TENSION CONTROL

Proceedings of the Fourth Annual Meeting of
the
American Association for the Advancement of
Tension Control

Edited by
F. J. McGuigan, Ph.D

Chicago, Illinois
October 15-16, 1977
Table of Contents

About the Association...........................................v
Board of Sponsors...............................................vi
Chairmen of Fields of Application.........................vi

Program

Saturday, October 15, 1977

Progressive Relaxation........................................2
  Edmund Jacobson, M.D., Ph.D.

The Rationale and Use of Relaxation in Systematic Desensitization.....5
  Joseph Wolpe, M.D.

Progressive Relaxation and Autogenic Therapy: Similarities and
  Differences................................................11
  Wolfgang Luthe, M.D.

Invited Research Papers

Progressive Relaxation, Treatment of General Tension and Sleep
  Disturbance................................................30
  Thomas D. Borkovec, Ph.D.

Stress Reduction Procedures and Suggestion: Sensory Restriction and
  Low Arousal Training......................................37
  Ian Wickramasekera, Ph.D.

The Assessment and Treatment of Dental Fear......................41
  Douglas A. Bernstein, Ph.D.

Banquet Address

7:00 p.m., October 15, 1977

Some Research on Inner Speech and Visual Imagination............51
  Yves Chesni, M.D.
STRESS REDUCTION PROCEDURES AND SUGGESTION:
SENSORY RESTRICTION AND LOW AROUSAL TRAINING

Ian Wickramasekera, Ph.D.
Peoria School of Medicine
University of Illinois, College of Medicine

Varied psychological procedures, to reduce clinical symptoms of stress, appear to involve certain common elements. These elements include sensory restriction, low-arousal training and structuring positive expectancies. These three elements have been shown in controlled studies to increase human suggestibility. It is hypothesized that potentiated suggestibility, induced by these psychological stress reduction techniques, is implicated in the mechanisms of change in clinical symptoms.

Psychological stress has been implicated in the exacerbation or etiology of several psychological and medical disorders and diseases (e.g., peptic ulcers, essential hypertension, etc.). Analyses of psychological stress emphasize the critical role of cognition (e.g., appraisal and labeling) in the sequence of events that comprise stress (Arnold, 1960; Schachter, 1971; Mandler, 1975).

Several psychological methods have been proposed to combat stress. The best known of these methods are Autogenic Training, Progressive Relaxation, Systematic Desensitization, and Biofeedback. These procedures vary widely in their historical roots and philosophical rationales, but there is some evidence of their clinical utility to some patients with some stress related problems (Budzynski, et.al., 1973; Wolpe, 1973; Schultz and Luthe, 1959; Jacobson, 1970). Where data are available, careful study demonstrates that: a) there are large and significant individual differences in response to these stress reduction methods, b) the effective components are not clear in these superficially very different procedures, and c) the mechanism of change is not clear in these studies.

Tolerance of stress and pain is known to be related to several subject characteristics including hypnotizability or suggestibility (Hilgard, 1975; Barber, 1969; Melzack, 1973). It is known that there are large and stable individual differences in hypnotizability (Hilgard, 1975; Barber, 1969) and it appears that these differences are, at least in part, due to genetic factors (Hilgard, 1975). It is possible that part of the variability in patient response to these stress reduction techniques is due to individual differences in hypnotizability, and that one of the mechanisms of change in clinical symptoms is explicit or implicit expectations and suggestions to the patient.

In spite of many differences in these stress reduction methods at a historical, cultural, and philosophical level, it appears that they share at least three similarities at a procedural level. First, they are all presented as clinical therapeutic procedures and their claims of clinical effectiveness are supported by at least plausible logical rationales. Second, all five techniques encourage or require the trainee to restrict sensory stimulation during the exercises. (For example, subjects are asked to close their eyes, lie or sit
some controlled and independently replicated studies demonstrate that sensory restriction and low arousal training procedures increase hypnotic susceptibility at least temporarily (Penz, 1969; Wickramasekera, 1969, 1971; Enstrom, 1975; Sanders and Rehner, 1969). Several studies reviewed by Diamond (1974) have shown that structuring positive expectancies can also increase suggestibility.

In terms of the present definition (Wickramasekera, 1976), hypnosis can contribute to the potentiation of the verbal-cognitive control of biological and behavioral functions. It is predicted that more systematic attention to and manipulation of the cognitive events and covert verbalizations that occur before, during, and after these stress-reduction procedures will increase the probability of positive clinical outcomes.

In conclusion, this formulation suggests that there are at least two levels of hypnotic control of physiological-autonomic functions (baseline suggestibility or hypnotizability, and sensory restriction and low arousal conditions) that contribute to this cognitive control. The clinical effectiveness of the various psychological stress-reduction procedures proposed may at least in part be related to positive subject expectations, potentiated by the sensory restriction and low arousal conditions built into these disparate psychological stress-reduction techniques.
References


Wickramasekera, I., Effects of EMG feedback training on susceptibility to hypnosis: In J. Stoyva et al., (Ed.s) Biofeedback and Self Control, Chicago, Aldine, 1971.
