

Discomfort Anxiety: A New Cognitive-Behavioral Construct

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DISCOMFORT ANXIETY VERSUS EGO ANXIETY

For the past several years, as the result of my clinical and supervisory experience, I have been distinguishing between two major forms of anxiety: discomfort anxiety (DA) and ego anxiety (EA). I define *discomfort anxiety* as emotional tension that results when people feel that (1) their comfort (or life) is threatened, (2) they *should* or *must* get what they want (and *should not* or *must not* get what they don't want), and (3) it is *awful* or *catastrophic* (rather than merely inconvenient or disadvantageous) when they don't get what they supposedly *must*. I define *ego anxiety* as emotional tension that results when people feel that (1) their self or personal worth is threatened, (2) they *should* or *must* perform well and/or be approved by others, and (3) it is *awful* or *catastrophic* when they don't perform well and/or are not approved by others as they believe they *should* be.

Ego anxiety is a dramatic, powerful feeling that usually seems overwhelming. It is often accompanied by feelings of severe depression, shame, guilt, and inadequacy and frequently drives people to therapy (or to suicide). Discomfort anxiety is often less dramatic, but perhaps more common. It tends to be specific to certain un-comfortable or "dangerous" situations, and shows up in phobias such as fear of heights, open spaces, elevators, and trains. But it can also easily generalize to uncomfortable *feelings* themselves, such as feelings of anxiety, depression, and shame. Thus, DA may be a *primary* symptom (e.g., anxiety about elevators) or a *secondary* symptom (e.g., anxiety about feeling anxious about elevators).

As a secondary symptom, DA may generalize to almost any kind of anxiety. Thus, people may first feel anxious about feeling anxious about elevators; but they may later worry about whether they are *also* going to feel anxious about trains or escalators. As a result, they may actually make themselves exceptionally uncomfortable (anxious) about *many* forms of anxiety (discomfort) and may thereby become pandemically anxious. Or they may at first feel anxious about a specific event (e.g., about entering an elevator) and later, realizing that they may well become anxious about that event, they may also make themselves anxious about any *symbol* of that event (e.g., a picture of an elevator) or about any thought of that event (e.g., the thought "If I have to take an elevator when I visit my friend, that would be awful!")

Because it is often less dramatic than ego anxiety (or self-downing), and presents as a secondary rather than a primary symptom, discomfort anxiety may easily be unrecognized and be somewhat

wrongly labeled as general or free-floating anxiety. Thus, if people are anxious about elevators, they may recognize their anxiety and label it “elevator phobia.” But if they are anxious about being anxious (that is, fearful of the uncomfortable sensations they think they will feel if they enter an elevator), they may feel very anxious but may not see clearly *what* they are anxious about. Nor may their therapists!

The construct of discomfort anxiety helps to explain several phenomena related to emotional disturbance in clearer and more therapeutic ways. Thus, if clients tell me they are so terrified of snakes that they feel upset whenever they see even a picture of a snake, I can pretty well guess that they hardly think the *picture* will bite them. I quickly surmise that they are not only afraid of snakes but also of their anxiety itself: of the uncomfortable *feelings* they will have when they think about (or view a picture of) a snake.

My goal with these clients is therefore to get them first to stop awfulizing about their feelings of anxiety and to help them accept their discomfort (or potential discomfort) as a damned bother — and not a holy horror. When they truly see that it’s not awful to *feel* anxious, they can more successfully stop obsessing about this feeling and work on anti-awfulizing about the original feared object, the snakes. Their discomfort anxiety about their feelings helps keep them from confronting these feelings and working through them.

A research study that possibly shows the explanatory and therapeutic value of the construct of discomfort anxiety is that of Sutton-Simon (1979), who found some seemingly contradictory results that may be explained by the use of this construct. In a study of subjects with (a) fears of heights, (b) social anxiety, and (c) fears of heights plus social anxiety, she found that those with fears of heights did not display significant irrationality on the Jones (1968) Irrational Beliefs Test; while those with social anxiety did show significant irrationality on the IBT.

This would be expected, according to the construct posited in this chapter, since fear of heights would presumably largely involve discomfort anxiety, while social anxiety would largely involve ego anxiety. Sutton-Simon observed that ego anxiety may be cross-situational, while discomfort anxiety may be specific to situations, although one person may experience discomfort anxiety in many situations. DA may be “hooked up” to the particular cues of the situation, while EA may be more of a quality of a person.

Although the construct of discomfort anxiety presented here seems to have some new and useful elements, it overlaps with several previous hypotheses about emotional disturbance and its treatment. Low (1952) pointed out that disturbed individuals often get upset about their symptoms of anxiety and panic, and that they may be helped by defining these symptoms as uncomfortable but not dangerous. Ellis (1962, 1979) emphasized secondary symptoms of disturbance, such as anxiety about anxiety, and stressed the role of low frustration tolerance and short-range hedonism in clients’ disturbed behavior and their resistance to changing this behavior. Weekes (1969, 1972, 1977) highlighted the importance of anxiety about anxiety, especially in agoraphobia. Rehm (1977) offered a self-control model of depression that

stresses hedonic as well as ego factors in this disturbance. The present formulations go somewhat beyond these other theories in developing a construct of discomfort anxiety and in distinguishing it more clearly from ego anxiety.

DISCOMFORT ANXIETY AND DEPRESSION

The concept of discomfort anxiety also tends to give a better explanation of the origins and treatment of depression than many of the other explanations. Abramson and Sackheim (1977) point out a seeming paradox in depression. On the one hand, depressed individuals blame themselves and look upon themselves as unable to help themselves; they are distinct self-downers. On the other hand, they somewhat grandiosely insist that they must have certainty and control over the outcome of the events in their lives; and then depress themselves when they don't actually have that kind of full control.

In REBT terms, and in terms of ego anxiety and discomfort anxiety, this paradox (in which the individual is both self-denigrating and self-deifying) seems quite resolvable. REBT posits that individuals tend to have three basic irrational beliefs (iB's) about themselves and the universe: (1) "I *must* succeed at the important things that I do in life and win the approval of significant people in my life, and it is *awful* when I don't. I am therefore not as good as I *should* be, and am worth less as a person." (2) "Others *must* treat me kindly, fairly, and considerately, and it is *horrible* and they are louses when they don't." (3) "Life conditions *must* be easy, or at least not too difficult, and I *must* get all the things I want quickly and without too much of a hassle; and it is *terrible* when they aren't that way. The world is a really rotten place and *should* not be the way it is."

Very often, depressed people have two of these basic ideas—the first and the third—and sometimes the second as well. There is no reason, of course, why they should not have two or three; and I also do not see why the first and the third, when they are strongly held, necessarily conflict with each other. The first one, "I *must* succeed at the important things that I do in life and win the approval of significant people in my life; and it is *awful* when I don't!" seems to be essentially self-downing. At the same time, there is a rather perfectionistic implication that "I *must* be outstanding, perfect, and godlike; and if I am not what I must be in these respects, then it is *awful* and I am a worthless or rotten person." This same kind of grandiosity is also implied in the third irrationality: "Because I am (or *should* be) a great person for whom everything goes easily and well in life, *therefore* the conditions under which I live must not be too difficult, and it is *terrible* and the world is a horrible place if they are that difficult."

Implicit grandiosity, therefore, underlies virtually all emotional disturbance; namely, the unspoken (or spoken!) demand and command that "I *must* succeed and be universally approved; others must treat me kindly and fairly; and *world conditions* must be easy and immediately gratifying for me." When these demands and commands are not met—as, in reality, they usually are not—then I "logically" make myself anxious, despairing, depressed, or angry. Without these omnipotent insistences, I would only tend to make

myself sorry, regretful, annoyed, or irritated.

Discomfort anxiety is particularly important in anxiety and depression, as will be shown in the following case illustration. Several years ago I saw a man of 28, who was severely anxious or panicked, as well as angry and de-pressed, virtually every day of the year, and had been so for 10 years prior to that time. He had been in intensive psychotherapy since the age of 15, and had improved moderately and thus been able to complete college and work steadily as a bookkeeper. But he had been hospitalized twice, had not been able to achieve any intimate relations with women, and had led a very restricted and highly routinized existence. He frequently became so depressed that he seriously considered suicide.

On the surface, this man's problem was ego anxiety, since he insisted that he had to do things well and win others' approval and then put himself down severely whenever he failed to do so. He expressed hatred for himself, had no self-confidence, and had an enormous fear of failure; and was afraid to make any major decisions lest he make a mistake and then have to castigate himself for this mistake.

Actually, however, this client had benefited somewhat from previous therapy, particularly from reading *A New Guide to Rational Living* (Ellis and Harper, 1975) — which he used virtually as his bible. In many respects, he was able to feel relatively little shame or guilt when, for example, he dressed sloppily or was criticized for not socializing or for acting “selfishly” — even by friends and relatives whom he loved and respected. So I began to suspect that his main problem was discomfort anxiety, rather than ego anxiety, although he also had aspects of the latter (as perhaps almost every human does). In a typical fit of anxiety, depression, and anger, he would react as follows:

1. He would become exceptionally anxious or panicked when he had to wait in line at a store or wait to be served at a bar. In these situations he seemed to be demanding that conditions be easier and that he be served immediately; i.e., he seemed to be experiencing low frustration tolerance or discomfort anxiety.

2. Once he became panicked, he would tell himself, “I *must* not over-react in this manner; what a worm I am!” and would experience ego anxiety. But, often much more strongly, he would insist to himself, “I *must* not be panicked and feel such horrible discomfort at being panicked!” and would experience secondary symptoms of discomfort anxiety.

3. As he continued to experience panic over hassles and difficulties, he would then insist that life was *too* hard and that it *was* awful that he kept experiencing these horrible feelings. He would ask me, “Don't *you* feel terrible when you have to wait on line for a long time?” When I answered that I certainly didn't like it but that I accepted it and was thereby able to edit out most of the inconvenience, he simply could not understand how I could possibly accept it. He considered it intrinsically horrible to be balked in any desire, even relatively little ones like waiting on line, and believed that everyone in the universe thought it equally horrible.

4. As he began to realize how beyond the norm he was in the degree of his upsetness, he then put himself down for that, and thus began to experience ego anxiety. And because he also felt horrified about the uncomfortableness of continually feeling panicked, he reverted once more to discomfort anxiety, viewing his discomfort as an intolerable state. Because of these continued feelings, and his belief that his occasional suicidalness made him a freakish, rotten person, he began to feel increasingly justified in wanting to kill himself.

5. Because this client defined almost all of his strong wants or desires as absolute needs — which is the philosophical essence of discomfort anxiety — he re-emphasized his irrational belief, “I *must* do well!” He devoutly believed that only by doing well would he get more of the things that he absolutely “needed.” When he did not perform well, he not only downed himself for his inadequacy but also felt that his performance was below his “need” level, and he thereby experienced discomfort anxiety as well as ego anxiety.

All in all, this client’s DA continually intermingled with and helped reinforce his EA, and vice versa. Like many severely disturbed people, he probably would have functioned poorly with only EA, for he often seriously downed himself for his errors and for experiencing others’ disapproval. But it is unlikely that he would have been as disturbed as he was without his suffering from both ego anxiety and discomfort anxiety. **From observing him and many other clients like him, I hypothesize that some individuals suffer emotionally because of their ego anxiety and some because of their discomfort anxiety, and that those who have a combination of both are even more disturbed than those who have one or the other and are also less likely to change themselves or to significantly benefit from any form of psychotherapy.**

Another oft-noted phenomenon that might be explained by the hypothesis of discomfort anxiety is the observation that people who suffer severe depression frequently have lost a parent or other significant person early in life, or have had a job loss, serious economic reversal, or retirement from a satisfactory position. As Levitt and Lubin (1975) show, depression proneness is not related to such traditional demographic variables as age, sex, and race, but instead increases as educational background, annual income, and ability to improve one’s financial situation decrease.

If these observations are true, we can easily conclude that people who are deprived of parental or economic satisfactions early or later in their lives suffer loss of status and consequent ego anxiety, and are therefore more prone to having severe feelings of depression. But we can perhaps more logically conclude that people who are deprived in these affectional and economic ways often (though not, of course, always) have low frustration tolerance or discomfort anxiety, and that it is a combination of actual frustration and their discomfort anxiety *about* this frustration that often drives them into severe depressive reactions. Frustration, Dollard, Doob, Miller, Mowrer, and Sears (1939) once wrongly claimed, leads to aggression.

In itself, it doesn't. Nor does it lead to depression. But frustration of *people with abysmal discomfort anxiety* (for which there may exist a biological proneness or vulnerability, as well as a reinforcement or escalation resulting from unusually frustrating events) may lead to almost any kind of disturbed reaction, including aggression and depression.

As Beck (1967, 1976) and Ellis (1962) point out, depression is usually linked with ego anxiety — with people deprecating themselves for their poor performances and believing that, because *they* are worthless or hopelessly incompetent, they cannot handle difficult life situations. But even in this ego anxiety aspect of depression, discomfort anxiety is probably also a factor, for depressed individuals are not merely telling themselves that they are so incompetent that they cannot master normal life situations and prove how “worthwhile” or “great” they are. They are probably also telling themselves that they are so hopelessly inept that they cannot ward off present and future *inconveniences* and *discomforts*, and that therefore their lives are, and will continue to be, terrible and horrible.

Depression also involves another and perhaps more common element of discomfort anxiety. For depressed people frequently have such abysmally low frustration tolerance that they refuse to accept ordinary or mild hassles, let alone unusual ones, and they can easily whine and wail when they don't have *good enough* events in their lives, or when they once had it easy and comfortable, but now that they have lost their jobs or money they don't any longer have it *that* good.

Years ago, before I realized how important a factor discomfort anxiety may be in severe feelings of depression, I mainly showed my depressed clients that they did not have to rate themselves for doing poorly in life (or for doing less well than others were doing), and that they could accept themselves unconditionally *whether or not* they performed well and *whether or not* significant others approved of them. This helped them immensely in many instances, but in others I found that it was not sufficient.

I now also look for their discomfort anxiety, and I practically always seem to find it. If I am able to help them to give up their demanding that conditions be easier and more immediately gratifying, and their insistence that they get what they want quickly and easily, I find not only that they get over their profound depressions, but that they also have much less of a tendency to return to a depressed state when something unfortunate occurs in their lives at a later date.

TREATING DISCOMFORT ANXIETY

I do not find it easy to help people raise their level of frustration tolerance and thereby reduce or eliminate their discomfort anxiety. I am fairly convinced that virtually all human beings have a strong biological tendency to defeat themselves by being short-range hedonists and going for immediate rather than long-range gain (Ellis, 1976). That is why so many of them refuse to give up addictions such as smoking, overeating, alcohol abuse, and procrastination, which they “know” are harmful and which they keep resolving to overcome. But when they are induced by various kinds of therapy, such as REBT, to

stay with the discomfort and see that it is *only* inconvenient and *not* unbearable, they often increase their frustration tolerance, overcome their discomfort anxiety, and make significant changes in their dysfunctional feelings and behaviors.

One reason for this lack of change in clients who have significant elements of both ego anxiety and discomfort anxiety is that they often bring up these two elements as if they were *one* problem. Consequently, their therapists mistakenly shuttle back and forth trying to help them with this supposedly *single* problem and end up trying, in a sense, to solve a quadratic equation with two unknowns—an impossible task! Thus, in the case of the client mentioned earlier, he could be said to have had two somewhat distinct problems, both of which started from the same premise. This premise is, “I *must* get good results at the things I do, especially in producing adaptive feelings.” This premise then leads to two rather different conclusions: (1) “When I do the wrong things and produce the wrong kind of feelings, I can’t stand the *discomfort* I create; the world is just too hard for me and I might as well be dead!” (2) “When I do the wrong things or have the wrong kinds of feelings, I can’t stand *myself* for acting so foolishly; I am hopelessly inept, will always fail to get what I want, and don’t deserve to live!”

If clients with discomfort anxiety present material that shows these two irrational ideas, the therapist may get “hooked” into their system by trying to show them how to gracefully accept the discomfort that the world brings them and that they themselves produce. If the therapist fails to zero in on the client’s problems *one at a time*, the two issues may get confused with each other and the disputing of the client’s irrational ideas may be so confounded that a satisfactory solution is unlikely.

It is therefore important for the therapist to recognize these two *different* (though perhaps overlapping) points clearly, and to deal first with one and then with the other, so that clients finally see that they have two disparate irrational ideas and that both of them produce dysfunctional emotional and behavioral results. Thus, if the therapist initially focuses on clients’ discomfort anxiety, the clients may give up the idea that they *must* not experience “wrong” feelings because the discomfort of experiencing them is *too* difficult and *should not* be that difficult. After doing this, the therapist then probably has a better chance of zeroing in on clients’ ego anxiety and helping them give up the idea that they *must not* experience “wrong” feelings and are *lousy people* for so doing. Either one of the irrational beliefs may be clearly seen and uprooted if the therapist considers them *independently*. But if they are tackled together, or if the therapist and client keep shuttling back and forth from one to the other, then there is a good chance that neither will be seen clearly nor given up.

If I am correct about the existence of discomfort anxiety and ego anxiety and their tendency to reinforce each other, then these concepts serve to explain some other aspects of human disturbance and psychotherapy that have long been noted in the literature. For one thing, many forms of psycho-therapy have often produced good, albeit temporary, results. Thus, large numbers of malfunctioning individuals have felt better for awhile and achieved transient symptom removal as a result of hypnosis, suggestion, reassurance, approval, and catharsis. I believe that most of these clients actually start to *feel* better rather

than to *get* better in any permanent sense, but they definitely often do improve (Ellis, 1968, 1974). I would speculate that they do so largely because these somewhat indulgent techniques temporarily allay their discomfort anxiety. Even though it returns fairly soon—because the clients' basic notion that they *must not* suffer frustration and deprivation has not been surrendered and may even be augmented—they at least feel significantly better and relatively symptom-free for a short period of time.

Another interesting phenomenon that can be partially explained by the concept of discomfort anxiety is the case of individuals who are converted to some highly implausible idea, such as the idea that God or Jesus has a personal interest in them and will save them from harm. Such people consequently achieve a distinct personality change, such as becoming recovered alcoholics. I hypothesize that these people, through their devout belief in some kind of magical cure, become highly motivated to work at their discomfort anxiety and to go through present pain to reap the rewards of future gain. By doing the “right” thing — e.g., disciplining themselves to give up alcohol, drugs, overeating, smoking, or gambling — they then see that they *can* control their own destiny, whereas previously they incorrectly thought that they could not. They may even acquire some sensible ideas along with the somewhat irrational ones that initially led them to discipline themselves and ameliorate their low frustration tolerance.

Still another aspect of therapy that can be explained by the concept of discomfort anxiety is the phenomenon of therapists leading many clients to believe in false or scientifically groundless ideas and thereby inadvertently helping these clients to become less disturbed. Thus, orthodox Freudians show people that their parents treated them cruelly and that this past cruelty makes them neurotic today (Freud, 1965). Primal therapists go even further, and teach their clients that they all suffered from intense primal pain as a result of their parents' iniquity and that if they now scream, yell, and release this pain, they will significantly improve their ability to function (Janov, 1970). Both of these concepts are probably false, for they are largely stimulus-response rather than stimulus-organism-response theories, and they posit early childhood stimuli that may well have been nonexistent.

Interestingly, however, when a Freudian analyst or a primal therapist induces clients to mull over their past histories and experience feelings of intense distress connected to them, they are probably dealing with individuals who, because of their extreme discomfort anxiety, frequently refuse to face their anxious, angry feelings and instead suppress or repress them. Consequently, they do not give themselves a chance to deal with or change these feelings. In forcing such clients to get in touch with and face the discomfort of these feelings—albeit for the wrong reasons and often in a highly exaggerated way—Freudian and primal therapists may unwittingly help them see that feelings of anxiety and anger are not unbearable and may thereby help them to overcome some of their discomfort anxiety.

Several behavioral techniques, especially *in vivo* desensitization and implosion therapy, also seem explicable in terms of the concept of discomfort anxiety. Thus, I have found (Ellis, 1962), as have Marks, Viswanathan, Lipsedge, & Gardner (1972), that flooding or *in vivo* desensitization works much better with severely disturbed phobic or obsessive-compulsive individuals than more gradual or imaginal

methods of therapy. I think this is because these individuals avoid discomfort at all cost and consequently will not confront their phobias or compulsions in order to overcome them. If they can be forced to do this, they eventually discover that doing what they intensely fear, or not doing what they absolutely think they *must* do, helps them to surrender some of their discomfort anxiety, enables them to start working on eliminating their dysfunctional behavior, and eventually helps them not only to *feel* better but actually to *get* better.

One of the persistent puzzles about neurotic individuals is that they can easily upset themselves by not only encountering a fearful situation but by imagining it, hearing about it, or seeing it (e.g., on television). Wolpe (1978) cites this as an indication that cognitive therapy often does not work because (1) “most neurotic patients are afraid of situations that they clearly know are not objectively dangerous”; (2) “the stimulus to a neurotic anxiety response may be such that it is inconceivable that it could be regarded as a threat—for example, anxiety at the sight of a test tube full of blood”; and (3) “a patient who is continually anxious may be found to have a specific persistent fear (e.g., fear of going insane); strong reassurance may convince him or her to the contrary, yet the anxiety may not materially diminish.”

Wolpe may well be wrong here, because he uses the word “know” loosely, as if irrationality is totally “known.” Thus, a neurotic individual may partly “know” that a situation is not objectively dangerous but also “know” that it is. She or he may be “convinced” that a fear of going insane is false but also be “convinced” that it is true. Rarely, in fact, do we “know” anything with 100% absoluteness; instead, we simultaneously partly believe it and partly do not.

More to the point, all of Wolpe’s examples can be explained by the concept of discomfort anxiety. Thus, neurotic individuals may “know” that riding the rollercoaster at an amusement park is not threatening or dangerous, but they also may know that they are likely to experience anxiety if they ride it and therefore be afraid of their anxiety (and its consequent discomfort) rather than of the rollercoaster itself. They may “know” that the sight of a test tube full of blood will not threaten them with pain of bloodletting, but they also may know that it reminds them of their anxiety about bloodletting and be threatened by this anxiety (discomfort) rather than by bloodletting. They may “know” that they have little chance of going insane, but they may still have both discomfort anxiety (“It would be horribly uncomfortable if I *did* go crazy”) and ego anxiety (“I would be a weak, rotten person”). As previously noted, when people have discomfort anxiety they tend to be afraid of any reminder of a feared object, not because the representation of the object is seen as frightening but because their anxious, uncomfortable reaction to the object is viewed as “horrible” or “unbearable.”

Mineka and Kihlstrom (1978) have reviewed the literature on experimental neurosis, including the experiments of Gantt (1944), Liddell (1944), Masserman (1943), Pavlov (1927), and Wolpe (1958), and have developed the hypothesis that the common thread running through the entire literature in this area is that in each case important life events become unpredictable, uncontrollable, or both. They also point out that there are striking parallels between experimental neurosis and learned helplessness following exposure

to uncontrollable shock, which in turn has been linked to depression (Seligman, 1975). If there is some validity to Mineka and Kihlstrom's hypothesis about experimental neurosis and Seligman's hypothesis about learned helplessness, as I think there probably is, their theories can easily be related to my hypothesis of discomfort anxiety. I would guess that when people are faced with life events that they consider important to control and to succeed at, and when these events turn out to be consistently unpredictable, uncontrollable, or both, they not only tend to feel uncomfortable but they also conclude that these situations are *too* uncomfortable and there is no use even trying to do anything. They then give up completely or develop what G. V. Hamilton (1925) called a persistent nonadjustive reaction and become depressed or otherwise "neurotic."

I hypothesize that what I call discomfort anxiety is a biological tendency of humans and of certain other animals (e.g., rats or guinea pigs); that organisms of this sort innately strive to predict what is going on around them, to control their environments so that they get more of what they want and less of what they don't want, and thereby to survive satisfactorily or "happily." When they perceive that there is a high degree of probability that they will be able to do this, they persist in their adjustive reactions and therefore are "healthy" or "non-neurotic." When they perceive (rightly or wrongly) that they probably cannot control their life situations and get what they want, they either gracefully live with their continued frustrations (developing a philosophy of accepting the inevitable) or they refuse to accept this grim reality (whining and developing a philosophy of desperate nonacceptance, a neurotic or nonadjustive outlook that frequently results in depression and withdrawal).

I also hypothesize that human phobias are particularly related to discomfort anxiety. When people have, for example, a phobia of airplanes, they usually have some element of ego anxiety; that is, they devoutly believe that they should live practically forever and *must* not die before their time. They also frequently believe that it is shameful for them to display their fear of airplanes in front of others (e.g., flight personnel and passengers), and consequently stay out of planes to avoid this "shameful" activity.

More important, however, they seem to have enormous discomfort anxiety about the supposed unpredictability of the plane's falling ("Yes, I know there is little chance of its falling, but suppose it does!"), and they also have discomfort anxiety about their own uncomfortable anxiety reactions. They therefore avoid flying, often to their own disadvantage.

In desensitizing these individuals to the thing they fear, therapists have a choice of many methods, including systematic desensitization (Wolpe, 1958), imaginative implosion (Stampfl & Levis, 1967), and *in vivo* desensitization in the course of rational-emotive therapy (Ellis, 1962; 1973; Ellis & Grieger, 1977). These seem to be radically different methods of desensitization, but as Teasdale (1977) points out, they have one thing in common: repeated presentation of a fear stimulus with no apparent disastrous consequence.

It seems that people with airplane (or other) phobias keep telling themselves, for one reason or another, "Going in a plane is too frightening, too painful; I can't stand it. I will completely fall apart if I have to

experience this terrible event!” They then keep reindoctrinating themselves with this fear and reinforcing their belief in it by not flying. Every time they refuse to do so, they keep telling themselves (overtly or tacitly), “If I did fly, it would be horribly uncomfortable and now that I am avoiding flying, I can see how relatively comfortable I feel!” Moreover, by fearfully refusing to confront their phobia and do something to overcome it, it becomes almost impossible to get rid of it.

In virtually all kinds of desensitizing procedures, people *do* something about their phobia: They actively confront it, either imaginatively or *in vivo*, and they discover that (1) the unpredictable event has more predictability than they originally thought it did; (2) nothing disastrous happens to them and they are *only* uncomfortable, and not, as they imagined, utterly *destroyed* by the confrontation; (3) they learn a technique such as systematic desensitization, implosion therapy, or REBT that gives them some possibility of *coping* with their anxiety in the future; (4) they learn that although they cannot control the feared event (the possibility of the plane’s falling), they can definitely control some of their own *reactions* to it and therefore face a much “safer” kind of situation should they actually confront the feared object.

Let us make one other observation about the concept of discomfort anxiety in explaining and dealing with phobias. In a study showing that *in vivo* desensitization works better with agoraphobics than do three different kinds of cognitive restructuring without *in vivo* retraining, Emmelkamp, Kuipers, and Eggeraat (1978) point out that clinical agoraphobics probably differ from subjects in analog studies in that they have a higher degree of physiological arousal in anxiety-engendering situations than do the former subjects. They note that “it is quite possible that cognitive restructuring constitutes an effective form of treatment for low physiological reactors (such as the subjects of analog studies), while such treatment will be effective for high physiological reactors (such as agoraphobics) only after the autonomic component has been reduced.”

I quite agree with their observation. For if it is true that agoraphobics (and many other serious phobics) are high physiological reactors—and my own clinical findings for many years lead me to strongly support this hypothesis— then I would assume that they tend to feel more discomfort, and presumably more discomfort anxiety, than certain other disturbed individuals. Consequently, it seems likely they would tend to develop more phobias and hold on to them more strongly than would less physiologically involved phobics. The discomfort anxiety theory helps explain why agoraphobics are somewhat different from other phobics and why they are so difficult to treat.

In many important respects, then, the concept of discomfort anxiety seems to shed light on human disturbance and on psychotherapeutic processes. It especially leads the way toward creating and utilizing more effective, elegant, and long-lasting forms of psychological treatment. I would posit that many or most of the therapeutic methods used today are forms of indulgence that in the long run reinforce people’s discomfort anxiety and possibly do more harm than good. Take, for instance, muscular relaxation methods, which are so popular among behavior therapists. While there is no question that such techniques frequently work and result in considerable symptom removal, like all methods of therapy, they also have

ideological implications, some of which seem to be iatrogenic:

1. Usually, as in Wolpe's (1958, 1973) systematic desensitization, re-laxation is used in a gradual way to interrupt clients' feelings of anxiety. The very gradualness of this procedure, I believe, may easily reaffirm these clients' beliefs that they *must* slowly, easily, and by comfortable degrees, tackle their anxieties, and that as soon as they experience any intense feelings of fear they *have* to relax their muscles and thereby distract themselves from these feelings. Such beliefs may well serve to increase, rather than to decrease, their discomfort anxiety.

2. Relaxation methods essentially consist of cognitive distraction rather than cognitive restructuring. If, for example, clients are afraid of elevators and they imagine themselves getting closer and closer to elevators and then, as they feel anxious about this imagined closeness, they focus on relaxing their muscles, they automatically distract themselves from the idea that "I *must not* enter elevators; it would be *awful* if something happened to me!" Although they may decrease their anxiety by this distraction procedure, they usually have not worked at really *giving up* their irrational beliefs about riding in elevators. Relaxation and other forms of cognitive distraction are almost always much easier than actively combating and rethinking one's basic irrationalities. They may consequently reinforce people's notions of the horror of work and thus may increase their discomfort anxiety.

3. Cognitive distraction, though a viable method of psychotherapy, probably is not as effective in most instances as *in vivo* desensitization. By employing it with clients, the therapist avoids getting them to face the feared object, and thereby gives them an inelegant method of solving their problems. Again, it tends to sustain or augment their discomfort anxiety.

It is tempting for me to over-emphasize the significance of discomfort anxiety and to relate all forms of emotional disturbance to this concept. Thus, humans tend to believe that they *must* perform well and have approval, that others *must* treat them well, and that the conditions under which they live *must* be easy and enjoyable. When these three *musturbatory* views are not affirmed by reality—which is often the case in this frustrating world—they usually conclude that they *can't stand* their own, others', or the world's imperfections and that it is *awful* that such unpleasantness is allowed to occur. In some respects, they seem to have low frustration tolerance (LFT) or discomfort anxiety as an aspect of virtually all their emotional disturbances—their self-downing, hostility, and self-pity. In a sense, then, we could say that virtually all emotional disturbances arise from LFT.

My clinical perception and judgment, however, tells me that this formulation omits some essential data about people and their disturbances. Although ego anxiety and discomfort anxiety are found in almost all individuals and, as previously noted, significantly interrelate and reinforce each other, I think it is best to view them as separate but interlocking behaviors. In that way, they have maximum explanatory and therapeutic usefulness.

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