

Do you guarantee results?

*No ethical psychologist or physician will guarantee you a specific positive outcome from a specific therapy. I also cannot and will not make such a guarantee. I will say, however, that CBT has been thoroughly researched and outcome **evidence** indicates that it is highly effective for a variety of psychological disorders or disturbances. I have seen very good results using CBT and that is why I chose to pursue advanced training in it and am excited to offer it to you. The data shows that, for patients who are very committed, work hard with the psychologist in each session, and work between sessions, the outcomes are usually good to very good. How “good” depends on the level of the initial problem, the amount of work the patient completes, and factors relating to the presence of other medical, social, or psychiatric problems that may make progress more difficult. Additionally, some people may respond more positively to other therapeutic approaches in part because they may not like the level of involvement CBT requires or they may simply prefer one of the other traditional therapies. If you feel that describes you, then I *strongly* encourage you to pursue the kind of therapy and therapist you feel will offer you the most benefit. What matters, ultimately, is improvement—pursue whatever legitimate therapy will help you meet your goals!*

What about medications?

As a Clinical Psychologist I do not prescribe antidepressant, anti-anxiety, or other medications of any type. I can refer you to some excellent local psychiatrists who can work with you in terms of medication. My *opinion* is that wisely prescribed medications can provide additional support and offer patients a **window of opportunity** during which to learn CBT skills with the hope that, if possible, medications can be reduced or discontinued altogether. CBT research has shown that it helps *prevent the*

relapses seen in patients who use antidepressant medications *alone* and then discontinue their use. Relapse risk is reduced because the patient continues to use the **skills** learned in CBT and some of the core irrational beliefs that had supported depression have been disempowered throughout CBT work. *Final decisions about all medications lie with you and your psychiatrist or other physician.*

What is your background/training?

I hold a PhD in Clinical Psychology from Georgia State University and am licensed as a psychologist in the state of South Carolina. I have completed a number of research projects that have been published in medical journals such as *Journal of Family Practice* and *Family Medicine*. I have also published, in *Biological Psychiatry*, research investigating some of the neurobiological mechanisms that may be involved in the pharmacological and electroconvulsive treatment of depression and have devoted much of my clinical practice to treating depression—this is what led me to become certified in CBT over 10 years ago. I am currently the only psychologist in South Carolina certified by the *Academy of Cognitive Therapy* (founded by Aaron T. Beck, MD, the originator of CBT). In the past I have also worked with organizations as an organizational and leadership development consultant and have published a number of articles in journals devoted to those topics. I believe that the work I do in CBT is fundamentally about **helping people learn to lead themselves more effectively**. It is my belief that as one leads oneself better, one is then in a position to lead others (children, partners, friends, spouses, etc.) more effectively and positive impacts ripple outward. I initially became interested in the relationship between personal leadership, mood management, and pursuing one’s overarching sense of purpose when I was, from 1983-1990, a Catholic Priest. You can read more about my background, see my publications list, book chapters I have written, and learn more about working with me on my practice website:

www.coastalcognitive.com



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What is Cognitive Therapy?

Cognitive Therapy, sometimes also called *Cognitive-Behavioral Therapy* (CBT), is a time-limited, focused, collaborative problem-solving psychotherapy shown in over 375 outcome studies to be highly effective for the treatment of many mental health problems such as:

- ▶ Depression & Mood Disorders
- ▶ Anxiety & Panic Disorders
- ▶ Anger Management
- ▶ Marital/Relationship Distress
- ▶ Stress
- ▶ Low Self-Esteem
- ▶ Work/Career Problems
- ▶ Grief and Loss

and in medical conditions such as:

- ▶ Chronic Pain
- ▶ Hypertension
- ▶ Migraines
- ▶ Irritable-Bowel Syndrome
- ▶ Sleep Disorders
- ▶ Pre-Menstrual Syndrome
- ▶ Eating Disorders
- ▶ Substance Abuse

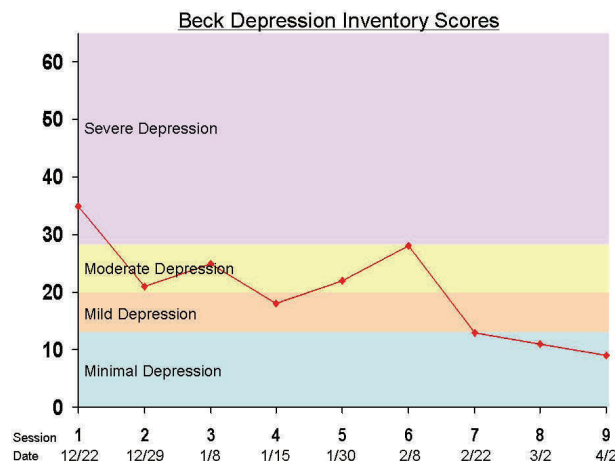
CBT focuses on correcting underlying distorted beliefs about one's world, self, and future that are often expressed in negative or dysfunctional automatic thoughts. Psychologists using CBT work in partnership with patients to help them change the dysfunctional thinking and beliefs that *contribute to negative moods*. They also help patients learn specific skills they can use on an ongoing basis. Some of the skills deal with learning to self-correct dysfunctional thoughts (cognitions) and replacing faulty beliefs with more realistic ones. Other skills deal with adopting new, better, specific behaviors that will result in better outcomes. Because learning and practicing improved *cognitions and behaviors* are the purpose of the therapy, it is called *Cognitive-Behavioral* therapy.

How is CBT different?

CBT differs from other therapies in that it focuses much more on **specific problems that are occurring right now** without spending too much time delving into the early origins of the problems or disturbance. Although information about one's past can offer some insights into the problems experienced today, CBT shifts quickly back to the **present** and helps the

patient investigate specific situations occurring **now** that are samples of the problem or disturbance. The psychologist works with the patient in a very **collaborative partnership** to dig into specific dysfunctional thoughts, beliefs, and behaviors that are causing or supporting the problem. Specific methods such as the *SEAT Method* (**S**ituation, **E**motion, **A**utomatic Thought, **T**ruth), also called the *Dysfunctional Thought Record*, are used to examine a situation, rate emotions, examine the evidence (or its lack) for dysfunctional thoughts/beliefs and arrive at a more correct perception of reality without distortion.

CBT differs from other therapies in that it uses much more frequent (usually each session) **assessments** of depression, anxiety, etc. and often this data is plotted so that patients can see their improvement—in real numbers—from session to session. This helps people to become more **objective** about their progress and is a huge **encouragement** to them to keep working to make improvements (see actual patient example below).



Unlike some other therapies, the course of CBT is **time-limited** and averages between 5 and 15 sessions. Sessions occur weekly at first and, toward the end, may taper to 1 or 2 per month and then only as needed. CBT

seeks to **transfer skills and abilities to the patient to enable them to act as their own therapist in the future**, making continued visits with the psychologist unnecessary.

What is a typical CBT session like?

The first session includes a brief assessment of depression, anxiety, etc. using a easy-to-use standard written form. A history of the patient's problems, background, medications, etc. is taken and, at the end, a initial treatment **goal** and **plan** is co-created. Patients will be asked to do some reading about CBT after this initial session and may be given handouts to review. Patients usually feel much more **hopeful** after the initial session because they can see a **clear, structured** plan to help them feel better.

The second and following sessions start with another brief mood assessment, a review of reading or other **homework**, an **agenda** for the session is mutually created, and then agenda items are discussed. Specific problems that are important to the patient are reviewed, associated dysfunctional ideas are identified and evaluated, a reasonable plan is devised, and the patient and psychologist assess the effectiveness of the intervention. Problems discussed may come from all areas of the patient's life: work, marriage, family, partnerships, parenting, friendships, school, church, spirituality, health, sexuality, career and personal goals, etc. After all agenda items have been covered, homework assignments for between-session work are **co-created based on the specific issues discussed in the session**, and patient **feedback** about the session is requested and used to modify future sessions.

The last two or three sessions are scheduled with greater time between each and, when the patient feels ready, therapy is terminated with the understanding that the patient can come back anytime s/he wishes for support or additional work ("booster" sessions).