Chapter 2
Higher Education Transitions and Autism

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ABSTRACT

This chapter intends to examine the segment of adolescent and young adult development; particularly, how interactions with academic establishments create difficult challenges. In the first part of the chapter we review the ASD from neurological angle. Then, we discuss the general problems with counseling of those on the spectrum. The chapter then continues by examining the decisions that individuals on the spectrum and their parents must make. Parents need to make decisions with their children on the spectrum as to level of involvement; the specific concerns needed to be addressed are examined. This chapter also looks at the specific issues that institutions of higher learning need to address if they intend to label themselves as "autism-friendly institutions." Each office within a college needs to make some adjustments in order to properly serve students on the autism spectrum, and this chapter examines the role of the counseling center, dean's office, academics and residential living.

INTRODUCTION

Diagnostic History and Current Neurological Research

Autism was first described in a 1943 case report by psychiatrist, Leo Kanner as a disorder resulting in children's "inability to relate themselves" to other people or their environments (Kanner, 1943, p 242). In the early days it was considered part of childhood schizophrenia and thought to be the result of parenting deficits. It was first introduced as a disorder distinct from childhood schizophrenia in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). Today, the DSM-5 classifies ASD as deficits in social skills, and restricted and repetitive behaviors and interests (American Psychiatric Association, 2013). To this day, the exact etiology of Autism Spectrum Disorders (ASD)

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is still unknown with research pointing to genetic and environmental influences (Bailey, Phillips, Rutter, 1999; Dufour-Rainfray, Vourc'H, Tourlet, Guilloteau, Chalon & Andres, 2011). Narrowing down a specific mechanism for ASD has posed a challenge because of the wide variability in genetic markers and presentation. One theory is that there is disrupted cortical connectivity in ASD youth (Kana, Uddin, Kenet, Chugani & Müller, 2014). This refers to both an underconnectivity and overconnectivity between brain regions resulting in under and over stimulation respectively. Researchers have also found a link between increased paternal age and autism (Alter et al., 2011). It appears that gene expression levels are altered with increased paternal age, which can manifest as autism or other neurodevelopmental disorders. Finally, there is also evidence that exposure to certain teratogens, such as alcohol, during the prenatal period has been linked to ASD (Dufour-Rainfray, Vourc'H, Tourlet, Guilloteau, Chalon & Andres, 2011). This is by no means an exhaustive list of potential biological and developmental factors related to ASD, but rather it is meant to offer a sense of the complexity that is involved in the diagnosis. Currently, the exact biological and developmental underpinnings of autism are still being determined.

Counseling Clients on the Spectrum

Beginning a therapeutic or counseling relationship with an ASD client can require more initial groundwork than with a neurotypical client. The counselor may need to review the expectations and roles for therapy in order to establish a good working relationship that is mutually beneficial for client and counselor (Paxton & Estay, 2007). Modifications such as shorter sessions and written diagrams can help reinforce concepts without becoming overwhelming for the client. Behavioral therapies have been found to be particularly beneficial for ASD clients given the proclivity for restricted behaviors at the expense of other, essential activities. Indeed, behavioral scales have been created specifically for ASD clients in order to assess for potential emotional stress. The Stress Survey Schedule for Persons with Autism and Other Developmental Disabilities asks the client to rate the level of stress he or she experiences during various scenarios (Groden, Diller, Bausman, Velicer, Norman & Cautela, 2001). This can be used to tailor treatment to address the client's specific stressors, and it can be re-administered to assess progress. Overall, it is vital that the counselor is attuned to the needs of ASD client and modifies treatment in order to provide the compassionate care that is useful for the individual.

Moving Beyond High School

Post-high school approximately only 35.0% of youth with ASD receive mental health services, 41.9% receive case management, 9.1% receive speech therapy, and 39.1% receive no services at all (Shattuck, Wagner, Narendorf, Sterzing & Hensley, 2011). African-American youth were also 3.31 times less likely to receive services compared to their White counterparts. For better or worse, 79.0% of these youth also continue to live at home with their parents upon graduation. Deciding on school and work can also be challenging for ASD youth. A common phrase applied to youth with ASD who have reached their 21st birthday is that they "have fallen off the cliff." This term is not parental hyperbole. Youths with ASD have the lowest rates of participation in the workforce compared with youth in any other disability category (Shattuck, Narendorf, Cooper, Sterzing, Wagner & Taylor, 2012). If, in addition to the diagnosis of ASD, the family is poor, the outcomes for that youth are even more distressing. More than 50% of youth who leave high school, with the ASD diagnosis, have no participation in employment. One study found that ASD youth are more likely to be denied vocational rehabilitation services compared to those classified