Recent innovations in behavior modification have, for the most part, detoured around the role of cognitive processes in the production and alleviation of symptomatology. Although self-reports of private experiences are not verifiable by other observers, these introspective data provide a wealth of testable hypotheses. Repeated correlations of measures of inferred constructs with observable behaviors have yielded consistent findings in the predicted direction.

Systematic study of self-reports suggests that an individual's belief systems, expectancies, and assumptions exert a strong influence on his state of well-being, as well as on his directly observable behavior. Applying a cognitive model, the clinician may usefully construe neurotic behavior in terms of the patient's idiosyncratic concepts of himself and of his animate and inanimate environment. The individual's belief systems may be grossly contradictory; i.e., he may simultaneously attach credence to both realistic and unrealistic conceptualizations of the same event or object. This inconsistency in beliefs may explain, for example, why an individual may react with fear to an innocuous situation even though he may concomitantly acknowledge that this fear is unrealistic.

Cognitive therapy, based on cognitive theory, is designed to modify the individual's idiosyncratic, maladaptive ideation. The basic cognitive technique consists of delineating the individual's specific misconceptions, distortions, and maladaptive assumptions, and of testing their validity and reasonableness. By loosening the grip of his perseverative, distorted ideation, the patient is enabled to formulate his experiences more realistically. Clinical experience, as well as some experimental studies, indicate that such cognitive restructuring leads to symptom relief.

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