Understanding trauma in children and young people in the school setting

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Aim

Educational practitioners are increasingly aware of trauma experiences in students as a factor in child disturbance and schooling problems. This discussion paper aims to clarify definitions of trauma and differentiate them from other Adverse Childhood Experiences (ACE), describe trauma impact in terms of clinical outcomes (PTSD, emotional and behavioural disorder) and how attachment factors mediate risk and discuss the challenges and ethics of identifying and enquiring about trauma experience in a school-setting.

Rationale

Schools are increasingly required to be 'trauma sensitive' and to intervene where possible, with government requirements of improving mental health in schools. However, this poses a real challenge for educationalists given the barriers due to ethics, stigma/secrecy, referral implications and measurement availability for whole school approaches. Universal screening may provide a framework that helps schools recognise, measure and treat trauma.

Findings

A conceptual model clarifying trauma exposure, trauma impact and mediating factors is identified to aid understanding for teachers. Use of technological screening methods for whole school monitoring of trauma impacts, including mediating risks, are outlined.

Limitations

A full literature review of trauma or school-based interventions is not provided. Nor are biological impacts of trauma at different developmental stages described.

Conclusion

Teachers would benefit from having a psychological understanding of trauma models and their component parts in order to identify what lies within the remit of schools for identification and intervention.

Approximately 20 per cent of children or adolescents have experienced trauma involving maltreatment, including types of neglect or abuse (Saunders & Adams, 2014). This is equivalent to six pupils in every classroom. Furthermore, many have additional trauma involving sudden and untimely bereavements, family or neighbourhood conflict, or wider trauma associated with refugee status. If this is extended to other childhood adversity without the trauma label, it is estimated almost half of all children (48%) have at least one Adverse Childhood Experience (ACE) before age 17 (Felitti, 2002; Tink *et al*., 2017).

Exposure to trauma events and other childhood adverse experiences is thus common and affects families, schools and communities. At a time of Covid19 we are more aware of potential trauma experience in the form of sudden and untimely bereavement. This seems to be disproportionately high in those from ethnic minority backgrounds, those living in three generation households, and those socially deprived (Onder *et al*., 2020). Other trauma experiences likely to have increased include domestic violence (Scotland, 2020) where families can be entrapped with abusive partners or parents.

Whilst children themselves are rarely affected by the virus, they have been living in socially distanced environments where unusually high numbers of grandparents or even parents have been afflicted with serious respiratory illnesses requiring intensive care with added restriction on visiting and face to face communication. Thus, in 2020 the potential for traumatic bereavement exposure has been amplified. Given children have been home schooled, without access to their usual routine, friends and after school clubs, many will be experiencing reduced resilience (Jiao *et al*., 2020) and may have heightened anxiety about the virus effects (World Health

Organization, 2020). On return to school there is likely to be a period of adjustment which has implications for their mental health. It is in this context that we revisit definitions of trauma experience in relation to the school environment. We define and discuss the experience of trauma and its impacts, together with related adverse experience and its impact on the young.

Defining trauma exposure

Despite being distinct although related concepts, discussions of childhood trauma have become interlinked with ACE, therefore they warrant some clarification. Trauma itself consists of two separate but related constructs; exposure and impact. The DSM-5 definition of a trauma event states:

> The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): direct exposure; witnessing the trauma; learning that a relative or close friend was exposed to a trauma or indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics). (American Psychiatric Association, 2013)

Examples usually given include aspects of maltreatment; witnessing of parental violence, as well as sudden, untimely and shocking bereavements. Other experiences often included, but with less definite fit to the standard definition, include neglect, emotional abuse and stigmatising events such as peer aggression. Wider events which are a threat to life or violent, include fires, floods, car accidents, terrorism or war. Some such events affect whole communities (flooding, war), others are more specific to a family (bereavement or parental violence) or to a child (extra-

familial sexual abuse). Whether the trauma exposure is personal/familial or community-based can have particular significance for family or peer impacts and for preventative action.

DSM-5 definitions of Post-Traumatic Stress Disorder (PTSD) require the presence of both trauma exposure (Criterion A) and a range of trauma impacts, including intrusive symptoms (B), avoidance (C), negative cognitions and mood (D) and alterations in arousal and reactivity (E) all of which need to last at least a month (APA, 2013). This holds for children over age 6 as well as adults. Whilst trauma exposure is required for diagnosis, most who experience such an event will not have the disorder. This is due to moderating factors, those identified include Attachment, self-Regulation or Competence/identity (ARC) which can make individuals more or less vulnerable (Hodgdon *et al*., 2013). These can all be subsumed under attachment models whereby insecure styles also involve poor emotion regulation and low self-esteem or identity issues (Bifulco & Thomas, 2012).

ACEs encapsulate a greater range of experiences than trauma. The ACE research based in the USA 20 years ago examined the health records of middle-aged Americans sending out brief questionnaires on childhood experience to look for explanatory lifelong risk. The items included five maltreatment and five family difficulty items, with a single 'yes/no' response for each experience. The total score is thus 0-10 with each item having the same weighting. The maltreatment items include physical abuse, sexual abuse, emotional abuse, emotional neglect and physical neglect to the child. The family difficulties include separation from parent, partner violence, parental health, substance abuse, mental health or criminality. Whilst all these experiences are known to be damaging to a child, most of the family difficulty events, are not

trauma events according to DSM definitions and therefore would not be linked to trauma models and specific impacts such as PTSD. For example, parental separation is common and often managed by parents to reduce impacts on the children. It does not add to predictive models of depression when other maltreatment factors are taken into account (Bifulco & Schimmenti, 2019). This in contrast to sexual abuse which has a nearly eight-fold increase on teenage or adult disorder (op cit).

Nevertheless, the 10-item questionnaire showed strong associations between childhood adversity and later life physical and mental health, as well as early morbidity, with increased risks for multiples of adverse experience showing a 'dose' effect with four or more having particularly high health risk (Felitti *et al*., 1998). The research was important in bringing the already established child abuse and mental health risk into the public health arena for physical illness, as well as establishing the brief checklist questionnaire as a quick screening tool readily available online. This approach has become established as a quick means of assessing risk related to childhood adversity.

Criticisms of the ACE approach include reliance on cursory self-report measurement which may not be well adapted to child response; a focus on the event rather than impact as though these were the same, and a mix of trauma and non-trauma experience (Barratt, 2018; Bifulco &Schimmenti, 2019). However, it has proved influential in highlighting the environmental causes of psychological disorder to mitigate medical and genetic approaches to mental health. Differentiating between types of childhood adverse experience can be important for teachers to understand differential impacts. For example, ACEs were shown to increase school absenteeism,

behavioural issues and poor performance in mathematics, reading and writing (Blodgett & Lanigan, 2018).

Trauma impacts and mental health

Similarly, trauma can impact children both in the short and long term. Trauma experiences are associated with the deregulation of emotional states, leading to hyper-arousal including fear, panic and uncontrolled anger (van der Kolk, 2005). Inter-personally, it limits the individual's ability to empathise and form attachments with others. Long-term, trauma experiences can lead to physical and psychological problems such as cardiovascular disease, diabetes and depression; this is especially true as the number of trauma experiences increase (Mock & Arai, 2011). If the associated psychosocial needs of trauma go unmet, not only is the ability for young people to learn undermined, but it also leads to poorer long-term outcomes with societal impacts including increased healthcare use, unemployment and being more likely to be involved in crime, violence or substance misuse (Boyer *et al*., 2016; Joint Commissioning Panel for Mental Health, 2013). Indeed, estimates of the yearly additional health, social care and educational costs associated with children's psychiatric disorders in the UK are around 1.47 billion (Snell *et al.*, 2013). Therefore, providing early support to young people is not only crucial for their lifelong development and health but also for society (Marmot, 2020).

Figure 1 shows a trauma model identifying trauma exposure as well as related childhood adversity and impacts on psychological disorder and school behaviour, mediated by ARC factors. It is important to note that many of the elements are inter-related, for example, neglect (trauma) is more common after parental separation or in families with parental violence (ACE);

PTSD is often comorbid with emotional disorder; and emotional associated with behavioural disorder. Emotional and behavioural disorder encompasses depression, anxiety, conduct disorder and hyperactive disorder (Saigh *et al*., 1999).

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Trauma interventions

Despite the impact of trauma and ACEs, most children and young people are not receiving the psychological care they need. Whilst it is encouraging to note that referrals to specialist NHS Child and Adolescent Mental Health (CAMHS) services have increased by 26 per cent since 2013 this by no means meets current need and a quarter of children with a diagnosable condition are rejected from services (Crenna-Jennings & Hutchinson, 2020). Clearly, given the scale of the current problem more needs to be done to intervene if problems are to be prevented from escalating and damaging children's long-term opportunities, health and wellbeing. However, nationally child and adolescent services are struggling to meet increasing demands; a lack of funding has reduced services and resources and increased waiting times and staff shortages (Care Quality Commission, 2018). This can lead to further increases in waiting lists even without any concomitant increase in demand (Rawlinson & Williams, 2000).

Due to this pressure, some CAMHS services have eligibility criteria that has risen to serve only the most in need. Such thresholds for treatment have excluded young people who self-harm and even those who have attempted suicide (Frith, 2016). Thus, young people are facing service level

barriers. This is in addition to other barriers to access, such as lack of awareness regarding available services, inflexibility of policies and regulations and stress associated with help-seeking (Anderson *et al.,* 2017). Left untreated, mental health issues are more likely to persist over time and require more intensive services (Torio *et al.*, 2015). Therefore, systems which deflect pressure away from such specialist services are needed and school-based approaches are increasingly being seen as one such solution.

Despite the possibility of identification within the education system, many young people who have experienced trauma are simply not being identified by educators. This can mean pupils are left unaided until their symptoms are at a level where early intervention services are no longer likely to be beneficial (Dvorsky *et al.,* 2014). The adoption of a reactive, rather than a proactive approach of waiting until student difficulties become apparent or a cause for concern has been termed a 'wait-to-fail' model (Glover & Albers, 2007). Partly, this may be because schools overwhelmingly have to rely on staff to recognise which students are in need, or they use behavioural indicators such as deteriorating attendance or academic progress (Marshall *et al*., 2017). This method places the burden on staff, many of whom feel their workload is unmanageable (Ainsworth & Oldfield, 2019) and who may not have the training or time available to identify such students. It can also lead to students who develop internalising problems such as anxiety, being missed due to the covert nature of their symptoms (such as feeling on edge, stomach ache). This approach also relies on schools fostering a culture of mental health awareness and acceptance. But mental health problems are often stigmatised, reducing the likelihood that they will be reported (Chandra & Minkovitz, 2006). Yet given that schools are a 'universal service', they can provide a vital role in promoting mental health for young people and

providing interventions or referral for those suffering trauma issues. It is imperative they continue with early recognition of trauma and taking proactive steps to ensure the wellbeing of their pupils.

The trauma-aware (or trauma-sensitive) school initiative started in the USA demonstrates the ability of schools to identify and support children who have experienced trauma. Indeed, it is already yielding some positive results after three years (Atallah *et al*., 2019). A Trauma and Learning Policy Initiative (TPLI) in three schools in Boston aimed to deepen understanding of the impact of trauma on learning, and through empowering teachers address school-based priorities and school culture. Qualitative findings showed changes in school leadership, greater communication about trauma themes and higher levels of socio-emotional skills and improved relationships (op cit). This is being taken up in UK Schools with the iTIPS plot held in inner London (Aspland *et al*., 2020). This studied five North London primary schools, together with a pupil referral unit (PRU), and the local authority and NHS to embed trauma-informed practice. The partnership implemented the ARC framework aiming to give school staff more knowledge to understand how trauma manifests in behaviour and provide skills to support children and increase self-resilience. This initiative is now in its third wave with just under a third of the local authority schools in that borough included. Over three thousand assessments were analysed to show 1 in 15 children having ACE experiences in any one year. Domestic violence was shown to be the most frequent experience. The intervention consisted of ARC training for teachers with regular support form clinicians, production of a tool kit both to develop teacher resilience and to recognise stress responses in children. Results showed reductions in school exclusion, teachers reporting greater understanding of trauma and how to

respond to children's demands and more reflective conversations with children as well as reduction in behaviour incidents (Aspland *et al*., 2020).

The latest government policy is to enshrine in law that primary and secondary schools monitor the mental health of their pupils. Whilst this is more general than trauma impacts the same principles apply. In 2015, it announced *Future In Mind* (Department of Health, 2015), its vision for transforming children and young people's mental health services to make access easier. *Transforming Children and Young People's Mental Health Provision: A Green Paper* (Department of Health and Department for Education, 2017) built on those earlier ideas by setting out a new approach which reflected the assumed responsibility of schools in promoting mental health and pursing preventative approaches to ensure both social and emotional needs of pupils are met and do not become barriers to effective learning (Department for Education, 2017).

However, as it stands the Government's approach may fall short of being able to help schools deal with the prevalence of problems. One of the Government's major aims was to increase access to services by young people in need, partly through the creation of mental health support teams working with schools (Department of Health and Department for Education, 2017). Although the Government's strategy commits to recruit and train more mental health staff, the NHS reports falling numbers of mental health nurses, with school nurses at their lowest number in almost a decade. Additionally, the National Audit Office (2018) cites slow progress on workforce expansion with difficulties recruiting as a major concern for delivering the government's strategy.

Universal screening may be one relatively low cost way in which schools can detect problems early and facilitate early intervention and access to services if needed, without having to have access to greater clinical expertise. Certainly, there would still be numerous issues, both methodological and ethical, associated with successfully implementing a trauma-informed universal screening approach in schools, but the adoption of such a programme could ensure the systematic detection of children and young people in most need. Practical considerations would include the development of a process that can not only identify such youth but also reliably measure and track their wellbeing. Any system would also have to be available at scale and, to ensure its use across each young person's educational career, it would need to be appropriate to a range of developmental stages to encompass both primary and secondary education. Furthermore, given the breadth of any such school-wide undertaking and the heavy administrative and assessment obligations already placed on staff, any process would have to limit further burden and allow a continued focus on learning and development.

Ethics

Ethically, there are numerous considerations around collecting trauma information. At one level this involves the principle of 'not doing harm' (British Psychological Society, 2018) given assessing trauma directly may in some instances re-traumatise children (WHO, 2017). But also it involves a fundamental issue of how informed consent is possible (National Society for the Prevention of Cruelty to Children, 2020). This not only involves consideration of the Gillick competencies of the child/young person's understanding, but also the issue of parental consent for sensitive information. Given trauma involves abuse and neglect much of which is familial

(Flatley, 2016) schools would have to consider whether testing would be with or without parental agreement. Another issue concerns that of feedback or indeed referral to appropriate agencies if maltreatment was potentially identified. Once trauma impacts are identified the schools would have to consider what appropriate interventions should be taken and how they would be implemented, given their resources and knowledge. Additionally, schools would need to consider at what thresholds various actions would take hold, from potentially whole school programmes with psychoeducation for everyone, to one-to-one interventions for young people exhibiting high risk levels of problem, including referral and psychotherapy. Furthermore, in order to avoid stigmatising young people that were in need of greater help, schools would need a system for how any such interventions would be integrated, or not, into other school activities. For example should pupils be taken out of class, required to stay after school or given tasks during class time?

Technological screening for risk

Currently, there is technology available which allows for young people to be easily screened for mental health problems in large numbers. Whilst this does not typically involve screening for trauma, it does cover the emotional and behavioural symptoms which are triggered by varied adversities. In the UK, the online Strengths and Difficulties Questionnaire (SDQ) has already been used by schools and CAMHS services to assess and monitor young people (Curvis *et al*., 2013; Ford *et al*., 2012; Ohl *et al*., 2008). The SDQ is a short standardised questionnaire that screens children and young people for psychological difficulties, including emotional symptoms, conduct problems, hyperactivity, inattention, peer relationship problems and prosocial behaviour. It has well-established validity and reliability (e.g. Goodman, 2001; Seward *et al*., 2018; Truman *et al*., 2003), can incorporate reports by children, parents and teachers and is administered by

non-clinically trained staff and produces results that stratifies children by their risk for more serious clinical disorder. It is also linked to clinical diagnoses through the DAWBA, delivered on the same online system with clinical reviewers. This includes trauma responses.

Nevertheless, the SDQ has been criticised for a sole focus on common mental health conditions with failure to capture developmental trauma and related attachment difficulties (Wright *et al*., 2019). Indeed, the National Institute for Health and Care Excellence (NICE, 2015) argue that attachment theory should be used as a way to understand the effects of relational trauma and improve interventions for young people. Young people who have experienced interpersonal trauma through abusive or neglectful caregiving tend to develop insecure attachments. This is in turn related to the self-regulation or emotional control aspects and the competency around identity labelled in ARC. Attachment style is a pertinent element which refers to the internal working model of relationships that an individual develops during infancy to determine how they form and maintain relationships across their life (Bowlby, 1988). Securely attached individuals have flexible relating styles characterised by trust and autonomy, whereas insecurely attached exhibit maladaptive behaviours such as being clingy or avoiding intimacy. Thus, the online SDQ system would benefit from the addition of other measures to capture aspects of relational and experiential disruption to better identify those who have the hallmarks of having experienced trauma. Indeed, although ethical issues would still have to receive careful consideration, screening for the sequelae of trauma in this way rather than trauma itself, may be more prudent. For instance, asking about a young person's interpersonal relationships and wellbeing is less likely to traumatise the young person, is more likely be acceptable to families and is more likely

to sit comfortably within a school's remit of pastoral care. Yet, it would still indicate youth at heightened risk who may need extra support.

Bifulco and colleagues have used an attachment mediated model of trauma with young people in care to monitor adjustment over time (Bifulco *et al*., 2016; Jacobs *et al*., 2019). The model proposes that insecure attachment style acts as an underlying vulnerability factor which interacts with external stressors to increase the risk of psychological symptoms. The different attachment attitudes associated with the various attachment styles can then be used as a focus of care planning and interventions for positive change (Jacobs *et al.*, 2019). As such, Bifulco and colleagues assess SDQ rated psychological symptoms, life events using the tailored Life Events Checklist which establishes any external stressors the young person might have experienced recently and the Vulnerable Attachment Style Questionnaire (VASQ; Bifulco *et al*., 2003). It does not however directly tackle earlier familial trauma experience considered overly sensitive for children who have been through care proceedings.

The VASQ measures cognitive-affective attitudes to closeness and autonomy with a focus on current relationships. Individuals can be classed as Secure, those who can effectively use relationships to regulate their distress, or Insecure with Mistrustful Avoidant or Anxious/Enmeshed sub-types. Mistrustful Avoidant is marked by high need for autonomy and a view of others as untrustworthy, whereas Anxious/Enmeshed is characterised by fear of rejection and low self-reliance. Lastly, individuals can be classed as Disorganised, which is a disordered attachment style with aspects of avoidant and anxious behaviour. Although such patterns often

persist across the life course, with support, change is possible for a third of young people (Jacobs *et al*., 2012).

Mistrustful Avoidance is particularly linked to parental rejection and physical abuse (Bifulco & Thomas, 2012), Anxious/Enmeshed is associated with emotionally abusive relationships with parents (Riggs, 2010) and the Disorganised style is common in those with histories of previous trauma and abuse (Cassidy & Mohr, 2001) but also neglect (Bifulco & Thomas, 2012). Insecurely attached youth are less able to regulate their emotions, form attachments, demonstrate less self-control, have poorer educational achievement and are more likely to develop psychological disorders. Therefore, an attachment based model could be operationalised within educational settings as a potential mediator of trauma exposure, to aid in identifying interventions specific to particular problematic relational behaviours or attitudes (e.g. building trust, reducing fear of rejection) and a way of measuring interpersonal improvement. Furthermore, it could provide teachers a framework for understanding insecurely attached relating styles and how children might present in the classroom.

In addition to attachment measures, other scales can be utilised around identity and competence to allow for identification of the mediating factors which can be triggered from, or flow from trauma experience. Thus the characteristics surrounding trauma can potentially be identified in whole school online screening, with identification of more sensitive and personal trauma experience reserved for later interview in a safe psychotherapeutic setting. Such a holistic screening could establish the mental health and resilience across schools over time, identifying particular individual children who need either light touch intervention to be undertaken in

schools and those requiring more specialised help. Repeating the assessments can then show whether there is improvement over time in relation to intervention and changes in school culture. It can also allow for anonymised school comparison, and in time, provide national data on our children and young people in schools.

Evidence-based, computerised systems already aid clinicians in dealing with the massive volume of screening, monitoring and diagnosing required in health settings. Use of the online SDQ demonstrates that this approach can easily be translated into school settings. Neglected disorders may progress to disruptive behaviour, chronic problems and greater need of services later in life, whereas if detected and treated in time, most young people who are in need of help will benefit significantly (McCrone *et al*., 2005). Implementing general screening programmes could not only reduce staff burden, but as all pupils are assessed they can help create environments conducive to more frank discussion about mental health as well as improving the rate at which problems are identified because all students, not just those deemed high risk, are assessed.

Currently, only 15 per cent of schools conduct universal screening of pupils and only a quarter of schools conduct targeted screening (Department for Education, 2017). However, there are many benefits to adopting a standardised, widespread and evidence-based approach to screening young people, not least that standardised assessments can be easy and quick to administer. Universal screening could also allow for more sensitive targeting of resources, identifying young people who already need treatment or referral but also highlighting young people at risk who could benefit from 'lighter touch' interventions without stigmatising individual pupils. Similarly, the scores can be recorded over repeated measurements, which means changes can be tracked across

time. Therefore, it can be used to detect the appearance of problems as they arise or measure progress towards meeting specific needs, including comparing scores before and after interventions providing evidence of what works and for whom. Nationally, it would enable rates to be compared across schools and geographical locations, as well as trends to be tracked over time allowing Heads and SENCOs to better understand the characteristics and dynamics of their student populations and to better manage resources and to prepare cases for investment. Indeed, generalised screening would be a powerful mechanism for schools to quantify and support requests for funding.

Furthermore, use of the same measurement tools and trauma informed model across organisations enables multi-agency approaches to be developed and eases communication between disciplines. One of the great advantages that could be achieved by rolling out an assessment model such as this, is that it could keep track of every child's ongoing wellbeing throughout childhood and even through to early adulthood in a confidential and secure manner. Use of tools such as these across schools and integrating this with child and youth NHS services would enable the realisation of the national strategy set out by the Government whilst keeping the burden felt by schools to a minimum. Wellbeing could be tracked on an individual and a mass scale to tackle the impacts of trauma in our young and significantly increase the productivity of professionals currently struggling to cope with the volume of cases.

Limitations

This discussion has sought to draw out some of the implications of identifying trauma impacts in the school context in light of government and public health policies around early interventions, a

national and school-based mental health programme and trauma-sensitive (or informed) schools. It has not sought to provide systematic coverage of school-based interventions, nor is it a comprehensive review of trauma and developmental stage.

Conclusion

It is widely recognised that schools need proactive trauma informed strategies around mental health to better serve the young people they educate. Identifying trauma events is contentious given their highly personal and familial, stigmatising, sometimes secret and threatening nature. Alternative approaches could focus on mediating risk factors such as attachment characteristics including peer relating, or self-esteem which can be moderated on a schoolwide basis. Currently, assessment remains disparate with schools adopting a multitude of strategies. This hinders the creation of a coherent national approach that could allow for comparisons across schools, locations and time and enable multi-agency working. Additionally, reliance on individual staff to identify at risk youth can mean treatable problems go unnoticed until too late.

We have argued that the widespread adoption of an online suite of evidence based measurement would be the most practical first step that schools can take to quantify and categorise the wellbeing of their student body; enabling large scale screening of common trauma indicators to take place. This would not only ensure that every young person is assessed, but it would signal those that may need an intervention, including those who would otherwise remain undetected until their problems escalate out of control. Universal screenings could also be used to forge stronger links between schools and NHS services such as CAMHS or Single Point of Access services as they begin to ‘speak the same language’ in terms of need and work together to use

their different areas of expertise to provide a wraparound service for young people. Schools could provide invaluable information regarding symptoms, attachment issues and stressors to these more specialist services which could then utilise this information to inform further assessments and tailored interventions. These decisions could in turn be fed back to the school which can continue to monitor, potentially for longer than more pressurised services are able to, and inform. Working together in this way to identify, assess and determine which service might best meet the young person's needs, ensures everyone gets the help that they deserve.

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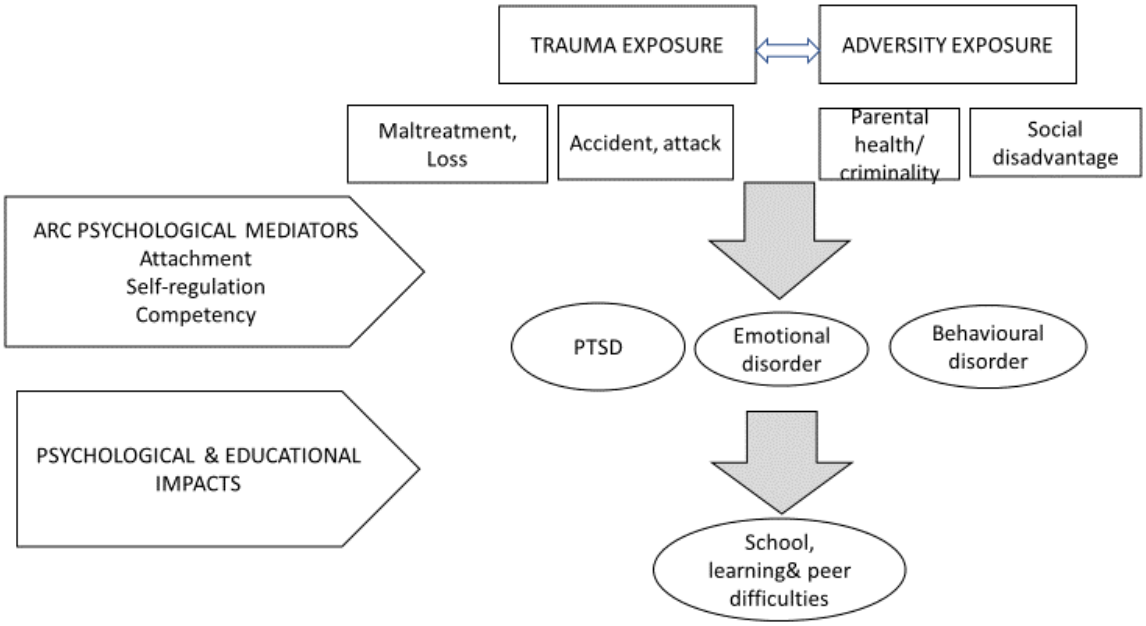
Figure 1: Trauma model


TRAUMA EXPOSURE
ADVERSITY EXPOSURE
Maltreatment, Loss
Accident, attack
Parental health/ criminality
Social disadvantage
ARC PSYCHOLOGICAL MEDIATORS
Attachment
Self-regulation
Competency
PTSD
Emotional disorder
Behavioural disorder
PSYCHOLOGICAL & EDUCATIONAL IMPACTS
School, learning& peer difficulties