CHAPTER 1

Introduction

> You can't solve a problem with the same thinking that created it.
> —Albert Einstein

Depression hit quickly during the winter break of my second year in college. I moved back home during the break and was working part time at a department store. I put on a good face for my parents, friends, and coworkers. Inside, I felt like a scared little kid who was going crazy.

As a newly declared psychology major, I grabbed my psychopathology textbook to learn more about my problem and how to change it. I read the depression chapter twice and was struck by a recurring theme—if you figure out why you're having a problem, then you'll know how to change it. It's called the diagnostic-prescriptive model, a term reflecting the medical origins of psychology and psychotherapy from Freud to the present. First, you diagnose the problem, then you prescribe a solution. This made sense and gave me hope. It was also the driving force of psychotherapy since the early 1900s. Who was I to question it?

Armed with the diagnostic-prescriptive model, I read up on common causes of depression to get a better handle on my situation. Genetic predisposition? Unlikely. My parents and grandparents were fine, and if I was predisposed to depression, it would have shown up earlier. Situational stressors? A few, but none of them were new or serious enough to explain my situation. Trauma? No. Even the hardest experiences of my life did not qualify as trauma. Faulty thinking? Possibly, as I was increasingly worried about how bad I felt and what would happen if it didn't change soon.

Attributing my problem to faulty thinking did little to change it, despite my use of thought stopping and other cognitive strategies. On the upside, I learned more about myself and about possible causes of depression. On the downside, I was no closer to a solution.

I was tired of putting on a good face for the outside world when I was feeling so bad on the inside. I finally told my mom and one of my friends how I was feeling. They asked how they could help and invited me to talk to them whenever I wanted to. Beyond the temporary relief of having told someone, nothing changed for the next few days.

I got home from work one afternoon to find my dad refinishing an oak table in the garage. He handed me a piece of sandpaper and asked me to help. A few minutes later, he said, "Mom tells me you got the bull goose loony."

"The *what*?" I asked.

"The bull goose loony," he said, as if it was common knowledge. "Everybody gets it now and then, but it passes. Just hang in there and keep doing what you need to do. It'll pass. You'll see."

Instant relief, courtesy of a tool and die maker with no knowledge of the diagnostic-prescriptive model. I felt calmer and more settled that evening and the next day as I worked my shift and had dinner with a friend. By the time I drove back to school a week later, I was eager to start the semester and take more psychology classes. Who knows, I thought, someday I might have a job helping people with similar struggles.

How can a short conversation lead to lasting changes? I've been intrigued by this question ever since that afternoon in the garage, but it wasn't until my second year as a school psychologist that I began to explore it in more detail. My assessment caseload left little time for anything else. However, most of the students I worked with had psychological and behavioral challenges on top of the academic problems that led to their assessment referral.

I was determined to provide some form of therapeutic support while continuing to meet my assessment duties. However, the counseling models I was familiar with took more time than I had. I searched high and low for practical therapeutic techniques that were evidence based *and* efficient. I found them in the writings of brief therapists and began using them whenever and wherever possible—in the lunchroom, on the playground, between class changes, and in brief chats before, during, and after assessment sessions.

Students appreciated these conversations because they were different from their usual interactions with adults. I experienced enough positive feedback and changes from students to continue using brief therapy techniques in my interactions with students and caregivers—a process that continues to this day. I am more convinced than ever that the brief counseling techniques in this book can help students make rapid and lasting changes in their lives.

WHAT IS BRIEF COUNSELING?

Brief counseling, also called brief therapy, is a collaborative approach that helps PreK–12 students move forward from psychological and behavioral problems as quickly as possible.[1]

[1]Although *brief counseling* and *brief therapy* are interchangeable, "counseling" is used here because it fits better in school settings. *PreK–12* includes preschool, kindergarten, elementary, middle, and high school. *Student* (or *students*) is used in most places and examples; however, brief counseling techniques are equally applicable to teachers, parents, administrators, and others involved in counseling. *Practitioners* refer to school psychologists, counselors, social workers, paraprofessionals, and other service providers. *Brief practitioners* refer to practitioners of brief counseling. *Caregivers* include teachers, parents, or others who supervise and care for students. *Solutions* refer to small steps forward rather than ideal outcomes or absence of problems.

Instead of diagnosing problems, it gets right into building solutions by collaborating with students to set goals, leverage resources, and change problem patterns. It can be used by itself, combined with other approaches, and applied by practitioners of all theoretical orientations. These features make brief counseling an effective preliminary (and often sufficient) intervention for a wide range of problems.

School practitioners and students like brief counseling because it is practical, goal focused, strengths based, student centered, and culturally responsive. Practitioners feel more hopeful, and students appreciate being asked what they want from services and being treated as capable of improving their lives. Both groups value its efficiency, as reflected in the age-old principle of parsimony: *Never use more to do what could be done with less.*

Even though students often make rapid improvements, brief practitioners do not rush the process or put a limit on the number of sessions. They follow the practical motto "for as long as it takes and not any longer." This creates a brief counseling mindset that expedites solutions while ensuring that students who need extended counseling receive it. Brief counseling has helped students who have experienced trauma and other major challenges, and it includes activities such as sit-down counseling sessions, quick chats in the hallway, teacher and parent consultations, and more. As schools face staff shortages and growing demands for mental health services, this book offers hope in the form of brief, evidence-based techniques that enable practitioners to serve more struggling students.

The book describes 40 techniques that can be used with any student, problem, and change-focused activity. Every technique has passed the real-world test and proven useful in the trenches of everyday practice. The techniques are listed in Appendix 1.1 and illustrated through real-life examples in Chapters 3 through 7.

Three Guidelines

Brief counseling techniques follow three practical guidelines of brief strategic therapy (Schlanger et al., 2019), solution-focused brief therapy (de Shazer et al., 2021), and single-session therapy (Cannistrà & Hoyt, 2025). The guidelines work in complementary ways to accelerate school solutions.

Guideline 1: If It's Not Broken, Don't Fix It

Focusing on people's stated concerns and goals—*and nothing more*—distinguishes brief counseling from other approaches that explore underlying motives, root causes, childhood experiences, problem origins, and more. Going beyond the student's or caregiver's main concern and goal prolongs counseling and implies that practitioners are better able to determine the focus of counseling than the very people for whom it is designed. Even if it were possible to pinpoint problem origins or causes, effective solutions may have little or nothing to do with them.

My dad's no-nonsense approach in the garage exemplified this guideline's here-and-now focus by getting to the point rather than discussing topics unrelated to my immediate

concern. And it worked. Despite the allure of the diagnostic-prescriptive model, I was more interested in finding a way forward as quickly as possible—just as most students and caregivers are when they enter counseling.

Guideline 2: If It Works, Do More of It

This core principle of solution-focused brief therapy mirrors the efficiency of the first guideline by assuming people already possess the resources needed to help them move forward. Instead of trying to give students something they don't have, brief counseling practitioners (hereafter "brief practitioners") encourage them to build on available strengths, skills, and other indigenous or "naturally occurring" resources that support their counseling goals. Inviting students to leverage their resources is the quickest path to school solutions.

My winter break experience shows how an available resource (my dad) prompted an efficient solution. In the spirit of brief counseling, my dad viewed me as stuck versus sick and my problem as a setback rather than a symptom. In addition to accelerating school solutions, resource-based changes are more likely to last because they are built on naturally occurring elements of the student's life that were there before counseling began and will be there after it ends. Every student offers a one-of-a-kind set of resources, and the techniques in Chapter 5 help them leverage these resources in productive ways.

Guideline 3: If It Doesn't Work, Do Something Different

This guideline, like the previous two, is simple to understand but not easy to do. Humans have a unique tendency to repeat an unsuccessful solution strategy over and over, especially when it is seen as the only sensible response to the problem. This is true for practitioners and students alike. No matter how reasonable a counseling strategy or suggestion seems to the practitioner, it should be discarded if it doesn't work. Rather than blaming students when they do not improve or do not implement a suggestion, brief practitioners simply try something different.

Brief counseling also embraces the idea that one small difference or change can lead to another, then another, and so on. This is exactly what happened for me following my dad's bull goose loony comment. I stopped trying to figure out why I was feeling depressed and adopted a different view of my struggle, which turned out to be what brief practitioners call "a difference that makes a difference" (de Shazer, 1991, p. 8). The techniques in Chapter 6 invite students and others to change any part of the problem pattern in the hopes of creating a difference-making difference. Box 1.1 invites you to apply this guideline to a current concern or goal in your life.

BOX 1.1. If It Doesn't Work, Do Something Different

Have you ever persistently repeated the same attempted solution, despite its ineffectiveness? If so, what did you do differently to bring about a positive change? How might you apply "if it doesn't work, do something different" to a current concern or goal in your life?

Practitioner's Stance

The practitioner's stance in brief counseling centralizes the student, decentralizes the practitioner, and promotes the type of collaboration associated with strong alliances and effective outcomes (Tryon et al., 2019). Brief practitioners collaborate with students and caregivers on every aspect of their care. Instead of prescribing interventions from an authoritarian position, they approach students from a stance of respectful curiosity (Murphy & Sparks, 2018) and cultural humility (Hook et al., 2025). They view every student as a culture of one and every interaction as a cross-cultural exchange (Murphy & Sparks, 2018) that strengthens the therapeutic alliance and promotes individualized solutions.

Practitioner collaboration and humility are supported by research on multicultural effectiveness and common factors of successful counseling. For example, studies have linked positive client outcomes to practitioners' cultural humility (Hook et al., 2025), flexibility, and healthy levels of self-doubt (Nissen-Lie et al., 2017). Collaboration is particularly important when working with young people, many of whom enter counseling against their will with an understandable level of mistrust (Fernández et al., 2016; Karver et al., 2019).

Brief practitioners see it as their job to cooperate with students and not the other way around. When students do not engage in counseling or do not implement a suggestion from the practitioner, the practitioner changes the suggestion or approach rather than calling students resistant and attempting to coerce their cooperation. Practitioners assume students are always cooperating in ways that fit their perspective. They also assume students are doing the best they can given their experiences and perceptions. Finally, they assume students want to succeed and will work toward goals that are important to them. Box 1.2 provides an opportunity to consider how your stance compares to the practitioner's stance in brief counseling.

When asked what they need from adults, students emphasize the importance of listening to them, asking for and respecting their opinions, and involving them in decisions rather than telling them what to do (Everall & Paulson, 2006; Freake et al., 2007). It is no accident that listening and asking are the first two alliance-building techniques in Chapter 3.

BOX 1.2. What Is Your Stance?

How would you describe your position or stance in working with students? What are the similarities and differences between your stance and the practitioner's stance in brief counseling? What aspects of the brief practitioner's stance do you want to emphasize in your future work?

THE NEED FOR BRIEF COUNSELING IN SCHOOLS

The worldwide gap between people needing and receiving mental health care is growing every year. The need-to-treatment gap or "treatment gap" exceeds 50% in every country and reaches 90% in low-income countries (Mongelli et al., 2020; Singla et al., 2023). The World Health Organization (WHO; 2022) reported that 76 to 85% of youth and adults with

mental disorders lack access to needed care. The treatment gap is even larger for marginalized groups due to systemic, logistical, and structural inequalities such as race, geography, income, workforce shortages, and professional reliance on lengthy interventions, to name a few (Flores et al., 2023; Hoffmann et al., 2023; Singla et al., 2023).

Simply put, most PreK–12 students who need mental health services do not receive them (WHO, 2022). This is true for all youth, including those from wealthy and industrialized countries like the United States and other countries with greater access to mental health services. Even before the COVID-19 pandemic, there was a steady rise in youth anxiety, depression, and suicidal ideation. From 2009 to 2019, the number of secondary students reporting persistent sadness or hopelessness rose by 40%; those who seriously considered suicide grew by 36%; and those who created a suicide plan increased by 44% (Centers for Disease Control and Prevention [CDC], 2020). There were approximately twice as many pediatric emergency department visits for mental health reasons from 2011 to 2020, which included five times more suicide-related visits (Bommersbach et al., 2023). As Insel (2025) noted, "The deterioration of mental health among young people is now becoming a generational threat" (p. xiii).

Between 2013 and 2019, 21% of U.S. teens were diagnosed with a major depressive disorder, and 9% were diagnosed with an anxiety disorder (Bitsko et al., 2022). As if those numbers aren't disturbing enough, pandemic-driven disruptions in social, family, and school life have doubled the rate of youth depression and anxiety (Ghafari et al., 2022). Students have also displayed increasingly higher rates of disengagement and chronic absenteeism (Carnegie Foundation for the Advancement of Teaching, 2025). This worsening situation has occurred despite having more mental health practitioners in schools, greater access to in-person and virtual services, additional training opportunities, and a wider range of insurance options. The demand for school-based counseling far exceeds the number of providers with no foreseeable end in sight. The treatment gap continues to grow, as do the accompanying emotional burdens and other costs for students, caregivers, and schools.

The need to prevent and address youth mental health problems has never been greater, and it will take widespread efforts to meet this need (Dodge et al., 2024). Schools can play a pivotal role in these efforts by providing a multi-tiered continuum of evidence-based prevention and intervention services accessible to students at all levels of academic, behavioral, and psychological need (Adelman & Taylor, 2024; CDC, 2020; Dodge et al., 2024; Goodman-Scott et al., 2023). The multi-tiered systems of support (MTSS) framework is designed to offer comprehensive mental health support for all students (Tier 1), targeted support for a smaller percentage of students (Tier 2), and intensive Tier 3 interventions like individual counseling for an even smaller number of students (Zhang et al., 2023). The "even smaller number" of Tier 3 students is getting larger, making it increasingly difficult for schools to provide counseling to students who need it most.

One of the biggest barriers to offering timely counseling services to more students is professional reliance on long-term treatment models (Cohen et al., 2024; Singla et al., 2023). The evidence-based brief counseling techniques in this book enable schools and school practitioners to serve more students suffering from psychological and behavioral problems.

KEY POINTS

- Brief counseling is a collaborative, goal-directed approach that helps students move forward from problems in the shortest time possible. Brief counseling techniques can be used by themselves, combined with other approaches, and applied by practitioners of all theoretical orientations. These features make brief counseling an effective preliminary (and often sufficient) intervention for a wide range of students and school problems.
- The 40 techniques in this book are driven by the three practical guidelines—if it's not broken, don't fix it; if it doesn't work, do something different; and if it works, do more of it. These guidelines appeal to students, caregivers, and practitioners seeking the shortest path to solutions.
- Brief practitioners approach students from a stance of cultural humility and respectful curiosity, which enhances the cultural responsiveness and effectiveness of brief counseling techniques.
- The need-to-treatment gap continues to grow, along with its emotional and other costs for students, caregivers, and schools. This book addresses the treatment gap by providing evidence-based techniques that expedite solutions and enable schools and school practitioners to reach more struggling students.

DISCUSSION AND PRACTICE

1. This chapter began with a story about a short conversation that led to long-term changes. Individually or in small groups, share a personal experience in which a brief conversation, comment, or question made a positive difference in your life.
2. Think of a personal concern or a concern of a friend, family member, or student you are working with. How might you/they benefit from applying one or more of the three practical guidelines of brief counseling?
3. Individually or in small groups, discuss how the practitioner's stance in brief counseling differs from traditional counseling approaches.
4. Which features of brief counseling fit particularly well with your ideas about helping people change? In what other ways does brief counseling appeal to you?
5. The need for school-based mental health services has never been greater. What are the advantages of providing these services in schools rather than clinics, private practice offices, and other nonschool settings?
6. What stood out most for you in Chapter 1, and how might you apply it in your everyday work or life?
7. Describe one small step you want to take in your work as the result of reading this chapter. On a scale of 0 to 10, where 10 means you are very likely to take this step and 0 means the exact opposite, where would you put yourself now? What puts you there instead of at a lower number? What would it take to move a half-point higher?