it as a rallying cry. They managed to kill the boss and survive without any more casualties. It was a really powerful, emotionally charged moment, made all the more so by the honest emotion my co-players felt when my character died. We posted about it on Twitter for several days afterwards, planning ways to resurrect my character, and have become online correspondents. I absolutely loved it.

My most positive memory as a DM isn't quite so epic, but it makes me even happier. About two years ago I started playing a regular game with some friends. Two of them were friends who had moved away that I wanted to keep in touch with and one of them was the girlfriend of my girlfriend's coworker. We'd only met in passing once or twice. However, after getting together almost every week for two years, we've all become firm friends. I've been to all of their weddings, helped them move, sat for their pets, talked them through some tough times, and they've done the same for me. Playing regularly also motivated me to get more involved in the DnD community, to go out and meet people, publish things, and keep learning more

JS: Surely things aren't always wonderful. What is a prominent negative memory involving D&D? What was your takeaway from that memory?

Ironically, my most prominent negative memory comes from that same DnD group that kick-started my involvement with the game. We were all new players in that group and really didn't know what we were doing, so we made a lot of the classic blunders of trying to play solo, not sharing information, splitting the party, not taking notes, and just generally being a little bit terrible. I share blame in that because I played way too aggressively at first, but even after I tried to calm down and be more communicative, I couldn't get the rest of the party to support my character or the DM to help mediate some of the problems we were having. Eventually, I decided to quit because it felt like I was constantly getting either attacked or abandoned by my own party members and just wasn't having fun.

Since then, I've learned how important it is to bring up issues not just to the DM but to the whole party. While the DM does serve as a kind of referee, it's up to everyone to work together. Had I been more upfront about my issues (or even just openly apologized about my aggressive gameplay), I might have been able to stay in the group and have fun with everyone.

JS: You've run a fair share of games as a Dungeon Master. Could you name a few things you have observed in other players that has intrigued you?

I love seeing how creative and adaptable players are. I have a tendency to tunnel vision things and choose the most direct route, so when I see players make complicated plots to open doors, get an item from an NPC (non-playable character), or otherwise get out of a situation, I am always really impressed. It reminds me that there is more than one way to accomplish something and, just because it's not what I would have done, doesn't mean it wasn't a good idea. I also really love seeing players support each other, sometimes deciding to forego a reward, take damage, or not get the killing blow. I remember the first time one of my players willingly took opportunity attack damage just so they could heal another player that was bleeding out; it was such a selfless act and it really did turn that tide of that encounter.

JS: In your own words, what do you think the "average person" who has never before played D&D could learn from the experience?

I think they could learn how to improve their collaborative and problem-solving skills. DnD is fun and can be terribly silly, but it's also one of the few ways we can practice these skills in a safe environment. Sometimes when we're at work or with our loved ones, we don't choose new coping mechanisms or take risks because we're afraid and worry about offending people, ruining relationships, or other negative consequences. And, even if we learn these skills in therapy or through self-help books, we don't always have the chance to practice them in a live environment. However, DnD is just a game, and it is fully possible to retcon* an action or talk it out later. If you make an interpersonal or problem-solving mistake, it doesn't have to bleed into your real life. I think everyone could use more opportunities to practice those skills.

**Retcon stands for retroactive continuity. It's a literary term describing when an author imposes new information or a different interpretation of past events in order to provide continuity across related works. Most often, a retcon is an improvisation as a narrative changes midway through the story.*

JS: What tips do you have for new players to get the most out of the game?

Remember that it's not all about you! You're playing a collaborative game, and **everyone** should be having fun. Sometimes that means taking turns, doing something you don't really want to, or trying something new. The **best** encounters I've had are ones in which everyone did something unexpected. Sometimes that means letting someone else lead the charge or using a support spell instead of an offensive one or not plunging into your super edgy backstory. Just focus on having fun with your friends (or making new friends in the process), and you're going to do great.

JS: And finally, there's an old wives' tale that D&D is only for "nerds" or "losers" – social outcasts who prefer to live in a fantasy world, rather than the real world. Sometimes, parents might worry their children are "missing out" on more meaningful exchanges if they spend too much time in role play. Others fear they may be judged harshly if word gets out they are playing the game. What would you say to people who might express these (and other related) skeptics?

I would remind them that, regardless of how old you are, you **need** play and socializing and that's exactly what DnD provides people. At its core, it's just a game, and if you don't have a major objection to your kids playing Monopoly or football or reading books or watching movies, then there's no real reason to fear DnD. Yes, some people still think that DnD is nerdy and weird, but by stigmatizing its play at home and telling kids not to play it/hide their love of it, you're contributing to that problem. Besides, highly successful people like Stephen Colbert, Felicia Day, Dwayne Johnson, and Tim Duncan play DnD as do millions of other people. So let your kids play DnD and learn how to play with them; you'll be pleasantly surprised how resourceful and creative they are.

Storytime

Shadows in the Sunlight

by "Tess"

Names and several details have been changed to protect the identity of the original author, and the story is published here with the author's permission.

Trigger warning: This issue's story is designed for an older audience. It deals with trauma, including witnessing a brutal murder and sudden infant death. It's told from a child's perspective, and ultimately ends with a healing message, but readers should be aware that the content can be triggering for some, especially for those who may have their own unresolved trauma. The story uses direct terminology, and doesn't sugarcoat. This is a real story, with enough details changed so that the author can't be identified. If you find yourself having similar experiences as the protagonist in this story, don't be afraid to reach out to a mental health professional for help. As Tess tells us in this story, there is a way to heal, even if it isn't so easy.

"Perhaps there is more understanding and beauty in life when the glaring sunlight is softened by the patterns of shadows."

Virginia Axline, Dibs in Search of Self

Tess awoke drenched in sweat, panting for breath; her heart was racing. Another nightmare! This one was worse than the last. She searched for her mother, but mother wasn't there. For a moment, Tess had forgotten she wasn't sleeping in her own bed. She wasn't even sleeping in her own room. She looked around, and everything looked strange. The walls weren't her walls. The door wasn't her door. She didn't have any of her toys. She wasn't allowed to bring them. Nothing was familiar. This frightened her more! Who could she call to calm her from the nightmare? Where would she go? She only met her new parents yesterday. They seemed nice enough, but so did the last family at first. "They all seem nice at first," Tess thought, "but none of them are Mother."

Tess's dreams were always the same – memories. Some happy; some terrifying! Tonight's dream was the one she had most often. It was the dream that started her real-life nightmares – when she was 9 and saw a man kill her mother at the park. She was walking home from the movies that night. Her mother took her to see a cartoon. It was a fun night. After the movie, they stopped for ice-cream, even though it was getting late. Mother wanted to "spoil Tess a bit," telling her she was proud of her for her hard work at school. She doesn't remember a lot of what happened next. Tess's doctors tell her it's because she got so scared her brain got confused and lost track of the memories, even though they're in there somewhere. What she does remember is seeing her ice-cream on the ground, next to her mother's body. She remembered thinking the blood looked like strawberry syrup. She doesn't remember why it happened. She doesn't remember the man's face. She only hears her mother's voice, "I'll give you anything! Don't hurt my baby!" But the man didn't say anything. Tess only remembers the knife – a hunting knife like the one her grandfather used. She didn't see it go inside her mother. She only saw her mother fall over and go all white. She saw the man run away. She was alone in the dark. She got her mother's phone and called 911. She remembers the dispatcher's voice – it was calm and quiet, soothing. She tried to cover her mother's wounds to stop the bleeding. She saw Mother's eyes blink slowly. She heard Mother try to speak. She told Mother, "I love you! Help is coming!" But help was too slow. Help couldn't save Mother. A person from across the street came over to help. Another man. A stranger. Tess remembers being frightened by the stranger. She let go of mother's wounds and backed away. She saw a bunch of blood spill out when she let go. That detail always hurt. Tess can't help but think if her mother would've lived if she didn't let go. Her doctors tell her it's not her fault, that there's nothing she could've done. The man that came put his hand on Mother's wounds. He told Tess, "It's okay honey! I'm here to help! You did a good job! Is that the police on the phone? Can I talk to them?" Then

another woman came. She grabbed Tess and gave her a hug. Tess didn't care that this woman was a stranger. She just cried, and the woman held her. She was an older woman. She smelled like Tess's grandmother. Tess buried her head in the woman's arms. She didn't want to look. She can't remember the woman's name now.

By the time the ambulance came, Mother was already dead. Tess was still holding onto the older woman. She can't remember the rest. Another woman came. A social worker – Marta. Marta was there the next day when the police talked to Tess to ask her what happened. Tess wanted to help the police, but she couldn't. She couldn't remember. If only she could remember, maybe they would catch the bad man! Another thing that was her fault! The police told her it's okay. Detective Reedy was kind. He had soft, blue eyes. He made Tess feel safe. Tess remembered that if she ever had a dad, she'd want him to be like Detective Reedy. But Tess didn't have any family left. Grandfather died peacefully in his sleep a few years ago. Grandmother was in a home. She couldn't remember Tess anymore, even though Tess still visited. Grandmother couldn't take care of Tess.

Marta helped Tess find a foster home. "A foster home is a family you stay with to take care of you while we find you a permanent home," Marta explained to Tess. But Tess had a permanent home – her home. The home she lived with her mother in. She didn't want a new home. But Tess needed adults to take care of her. Marta found a home quickly, The Smiths. The Smiths had a lot of foster kids, and Marta said they could always be counted on to take in a kid who needs a home. After about a week in the Smiths home, she learned why. One of the older kids in the home warned her that the Smiths were "okay," but they "hardly ever talk to us." He explained to Tess that the "Smiths get money for every kid they take in, but they don't really care about us. It could be worse, though. The last family I had used to hit us." Tess soon learned what the boy meant. In the 3 weeks she lived with the Smiths, they only spoke to her probably 10 times. They didn't bother her, and she didn't bother them. There were many kids in the home, but it was a lonely home, without love. After 3 weeks with the Smiths, Marta found Tess a "better" home. Marta explained that the Rogers wanted to take in Tess with a chance of adopting her. They would foster first, and then would decide if they wanted to adopt her.

Tess's nightmares about her mother's death started coming more frequently. Marta helped her find a therapist, but Tess didn't like her therapist and she didn't like therapy. She didn't want to talk about what happened anymore. Talking only made the nightmares worse. Tess also started to feel sad and angry all the time. She yelled at the Rogers when they told her what to do. When Mrs. Rogers tried to hug Tess, Tess would cry and push her away. One time, Tess even hit Mrs. Rogers in the eye. It gave her a black eye. Tess also started to throw things and break things. That's when Mrs. Rogers found out she was pregnant. One day, Marta came to see Tess and told Tess she couldn't live with the Rogers anymore. When Tess asked why, Marta tried to explain that "sometimes these things happen" but that she would keep looking for a permanent home for Tess. But Tess knew the real reason was because the Rogers were scared of her and didn't love her enough to keep her.

Tess started to wonder if anyone would love her again. It had now been 8 months since her mother died. The police still didn't find the killer. Detective Reedy came to visit Tess everyone once in a while to keep her updated. But the last time he came, he told her, "Tess, I'm sorry. I'll keep trying, but I haven't gotten any new information in months. The trail is cold." Tess knew what this meant. Tess started seeing a new therapist. She liked this one better. He was easy to talk to. She told him she knew what it meant when Detective Reedy said the trail was cold. She said it meant he gave up, that they'll never find the killer. That's when Tess started to feel afraid the killer would find her. "What if he thinks I saw his face?" "What if he thinks I can identify him?" That's what made tonight's dream so scary! When she lay down to try to go back to sleep, she thought she could see the man outside her window. She screamed! Mrs. Singer came in to check on her. Tess told Mrs. Singer there was someone outside. Mrs. Singer went to look and didn't see anyone. She came back to the bed and said, "Tess, did you know that I once had a little girl who would be about your age now? Her name was Lynn. She died when she was a baby, while asleep in her crib. The doctor's told us that just happens sometimes, that there was nothing we could do. But I didn't believe it at first. I thought, 'If I would've been there, I could've noticed when she stopped breathing and I could've woke her up and everything would've been fine.' I blamed myself. For the longest time, I couldn't sleep at night. I would dream about finding Lynn. Sometimes, my dreams would be so real I couldn't tell what was a dream and what wasn't anymore. It's been 10 years, and I still remember Lynn, but now, I remember her smile. I remember her laugh. I remember her smell. I remember everything I loved about her. I still feel sad that I don't have her anymore," Mrs. Singer was crying a bit now. "Whenever I have bad dreams, I look around for Lynn, like she's still there. I know we just met yesterday, but if it's alright with you, if you want, I can sleep in here with you. I'll sleep on the floor. That way, if either of us has a bad dream, and we start looking around for somebody, someone will be here. But you can say 'no' if you want. It's your choice. You always have a choice in our home."

Tess could tell something about Mrs. Singer that night. She could tell that even though Mrs. Singer wasn't *her mother,* she was *a* mother. Tess told Mrs. Singer, "Okay, you can sleep in here." Mrs. Singer then said, "And Mr. Singer will help keep you safe too." Mr. Singer, who was standing outside the door, peaked in with his soft eyes, not blue like Detective Reedy's, but a deep brown. He smiled at Tess and said, "I won't let anything bad happen to you. I promise!" Tess knew he couldn't really keep that promise, but it was nice of him to say, and it made her feel better at least to know he understood her fear and didn't try to tell her, "it was only a dream."

Tess started seeing her therapist every week. Together, they did something called "Trauma-Focused CBT." Tess's therapist explained why she had such a hard time in the Rogers' home – PTSD, he called it. He also told her that it won't always be so hard. That people get better from PTSD. That it can be treated. More importantly, the Singers came to therapy too. They learned about PTSD and TF-CBT. They told Tess, "We're in this together with you! We can do this together!" None of Tess's other foster families tried. They just dropped her off at therapy and left her, and they never asked the therapist questions.

One day, after Tess had lived with the Singers for about 4 months, and after Tess had started to finally feel better – she was making progress in her therapy – the Singers sat down with Tess to tell her something. She was nervous. She really liked the Singers and she was afraid they were going to tell her they couldn't keep her. It happened before, with the Rogers, after all. And she knew she was a lot of work, and felt the Singers may be getting tired of her. But that's not what happened this time. Instead, the Singers told Tess, "We want to tell you something, but first we want you to know that you don't have to say anything back if you don't want. Remember, you always have a choice in this house, and this is no exception – you have a choice here too." Then, they both said, in unison, "We love you, Tess!" and then Mrs. Singer added, "And we want you to be in our family forever, if you want! We want to adopt you!" Tess wept. But this time her tears were tears of joy. She grew to love the Singers too. She beamed a smile, stood up, hugged them, and said, "Yes!"

Tess is now 15! She still lives with the Singers – Mom and Dad now – but she no longer has PTSD. She thinks of her mother often, and still occasionally has nightmares, but they aren't as often, and they aren't as bad. Detective Reedy never found the murderer, and still no one knows who killed Mother or why he did. Tess believes now she'll probably never find out. She hates the man who took her mother away. She hates that there is darkness and death in the world, but the Singers, and her therapist, who she still sees once a year for an "annual checkup," helped show her that there is also light in the world. And she has learned to love the Light, in spite of the Dark. The monsters in her memories are not gone, and Tess will always carry her pepper spray now, to help her feel safe, and she still can't eat ice cream with strawberry syrup. But Tess has control over her monsters now. They no long come out without warning, and Tess can put them back where they belong when she needs. And that's what being "better" means – it means not forgetting, but not letting trauma control your life.

CAPTVRE Imagination

Fall 2019

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