Facilitating the High School-to-College Transition for Students With Psychiatric Disabilities: Information and Strategies for School Counselors

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Abstract

The transition from high school to college is challenging for many students. In addition to the typical challenges faced by students starting college, students with previously diagnosed psychiatric disabilities have illness-related challenges to face as they transition to college. This article provides information on the current state of concerns related to psychiatric disabilities among college students, as well as the developmental and transition factors that place college students at risk. Finally, the role of school counselors and ways they can help facilitate the transition to college for students with psychiatric disabilities are outlined.

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The transition from high school to college is stressful for many students. Every August parents arrive on campus with packed vehicles and even small moving trucks, to help their children move to campus and begin the first year of college. Most students seem eager to begin the next chapter of their lives. Some seem a bit overwhelmed, while others seem afraid. As staff psychologists at two Minnesota universities, the authors have knowledge that some students already find their way to the campus counseling center the first week of class. Some students are homesick, the eagerness of Orientation Week shifting to the realization that they are now on their own. Some students are panicked, because professors have already assigned incredible amounts of reading and there is no one to monitor how they spend all their unstructured time. Some students find themselves ill-prepared for the academic rigors of a postsecondary setting, with the common lament that they never had to study in high school.

In addition to the typical challenges faced by students starting college, students with previously diagnosed psychiatric disabilities, such as those the authors see in their clinical settings, have additional challenges, including considerations such as medication management, counseling appointments, academic accommodations, emotional variability, and sleep difficulty. Brackney and Karabenick (1995) found that psychological distress was significantly related to academic performance. Those students with higher rates of psychological distress displayed lower academic motivation and ineffective use of learning strategies. This, in turn, corresponded to lowered academic performance, lowered academic confidence, less effective time

management, less effective use of study resources, and higher test anxiety. These students were less likely to persist in college and less likely to seek academic assistance. Likewise, Randall and Dobson (as cited in Kitzrow, 2003) found that individuals with high levels of psychological distress demonstrated impairment in information-processing skills, a factor critical for academic performance.

Psychiatric disabilities may negatively impact academic performance, retention, and graduation rates (Kessler, Foster, Saunders, & Stang, 1995; Kitzrow, 2003). Breslau, Lane, Sampson, and Kessler (2008) used information from the National Comorbidity Survey Replication to consider educational completion for individuals with a variety of psychiatric diagnoses. They found that students with impulse control disorders and substance use disorders were most at risk to quit college. Panic disorder and bipolar disorder were the only two mood disorder diagnoses associated with significantly higher rates of dropping out of college. Having three or more psychiatric diagnoses also was associated with significantly higher drop-out rates. Research estimates that 4.29 million people would have graduated from college if not for the onset of psychiatric disabilities and grows to 8 million with the addition of students who do not graduate from high school due to the onset of psychiatric disability (Tainter, 1998).

Educational settings are not immune from the issue of psychiatric disabilities in students at the high, middle, and even elementary school levels, and school counselors play an important role with students at those educational levels. It is not uncommon in the college setting to have a student present with a history of depression or anxiety that was initially diagnosed in the childhood or early teen years. In addition to other school counselor duties, it is likely that a substantial amount of time is spent providing ongoing

support for students who have psychiatric disabilities and participating on individual education program teams that focus on the success of students with disabilities, including psychiatric. School counselors are often the link between high school and college during the transition process, as they coordinate college recruiter visits, discuss college and career options with students, and field endless college-related questions. For students with psychiatric disabilities, school counselors have the opportunity to play an even larger role as students and families attempt to navigate the myriad transition components.

College counseling center staff can offer a lot to the transition planning process. These staff members are familiar with the stresses students face as they transition to a postsecondary setting, and can inform the process, helping school counselors support students through the transition process. This article, therefore, provides information on the current state of concerns related to psychiatric disabilities among college students, as well as the developmental and transition factors that place them at risk. The role of school counselors and ways they can facilitate the transition to college for students with psychiatric disabilities are outlined. The importance of early planning, skill building, service coordination, and open communication are stressed.

Current State of College Student Psychiatric-Related Concerns

Students with previously diagnosed psychiatric disabilities are entering college in greater numbers than ever. Since 1998, the American College Health Association (ACHA) has conducted an annual, national survey of college students regarding perceptions of many health areas. The Spring 2008 survey had 80,121 respondents from 106 schools. Of that group, 14.9% had a previous diagnosis of depression and

43% said that within the past year it was hard to function due to feeling depressed (American College Health Association, 2008a). The rate of students reporting previous diagnoses of depression was 10% in Spring of 2000, and 16% in Spring of 2005, an increase of 56% (American College Health Association, 2009). Depression, anxiety, and seasonal affective disorder (SAD) were reported among the top 10 health impediments to students' academic performance (American College Health Association, 2008b).

Concerns regarding suicide affect many college students. Compared to 1988, three times as many students seriously consider suicide (Kadison & DiGeronimo, 2004). The Spring 2008 ACHA survey indicated that 9% of respondents had serious suicidal thoughts at least once, and 1.3% or 1,041 students attempted suicide at least once in the past year (American College Health Association, 2008a). Suicide is the second leading cause of death for college students, and a typical college campus with an enrollment of 10,000 students can expect one suicide a year, in addition to numerous suicide attempts (Marano, 2006). First-year students seem to be particularly at risk; a USA Today analysis of 620 deaths of undergraduate students that occurred from 2000-2005 found that more than one-third was college freshman (Davis & DeBarros, 2006).

Statistics from the Spring 2008 ACHA survey provide information about the number of college students affected by other psychiatric disabilities as well. Negative academic impact due to ADHD was reported by 7.4% of students. Anorexia was reported by 1.8% of students, and bulimia was reported by 2.1%. Anxiety disorders were reported by 13.2% of students (American College Health Association, 2008a).

Regarding substance use concerns, negative impact of alcohol on academic performance was reported by 7.8% of respondents to the Spring 2008 ACHA survey,

and negative impact of drugs was reported by 2.4% (American College Health Association, 2008a). Over 1,400 college students die yearly from events related to alcohol, mostly traffic accidents (Saltz, 2004). This number grows to nearly half a million when other alcohol-related injuries are taken into account. The National Institute on Alcohol Abuse and Alcoholism (2007) indicated that 31% of college students ages 18-24 meet criteria for substance abuse, and 6% meet criteria for substance dependence.

Other alarming statistics extend the list of tragedies related to substance abuse. According to the National Institute on Alcohol Abuse and Alcoholism (2007), nearly 700,000 college students (ages 18-24) were assaulted in a year by someone who had been drinking. Alcohol-related sexual assault or date rape was experienced by 97,000 students, and 100,000 said they were too intoxicated to know if they consented to sex.

Within this setting of increasing concerns, college counseling centers are on the front line, helping students personally and academically. Gallagher has conducted an annual survey of college counseling center directors since 1981. The 2008 survey, with data from 284 participating schools, indicated that 26% of college counseling center clients are on psychiatric medication, up from 20% in 2003 (Gallagher, 2008). The Spring 2008 ACHA survey noted that 35.6% of college students were taking depression medication (American College Health Association, 2008a). Many of these students come to campus already on psychiatric medication. A large HMO saw the number of prescriptions for psychiatric medications for individuals under age 20 triple from 1987-1996, up from 18.6 people to 59.1 people per every 1,000 (Young, 2003). In fact, psychiatric medications hold the top three spots among all medications prescribed for

college students, with Prozac in first place, antianxiety medications second, and all other SSRI antidepressants third (Kadison & DiGeronimo, 2004).

In addition to increased use of psychiatric medication, the 2008 counseling center directors' survey noted that 2,075 students were psychiatrically hospitalized during the previous year, and 118 students committed suicide. The number of students with significant psychiatric problems was a growing concern for 93% of directors surveyed. Directors estimated that 49% of clients have severe psychiatric concerns. Of these, 7.5% are so impaired that they cannot remain in school or can do so only with extensive psychological and psychiatric care (Gallagher, 2008).

Counseling center staff members perceive student problems as shifting from informational/educational problems to more serious emotional/behavioral problems. Benton, Robertson, Tseng, Newton, and Benton (2003) studied counseling center client problems from 1989-2001 at Kansas State University. They found increases in 14 of 19 concern areas. They concluded that students who used college counseling centers in recent time periods have more complex problems than in the past, including both normal developmental stressors as well as more severe problems.

The college counseling center rate increases are attributable to a variety of factors. The Americans with Disabilities Act and Mental Health Parity Laws helped decrease stigma, thereby facilitating diagnosis disclosure. This, combined with increased medication options, better assessment, and earlier treatment, help make college available to more people. As summarized by Marsh (2004):

> We stand at a confluence of several forces: increasing numbers of students, with increasingly severe emotional problems; students and

> families who look increasingly to universities to provide mental health and other supportive services for their students; levels of student stress and clinical depression that show no signs of abating; and budgetary cutbacks that make growth in mental health staffing difficult at best… (p. 4)

In greater numbers than ever, students are entering college with a psychiatric diagnosis or will experience a first episode of psychiatric illness while at college. It goes without saying that many college counseling centers face a challenging situation, often representing a continuation of the challenges school counselors encountered in the high school setting.

Transition Tools for School Counselors

While these statistics as an aggregate are concerning, they highlight the very real challenges faced by students, families, high schools, and colleges. Despite these alarming statistics, there is a paucity of information in the literature specifically addressing the college transition for students with psychiatric disabilities. This seems to reflect a trend in higher education service provision. Collins and Mowbray (2005) interviewed individuals in 10 states regarding higher education services for students with psychiatric disabilities. They found that students with psychiatric disabilities were considered among all students with disabilities rather than having unique services and/or programs. Megivern, Pellerito, and Mowbray (2003) investigated difficulties that students with psychiatric disabilities encounter in college. In their survey of 35 individuals with psychiatric disabilities who pursued higher education, they noted a lack of specialized programming for students with psychiatric disabilities.

There are, however, a variety of individual characteristics and transition factors that improve the likelihood that students with psychiatric disabilities will succeed in college. Providing education about these characteristics and factors may fall on the shoulders of the school counselor, either when following the mandates of the Individuals with Disabilities Education Improvement Act of 2004, when serving as a member of a transition planning team, or when providing general programming to all secondary students regarding college options. One essential thing school counselors can do to assist the college transition of students with psychiatric disabilities is to communicate with parents and students about the importance of early planning, well before the student's arrival to campus. The planning process and dissemination of information for students and families can be facilitated by school counselors through the use of "transition tools" presented in the next sections.

Wellness Model

One tool mirrors the wellness model developed by Hettler (1984), a college-health physician. He proposed six dimensions of healthy functioning – physical, emotional, social, intellectual, occupational, and spiritual – organized in a hexagonal or wheel format. When these areas are attended to in a balanced manner, good health and well-being may be facilitated. If we are to follow Hettler's wisdom that wellness is "an active process through which individuals become aware of, and make choices toward, a more successful existence" (p. 13), then important transition information can be organized in this format to enhance student and parent awareness and decision-making.

School counselors can use this wellness model to help students on an individual or group basis to develop balance and a healthy foundation in various life areas. School counselors can introduce this format by assessing what students are currently doing in each area, acknowledging strengths to build on, and assisting students in goal development and progress tracking. School counselors can help students develop specific goals in each area as well as strategies for working on the goals. Future sessions can be scheduled, with progress toward goals reviewed at each session. Students can also be taught to use the wellness model on their own as a way to identify strengths and weaknesses in their lives and develop goals to work toward.

In addition, the wellness model can be used as a structure to guide the dissemination of transition information to students and parents. It can serve as a means to open communication between the school and families, present information that families may not have considered in an understandable format, and facilitate family discussion about difficult topics. The school counselor might begin an information session by highlighting the developmental and risk factors that accompany the transition to college. Examples of introductory information could include the following.

The prime time for development of psychiatric disability is ages 18-25, making the college years a vulnerable time (Marano, 2006). Individuals may have a predisposition to psychiatric concerns, but not develop them until faced with a stressful time in their lives such as the transition to college, with its inherent academic and living demands. For those students with previously diagnosed psychiatric disabilities, the challenge of transitioning to college is complicated further.

The years 18-25 are filled with profound growth and development. Fresh out of high school, the first-year college student may feel invincible. Simply put, bad things will not happen. As a result, students may take more risks, feel that they do not need help, and believe things will improve without intervention. Likely influencing this is the brain's prefrontal cortex – the part of the brain responsible for impulse-control and complex thought processes – which does not fully mature until around age 20. Davey, Yucel, and Allen (2008) found that significant prefrontal cortical development in adolescence is linked to increased rates of depression in adolescence and early adulthood.

The academic and living demands inherent in a college environment are transitional factors that impact students' psychiatric well-being. As students enter college, they experience levels of freedom and choices for using that freedom like never before. They are away from the support system of family, friends, and communities at home, often for the first time, encountering new people, ideas, living arrangements, and academic demands. This combination of factors can trigger the development of a psychiatric disability or trigger increased difficulty with a previously existing one.

Additionally, students who currently enter college are known as the millennial generation (born beginning in 1982). Developmentally, students in this generation face some of the greatest pressures to study hard, attend college, and succeed in a well-paying career. It also may be the generation with the most documented learning, substance abuse, and psychiatric problems (Hernandez, 2006). These factors all contribute to the challenges these students face in college.

After the introductory information is shared, school counselors could introduce the audience to the wellness model, giving some brief background and explanatory

information on it. Copies of the wellness model could be handed out and/or projected on a screen as a visual aid. The information session could then use the wellness model as the structure for sharing important transition information related to each section of the wellness wheel, with the sections covered in any order. Examples of relevant information for the various sections follow. The information is presented in this article in a scholarly format with references, so school counselors know where the information came from and where additional information can be found. School counselors would want to adapt the information into a more conversational format appropriate to their audience prior to presenting it to parents and students.

Intellectual wellness. College provides different structure and demands from high school, highlighting the intellectual section of the wellness model. Fallon (1997) presented ways that school counselors can help students plan for college, and pointed out the need to communicate with students about the differences between high school and college and to reach out to parents to engage them in the process. Important differences between high school and college include social status, academic demands and structure, and information about how these differences may impact psychiatric disabilities. Related to the differing academic demands, Harper and Peterson (2005) indicated that academic unreadiness plays a role in student retention. Many college students received good grades in high school without learning how to study, leading to inadequate college study skills and increased anxiety. Additionally, some students lack academic preparedness in foundation skills such as math, grammar, and reading comprehension.

In addition to a foundation of adequate study skills and learning strategies, the intellectual section of the wellness model speaks to the importance of effective time management. Students should learn how to maintain a workable schedule that stresses the importance of a balance between time for academics and time for other intellectual and creative activities. The appropriate use of technology should be encouraged, as well as the maintenance of pre-college hobbies and interests.

Stress can affect cognitive functioning in such areas as attention, concentration, rehearsal abilities, organizational skills, and communication skills, and can lead to the development or exacerbation of psychiatric disabilities (Substance Abuse and Mental Health Services Administration, 2004). Negative impact on academic performance due to stress was reported by 33.9% of college students (American College Health Association, 2008a).

Physical wellness. Most students encounter a new living environment as they transition to college, so the physical section of the wellness model has a variety of considerations. Examples of areas to assess and discuss with students and parents include regular exercise, sleep, and balanced nutrition. School counselors can help facilitate discussions that may be difficult for parents and students to engage in related to drugs, sex, alcohol, peer pressure, and consequences of risk-taking (D'Angelo & Kamboukos, 2007).

For individuals with psychiatric disabilities, erratic schedules can impact medication dosing schedules and the effect of medication in the body. The transition to college often means that no one is monitoring whether or not students with previously diagnosed psychiatric disabilities take their medication as prescribed. In most states,

students are legal adults at the age of 18 and are responsible for decisions about whether or not to take medication. In addition, a significant proportion of students discontinue taking medication either during the summer months prior to arriving at college or once they get to college. They may decide to discontinue because they are out of their parents' home, think their problems are gone, or feel beginning college represents a fresh start and things will be different (Marano, 2002). Although the semester may start out well, all too frequently the unfortunate result is a relapse of the psychiatric disability once the semester becomes busier and more stressful. Students taking psychiatric medications should be discouraged from discontinuing their medication regimen until a successful transition has been made. The impact of substance use on prescription medications should also be stressed. College students may mix alcohol or drugs with prescribed medications or decide to stop taking their medication to recreationally use alcohol or drugs.

Likewise, discussion should occur regarding living arrangements and whether a student will do best with a single room or a roommate and whether the setting will be on-campus or off-campus. Another important consideration is how the room or apartment should be organized to meet a student's needs. A study space can be created in the student's room or identified on campus.

Depending on the student, looking at community college or school close to home to start with may be a viable option. Community colleges, for example, may provide students the opportunity to attempt college coursework while maintaining their home routine and connections with friends and family. Community colleges may offer students the chance to mature socially and to improve academic skills (Brinckerhoff, 1996).

Sleep difficulty is a concern often related to on-campus living. A negative impact on academic performance due to sleep difficulty was reported by 25.6% of college students (American College Health Association, 2008a). Other factors that negatively impact sleep patterns include all-night cram sessions, time spent with friends instead of sleeping, and electronic distraction, such as texting, online games, and social networking websites. Sleep deprivation can trigger a manic episode, and an erratic sleep schedule can contribute to depression due to dysregulation of body systems (Marano, 2002). Sleep deprivation research indicates a significant negative impact on the performance of complex cognitive tasks, with sleep-deprived participants reporting significantly more fatigue and confusion (Pilcher & Walters, 1997).

Emotional wellness. For students with psychiatric disabilities, the emotional section of the wellness model plays a tremendous role in their college success. Children with a history of psychological problems, trauma, or loss may show increased rates of anxiety and experience a more difficult transition to college (D'Angelo & Kamboukos, 2007). Likewise, increased rates of sexual and physical abuse in childhood contribute to depression (Marano, 2006). Further complicating things, college-age students may lack the emotion-regulation skills that can help them cope with difficult or negative emotions (Marano, 2002). The lack of ability to identify and understand emotions is associated with poor personal and emotional adjustment, factors that can negatively impact the transition to college and impact college persistence (Kerr, Johnson, Gans, & Krumrine, 2004; Parker, Hogan, Eastabrook, Oke, & Wood, 2006). There may be several factors related to this, including growing up in a disruptive background. Past trauma and abuse are associated with poorer academic and personal-emotional adjustment, and are

mediated by the meaning attributed to the experience, an internal locus of control, and supportive relationships (Banyard & Cantor, 2004).

Parents and students should understand symptoms of psychiatric illness, including depression and anxiety, and be able to communicate with one another about them. This can encourage early diagnosis and treatment (Laughlin & Robinson, 2004). There may be a need for education about what it means to have a psychiatric disability and the possible implications of it. Lack of education related to psychiatric disability compounds the difficulties faced by students. A National Alliance for the Mentally Ill and Abbott Laboratories study released in August, 2004 found high rates of psychiatric disability among college students, but a lack of education and understanding among both students and parents. Specifically, the study found that 50% of students rated their mental health as below average or poor, while only 25% of parents rated their students' mental health in that range. In addition, 30% of students reported that they or a friend had problems functioning in school because of psychiatric concerns, while 7% of parents reported their students having this problem. Nearly 50% of students reported receiving no education on psychiatric issues prior to starting college, despite nearly 75% of parents indicating that they or another family member talked with their student about psychiatric concerns (Laughlin & Robinson, 2004).

Students and parents should be encouraged to find out about available counseling and psychiatric care. Kadison and DiGeronimo (2004) recommended establishing health support in the college community even if the student plans to maintain care relationships at home. Relationships with home care providers can be helpful, but it is important to have local connections in crisis situations (Clemetson,

2006). The school counselor can take the opportunity to discuss the role of counseling in college with parents and students. Even if a student's psychiatric disability has been managed without counseling, the support of counseling can help with the college transition. DeStefano, Mellott, and Petersen (2001) found that individuals who received counseling were affected positively by the experience in personal, social, and academic adjustment realms. Factors important to academic success and retention have also been found among counseling participants (Gerdes & Mallinckrodt, 1994). Wilson, Mason, and Ewing (1997) found that students who received counseling at college had a 14% retention advantage over those students who did not receive counseling. Counseling helped students manage stressors during a vulnerable transition and helped students acquire better social skills to more fully integrate into university life.

The school counselor can help parents and students determine if the university counseling center can meet the student's needs. The majority of counseling centers reserve the right to deny services to students whose psychiatric needs exceed the counseling center's resources and expertise. University counseling centers are not treatment facilities (Kitzrow, 2003). If possible, counseling and other support resources should be set up prior to the student starting college.

In addition, it is important for students to have emergency contact information and a safety plan outlining what should be done and who should be contacted in specific circumstances. Local resource contact information is an important part of any safety plan. Insurance coverage is also essential. Some insurance plans do not cover a student if the student drops below 12 credits. An additional consideration is whether insurance will cover care providers in the college community. When college offices need

to refer students off campus, the most difficult referrals are for students who do not have insurance. Discussion of illness management is important, as is discussion of possible illness-related difficulties that may be experienced in college. Problem-solving considerations for potential difficulties should be addressed (Wodka & Barakat, 2007).

Beyond information about psychiatric illness symptoms and community and campus counseling resources, the school counselor can facilitate students' emotional wellness and coping by discussing the importance of maintaining a balance between taking enough time for self-care, while still devoting adequate time to academics.

Social wellness. All areas of the wellness model are important for consideration during the college transition, and the social area can be one of the most challenging. Today's college students often lack the social skills necessary to build deep and satisfying connections. In an age of increasing technology, students' preferred modalities of communication seem to include social networking websites, instant-messaging, and texting rather than face-to-face connection. Instead of talking with each other on the way out of class, for example, students quickly pull out their cell phones, calling those safe, back-home connections. Gerdes and Mallinckrodt (1994) found that social connections and integration into campus life were important retention factors.

Identity development and peer relationships are two additional factors impacting the transition to college. According to the Spring 2008 ACHA survey, 15.9% of college students reported that relationship difficulties negatively impacted their academic performance (American College Health Association, 2008a). In terms of identity development, individuals who may have been popular in high school may be just an average student in college. Such factors affect social status and perception of self and

social status. Research suggests that a pain center in the brain is affected by social exclusion as much as by physical harm (Kadison & DiGeronimo, 2004).

Regarding family relationships, school counselors can discuss the role of parental support when the student goes to college. Parental support is good, to an extent. Research suggests that too little support or attachment is detrimental. Raja, McGee, and Stanton (1992) found that lower perceived attachment to parents correlated with lower scores on measures of well-being among adolescents. In addition, overly detached family ties do not promote individual identity development (Kenny, 1987). On the other hand, research cautions against too much support and attachment. 'Helicopter parents' may not have allowed enough opportunities for differentiation and responsibility prior to college and may be associated with dependency on family, making the college transition and identify development more difficult. Excessive family support is associated with more physical concerns (Zaleski, Levey-Thors, & Schiaffino, 1998), loss of self-confidence and perceived self-competence (Taub, 2008), and lack of individual identity development (Kenny, 1987). Higher family support may negatively impact students' ability to connect with campus and work toward emotional independence (Zaleski, Levey-Thors & Schiaffino, 1998). Students most dependent on parents may not be prepared to handle the stress of college (Clemetson, 2006).

Occupational wellness. The occupational section of the wellness model underlies all the other wellness areas for students, since the planned outcome of a college education is employment in an occupational area. Accompanying this is the keen sense of pressure and competition that characterizes the typical millennial student. Transition stressors occur in an increasingly complex world where concerns about

greater financial burdens, failing economies, fierce job competition, and seemingly endless wars are commonplace.

Students should be informed about essential campus resources and the importance of connecting with an advisor. Good advising and discussion of an appropriate course load during the first semester can have a positive impact on a student's academic success. Too many credits or too difficult classes the first semester will jeopardize success, while a good balance of classes and appropriate course load may help build confidence and academic success (Gerdes & Mallinckrodt, 1994).

School counselors can discuss the role of the disability services office at colleges and encourage parents and students to research and visit schools to determine available resources. Tagayuna, Stodden, Chang, Zeleznik, and Wheeley (2005) surveyed post-secondary institutions nationally regarding the accommodations provided for students with disabilities. Schools responding to the survey indicated variation in the accommodations provided. Parents and students should evaluate the available services, arranging opportunities to talk with staff at disability services.

School counselors also can provide information about vocational rehabilitation services and encourage families to connect with them. Scarborough and Gilbride (2006) indicated that not all students who received special education services in school will be eligible for rehabilitation services. If they are eligible for those services, however, the support they receive may be very helpful with the transition to postsecondary education. As with other services, connecting with rehabilitation services early is important.

Impacting the transition, students with psychiatric disabilities may not want to disclose their diagnosis in college and infrequently use services for students with

disabilities (Tainter, 1998). One survey of current and former college students found that students did not request accommodations because they did not know about the services, did not want to disclose their diagnoses, or were concerned about the stigma attached to having a psychiatric disability (Salzer, Wick, & Rogers, 2008).

In helping students with learning disabilities transition to college, Harris and Robertson (2001) recommend setting up accommodations before starting college. They found that students who set things up ahead of time earned more credits and had higher grade point averages. This recommendation is applicable to students with psychiatric disabilities as well. Using accommodations in college may be more difficult than in high school, with more components to negotiate, and more planning and organization necessary to utilize accommodations (McCarthy, 2007). Documentation of a DSM-IV-TR diagnosed disability is often necessary to use accommodations in college, again highlighting the need for early planning.

Harris and Robertson (2001) also stressed the importance of greater self-advocacy at the college-level, emphasizing the need for students to move toward more independence during the last two years of high school. Whereas parents may previously have always advocated for the student, students in postsecondary settings are not closely monitored and it is the student's responsibility to inform parents and postsecondary personnel when they need assistance. Related, a discussion about information sharing at the college level will likely be helpful. It is important for students and parents to keep the dialogue open, because data privacy laws such as HIPAA and FERPA may prevent sharing of information from the college to the parents.

School counselors can talk with parents and students about realistic options and develop an accurate appraisal of the level of support needed in college. Harris and Robertson (2001) presented qualities that facilitate college success for students with learning disabilities. They felt that students who have a good understanding of their disability and are able to take control of their situation have the best chance of success in college. This information is relevant to students with psychiatric disabilities, and school counselors can discuss realistic expectations with parents and students and caution parents to avoid too much pressure to succeed. Expecting too much can lead to fears of failure and demoralization (Clemetson, 2006).

Spiritual wellness. Spiritual wellness is the final section of the wellness model. During college, students are exposed to different values and lifestyles not experienced growing up, creating cognitive dissonance and adding to transitional stress (Kadison & DiGeronimo, 2004). Additional spiritual considerations include spiritual/religious practices and connection to a campus faith-based organization, the role of nature, volunteer opportunities, and discussion of relaxation's importance and how it is practiced.

The list of transition wellness factors to consider can seem endless and overwhelming for the school counselor, student, and parents. Advance planning and open communication are essential for facilitating the transition process. The wellness model is one example of a tool that school counselors can use to make information sharing manageable. A checklist of wellness factors to consider is included in the Appendix. The authors have also organized a wellness transition checklist in a brochure format, which can be obtained by contacting them.

Bronfenbrenner's Ecological Theory

Additional transition tools can be used by the school counselor to complement the wellness model. Ecological theory, proposed by Urie Bronfenbrenner, presents a systemic view of individuals within the context of interacting in five environmental systems. The individual is at the center of this concentric circle model, and the individual's relationship to each system decreases in influence going out from the center of the circle. The five systems include: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Santrock, 2009).

Milsom (2007) presented information about helping students with disabilities with transitions. She suggested considering students' situations using Bronfenbrenner's ecological model to examine current and future microsystems and their interaction. According to Bronfenbrenner's theory, microsystems include a student's direct interactions with family members, friends, teachers, co-workers, etc. The mesosystem is concerned with the relationship between microsystems, for example, how a student's relationships with parents impact the school setting (Santrock, 2009). For a student with a psychiatric disability, the mesosystem components might include the parents' attitudes, follow-through, and assistance with medication and counseling for the student; the parents' interaction with school personnel regarding student concerns and IEP meetings; and parental monitoring of homework and the student's schedule.

While the wellness model presents holistic consideration of student life areas, it does not focus on interactions within the environment. Bronfenbrenner's ecological theory can be used by the school counselor in conjunction with the wellness model as a transition planning tool. Microsystem and mesosystem relationships are important to

consider for each section of the wellness model. It is not only the student's strengths and weaknesses in each area that are important to consider, but also relationships and environment factors that may support or hinder the student in each area.

For example, a student may identify a goal of establishing friendships early in the semester for the social area of the wellness model. The school counselor could then query the student about microsystem and mesosystem relationships and environmental factors that may affect that goal. A student may plan to stay at college on the weekends in an attempt to establish friendships, but parents or a significant other at home may pressure the student to return home most weekends. Another student may consider exercise as an important component in the physical area of the wellness model, with the goal of using the campus fitness center to stay in shape. The student's schedule and proximity of the residence hall to the fitness center are two environmental components that should be considered to help the goal become a reality.

Milsom (2007) discussed the use of Bronfenbrenner's ecological model in the context of preparing the environment for the student. For example, requesting accommodations at college may be a consideration for the occupational aspect of the wellness model, with the goal of setting up accommodations before starting college. Bronfenbrenner's ecological theory can be used to facilitate discussion about everything that needs to happen for that goal to become a reality, including preparing the environment by having relevant records necessary to set up accommodations, and even having the student schedule an appointment with the disability coordinator at the college to discuss the student's unique situation.

Related to Bronfenbrenner's ecological theory, Tinklin, Riddell, and Wilson (2005) advocated the use of a social model of psychiatric concerns rather than a disability model. The social model views the environment as causing difficulties for students and considers ways students can cope with barriers in their environment. The social model presents a format helpful for decreasing stigma regarding psychiatric concerns, because it views the environment as presenting barriers to students' success rather than viewing the students as the problem.

Summary of Functional Performance

Transition planning is an ongoing process, and Kochhar-Bryant and Vreeburg Izzo (2006) presented the Summary of Functional Performance (SOP) document to aid in transition planning for students with disabilities. The SOP is a document that can evolve throughout the student's high school years. The SOP was created by the National Transition Documentation Summit to assist with the transition from IDEA requirements in high school to Section 504 and ADA requirements in college. The authors stated that the SOP can be used and modified freely. They shared that the National Council on Disability stated that students and parents are often not aware of all the differences in services, accommodations, and policy between high school and college. The SOP provides a structure to help bridge the gap between high school and college. It is divided into sections that include information such as general background of the student; the student's goals after high school; the student's academic, cognitive, and daily living areas (along with accommodations used); recommendations to help meet the student's goals; and the student's view of the disability and what works.

The SOP could be used in conjunction with the wellness model and consideration of microsystem and mesosystem elements to identify transition planning components. Ideally, these planning tools would be used and updated on an ongoing basis to identify and revise goals, timelines, strategies for working toward goals, and individuals responsible for assistance in working toward goals. As the student matures and becomes familiar with the planning process, responsibility of various components can be transitioned. The use of such a process throughout the student's high school career provides a longitudinal measure of the student's progress and accomplishments, further facilitating confidence and success in preparation for the college transition.

Conclusion

School counselors play an important role in facilitating the high school-to-college transition for students with psychiatric disabilities. As evidenced by American College Health Association statistics, National Survey of Counseling Center Directors' data, and other information presented in this article, psychiatric disabilities affect a large number of college students. In today's increasingly complex society, the number and complexity of transition considerations is overwhelming. There are no easy answers, and ultimately, school counselors cannot do it all. Early planning and taking a long-term approach is important. Using efficient, targeted interventions and tools to disseminate information to students and parents can help school counselors promote the college success of students with psychiatric disabilities or at least allow students to focus on academics right away their first semester of college rather than having to recognize and deal with a variety of transition factors that could have been considered before starting college. Good transition planning will allow the student and their college service

providers to take a developmental, future-focused approach to college rather than a crisis management, illness-focused approach.

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Appendix

Wellness Wheel Model Transition Checklist

Intellectual Wellness: *activities and information related to expanding one's knowledge, mental stimulation, and creativity*

_____ Awareness of differences between high school and college

_____ Study skills/learning strategies

_____ Time management skills (workable schedule, to-do lists, balance)

_____ Reading for fun, poetry

_____ Crossword puzzles, board games

_____ Campus events, lectures and discussions

_____ Watching movies

_____ Appropriate use of technology

_____ Creative outlets (playing an instrument, crafts, other hobbies)

Physical Wellness: *activities & information related to physical health and environment*

_____ Regular exercise (what, when, where)

_____ Sleep (amount, schedule, sleeping environment)

_____ Balanced nutrition (meal plans, healthy choices)

_____ Caffeine intake

_____ Water intake

_____ Risks of drugs and alcohol (healthy choices)

_____ Vitamins

_____ Sexual health

_____ Routine physicals and preventative care

_____ Psychiatric medication management/regimen (not discontinuing medication until successful transition, combining medication with alcohol/drugs, follow-ups with local provider)

_____Living arrangement considerations: single room vs. roommate, on-campus vs. off-campus, access to vehicle, study space

_____ Educational setting considerations: community college vs. university, vocational and technical school options, distance from home, level of support offered

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Emotional Wellness: *activities and information related to taking care of oneself and enhancing inner resources*

_____ Learning to cope with stress

_____ Self-care strategies (e.g., meditation, breathing, journaling, music, etc.)

_____ Healthy balance between academics and self-care

_____ Self-esteem (identification of strengths, positive self-statements)

_____ Self-management/life skills (hygiene, social skills, problem-solving, money management, laundry, cooking, shopping, car care)

_____ Assertiveness and independence skills

_____ Self-advocacy (understanding of one's disability, awareness of rights, awareness of how disability may impact academics, ability to communicate needs related to disability)

_____ Knowledge of symptoms of mental illness

_____ Counseling and psychiatric care options on campus

_____ Emergency contact information and safety plan

_____ Insurance coverage for community resources

Social Wellness: *activities and information related to social connections and support*

_____ Maintaining connections with family and friends in home setting

_____ Role of parental support (balance between encouraging independence and providing support; developing healthy sense of individuation; realistic expectations)

_____ Plans to stay on campus and develop new friendships

_____ Student organizations and clubs

_____ Intramural sports

_____ Social entertainment

_____ Support network: residence hall staff, disability services coordinator, advisor/counselor, faculty and staff

_____ Alone time

Occupational Wellness: *activities and information related to skill development, career satisfaction, and general college success*

_____ Awareness of data privacy laws (HIPAA/FERPA)

_____ Vocational Rehabilitation Services

_____ Disability Services (interview, campus visit, level of support)

_____ Accommodations (documentation, including DSM diagnosis; awareness of strengths and weaknesses, need to self-disclose)

_____ Transfer options and process if first educational setting does not work out

_____ Career/college major exploration and decision-making

_____ Option of part-time job

_____ Connection to and regular sessions with advisor

_____ Course load considerations

_____ Tutoring resources

_____ Summer bridge program

_____ First-year experience program

Spiritual Wellness: *activities and information related to enhancing the mind-body connection; personal growth*

_____ Clarification of values

_____ Volunteerism/service to communities

_____ Maintenance of spiritual/religious practices

_____ Connection to campus faith-based organizations

_____ Nature

_____ Spending 15 minutes each day to be quiet and relax

_____ Meditation

_____ Journaling

Biographical Statement

Sara Fier is a Licensed Psychologist and Assistant Professor at Southwest Minnesota State University Counseling & Testing Services, where she has worked for eight years. She also serves as an academic advisor to undeclared students and has taught psychology courses on an adjunct basis, including General Psychology, Child & Adolescent Psychology, Developmental Psychology, and Abnormal Psychology. Her previous experience includes individual, group, and in-home family counseling for children and adolescents.

Lynda Brzezinski is a Licensed Psychologist and Associate Professor at Winona State University Counseling Center, where she has worked since 2000. Lynda has a special interest in first-year college students, having taught a college success course for 12 years and serving as an advisor to undeclared majors. She works with a wide variety of issues, including depression, anxiety, adjustment to college, stress management, relationship concerns, and career/major indecision.