

Using the Stepped Care Model to Empower University Students With Learning Disabilities

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Students with learning disabilities face several challenges in postsecondary education settings. The authors explore the issue and shed light on the importance of self-advocacy for academic success. The stepped care model (SCM) is suggested as an approach to assist college students with learning disabilities in developing these skills and obtaining services. A brief case example from 1 of the authors' work is shared to illustrate the use of the SCM with a student with a learning disability.

Keywords: stepped care model, learning disabilities, self-advocacy, college counseling, case study

Even under the best circumstances, the transition to postsecondary education can be a significant challenge and one of the most dramatic changes of a young adult's life (Bardi, Koone, Mewaldt, & O'Connor, 2011). Many first-year students find it difficult to adapt, with roughly 30% choosing not to enroll at an institution of higher learning the following year (National Student Clearinghouse Research Center, 2015). For a variety of reasons, the challenge of adjusting to and eventually completing college is even more difficult for students with learning disabilities. In fact, only 41% of students with learning disabilities ultimately obtain a college degree as compared with 52% of those without learning disabilities (DuPaul, Pinho, Pollack, Gormley, & Laracy, 2017).

Many factors are important to the success of students with learning disabilities during the transition to postsecondary education (Yssel, Pak, & Beilke, 2016), including foundational academic skills and personal dispositions, such as independence, resilience, and problem-solving (Eckes, 2005; Shifrer, Callahan, & Muller, 2013). Under ideal circumstances, students would develop these attributes during their K–12 education and be fully prepared for college, but unfortunately, this is frequently not the case (Eckes, 2005; Shifrer et al., 2013). The reality is that many students with learning disabilities begin their postsecondary journey with little understanding of their disabilities, the impact of learning disabilities on learning, or how to access disability services on campus (Brinckerhoff, Shaw, & McGuire, 1993; Burley, 2010).

This article begins with an exploration of the challenges faced by college students with learning disabilities and the importance of self-advocacy skills in attaining success. We then introduce the stepped care model (SCM) and demonstrate via a brief case example how the counseling center at one university is using this approach to build self-advocacy skills in students with learning

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disabilities by empowering them with choice throughout the counseling process and equipping them with the skills needed to locate and advocate for necessary educational services.

Higher Education With a Learning Disability

The term *learning disabilities* has been defined as

a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the life span. (National Joint Committee on Learning Disabilities, 2016, para. 1)

Students with learning disabilities face a variety of challenges in higher education, all of which contribute to the alarming completion statistics cited above. In addition to specific difficulties with academic skills such as word reading, processing speed, semantic processing, and working memory (Bowden et al., 2008; Trainin & Swanson, 2005), students with learning disabilities have been found to be at risk for greater academic procrastination (Hen & Goroshit, 2014), higher academic stress (Heiman, 2006), and lower levels of academic and social melding in the college environment (DaDeppo, 2009). They also report struggles with managing their time, attending to academic assignments, and communicating their needs to instructors (Smith, English, & Vasek, 2002).

Although previous research has found that academic accommodations targeted at these challenges are associated with improved grades (Troiano, Liefeld, & Trachtenberg, 2010) and rates of degree completion (Mamiseishvili & Koch, 2010), it is estimated that only one third of postsecondary students with a diagnosed learning disability actually receive accommodations (McGregor et al., 2016). There are many reasons for this, but the complex and highly individualized choices involved with disclosing one's disability, seeking out services on campus, and utilizing accommodations are likely key contributors (Denhart, 2008). Previous studies on the subject have found that many issues factor heavily in these decisions, including perceived stigma, knowledge of one's disability, and the availability of quality transition services (Denhart, 2008; Lightner, Kipps-Vaughan, Schulte, & Trice, 2012). Additional research has found that although some students with learning disabilities intentionally forgo or postpone disability services because of a highly scheduled freshman year, a general feeling that things are going well, or a desire to forge an identity free of disability (Lightner et al., 2012), others do make the decision to seek out services but find themselves unable to secure them because of difficulties navigating the campus, forming relationships with students and staff, locating the disability support services (DSS) office (Brinckerhoff et al., 1993), or obtaining updated documentation of their disability (Denhart, 2008).

Whatever the reason, it is clear that university students with learning disabilities who receive accommodations are more likely to overcome the challenges associated with learning disabilities and find academic success. Nevertheless, the responsibility for seeking out and advocating for these services ultimately falls on the student, many of whom are facing a tumultuous transition to college without the self-awareness, resilience, and self-advocacy skills necessary to meet the challenge.

Self-Advocacy Skills and Students With Learning Disabilities

Previous literature has defined self-advocacy broadly as public recognition of the resilience of people with learning disabilities (Goodley, 2005) or a knowledge of self, knowledge of rights, and leadership (Test, Fowler, Wood, Brewer, & Eddy, 2005). Other researchers have suggested that specific knowledge and skills comprise self-advocacy, such as self-determination and the abilities to make independent decisions and express one's needs (Phillips, 1990). Self-determination has been further defined as a dispositional characteristic indicated by behaviors that are based on autonomy, self-regulation, self-realization, and psychological empowerment (Farmer, Allsopp, & Ferron, 2015). Therefore, self-advocacy might be thought of as the expression of one's needs made possible by knowledge of self, the ability to make independent decisions, and an empowered psychological state. Unfortunately, many students with learning disabilities find themselves entering postsecondary education without these skills (Eckes, 2005; van Ingen et al., 2015).

Although no student's journey is the same, a number of factors affecting the current generation of students with learning disabilities are likely to contribute to underdeveloped self-advocacy skills. One such factor is the trend of overinvolved parents, sometimes dubbed "helicopter parenting" (Padilla-Walker & Nelson, 2012). A lingering issue in K–12 schools for years, helicopter parenting has become a growing concern among postsecondary education administrators (Schiffrin & Liss, 2017) as increasing numbers of parents exert an unhealthy degree of influence in their children's lives—even going so far as to text their children's professors to solve class-related problems (Schiffrin et al., 2014). Although a full exploration of helicopter parenting is beyond the scope of this article, it is important to note the links between this phenomenon and a delay in the development of many skills and dispositions considered important for postsecondary success among students with learning disabilities, including self-advocacy (van Ingen et al., 2015), feelings of competence and self-determination (Schiffrin et al., 2014), and independent decision-making with regard to setting goals for accomplishing tasks (Hong, Hwang, Kuo, & Hsu, 2015).

Another factor that may contribute to underdeveloped self-advocacy skills among college students with learning disabilities is the structure of special education services in K–12 public schools. Although the most recent reauthorization of the Individuals With Disabilities Education Act (2012)

was an improvement, the roles of adults (e.g., teachers, school counselors or psychologists, parents) continue to be emphasized throughout the typical special education process, whereas students are frequently marginalized and therefore leaving high school unaware of the details of the services they received (Smith et al., 2002). For example, a study of students with learning disabilities attending new student orientation at Boston University revealed that although approximately half of the group remembered having an individualized education program (IEP) in high school, only a small number knew its purpose and even fewer knew what the acronym IEP represented (Brinckerhoff et al., 1993).

Many students with learning disabilities enter higher education without the self-advocacy skills critical for success (Eckes, 2005; van Ingen et al., 2015). Whether the result of overinvolved parents, a high degree of management by adults during the K–12 years, or some other factor, the fact remains that many of these students need help, encouragement, and training to find success.

The SCM

Originally created in the United Kingdom for use in primary health care settings (Cornish et al., 2017), the SCM is now commonly used by general practitioners in many parts of the world (Bower & Gilbody, 2005). Mental health and addictions treatment providers began adopting the approach in the late 1990s and early 2000s as a way to standardize procedures in order to improve efficiency, lower costs, and eliminate personal inconvenience for the client and counselor (Bower & Gilbody, 2005). Over the years, the SCM has been slowly incorporated into growing numbers of mental health settings, particularly those in which rapid access to services is needed and efficiency is paramount (O'Donohue & Draper, 2011).

Whether in a primary health care or mental health counseling setting, the SCM operates in much the same fashion. Interventions are grouped according to factors such as intensity, duration, and cost. Each resulting group is considered a “step” in the SCM, which is often presented as a pyramid (e.g., italk, n.d.). This pyramid is divided into three parts, with whole community–based interventions, such as mental health promotion and education, at the base of the pyramid. The middle part represents services delivered at the primary care level, and the top part is reserved for treatment by highly skilled staff. In this model, the bottom portion represents the bulk of the services offered, which are lower cost and of shorter duration, whereas more intense, less frequently used methods are near the top. Preference is given to interventions that are less restrictive and still likely to achieve clinically significant results, with the most intensive treatments typically being reserved for those who do not benefit from short-duration, frontline treatment in its many forms.

That said, as illustrated in Figure 1, the steps do not need to be implemented in a specific order. After an initial intake, clients and counselors work together to choose the best treatment modality from among all available interventions, keeping in mind that another hallmark of the SCM is that it is meant to be self-correcting, with the results of treatment guiding subsequent decisions about interventions

(e.g., modality, length) as both clients and counselors monitor progress and discuss modifications when desired outcomes are not being achieved (Bower & Gilbody, 2005). In a mental health setting, this means that although psychoeducation, short-term groups, and brief counseling would typically be used before extended individual counseling, every treatment option is on the table for clients and counselors to discuss and mutually agree upon to implement as appropriate.

The SCM is relatively new to college counseling centers. In fact, it is our belief that as few as 10 centers in the United States and Canada have adopted this approach—which is surprising given that the SCM has a great deal of utility in settings such as these (with notoriously long wait lists and typically inadequate staffing and budgets; LeViness, Bershad, & Gorman, 2017) and because the model is designed to guide counselors to the least restrictive and shortest duration treatment that creates clinically significant outcomes (Oosterbaan et al., 2013; van der Aa et al., 2015). In that way, the SCM is meant to facilitate more efficient, efficacious, and cost-effective approaches to treatment, thereby freeing up staff to see a greater number of clients over time—an obvious benefit in settings such as college counseling centers.

The SCM and Self-Advocacy

We believe that the use of the SCM in a university counseling setting empowers students to make choices about their treatment, thereby contributing to the



FIGURE 1

The Stepped Care Model

Note. From *Stepped Care Counseling*, by The George Washington University, Colonial Health Center, Division for Student Affairs, n.d. (<https://healthcenter.gwu.edu/stepped-care-counseling>). Figure reprinted courtesy of The George Washington University. Copyright 2019 by The George Washington University. All rights reserved.

development of self-advocacy skills that are useful in other settings, and that this phenomenon is especially true for students with learning disabilities. To illustrate this point, we provide a brief explanation of the general structure of the SCM, followed by a case example from one of the authors' work with a client with a learning disability.

The SCM begins with an intake session, the first 10 to 20 minutes of which is devoted to the client speaking freely about his or her concerns. As appropriate, the counselor will ask questions to obtain enough clinically relevant information to present appropriate treatment options. When enough information has been gathered, the counselor will present various treatment options or steps in the center's SCM that match the appropriate level of care for the client's concern. As noted earlier, these do not always include additional counseling sessions. In fact, less restrictive psychoeducational approaches in the form of movies, apps, and reading materials are frequently suggested. At this point, the client and counselor embark on a client-centered collaboration to decide which treatment modality is the most appropriate fit. Although the counselor will educate the client about various options as requested, highlighting the potential pros and cons of various choices, the counselor simply facilitates the process. The primary focus during treatment selection is on the client's use of critical thinking skills to evaluate each option and select and advocate for the one that will (a) be most appropriate for his or her stage of change (Prochaska, Redding, & Evers, 2015); (b) fit his or her personality, temperament, and developmental stage; and (c) help him or her grow and meet personal treatment goals with maximum buy-in.

When ready, the client will build an argument for why he or she prefers a particular approach. The counselor will then offer to answer any questions the client has and provide feedback on the client's choice of treatment. If the counselor disagrees, reasons will be provided, and the client will be gently encouraged to further analyze his or her decision given this new information. This is another point at which clients are given the opportunity to build their self-advocacy skills in a safe environment. Ultimately, clients will be allowed to make the final decision assuming it is safe and clinically appropriate (e.g., a client who is actively suicidal would not be allowed to completely refuse treatment), but they are consistently challenged to explain why they have made that choice and what potential benefits and pitfalls they foresee. When a final choice is made, the counselor will explain that the treatment plan will be monitored by both parties and can be adjusted at any time. The counselor will note that the SCM works best when clients take ownership and advocate for their personal care, and that it is therefore critical for clients to reflect on their progress, participate fully in the process, argue for change when needed, and demonstrate the self-agency needed to experience optimal treatment outcomes.

In our opinion, the SCM creates a unique, developmentally appropriate opportunity for university students to begin learning the skills associated with self-advocacy and self-determination. We believe that this is particularly true for students with learning disabilities, who, as noted previously, often do not come to college with the will or skills needed to seek out and secure

the services they might need in order to succeed. A counselor using the SCM creates the conditions for students to practice these skills via engaging in critical thinking, building an argument, and ultimately advocating for their preferred method of care in a safe, secure, and nonjudgmental setting such as a counseling center, all the while receiving encouragement and feedback from a nonjudgmental supporter.

Case Example

To further highlight how the SCM works in a university counseling center with a student with a learning disability, we provide the following case example. Consider Eric (pseudonym), an 18-year-old male, cisgender, White, first-year student who voluntarily sought services at a university counseling center during his first semester. Eric's presenting concerns were mild depression and significant anxiety related to academics and the adjustment to college. Specifically, he was struggling to keep up with the work in his writing class, which is a core general education requirement. During the 30-minute assessment, it became clear that Eric was having a hard time with reading comprehension and retention. The counselor inquired about Eric's educational background, including any history of learning disability (given that it often manifests as reading issues), and Eric shared prior diagnoses of dyslexia and attention-deficit/hyperactivity disorder (ADHD). He further stated that he was aware he could receive academic accommodations but had not sought them out because he did not know where the DSS office was located, did not want to be seen as intellectually inferior, and could not imagine how accommodations would help.

At this point, the counselor educated Eric about the SCM and the array of treatment options available, including long- and short-term individual counseling, groups, and informal check-ins. As explained in the previous section, the counselor first emphasized Eric's role as a self-advocate who would determine the course of treatment with the support of the counselor, and then explained that in the SCM the client holds the power of self-determination and can adjust the treatment plan as necessary. Eric stated that he liked the flexibility of the approach and the feeling of empowerment associated with customizing his treatment. After about 20 minutes spent exploring various paths forward, the counselor encouraged Eric to build his case for a particular option, which he did by selecting short-term individual counseling to address his depression and anxiety, as well as to explore the possibility of engaging with the DSS office. The counselor agreed that this path seemed appropriate and commended Eric for advocating for the level of care he felt was necessary, despite other options being presented. The counselor closed the session by explaining that the SCM works best when clients monitor their own progress and advocate for change as needed so that the treatment plan could be modified at any point.

Shortly after, Eric and the counselor met again to begin working on mindfulness-based cognitive behavior therapy skills, which is the counselor's preferred approach to addressing anxiety and depression. The counselor also

used motivational interviewing techniques to build rapport, express empathy, and explore Eric's ambivalence toward seeking assistance from the DSS office. With Eric's permission, the counselor also provided extensive psychoeducation on dyslexia and ADHD, including information about the types of accommodations that might be available through the DSS office. The counselor frequently asked Eric to reflect on his progress and to consider whether the treatment was moving him closer to his goals. Eric consistently indicated that it was, and he was able to not only give examples of change but also articulate a case for why subsequent sessions were needed—a mark of the self-advocacy skills he seemed to be developing slowly.

Eric's treatment ultimately consisted of three 30-minute sessions and a final 15-minute check-in. He reported a significant reduction in depression and anxiety symptoms, a feeling of being more adjusted to college, and confidence that he would be academically successful. Furthermore, he overcame his ambivalence and made the choice to engage with the DSS office, where he was provided with a variety of possible accommodations. Working together with the DSS staff in ways that were very similar to his work with the counselor under the SCM, Eric was able to advocate for the accommodations he felt were most appropriate, including extended time on exams and written assignments.

Implications for Practice

The SCM seems to be a promising approach to helping college students with learning disabilities develop basic self-advocacy skills and obtain access to the help and services they need. Rooted in the beliefs that clients should take the lead in driving their own care and the least restrictive options should be used to obtain clinically significant outcomes, the SCM seems to make sense in settings such as college counseling centers in which efficiency and speed are important considerations, and in which students need every opportunity to practice self-advocacy skills in a safe environment.

Anyone can learn to provide care under the umbrella of the SCM, although it is most helpful when entire practices make the commitment to do so as a team. The SCM is not a manualized treatment, but rather an approach to organizing and providing services in the most efficient manner possible. Counselors remain free to treat clients using whatever methods and theoretical approaches seem most appropriate after considering the center's staffing levels and available interventions alongside each client's presenting concerns and preferred treatment modality. That said, the SCM is composed of standardized procedures that must be learned and practiced over time in order to be used successfully. Foundational knowledge is typically provided by experts in the field during full-day workshops that include training on the core components of the model, including steps available at the counselor's site, theory behind the SCM, case examples, and ethical considerations. Video vignettes and demonstrations by the trainers are also typically used to show how the model is applied in practice.

Following these trainings, counselors new to the SCM might also participate in regular coaching sessions with their senior colleagues if the model is already established at their place of employment. Weekly individual and group supervision by a senior counselor or SCM coordinator can help fine-tune a beginner's knowledge of the system. Once basic mastery has been demonstrated, adjunctive trainings can be provided on best practices around implementing the model with a specific clientele (such as students with learning disabilities), or counselors may attend in-depth workshops on therapeutic techniques that are useful in the model, such as motivational interviewing and solution-focused brief therapy.

Although the SCM provides a useful structure for organizing services, it may not be the best approach in all situations. One potential critique of the SCM in university clinics is that it may not be helpful to those with more severe psychopathology, especially in settings that overemphasize brief interventions or limit the degree to which counselors may offer treatments such as intensive ongoing counseling. Again, there is no one-size-fits-all approach within the SCM. Although short-duration, less-restrictive interventions are often tried first, the model allows for quick modifications to modality given that outcomes are monitored, with new approaches agreed upon by the counselor and client. The SCM is meant only to funnel clients into the appropriate level of care rather than restrict options or prevent clients from accessing costly interventions. In that way, the SCM also has utility for clients who may require longer term care (Oosterbaan et al., 2013) but may be unable to seek it outside the university for financial reasons or a desire to prevent family from discovering that they have sought help. If the counselor and client agree that open-ended individual counseling is the most appropriate treatment choice at that time, nothing within the SCM would prevent that intervention from being implemented.

Nevertheless, some conditions do present a challenge within the SCM, including delusions, hallucinations, paranoia, and other psychotic disorders that make it difficult for clients to monitor their progress and make choices about their care. Similarly, clients who are unable to use logic, are not oriented to reality, or are consistently under the influence of drugs or alcohol may find it difficult to benefit from the SCM. Although ongoing care and case management could be considered as high-level steps of the model and an option for treatment as explained above, there are ultimately situations in which students are not clinically appropriate for a university counseling center until they are stabilized in a hospital setting or receive other outside treatment, such as in cases of active psychosis.

Although a strength of the SCM is that it can create opportunities for clients to make choices about their care, ultimately empowering them to develop self-agency, such an approach may not be the best choice with all clients. For example, students from collectivist cultures may not value individualism and instead prefer making decisions in concert with friends and family. A culturally competent counselor will be aware of this dynamic and allow clients time to consult their support network and get back to the counselor before deciding

on a plan of action. Additionally, international students with learning disabilities for whom English is a second language may struggle with understanding the core concepts of the SCM as well as the idea of self-advocacy—especially if they were also raised in a collectivist culture. The counselor may have to slow the process a bit and take care in explaining the concepts in simple terms that increase client understanding. Aside from helping the student understand the SCM, counselors may need to explain the very foundations of personal counseling and the sharing of intimate information in a way that translates into the native culture of the student. This could be especially true for those who hail from regions of the world in which mental health services are stigmatized or rarely utilized.

Conclusion

Professional counselors work with many marginalized populations, including students with learning disabilities in higher education settings. Although there is no perfect approach to assisting these students, we offer the SCM as one option to consider. As demonstrated by the case example from one of the authors' work with a student with a learning disability in a university setting, the SCM can assist counselors in keeping the focus of treatment on the progress of clients toward their stated goals in the least restrictive and most empowering manner possible. By emphasizing psychoeducation, self-monitoring, and client choice, the SCM naturally fosters self-advocacy and self-awareness skills that are critical for success in postsecondary education and can be applied in settings outside the counseling office. Furthermore, as a structure for providing services rather than a theoretical orientation, the SCM lends itself well to a number of counseling approaches. Although research is needed on the efficacy of the SCM in a variety of counseling settings, including college and university clinics, we hope that readers will consider the SCM as a vehicle for empowering clients and teaching self-advocacy, especially among students with learning disabilities in university settings.

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