Chapter Ten
Addressing Cognitive Distortions

Basic Principles

Treatment for cognitive distortions, negative explanatory style and core beliefs has been used for bipolar spectrum disorder for decades. In addition to the better-known approaches for treatment of depression, additional treatment methods for episodes of mania have been developed. The approach differs because of the distinct differences in the cognitive distortions found in depression and mania. In depression, the focus is on understanding the link between thoughts, beliefs and feelings. The intervention is to refute cognitive distortions by replacing maladaptive core beliefs and challenging the negative explanatory styles.[1]

In contrast, cognitive therapy during episodes of mania or hypermania focuses on the link between thoughts and behaviors. The goal is to extend the interval between the two so that reality testing can take place.

Overview of Intervention

The first step is to assess cognitive distortions (also called cognitive errors), negative explanatory styles and core beliefs. (See Chapter Four: In-Depth Assessment and Assessment Tools in the Bipolar Toolbox.) Next, the client is helped to realize the effects these have on mood and to learn tools for cognitive restructuring. An important principle of treatment for Bipolar spectrum disorders is to recognize cognitive symptoms early in a given episode in order to intervene prior to the extremes of depression, but particularly in the case of mania, before psychosis and other symptoms can make it difficult to deal with cognitive realities.

Interventions for Cognitive Restructuring in Depression

The first step in addressing thought distortions associated with depression is helping the client learn to recognize distorted thinking. More often than not, the client is unaware of her distorted thinking. The next step after identifying the client's distorted thinking patterns is to point them out and contrast them with other ways of thinking about issues and situations. Share with the client a list of thinking patterns identified in the assessment and help her learn to identify the distortions by examining her thought responses in the context of real life situations or in anticipation of future events.

Next, practice with the client ways of refuting the distortions. Basic CBT interventions can be used, such as listing automatic thoughts and comparing them to alternate explanations. Role-playing alternate responses can be helpful with the therapist modeling different explanatory styles or with the client playing the role of refuting the distorted thoughts.

Have the client assign a numerical score indicating strength of belief of both automatic thoughts versus alternative explanations and how strength of belief can change after considering alternatives. For example, before the exercise the client may be 90 percent certain that he will never make friends because people do not like him. This is identified as black and white thinking as well as fortune telling. Dur-

ing the exercise the therapist may refute these distorted thoughts by countering that the client is fun to be with, has a good sense of humor, is well liked by his co-workers and that prior to his previous session a friend had asked him to attend a sporting event. Then the therapist can ask the client to role-play a situation in which the client refutes distorted thinking involving a relationship. Following this exercise the client rates the strength of his belief in the original thought that he will never make friends because people do not like him. The goal is to significantly reduce the strength of belief of the distorted thinking style.

In addition to focusing on the interpretation of events, address the emotional tone of self-talk. Is it critical or punishing? If so, teach alternate styles of self-talk. In the preceding example, the decline from 90 percent to 80 percent can be seen as having a positive effect on the client's emotional style and as having relieved some of the negative emotional impact associated with a core value of feeling unlovable.

In addition to practice during therapy sessions, homework assignments to analyze identified distorted thinking in daily life can help a client practice these skills and can be reviewed together at subsequent sessions to reinforce progress. For more information on this topic, clinicians are encouraged to review Mary Ellen Copland's Depression Workbook.[2]

Interventions for Cognitive Restructuring in Hypomania/ Mania

Educational interventions for hypomania include meeting the goal that the client understands the behavioral consequences of thought distortions and to be able to choose alternative behaviors. A longitudinal picture of the individual's experiences and how they have affected his life helps to put consequences of mania into clearer view and can serve as a motivator to take action as soon as early symptoms of mania are observed. Strategies are planned to prevent repetition of the previously experienced behavioral consequences of mania.

For example, plans may be made to hand over credit cards to another trusted individual prior to acting on the impulse to engage on a spending spree. Because clients often do not recall their behavior during a manic episode, it is often helpful to bring in trusted friends or family members in order to clarify the history of previous episodes of mania.

The client can learn techniques to test the reality of his thinking by taking daily thought records and consulting with trusted others. One such technique is called the two-person feedback rule. Planning during a period of stable mood, the client agrees that, when the therapist questions the safety of his plans, he will then consult with two other trusted people on the plans before implementing them. Then the client and therapist discuss the results of the feedback that was given. For example, if a client decides to quit his job in order to start a new business, according to previous planning, he will delay acting on the idea in order to consult two other individuals about the feasibility of his plan. This allows reality testing to occur as well as the passage of time. Testing of what could be an impulsive and self-destructive idea may prevent him from losing his means of earning a living.

Another technique is to list the productive potential of such a venture against the destructive risk of the project. This activity enables the client to gain insight into his thoughts and beliefs and to consider results of acting impulsively on what could be activities with destruc-

tive potential. Here again role-playing can be used to discuss pros and cons with the client playing the role of one who refutes the unrealistic and impulsive thoughts.

In addition to refuting thought distortions, techniques for reducing impulsivity and reckless behavior can be introduced. This can be done by delaying action for 48 hours or until at least one good night's sleep has occurred. Imagining outcomes that may be negative and scheduling activities are also helpful. In the latter technique, the client is helped to recognize that too many goal-directed activities could fuel mania/hypomania and that a decrease in the number of activities or the time spent in such activities can help achieve a more beneficial balance in life. To counteract symptoms of racing thoughts and inability to focus on conversations, the practice of intentional sitting and listening to others can be helpful. Decreasing the amount of stimulus in the environment is key in managing symptoms of mania/hypomania.

Another effective intervention is to teach that intense feelings are not necessarily long-standing and therefore do not have to be acted on. For example, it is better to wait until mood stabilizes before acting on strong emotions of affection for a stranger or acquaintance that can lead to a destructive relationship when the intense feelings pass. Here the client may equate intensity of emotions with the need to act immediately.

Testing of beliefs about mania/hypomania is also important in the client who feels he is more productive, creative or satisfied with life during these episodes. People experiencing mania/hypomania find it difficult to imagine the depressions that preceded the episode or the fact that depression could follow. They sometimes do not recognize the irritability and other dysphoric symptoms of mania/hypomania. Help clients test beliefs that deny the negative aspects of mania/hypomania by linking the depressive episodes to manic/hypomanic episodes. This can reinforce a realistic belief system about Bipolar illness. The extremes of mood do not produce the long-standing productivity and happiness of a mood that is modulated for avoidance of extremes.

Finally, disorganization and distractibility can be counteracted with skills of concentrating, memory, planning and problem solving. These skills provide structure. Difficulties in these areas also need to be addressed during therapy sessions as well as on a more global level because they can interfere with the effectiveness of therapy. Repetition, note taking and helping the client stay on track with the stream of therapy are all techniques that can be used.

Children and Adolescents

The therapist will likely need to take more responsibility for identifying cognitive distortions with children and teenagers than with adults. As mentioned in Chapter 8, memory and executive function impairments in children with bipolar disorder will add further challenges to helping youth understand the link between thoughts and feelings and behaviors. The therapist may also have to identify and address parental distortions as well. Themes such as, "I am unlovable," can often be extracted from children's cognitive distortions. Addressing themes rather than specific content of cognitive distortions can help lessen the child's feeling overwhelmed. Using the umbrella metaphor (page 78) may be helpful.

Consider limiting the number of cognitive distortions to work on to those that you suspect the child uses the most. Check in with

the child to validate that the child does indeed have the distorted thought—"Do you ever think or say this?"

The child can become quickly overwhelmed if presented with a long list, and may also perceive a long list as evidence of further failure in their short life.

Implications for Parents

Provide parents with handouts of cognitive distortions/beliefs the child is working on.

Work with the parents to build a chart that helps them distinguish behaviors caused by Bipolar Disorder from those that are due to oppositional, defiant, argumentative, uncooperative behavior or "attitude". Work with parents to identify those behaviors for which they can discipline and consequence and those that are Bipolar Mood Disorder or not completely under the control of the child and need help to achieve a "user friendly" environment to eliminate meltdowns.

Additionally the therapist can help the parents develop a system of rewards for when the child does practice the skills they are learning. Rewards that are relational in nature (such as playing games as a family or attending a sports outing together) may be more beneficial to increasing positive family dynamics than material rewards like a new toy. The child should be involved in the decision making process about what rewards they would like to earn. This will increase the child's investment in earning the reward.

References

1. Newman CF, Leahy RL, Beck AT: Reilly-Harrington NA Gyulai L: *Bipolar Disorder: A Cognitive Therapy Approach.* Washington, D. C.: The American Psychological Association, 2002.
2. Copeland ME: *The Depression Workbook 2nd Ed. A Guide for Living with Depression and Manic Depression.* New Harbinger Pub., Inc., 2002.