# Prenatal and Perinatal Imprints: Apparent Prenatal Consciousness as Revealed by Hypnosis

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**Abstract:** None available.

**Full Text:** Imprinting I define human imprinting in a manner somewhat different from the term used by ethologists in reference to birds and mammals. In humans, an experience associated with injury or great emotional stress can occur at any time in life. It and the emotional and physiological responses to the original stimulus will last without fading and can harmfully influence the individual throughout a life time. The maladaptive physiological and emotional reactions to the original experience can be mollified with hypnotic techniques but the original memory will remain unchanged. It will be reported in its original form with a subsequent age-regression when this is carried out at a subverbal level of association. This phenomenon of imprinted memory will be found in spite of efforts to alter or erase the original experience (Cheek 1984). Negative imprinting can erase the benefits of maternal and infant bonding as we know it. There have been many reports of birth experiences, but it has not always been easy to judge their validity. Chamberlain, a psychologist, has obtained convincing birth memories from young parents and has been able to compare their hypnotic memories with reports of their parents efforts to alter or erase the original experience (Cheek, 1984). Negative disappointing. Hospital records are ususally made in a most incomplete and strictured form on sheets of paper leaving little room for clarification. More credence may be given to a birth report when the obstetrician who delivered the child has recorded his observations shortly after the delivery. This reference material can be helpful several years later if the same obstetrician uses hypnosis and ideomotor review methods with the grown "baby" and refrains from referring to his record until after the hypnotic interview. Knowledge of Postural Sequences During Birth I have followed this program in reporting on babies who accurately recalled the postural sequences involved in descent through their mother's pelvis (Cheek, 1974). There can be no question about the ability of babies to retain memory for the postural changes occurring during birth. No adult other than an obstetrician or obstetrical nurse would have taught or talked about the mechanisms involved in a normal vaginal delivery. This memory, however, does not in any way prove that the verbal reports about a birth experience given by one of these "babies" are free of contamination from later family conversations. Subjective Impressions, Reassuring or Very Traumatic Prenatal memories have been presented to me often by patients and students in workshops who had only volunteered to explore their memories of birth. Initially, I was not looking for such memory because I was sure it did not exist. It seemed wise at least to listen to these reports. Hypnotized subjects believed important events had occurred prior to the onset of labor. Most of the prenatal reports have related very stressful experiences, but there was one instance of an unborn infant feeling elated on hearing that her mother really wanted a girl and was knitting clothing for a girl. This case is included here because the memory was substantiated by her mother and accurately placed at 18-20 weeks of gestation, and because this fetal understanding seems to have had a beneficial influence on the welfare and development of the child. Elsewhere (Cheek, 1980), I have reported on an instance of a very traumatic prenatal experience that seemed to have caused a lifetime of pain and illness directed toward winning approval from the mother she believed had tried to kill her. This event occurred during the sixth month of pregnancy. Her mistaken impressions were substantiated by her mother. This woman's health has been excellent during the 20 years since she learned the facts from her mother and realized that she did not need to feel guilty for her mother's troubles. Out of Body Experiences and Possible Prenatal Clairvoyance In the course of exploring the subjective impressions of people telling about intrauterine experience, I have been impressed by reports of visual as well as auditory and physiological awareness. Descriptions have been given as though the baby were outside the

mother's body, sometimes as a separate entity, sometimes as though looking at a scene through the eyes of the mother. Two examples are presented here, but there have been so many that I have been led to believe the fetus in utero has highly developed clairvoyant capabilities. Pregnant women also seem to have heightened sensitivities regarding their infant. How often such impressions are fabrications of fetal and maternal minds under stress and how often they are accurate descriptions will always be open to question. My belief is that the two examples given here are reliable factual reports because they were corroborated in both cases by the mother and in the second case by the grandmother as well. Subjective Reporting During a Breech Delivery A third case is included here because the impressions of the infant in a breech presentation are unusually clear. She was aware of each step in the process of being delivered. She knew that her arms were extended above her head as she was pulled out. This reflects failure on the part of the doctor to understand the maneuvers necessary to prevent this often fatal occurrence. If one or both arms are extended upward, they will take up space needed to get the unmolded head through the mother's pelvis. She did not believe her life was in jeopardy immediately after birth, but it was clear from her report that she must have been severely shocked and limp. The doctor was alarmed and so were her grandmother and grandfather. She saw them standing near the kitchen door, afraid to look as the doctor removed mucus from her throat and tried to make her breathe. This comment and her correction of what her parents had told her about the place of delivery added weight to probable validity of her memory. They had told her she was born in the living room. She was sure she had been born in the dining room and had been removed from that room into the kitchen for the resuscitation. Her mother would not have known what had happened after the delivery. She was left in the inner room according to the infantile memory. Criteria for Assessing Validity of Reports I am always suspicious of memories that are verbalized immediately during a hypnotic age-regression. I am also suspicious about the integrity of reports that follow a single strong movement of a designated finger. These are initiated consciously and are of no help in retrieving information that has never been registered consciously. They may be fabricated to please the hypnotist. True unconscious signals are always repetitive and often are barely visible. Sometimes we must rely on a shimmering impulse shown by the tendon leading to the designated finger. With recall of stressful experiences, it is sometimes possible to see an accelerated release of droplets of perspiration around the tip of the finger that eventually will lift. This is a physiological response preceding the skeletal muscle lifting of that finger. There is a definite sequence of recall of meaningful events: 1. First there can be seen changes in respiration and pulse rate. These demonstrate physiological memory. This occurs very rapidly and must appear before a designated finger lifts to show orientation to the time of an important experience. 2. Ideomotor action indicates subconscious awareness. This occurs within a few seconds of the physiological sign. At the moment the finger lifts indicating this second, higher level of memory, the subject has no verbal level awareness of the experience beyond perhaps feeling uncomfortable. 3. Verbal reporting of the experience follows the previous indications of recall. To reach this nearly conscious horizon of thought the entire experience may have to be repeatedly reviewed. One finger will lift to show the beginning and another finger to show the ending. The number of required repetitions to elevate the memory from deep subconscious zones of memory storage depends on the gravity of the experience. Relatively non-stressful events are revealed quickly but a subject may refuse to "know" about a very stressful event. We use special techniques to reach such memories (Cheek &LeCron, 1968). This sequence of recognition representing a hierarchy of physiological to skeletal muscle to talking levels of memory has stood the test of time. I found it reliable with verified surgical anesthesia experiences, other unconscious states and traumatic deep sleep ideation (Cheek 1959; 1981; 1963; 1965; 1966; 1969). Imprinted versus Casual Memory It is easy to shake the verbal level of memory of a hypnotized subject. We have known about this for a long time and demonstrations are to be found in any stage presentation of hypnotic phenomena. But I have tried repeatedly without success to alter the subverbally stored convictions of hypnotized subjects when an experience was associated with great emotional stress or physical injury. I think of these memories as "imprinted" rather than stored in a casual way. Imprinted memories do not

fade with the passage of time as do those which are not associated with outpouring of adrenal hormones. Testing the Persistence of Imprinted Memories I have tried emphatically denying the factual nature of an imprinted memory and have tried to superimpose a false one to take its place. The subject may accept the amended version at a conversational level in hypnosis but will rediscover the original experience and discard the suggested one after repetitive subverbal or "ideomotor" level review (Cheek, 1984). Troubled emotional or physical behavior can be corrected during therapy, but the original experience will remain. Heavy impact experiences associated with injury or the outpouring of epinephrine will take precedence over later, less stressful, inadvertent or outright purposefully misleading suggestions. I trust the integrity of hypnotized subjects when ideomotor techniques of investigation are used. I must add, however, that this trust is not yet shared by some of my colleagues. My observations must, therefore, be considered tentative until supported by others using the same methods of research that I have been using now for nearly 30 years. In evaluating subjective reports at any time, regardless of whether we are using hypnosis or communicating consciously, we must always remember that sensory perceptions are filtered and understood on the basis of an individual's experiential background and biases. Head and Shoulder Movements During Vaginal Birth Process While investigating the memories of surgical patients, I have frequently observed extension of the subjects head after giving a signal that consciousness has been lost. When I have asked why this has occurred, I have been told that the anesthetist is tipping the patient's head back and inserting something into his or her mouth. This is followed by a feeling of being unable to breathe. The chest muscles and diaphragm are paralyzed by the muscle relaxant used as an intravenous bolus prior to inserting a laryngoscope, followed by placement of a tube with its occlusive balloon into the trachea. Somewhat later, I began more detailed investigation of the muscular feelings of babies as they moved through the birth canal in a head first or vertex presentation. The subject was asked to orient back to the moment of emerging into the world and to pay attention to impressions, to notice if the mother was awake or asleep and to notice any sensations of head position in relation to the shoulders. During a normal head first presentation with the baby's back lying anteriorly on the mother's left side of the abdomen, the crown of the head will be anterior on the mother's left. As the head descends toward the outlet, it will rotate in such a way that the crown of the head will enter the greatest diameter of the outlet. This would be at 90 degrees to the floor if the mother is on her back in the usual unphysiological position required during hospital delivery. As the baby's head emerges with its crown anterior, its head will be extended as though the baby were looking upward. This is caused by the concave curve of the maternal sacrum. After coming free of the mother's perineum, the muscle tone of the baby will make its head rotate toward the mother's left side to regain its normal right angle relation to its shoulders. Since the first report of this matter in 1974,1 have reviewed the muscular sequences of close to 500 people. I have explored some 15 breech deliveries. One of these to be reported did not recall head positioning, but was certain her arms were extended to her head in a way that made delivery of her head difficult. I have reviewed 14 Caesarean section reports. None of the Caesarean babies had remembered any postural changes. There has been no memory at all for anything physical or emotional for babies that have been delivered by Caesarean section when the mother has not been in labor. Apparently, babies need some sort of stimulation in order to have impressions about their birth. I have been able to get vague memories from those whose mother had some labor but were forced for some reason to complete the delivery surgically. No Caesarean baby has shown any changes of head position. None has remembered which arm came out first. I have been privileged now to have reviewed head and shoulder movement sequences with four deliveries effected while I was practicing in Chico, California. My "babies" were all 16 years of age or older, suggesting that their muscle memory was imprinted and did not fade with the passage of time. Each went through the sequence that would be expected for her individual vertex presentation. On reviewing my delivery notes after the interview, I found that each had accurately demonstrated the pattern of her descent through the birth canal. I was told by one young lady who delivered in an occiput posterior presentation that her mother seemed very nervous during the last stage of her birth. I had noted this in my

record, but it is also quite possible that she had heard about this from her mother at a later time. Sometimes a birth memory is very convincing in its detail. It is a temptation to conclude that the report is accurate if a therapeutic cure or alleviation of a problem follows the search and reporting. It is never possible to be sure that any form of treatment has been completely responsible for achieving a therapeutic goal. There is a possibility that understanding the supposed origin has had a beneficial effect, but the placebo effect derived from mutual respect and faith in achievement of a therapeutic goal may be the sole factor. Comment: Vocabulary Used By Subjects Reporting Early Life Experience For those who are not conversant with hypnotic phenomena, I should explain that in an age regression report following an ideomotor level review of a past experience, the language expresses knowledge of the matter as of the time of the hypnotic session. Babies unborn and at delivery may know language but are certainly limited in their vocabulary even if they were able to speak. What we get is comparable to recording an impressive event associated with conversation. We would not be able to understand the language, for example, if it were carried out in Chinese. Later, however, if we replay the tape after studying Chinese we could understand the content of the original experience and translate it into our language. Case Reports Prenatal Out of Body Verified Description, Difficult Delivery, Guilt M.L., Ph.D., a psychobiologist, requested a review of his birth (12/17/81). He was 34 years old at the time and his conscious recollection was that his mother had a very difficult and painful delivery. Forceps were applied incorrectly and he carries a scar on his forehead. It would probably have been at least a midforceps delivery. He believed this was necessary because of indications of fetal distress. He entered hypnosis easily while discovering unconscious symbol movements of his fingers to represent, "yes," "no" and "I don't want to answer." He was asked to orient his memory back to just before his mother went into labor and to have his "yes" finger lift unconsciously when he was there. He immediately looked distressed and when able to talk said it was about a week before he was born. He said "Mother is at my grandmother's house. Her father has just died suddenly of a heart attack. (He had not known that his grandfather had died that close to the time of his birth). My grandmother is crying-she is sitting down on a sofa." "Can you see what she is wearing?" "She is wearing a dress with a flower sort of pattern." "Can you see your mother?" (His "yes" finger lifts.) "How does she look?" "She is pregnant." "What is she wearing? When you can see your 'yes' finger will lift and when it lifts please tell me what comes to your mind." "It's a gray and white striped maternity dress-a round collar with a pink bow around the neck.-Yes, it's a white and gray dress." "Where are you?" "Inside." At this point, he apparently shifted to the labor. He began moving his head from side to side while moving his arms and legs as though trying to walk. When asked about this, he says his mother is in labor and he has the feeling of struggling. The movements continued while he was observing his feelings and reactions. "What is happening now?" "My mother is afraid of dying-like her father. They were very close. Her labor stops. I'm stuck and they are trying to put forceps on my head. My head is trying to get away from the forceps." "Notice how your head moves as you come out into the world. Let your muscles tell you what is happening. Notice which arm is out first. Pay careful attention to the sounds around you. Notice whether or not your mother is awake, whether she is able to speak." His head rotates with the crown of his head turning toward the left as he emerges. This suggests that he was in a so called LOA or left occiput anterior presentation at the beginning of labor. He moves his right arm to indicate that it delivers first before his left arm. "Is your mother awake? (finger signals "no") How does the baby feel?" "I feel guilty. I feel I have caused my mother a lot of pain, a lot of trouble." "Does the baby feel in any way responsible for the death of his grandfather?" (I changed from first person pronoun to third to give him some distance from his troubled feelings. His "yes" finger lifted in answer to this question. He was surprised at this response.) I point out that no baby is responsible for a mother's pain or difficulty. He had already recognized that he could not possibly have caused his grandfather's death. His mother's grief would have been experienced even if he had not been in the picture and her pain was a matter that should have been relieved by her doctor. The baby should be allowed to come out into the world free of guilt and feeling good about himself. "Do you agree about that?" (very long delay before his "yes" finger lifts unconsciously). I tell him that fear on the part of his mother made the uterus stop its

expulsive contractions, that all laboring mammals will stop expulsive contractions in the presence of danger. Herd animals will stop labor in order to rejoin the herd and move away from a predator's territory. The danger to which his mother was reacting was not caused by the baby but by her fear of dying from a heart attack (his "yes" finger lifted in acceptance). He is now asked to go over the labor as it would have been with his grandfather still alive and his mother looking forward to seeing her son. He is able to hallucinate his mother looking pleased and saying, "Oh, what a beautiful baby." (Note that this is a verbal level acceptance of a suggestion not based on fact. If I had then asked him to go over the labor from beginning to end at an ideomotor level, he would have repeated the initial process but with less show of distress). In a letter written January 2,1982, he stated that he had talked with both his mother and his maternal grandmother and found that his observations about clothing checked out but that the "Oh, what a beautiful baby" was said by his grandmother when she first saw him in the nursery. He had hallucinated this remark as something his mother would have said if the delivery had been conducted differently. It was not related to facts as he remembered them. His grandmother was not in the delivery room.) In this case, there was muscular memory as well as an apparently valid, clairvoyant, out of body experience evoked by the mother's emotional distress over loss of her father. Prenatal Out of Body Clairvoyant Experience Verified by Mother In 1961, I was consulted by a woman I had delivered in 1948. With her was her 13 year old daughter. This woman, G.W., had moved with her husband and only child to Sacramento a few months after her post-partum checkup and we had not seen each other since then. Her reason for coming to San Francisco was to see if I could help her with a continuing anxiety state. My record stated that the baby had grasped my thumb as I held her up by the heels. I had commented to her mother that it would not be necessary to worry any more about her daughter, that she appeared to be in excellent condition and had good reflexes as demonstrated by her firm grip on my thumb. Before starting my interview, I asked her daughter, Debbie, to sit in with us because she appeared to be a caring, intelligent, outgoing youngster, the president of her class in school. I felt that it might bolster the self respect of the mother by pointing out what a success she had been as a mother. The mother was probably in a hypnotic state from the start selecting unconscious gestures for "yes," "no" and "I don't want to answer." As I began searching for the origin of her anxiety, I glanced over at her daughter. She had slipped into hypnosis also while watching her mother. This seemed an appropriate time to see if Debbie could give us some therapeutic help. I asked Debbie to set up her own signals and found that she had already done this along with her mother. I said, "Debbie, does your subconscious mind know what it was that has allowed you to grow up to be such a delightful young lady?" Her "yes" finger lifted in a typically intermittent way. She was in a deep state. "Is there one single event that started you off in this way?" (Again her "yes" finger lifted.) I continued, "Please go back to the start of that event. When you are there your 'yes' finger will lift. When it has ended your 'no' finger will lift. Don't try to remember anything. Just wait until a thought comes to your conscious mind as you go over that period." She began to smile after the initial subconscious review. After the third scanning she said, "It's when I know I'm supposed to be a girl." I said, "Please go to that moment and look around in your subconscious mind. see where you are. If there are people there, see them. When you know it well enough to talk about it your 'yes' finger will lift and as it lifts please tell me what is going on." Ten seconds after her finger lifted she moved her head from side to side as though looking at external objects. She said, "I'm inside." "What do you see?" "Mother is sitting on a couch. She's knitting something. Daddy comes in and is asking why she is knitting something for a girl. Mother says, "It's a girl. I know it's a girl. It has to be a girl." "See what your mother is wearing. When you can see that your 'yes' finger will lift." (Here I was simply trying to get an hallucinated picture to round out and strengthen the impact on Debbie. I was amazed at what she said.) "She has on a green plaid dress. I can't see any other color. I think it is dark." At this point I looked at her mother. She was totally alert with her eyes open, looking surprised. Fortunately, she did not comment until I asked for her comments. "Can you see what your Daddy is wearing?" "It looks like slacks and a gray sort of sweat shirt." (This was not anything surprising because she knew he often wore such clothing at home.) "What do you think about that?" I asked her mother. "I had a green and black plaid

dress on and I can remember when that was. I had just begun feeling Debbie kicking. It was in April. I gave that dress away right after my pregnancy. I would have been almost five months along. That's incredible!" In 1961, I was only beginning to shed my belief that newborn babies could possibly feel and remember. This went a long way past my mental boundaries at that time. I thought I would check on the birth experience because I had a vivid memory of it. This was one of my first deliveries after starting practice and I had just refreshed my memory with her mother's record. I turned back to Debbie who was still in hypnosis and said, "Please go over your birth. When you know you are out in the world your 'yes' finger will lift. Notice how you feel. Notice how the doctor is holding you." She began to frown before her 'yes' finger lifted and then said, "I'm upside down. I'm scared. I grab the doctor's thumb. He says something about reflexes but I'm just scared. I don't like that." Her part of the interview was terminated at this point. Traumatic Breech Birth-Near Death Experience R.J., a 41 year old unmarried Norwegian woman was seen as a patient because she was now thinking for the first time in her life that she would like to have a child. Although she had had several close relationships to men during the years, she had never committed herself to marriage and had been firm in her decision not to have children. Twice she had been pregnant and twice had had an induced abortion. During both pregnancies, she was vomiting so profusely and frequently that she could not function. She did, however, feel very guilty after both abortions and stated that she only had them done because she was so sick. During the interview in hypnosis, it was clear that she was carrying an inferno of suppressed rage against the way she had been treated prior to her birth and during the birth process. Her experience had made her feel she did not ever want a baby of hers to feel the way she had been made to feel. This irrational view has been frequently expressed by women consulting me about their infertility. It yields to correction easily when exposed to their conscious reason. Realization that she was approaching an age when she would not be able to have a child had softened this unreasoning pattern of thought. I have no parental or historical corroboration of the details reported here, but they are graphically described. Her impressions about her postural changes during delivery are clear and are convincing to me as an obstetrician. Her belief that she knows everything during the time when the doctor is struggling to resuscitate her reminded me of my own feelings as I regained consciousness during a football game and argued that I was perfectly able to go on playing. This subjective, all-knowing belief can be found with age regression studies of adults who have been unconscious from head trauma or under the influence of alcohol while driving an automobile. This patient had no knowledge of obstetrics, yet from her description, it is clear she had been in a frank breech position with her legs extended and her feet up by her face at the beginning of labor. She recognized that the doctor had been concerned about her presentation and had wanted to postpone delivery until he could be available. She was very definite about her anger during the discussion between her family and the doctor. She felt she should have been consulted. "The doctor has no right to decide when I will be born." This feeling has been reported to me a number of times during adult age regression in hypnosis to a time prior to birth. It adds weight to the growing realization that the onset of labor should be left to mutual agreement between the mother and her unborn infant and should never be induced for the convenience of a doctor. While reviewing her birth, my patient described her impressions. He is "groping" for her legs. He found one and pulled it down. She says, "I hate it. I hate to have my leg pulled down." When asked about the position of her arms she says, "I feel like they're up." I said, "That's why it's difficult" and continued with an explanation that with a breech birth of this sort the legs are allowed to stay up until the baby's buttocks have delivered far beyond the perineum of the mother. The doctor can then press behind a knee to make the lower leg flex. He brings this foot down and then does the same thing for the other leg. Then he rotates the baby keeping its back upward to make sure the baby's head will come out looking downward. It will not deliver if the face is looking upward. The back is rotated in the Potter maneuver first, for example, in a clockwise direction. This makes the left arm pull downward to allow that arm to be delivered. Then the baby is rotated 180 degrees in the counterclockwise direction to make the right arm reflexly pull down. It is very important to keep the arms from floating up above the baby's head because delivery may then be impossible and the baby may the of oxygen lack. "Feel what it's like now. You are

out in the world. Do you feel as though you are breathing all right?" (The patient takes a gasping deep breath. Her "yes" finger lifts. "My breathing is fine right now." "Do you cry?" "No, I'm quiet-I feel like I know everything. I feel that everything is fine and I'll come out. I'm fine and I feel they should salute me and just be real happy. - And they are scared shitless. And I'm so angry with him 'cause he won't let me cry. I know I can do everything. I know I can do everything in the world and he will not let me cry." "What is he doing that won't let you cry?" "He's choking me. He is in my way. He is scared for me and he won't let me be me and do what I know I can do.-Like-I know that I'm programmed. I know that I know everything. And I know exactly the next thing to do." "What should you do?" "I should just relax and be happy and cry and I know I can do it." "Feel it as it would have been if the doctor had been smart and had just stroked your head and the back of your neck and said, 'hello'." She sighs tearfully and says, "But I'm fine on my own. I don't need somebody to tell me what to do." Concluding Comments My purpose in presenting this report is to suggest strongly that infants are keenly perceptive long before birth. They are very sensitive to the thoughts and feelings of people around them as well as those of the mother. Imprinted impressions, right or misinterpreted, may affect a life time of behavior. We must, therefore, rid ourselves of the belief that the central nervous system of infants is incapable of sensing and remembering during prenatal and perinatal existence. All subjective impressions obtained during age-regression studies should be thoughtfully considered to see if the material can be used to make the way safer for obstetrical patients and their unborn infants in the future. We may be in a position to learn about guilt feelings, harmful identifications and feelings of rejection that have been unrecognized in the past because we have not known how to reveal them and to expose them to reassessment in the light of mature understandings. References References Chamberlain, D.B., Consciousness at birth. The range of empirical evidence. Paper presented at the First International Congress on Pre &Perinatal Psychology, 1983, July. Cheek, D.B., Unconscious perception of meaningful sounds during surgical anesthesia as revealed under hypnosis. American Journal of Clinical Hypnosis, 1, 101-103, 1959. Cheek, D.B. Physiological impact of fear in dreams: Postoperative hemorrhage. American Journal of Clinical Hypnosis, 5, 206-208, 1963. Cheek, D.B. Some newer understandings of dreams in relation to threatened abortion and premature labor. Pacific Medicine and Surgery, 73, 379-384, 1965. Cheek, D.B. Therapy for persistent pain states. American Journal of Clinical Hypnotherapy, 8, 281-286, 1966. Cheek, D.B. Significance of dreams initiating premature labor. American Journal of Clinical Hypnosis, 12, 5-15, 1969. Cheek, D.B. Sequential head and shoulder movements appearing with age regression in hypnosis to birth. American Journal of Clinical Hypnosis, 16, 261-266, 1974. Cheek, D.B. Maladjustment patterns apparently related to imprinting at birth. American Journal of Clinical Hypnosis, 18, 75-82, 1975. Cheek, D.B. Ideomotor questioning revealing an apparently valid traumatic experience prior to birth. Australian Journal of Clinical and Experimental Hypnosis, 8, 65-70,1980. Cheek, D.B. Awareness of meaningful sounds under general anesthesia: Considerations and a review of the literature 1959-1979. Chapter in Theoretical and Clinical Aspects of Hypnosis. H. Wain, Editor, Miami, Florida, Symposia Specialists, 1981. Cheek, D.B. Possibilities of ideomotor questioning methods in trustworthy memory enhancement with witnesses to crime. Paper presented at Scientific Meetings of the American Society of Clinical Hypnosis, San Francisco, 1984. Cheek, D.B. &LeCron, L.M. Clinical Hypnotherapy. New York: Grune &Stratton, 1968. AuthorAffiliation David B. Cheek, M.D. San Francisco

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