

Mania: Beliefs and Cognitions – Symptoms & Treatment

Authored by
mohammed looti

December 5, 2025

RECOMMENDED CITATION

mohammed looti (2025). *Mania: Beliefs and Cognitions – Symptoms & Treatment*.
Psychepedia. Retrieved from <https://psychepedia.arabpsychology.com/?p=29117>

Introduction to Cognitive Models of Mania

The understanding of bipolar disorder, particularly the manic phase, has evolved significantly, moving beyond purely biological explanations to incorporate sophisticated cognitive models. These models assert that specific, often dysfunctional, beliefs and cognitive processes play a crucial role in the precipitation, maintenance, and severity of manic episodes. While the neurobiological underpinnings of bipolar disorder are undeniable, cognitive psychology provides a vital framework for understanding the subjective experience and the maladaptive behavioral patterns characteristic of mania. This perspective shifts focus toward the individual's appraisal of self, the environment, and emotional states, highlighting how biased information processing sustains the pathological elevation of mood and activity. **Cognitive theories of mania** often address the profound changes in motivation, self-perception, and judgment that accompany the syndrome, offering targets for psychological intervention such as Cognitive Behavioral Therapy (CBT).

Key theoretical approaches, such as the Integrative Psychosocial Therapy (IPSRT) and various specific cognitive bias models, attempt to delineate the mechanisms through which cognitive vulnerability interacts with stress and biological predisposition. For instance, some models hypothesize that individuals with bipolar disorder possess heightened sensitivity to reward cues and hold extreme, rigid beliefs about achievement and self-worth. When these individuals encounter success or positive life events, these beliefs trigger an excessive and unsustainable escalation in goal pursuit and mood, effectively launching a manic episode. Crucially, these cognitive frameworks emphasize that the manic state is not merely an absence of depression, but an active, self-reinforcing process driven by distorted interpretations of internal and external stimuli, contrasting sharply with the cognitive patterns observed in unipolar depression.

The core cognitive domains most profoundly affected during mania involve the perception of **self-efficacy**, the processing of goal-relevant information, and the beliefs surrounding emotional volatility. Mania is associated with a dramatic shift in how personal resources are estimated, leading to an overestimation of abilities and an underestimation of risks. Furthermore, the cognitive system appears primed to focus selectively on positive or rewarding information while filtering out negative or cautionary feedback, creating a powerful feedback loop that exacerbates the elevated mood. Analyzing these specific cognitive distortions--such as grandiosity, hyper-focused goal attainment, and biased attributional styles--is essential for grasping the phenomenology of the manic state and developing effective therapeutic strategies that address the underlying cognitive architecture.

The Role of Elevated Self-Esteem and Grandiosity

One of the most defining cognitive characteristics of mania is the presence of dramatically elevated self-esteem, often escalating into full-blown **grandiosity**. This cognitive inflation involves beliefs in

unique talents, exceptional power, or a special relationship with destiny, far exceeding realistic self-appraisal. Unlike healthy confidence, which is grounded in objective reality and flexible in the face of contradictory evidence, manic self-esteem is rigid, impervious to criticism, and often bizarre in its content. For example, the individual may genuinely believe they possess the ability to solve global crises, communicate telepathically, or achieve impossible financial feats, leading to behaviors such as making reckless investments or engaging in inappropriate social interactions driven by this conviction of superiority.

The psychological function of grandiosity is complex. Some cognitive models suggest that this inflated self-view acts as a defense mechanism, compensating for underlying, pervasive feelings of inadequacy or low self-worth often experienced during inter-episode or depressive phases. When triggered into a manic state, the cognitive system flips into an extreme positive bias, radically overcorrecting the previous negative self-schema. However, other theories posit that grandiosity is an inherent feature of the neurocognitive dysregulation characteristic of the manic state, where the brain's reward and salience networks are pathologically activated, leading to the subjective experience of limitless potential and importance. Regardless of its origin, the belief in exceptionalism serves to rationalize and drive the high-risk, expansive behaviors typical of mania, as the individual views normal rules and limitations as inapplicable to their unique status.

This cognitive pattern manifests behaviorally in overt ways, such as excessive spending on luxury items, making promises that cannot be kept, or engaging in ventures requiring expertise far beyond their actual capabilities. The underlying belief structure ensures that any negative consequences resulting from these actions are immediately dismissed or reinterpreted. If a business venture fails, the manic individual does not attribute the failure to poor judgment or lack of preparation, but rather to external factors, jealousy from competitors, or insufficient resources provided by others. This **attributional bias**--which protects the grandiose self-concept--is critical to the maintenance of the manic episode, preventing the reality-testing necessary for mood stabilization.

Goal Pursuit and Over-Engagement Systems

Mania is fundamentally characterized by an intense and often chaotic acceleration of goal-directed activity, underpinned by a cognitive system that is hypersensitive to reward and success cues. This phenomenon is often discussed in relation to the behavioral approach system (BAS), which becomes pathologically activated. Cognitively, this translates into a powerful, unwavering belief that goals are not only attainable but immediately achievable, often leading to the simultaneous initiation of multiple, complex projects without adequate planning or resource consideration. The individual's cognitive structure overvalues the potential rewards associated with these goals while drastically minimizing the effort, time, and potential negative consequences involved in their pursuit, creating an unsustainable level of behavioral engagement.

The cognitive mechanism driving this over-engagement involves distorted estimates of time and resource availability. The manic individual genuinely believes they possess unlimited energy, intellectual capacity, and time to execute their plans. This leads to a pattern of **rapid goal switching** and fragmentation, where attention shifts constantly between tasks, driven by the belief that every idea is brilliant and requires immediate action. For example, an individual might start writing a novel, simultaneously launch a complex investment scheme, and begin remodeling their home, all within a few days. The cognitive system fails to prioritize effectively, treating every novel stimulus or potential reward as equally salient and urgent, resulting in a flurry of activity that rarely culminates in successful completion.

Furthermore, the cognitive distortion extends to the perceived social and logistical constraints of goal pursuit. The manic individual often ignores warnings from family or colleagues, viewing them as obstacles to their progress rather than valid concerns. They believe that their inherent brilliance or unique circumstances will circumvent normal logistical limitations, such as needing capital, specialized knowledge, or cooperation from others. This cognitive inflexibility and resistance to external reality checks fuel the escalating manic behavior, transforming productive energy into chaotic, potentially destructive activity. This relentless pursuit is sustained by the belief that stopping or slowing down equates to failure or, worse, a return to the dreaded state of depression.

Attributional Styles and Positive Self-Bias

The way individuals process and explain outcomes (attributional style) shifts dramatically during mania, exhibiting a strong and persistent positive self-bias. This cognitive pattern involves attributing positive outcomes--successes, achievements, favorable events--to internal, stable, and global causes (e.g., "I succeeded because I am uniquely brilliant and capable"). Conversely, negative outcomes, failures, or setbacks are attributed to external, unstable, and specific factors (e.g., "The project failed because the market was rigged, or the coworker sabotaged me"). This highly biased system serves a crucial function in maintaining the inflated self-esteem and grandiosity central to the manic state, shielding the ego from any information that might challenge the elevated self-perception.

This **manic attributional style** is the cognitive antithesis of the typical depressive style, which involves internalizing failures and externalizing successes. In mania, the bias is so pronounced that it creates a near-impenetrable cognitive barrier against reality testing. For instance, if an individual makes a disastrous financial decision, they will not only blame the broker or external conditions but will also maintain the belief that their overall financial strategy remains fundamentally sound. This cognitive defense mechanism ensures that the manic drive is preserved, as the individual never has to confront the limitations of their judgment or abilities. The bias also extends to interpersonal feedback, where criticism is universally dismissed as jealousy or misunderstanding, reinforcing the belief that the individual is superior and misunderstood by lesser minds.

The persistent use of this positive self-bias has profound implications for recovery and insight. Since the individual cognitively processes all information in a way that confirms their elevated status and abilities, they lack the necessary cognitive tools to recognize the pathological nature of their behavior. This lack of insight is a hallmark of acute mania and is directly linked to the rigid, self-protective attributional style. Therapeutic interventions must therefore gently challenge the stability and globality of these attributions, encouraging the individual to consider alternative, more realistic explanations for outcomes without immediately triggering a defensive, manic response.

Thought Speed, Racing Thoughts, and Cognitive Overload

A universal subjective report during mania is the experience of **racing thoughts**--a cognitive phenomenon where thoughts seem to accelerate rapidly, often feeling overwhelming or uncontrollable. The individual frequently believes that their mind is operating at peak efficiency, processing information faster and more brilliantly than normal. This belief in accelerated, superior cognition is deeply intertwined with the grandiosity; the speed of thought is interpreted as evidence of intellectual genius. This subjective experience can be exhilarating, contributing to the elevated mood and the sense of limitless possibility, fueling the expansive behaviors characteristic of the episode.

However, objective cognitive assessment often reveals a discrepancy between this subjective feeling of clarity and actual cognitive performance. While thought production may be accelerated, the quality of thought organization and execution is frequently impaired. Mania is associated with deficits in executive functions, particularly in areas requiring sustained attention, working memory, and inhibitory control. The speed of thought often leads to tangentiality, flight of ideas, and distractibility, as the cognitive system struggles to filter salient information from irrelevant stimuli. The belief that one is thinking clearly is a profound cognitive distortion masking a state of internal disorganization and reduced capacity for complex, sequential reasoning.

This leads to cognitive overload and fragmentation. The manic mind, believing that all incoming stimuli are critically important, fails to effectively utilize attentional filters. Every external sound, visual cue, or internal association becomes a potential distraction or a new branch for the thought process. The result is a cognitive state where multiple trains of thought run simultaneously, leading to difficulty in completing sentences, maintaining conversational coherence, and focusing on single tasks. The belief driving this overload is the pathological valuation of all information--the idea that every fragmented thought is a piece of a grand, integrated puzzle, demanding immediate cognitive resources, ultimately leading to communicative and behavioral inefficiency.

Deficits in Inhibitory Control and Affective Regulation

Cognitive deficits in inhibitory control are central to the behavioral manifestations of mania.

Inhibitory control involves the ability to suppress inappropriate or premature responses, a function often compromised in the manic state. Cognitively, this deficit translates into the belief that immediate desires, impulses, or novel ideas must be acted upon instantly, overriding rational constraints, long-term planning, or consideration of consequences. The individual loses the cognitive capacity to "put the brakes on" their own thoughts and actions, leading directly to impulsivity in spending, sexual behavior, and interpersonal interactions. This failure of cognitive control is often rationalized by the belief that the current impulse is uniquely important or too valuable to delay.

Regarding affective regulation, the manic individual holds rigid and dysfunctional beliefs about their high emotional state. They believe that the intense positive emotion (euphoria, excitement) is not only sustainable but represents their true, optimal self. Consequently, they resist any attempts, internal or external, to stabilize or moderate their mood, viewing such efforts as threats to their well-being or attempts to sabotage their success. The cognitive conviction is that moderation equals depression, and stabilization means losing their perceived intellectual or creative edge. This belief system actively works against therapeutic goals, as the individual views the pathology as a state of heightened functionality.

A significant aspect of this cognitive profile is the profound lack of insight, which is itself a failure of self-monitoring systems. The manic individual fails to recognize that their behavior is pathological, irrational, or harmful. They interpret external concerns--from family distress to professional warnings--as evidence of others' shortcomings, envy, or misunderstanding, rather than valid feedback about their own state. This cognitive insulation prevents the incorporation of reality checks, meaning the manic episode can continue unchecked until severe consequences or intensive intervention necessitates a change. The stability of the manic beliefs acts as a powerful barrier to recognizing the need for treatment.

Dysfunctional Beliefs About Mood States

Underlying the manic episode are specific dysfunctional beliefs related to the fragility and necessity of high arousal states. Many cognitive models suggest that individuals with bipolar disorder harbor an intense **fear of returning to low mood** or a neutral, less stimulating state. This fear acts as a powerful motivational engine, driving the manic individual to maintain high energy, activity, and emotional intensity. The belief is that if they slow down, stop, or allow themselves to feel anything less than euphoric, they will inevitably crash back into a severe depressive episode, making the manic state a perceived necessary defense mechanism against depression.

Furthermore, there is a cognitive distortion regarding the nature of positive emotions. The manic individual often perceives intense positive emotions (joy, excitement, euphoria) as inherently fragile and requiring constant external behavioral input to sustain them. This belief necessitates

continuous engagement in high-risk, stimulating, or goal-directed activities. If the stimulation ceases, the individual cognitively anticipates an immediate collapse of the mood state. This explains the relentless drive and inability to relax or engage in quiet contemplation, as these activities are cognitively linked to the threat of mood deflation and subsequent depression.

To maintain the desired high state, the manic cognitive system employs selective attention and processing biases. There is a deliberate, often unconscious, focus on positive cues, affirmations, and potential rewards, coupled with a systematic avoidance or minimization of negative, cautionary, or moderating information. This cognitive strategy ensures that the internal environment remains saturated with stimuli supporting the elevated mood. For example, the individual will seek out only those people who validate their grand ideas and will actively ignore or reject sources of realistic feedback, thereby reinforcing the pathological belief structure necessary to sustain the manic episode.

Cognitive Biases in Risk Assessment and Decision Making

The poor judgment and elevated risk-taking behavior characteristic of mania are direct outcomes of profound cognitive biases affecting risk assessment and decision-making processes. The manic individual exhibits a significant **underestimation of danger** and an exaggerated overestimation of their personal ability to manage adverse outcomes. This manifests in behaviors ranging from hyper-sexual promiscuity without regard for safety, to massive, inappropriate financial expenditures, to driving recklessly under the belief that they possess superior reflexes and control.

Two specific cognitive biases are particularly prominent: **optimism bias** and the illusion of control. Optimism bias involves the pervasive belief that negative events (accidents, financial ruin, legal trouble) are far more likely to happen to others than to oneself. This cognitive shield allows the manic individual to engage in extreme risk-taking without experiencing the normal inhibitory fear or caution. The illusion of control refers to the belief that one can influence random events or outcomes beyond their actual capabilities, such as believing they can manipulate the stock market or win impossibly long odds at a casino through sheer willpower or unique insight. These biases combine to dismantle the normal cognitive safety mechanisms that regulate prudent behavior.

The compromised decision-making framework during mania is exacerbated by the interaction between motivational drives and executive dysfunction. The powerful drive toward reward and goal attainment, coupled with deficits in working memory and inhibitory control, means that decisions are often made impulsively, based on immediate emotional salience rather than careful deliberation of long-term consequences. The cognitive structure fails to integrate necessary caution, viewing any delay or critical analysis as an impediment to success. Consequently, the individual makes choices that maximize immediate reward or excitement, even if those choices carry catastrophic long-term risks, demonstrating how deeply ingrained dysfunctional beliefs

underpin the destructive trajectory of a manic episode.

ARABPSYCHOLOGY.COM