IDEOMOTOR SIGNALS FOR RAPID HYPNOANALYSIS

IDEOMOTOR SIGNALS FOR RAPID HYPNOANALYSIS

A How-To Manual

By

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and

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With a Foreword by

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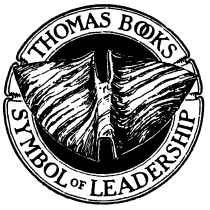

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We dedicate this book with love to David B. Cheek, M.D., FACS, physician, healer, teacher, OB-GYN, therapist, clinical hypnosis pioneer, and courageous visionary into the light.

Dr. Cheek was our mentor and our good friend.

Dabney M. Ewin, M.D., FACS, ABMH
Bruce N. Eimer, Ph.D., ABPP, FAABehP
May 16, 2005

FOREWORD

More than 25 years ago I took my first workshop from David B. Cheek, M.D., on ideomotor signaling and exploration. I was so fascinated by what I learned that I read his book (Cheek & LeCron, 1968) and then began searching out every article he had ever written. As I began applying ideomotor techniques in my hypnosis practice, I was startled at the effectiveness of these techniques. Finally in about 1982, I called David and asked him if it might be possible to consult with him and "pick his brain" for further refinements of technique. He said, "Certainly," and gave me his home phone number. I asked him how much he would charge me for these phone consultations and he said, "I won't charge you anything. If I can be helpful that would be great. Just call me at home, and if I'm busy I will tell you and ask you to understand, but usually I'm not all that busy and we can visit." This led to many hours of telephone mentoring by Dr. Cheek and to my developing a close relationship with this gentle, but humble giant of a man.

Dr. Cheek was an obstetrician and gynecologist. In one of those phone calls, I presented a case to David of a woman who had come to see me in the Sex and Marital Therapy Clinic for anorgasmia, but she also mentioned that she had uncontrollable, recurrent vaginitis. The woman was a nurse. She had seen half a dozen gynecologists, would go on medication, the vaginitis would clear up, and then within three weeks it would be back. No one, including gynecologists at the medical school where I practice, had been able to figure out her case. I asked David if he thought that vaginal infections could have a psychogenic component. He replied, "Absolutely," and went on to describe how emotions or inner conflict could throw off the pH balance of the vagina, allowing infections to develop.

In the next interview, we did ideomotor exploration and discovered that the vaginitis was an unconscious way of the patient punishing herself because of guilt about sexual involvement when she was not mar-

ried. We worked through her guilt within a matter of minutes and obtained an unconscious commitment that it was no longer necessary for her to continue having problems with vaginitis. In a 15-year follow-up on this case, I learned that in all those years, she had only had one or two episodes of vaginitis.

I could cite many similar "miraculous" cases involving chronic pain and other somatic symptoms, as well as a variety of psychological conditions. It was cases like this that convinced me of the power of the mind to influence the body, and of the power of ideomotor signaling to produce rapid therapeutic change–often allowing the insight-oriented phase of treatment to be dramatically shortened to just one or a handful of sessions.

My approach to psychotherapy and hypnotherapy has always been very eclectic, and I have tried to remain open to learning from a wide variety of approaches to the use of hypnosis. Yet, out of the many dozens of hypnotherapeutic techniques that I have learned and used through the years (Hammond, 1990), the single most valued and valuable hypnosis technique has been ideomotor signaling. I recall a conversation that I had with Ernest Rossi in the late 1980s, just after he published a book (Rossi & Cheek, 1988) with Dr. Cheek–a conversation with which I resonated. He shared that in the field of hypnosis, he had been most intrigued by the work of Dr. Milton Erickson, but that to him the next most fascinating figure in our field was Dr. David Cheek.

Despite my deep affection and appreciation for Dr. Cheek, David knew that I did not agree with him on a couple of points. He believed that there should not be an ideomotor signal for "I don't know," as there was in his original work with LeCron (Cheek & LeCron, 1968). He had come to believe that at some level, the patient did know the answer, and, therefore, that such a signal provided the patient with a "cop-out." However, research (as reviewed in Brown, Scheflin, & Hammond, 1998) has shown that not allowing someone to respond that they "do not know" an answer will result in increased confabulation.

In fact, this is one of the most serious flaws in the hypnosis and memory research on confabulation-research which by its very design, was destined to show increased confabulation, even though it has been documented (Brown et al., 1998) that hypnosis is no more likely to create pseudomemories than waking interviews.

Leading questions, in or out of hypnosis, are what can create memory distortion. Thus, to avoid possible contamination, I have recommended (Hammond, 1997, 1998) that when we utilize ideomotor exploration, we should also include a signal for "I don't know."

David Cheek (1994) also believed (as do Drs. Ewin and Eimer) that valid memories could be obtained for events before the age of three (and even birth or intrauterine memories), even though research has very seriously called this into question (Brown, et al., 1998). Nonetheless, I always encouraged David's workshop attendees who might well believe that such "memories" only represented projection on the part of the patient (which may nonetheless still have potential clinical value and, when believed in, may possibly be a catalyst for therapeutic change) not to allow David's examples and beliefs about this to discourage them from the many other wonderful things that they could learn about unconscious exploration.

I likewise encourage those who are reading this book, despite feeling that such events may only represent confabulation or demand characteristics, to still remain open-minded about the wealth of other therapeutic techniques you can learn from your reading.

Drs. Dabney Ewin and Bruce Eimer are highly experienced clinicians and teachers who studied with Dr. Cheek and who have very extensive experience in using ideomotor techniques. They have provided us with a practical clinical volume that contains invaluable modeling and captivating case examples. There is much to be learned here. Practitioners who utilize hypnosis as part of psychotherapy, or in working with pain or other medical problems, will find that their practice is enriched from studying this manual.

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Past President, American Society of Clinical Hypnosis
Diplomate, American Board of Psychological Hypnosis

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PREFACE

ORGANIZATION OF THIS BOOK

This book is about using ideomotor (IM) signals in the rapid hypnoanalysis of psychosomatic disorders. In Part I, we cover basic concepts and principles. In Part II, we cover basic applications of the technique, and illustrate their employment. In Part III, we present clinical transcripts of cases to illustrate the actual uses of the technique with psychosomatic patients. This is a "how-to" book. Thus, throughout the book, we provide numerous case examples and illustrations showing specifically how ideomotor analysis techniques are used.

Part I

Chapters 1 and 2 cover the value of ideomotor signals in hypnotherapy and basic principles of hypnotherapy. In Chapter 3, we cover special intake questions for gathering necessary information and preparing a patient for rapid hypnoanalysis. In Chapter 4, we cover treatment planning, and in Chapter 5, we describe in detail, how to efficiently set up ideomotor signals.

Part II

In Chapters 6 through 11, we explain how to use ideomotor signals effectively to uncover and reframe the fixed ideas ("idée fixe" of Janet) underlying one or more of the seven common causes of psychosomatic disorders (Cheek & LeCron, 1968).

In Chapter 6, we discuss applications of ideomotor signaling to direct suggestion in hypnosis (DSIH) and age regression. We specifically cover the seven common causes of psychosomatic symptoms, or "seven

keys," in Chapter 7. In Chapters 8 and 9, we discuss the applications of our understandings and the technique to working with surgical patients. In Chapter 10, we cover the treatment of persistent pain, and Chapter 11 covers self-hypnosis.

Part III

Chapters 12 through 16 present detailed case transcripts. These transcripts show the actual use of the technique for resolving specific psychosomatic symptoms.

BACKGROUND

As a medical doctor, I (DME) initially became interested in hypnosis after three things occurred. First, I was cured of something myself in a hypnotic trance. Second, my first hypnosis case was a spectacular success. Third, I came to realize that fixed ideas will make a person sick, and violating them will make people anxious, so these fixed ideas remain inviolate and fixed in place.

From the time I was 12 years old, I had a chronic sinusitis. It was actually a vasomotor rhinitis. I couldn't breathe through my nose from the age of 12 until my 30s. Every second or third winter, the swelling would stop up the foramen that drains the sinuses and they would have to fracture into my sinuses and drain the pus out of them.

When I was in my thirties, I attended a hypnosis workshop and volunteered to be a demonstration subject. I asked the instructor if he could do anything about my sinusitis. He took me back to the first time this sinusitis was a problem using hypnotic age regression. We went back to when I was 12 years old and I had a really bad case of sinusitis at that time. I had a headache worse than any pain I had ever had. I had always been an obedient little boy, and this was the first time in my life that I made no attempt to control myself. I was screaming and yelling and my parents brought me to their bed to console me.

Finally at around midnight Saturday night, my parents called our ENT doctor for a house call. Dr. L. was the Chief of ENT at Tulane University Medical School, Chief of ENT at Ochsner Clinic, and the President of the American Academy of Otolaryngology. He was past

the time of making house calls but he had been my father's roommate in college and he came.

I was reviewing and reliving these memories in hypnotic regression. "So Dr. L. examined me", and the instructor leans down and asks me, "What does he find?" I answered in trance, "He says I have a terrible case of sinusitis." Instructor: "He'd better find that hadn't he? But, you don't have to have a stuffy nose now to prove that you're not a bad boy, do you?"

Well, I immediately felt my nasal passages open up. I took my nasal spray out of my pocket and put it on the table, saying "I don't need this anymore." Ever since then, I know that if my nose gets stuffy, this signals me that I am feeling guilty about something. So, I can do self-hypnoanalysis and find out what I am feeling guilty about. Thus, the symptom actually becomes an asset. That is because it is specific to a certain emotion and it helps me understand what I am feeling emotionally. Once I've remedied what I've been feeling guilty about, I no longer need the symptom. For example, perhaps I failed to write a thank-you note and it's playing in the back of mind. Once I know what it is and remediate it, I am not guilty anymore and I no longer need the symptom.

Having had the experience of being cured of such a persistently aggravating disorder, I acquired a new attitude that makes me sincerely believe that my patients have the capacity to solve their problems too. In our training workshops and seminars, we tend to emphasize the importance of the patient's believing with conviction the therapy's potential to help him or her heal. However, we often do not put as much emphasis on the *therapist's* convictions. In 1922, Emile Coué said "Conviction is as necessary to the suggester as to his subject. It is this conviction, this faith, that enables him to obtain results where all other means have failed." The Bible says (First Corinthians 14:8): "For if the trumpet give an uncertain sound, who shall prepare himself to the battle?"

After my first basic course in hypnosis, my first case was a 6-year-old child with a seizure disorder. His mother told me that his seizures lasted for 20 to 30 minutes at a time. They had started 8 or 9 months earlier, and he had been diagnosed with epilepsy and was on phenobarbital and Dilantin without benefit. He was still having seizures about twice a week. I told her that this sounded strange because a typical epileptic seizure lasts less than a minute. I also mentioned that the

next time her son had an episode, I wanted to observe it, since they lived only five minutes away.

The very next day I got a call and this child was in bed with eyes rolled up having tonic activity of all extremities and rolling from side to side on the bed. I put a hand on his shoulder and asked, "Wes, are you trying to tell us something?" He opened his eyes and said "Yes!" I didn't think this was the proper venue to do therapy so I told him, "Good, your mother will bring you to my office tomorrow and you can tell me all about it."

The next day, Wes went easily into trance and told me that his whole family had gone to the emergency room with his first cousin who was having convulsions (due to spinal meningitis), and his cousin died in the emergency room. It became clear the little boy was hallucinating that his deceased cousin Eddie was coming back to take him with him–what we would now call "identifying" with Eddie.

I separated the identification and told Wes that "you are old enough to understand that Eddie is dead and you are alive, and you and Eddie are two totally separate people. Wouldn't it be better to keep your happy memories of Eddie and keep on growing and living a normal life?" Wes opened his eyes and came out of trance and hugged me and said "yes, that's what I want."

I have a 40-year follow-up and he has never had another seizure.

I had an uncle who was a lay hypnotist at the turn of the century. Although he died before I was born, I grew up hearing many stories about his demonstrations and was cautioned many times never to let anyone hypnotize me. This led me as an adult to develop some curiosity about what hypnosis really was.

At the first hypnosis weekend workshop I attended, there was a group induction. I thought I was resisting allowing myself to be hypnotized, but I apparently did drift into trance. Almost immediately, I became quite anxious, nauseated, and had to leave and go to the men's room to vomit.

I had violated a fixed idea that had been imprinted in my subconscious during my childhood. Over the years, I have realized that what we call "resistance" is often a patient's subconscious way of protecting himself against the anxiety of violating his own fixed idea. Resistance has to be worked with therapeutically. Identifying the fixed idea without violating it and presenting better choices is often the key to healing.

One of the things I have learned through the years is that I am very careful and even reluctant to do group inductions. This is because if the audience is large enough, there is probably going to be somebody who will have an anxiety attack. And if you think there can be nothing wrong doing a group imagery of going to the beach for example, think again. There is going to be someone there who had a near-drowning. And if you think there can be nothing wrong to take the group to a peaceful forest glen, there is going to be someone in the group who has been bitten by a snake.

In one of my courses with the medical students at Tulane, I thought I could take the group and have each person go to his or her own "laughing place". So I said "you start with a big smile on your face like a clown. Just feeling great." And I always announce before I do a group induction that if anyone has a problem they should feel free to contact me and we will work it out. Well, sure enough, a student had an anxiety attack. I saw her privately later on. She regressed to being three years old. At that time, she had a birthday, and a fellow had a little traveling merry-go-round on the back of his truck and he dressed like a clown. Well, she rode on his merry-go-round and she fell off the truck! And this guy with a big smile on his clown face was picking her up. It was not a good association.

So, even when you think you are doing the most benign imagery, you can run into trouble. Therefore, I am rather leery of group inductions.

It didn't surprise me (DME) that in the Hilgards' studies with the Stanford Hypnotic Susceptibility Scale (Hilgard & Hilgard, 1994), 6 percent of their students, when they came out of taking the test, had headaches. Why would taking a hypnotic susceptibility test that includes a simple induction give you a headache?

As a clinical psychologist, I (BNE) have always been interested in the reasons why people do what they do, and how they do what they do and experience what they experience. I have always believed that every behavior has a reason even though we may not always know what the reasons, or determinants are. Rapid hypnoanalysis enables us to help our patients understand how and why they have been experiencing what they have been experiencing. It enables us to find reasons for symptoms and better solutions to our patient's problem. That is why I became involved in the practice of this remarkable technique of hypnotherapy, and why I chose to help Dr. Ewin write this book.

In the last 15 years, managed care and its exclusive focus on "cost efficient" psychological treatment has come to dominate the mental health field. As a result, psychotherapies have been made briefer at the expense of deeper. Briefer is desirable, but superficial is not. Yet, superficial "quick fix" therapies have come into favor. One problem is that many of these therapies have become the equivalent of applying a pressure tourniquet to a gunshot wound! Yes, you first have to stop the bleeding, but then you need to clean out the wound and repair the tissue damage.

When behavior change and symptomatic relief are focused on to the exclusion of insight and changing beliefs, the results of the therapy are often superficial. The majority of adjustment problems people have are relatable to their subconscious beliefs and fixed ideas.

In today's managed mental health care environment, clinical hypnosis has become popular as a tool for alleviating symptoms quickly. The emphasis has often been placed on suggestive and behavioral approaches which have limited utility with deep-rooted problems. Unfortunately, many presenting problems are deep-rooted problems.

After having experimented with a wide range of rapid, behavioral and symptom oriented therapy techniques and approaches (Eimer, 1988; Eimer & Freeman, 1998), I (BNE) became aware years ago that something deeper was needed. I searched the literature and came up with the work of David Cheek and Leslie LeCron (Cheek, 1994; Cheek & LeCron, 1968) who pioneered the hypnoanalytic approach covered in this book. I later met my co-author (DME) at a clinical hypnosis conference and we became friends. Under his tutelage, I discovered firsthand, the power of clinical hypnosis and hypnoanalysis for uncovering pathogenic, fixed ideas and changing them.

While modern "cognitive" approaches to brief therapy purport to address fixed beliefs which they term "schemas" and "core beliefs," these approaches often require a year or more to work with people who are very depressed or who have personality disorders (Eimer, 1989; Eimer & Freeman, 1998). I have discovered that one of the major shortcomings of the cognitive-behavioral approach is its almost exclusive focus on the conscious part of the mind. The problem with cognitive therapy is that it is too cognitive! It largely emphasizes "left brain" thinking and behavioral strategies.

Quite to the contrary, most psychological problems are difficult to change because they are imprinted in the "right brain." So, to access

and change these "imprints," what is needed is a way to access state-dependent memories (Rossi, 1993; Rossi & Cheek, 1988) stored in the brain's right hemisphere, release the attendant affect, and then change or reframe these memories, thus creating new memories at the cellular level (Rossi, 2002).

Rapid Hypnoanalysis is a technique developed by Cheek and LeCron (1968), and refined by my co-author (DME) over the past 30 years. It makes it possible to accomplish the above with elegance. It puts the feeling back into brief therapy without taking out the logic or the efficiency. It addresses the whole brain.

I (BNE) have discovered through personal experience that Rapid Hypnoanalysis works. It can help both the healer and the healer's patients. When the healer is healed, it gives the healer conviction in the value of what he is doing. Much of that conviction has been losing steam over the past 15 years as treatment manual guided, "empirically validated therapies" focus exclusively on behaviors and conscious automatic thoughts. Rapid hypnoanalysis offers a refreshing alternative that allows therapists to go deeper while being even briefer. Rapid hypnoanalysis is not difficult to learn to practice and is very satisfying to practice because you get to see results.

B.N.E.

INTRODUCTION

The technique we describe in this book is applicable to treating sane patients with psychoneurotic disorders. It is a method of doing deep therapy briefly using hypnosis. Sigmund Freud abandoned hypnosis early in his career because his hypnotic method was to employ direct suggestions and authoritative hypnosis. He found that his suggestions just wouldn't hold and he got symptom substitution. His problem, at the time he was using hypnosis, was that his technique didn't help the patient develop any understanding of what the problem was. Freud's emphasis on sex overlooked the fact that reproduction is only the second law of nature, and the first is self-preservation. It was good that Freud wasn't a good hypnotist and went on to develop deeper understanding of psychodynamics through psychoanalysis.

Our technique helps us uncover and reframe the pathogenic fixed idea/s underlying the patient's problem and symptoms. We have found that by analyzing when and where the symptom started, and under what circumstances, we have been able to achieve long-term cures for many presenting problems in about five visits.

Nothing Happens for No Reason at All. Nothing happens for no reason at all. There's a reason why somebody has got a headache. There's a reason for whatever goes on. In psychosomatic problems, such as headaches, itching, stomach aches, irritable bowel, chronic coughs, and asthma, the "reason" is usually subconscious, and the patient cannot verbalize it. The patient doesn't know what the reason is. But all behavior, and all symptoms have a reason.

We view it as our job to find the reason and reframe it–to appropriately *re-interpret* the need for the presenting dysfunctional behavior. This can then lead to replacing the symptom with a more appropriate functional behavior, or helping the patient accept that the behavior can be modified or eliminated without the necessity of replacing it.

Symptoms as Inappropriate Coping Methods. Symptoms and symptomatic behavior are viewed as inappropriate, negative coping methods; leftover dysfunctional behaviors that started as a way of coping with some stressful situation (Zarren & Eimer, 2002). They continued because of repetitious imprinting and habit formation. When they are no longer needed as methods of coping with external reality, they are behavioral remnants from the past. They are viewed as a continuing attempt to cope with an old emotional wound in a manner that is no longer needed.

Throughout this book, we use the term *subconscious* rather than *unconscious* because some patients assign a negative connotation to the term "unconscious." By "subconscious" we refer to the nonverbal part of the mind that is involved in implicit learning. The patient knows it, feels it, believes it, and acts on it, but cannot express it verbally. It is usually associated with the right hemisphere of the brain and self-preservation.

It is the duty of the subconscious mind to protect the person. Sometimes we call it "instinct." Sometimes we call subconscious responses "intuitive" or "reflexive." Once you've heard the screech of brakes, you have an implicit, self-protective, mental and muscular reflex to the next screech, even if it's way down the street.

We know that when we change an idea, we can often change an illness. It is in the subconscious that fixed ideas are imprinted and reside. Insight-oriented psychotherapy is often more effective and permanent in facilitating change than suggestive and behaviorally-oriented therapies. This is because insight-oriented therapy addresses the subconscious fixed ideas that keep people from getting well.

When we do rapid hypnoanalysis, we want to find out what fixed idea the patient is clinging to that is making him or her sick. Often, it is NOT what seems apparent to the therapist or the patient's family, nor is it consciously available to the patient. After setting up ideomotor signals as described below in detail, our first request for an ideomotor response (IM) is *"Is it all right with your deepest feeling mind for me to help you with this problem?"* The usual (sometimes hesitant) "yes" response to this seems to seal the therapeutic alliance, and in our experience, therapy then proceeds more easily.

After this, we can start right in to questioning the patient about the seven common causes of psychosomatic illness so well described by Cheek and LeCron (1968). These are "conflict, organ language, motivation, past experience, identification, self-punishment and suggestion."

The optimum time to reframe the pathogenic fixed idea is when it is first identified–it is most pliable at the moment of insight! Often, we are able to accomplish successful therapy with this technique in 3 to 5 visits.

The first visit is devoted to conducting the intake evaluation and giving the patient his or her first brief experience of a hypnotic induction. The second and third visits focus on uncovering, identifying and reframing the fixed idea/s that have been hinted at in the intake. IM signals are set up in the second visit and are employed for reviewing the patient's sensitizing experiences and diagnosing the fixed idea/s. The information obtained in the intake is drawn on and consolidated into the analysis.

Each session is ended by debriefing and verbally processing the session with the patient who, at that point, may still be in a light trance state. The fourth or fifth session is devoted to debriefing with the patient about the therapy and consolidating any remaining unfinished business into the reframed fixed idea/s. If it is indicated, we make a personal self-hypnosis tape for reinforcement at home.

On occasion, it is possible to conduct a "marathon session" (3 to 5 hours) in which all 4 or 5 of the above sessions are combined into one long session. Marathon therapy has the added advantage of really "striking while the iron is hot."

This approach is not like psychoanalysis in terms of aiming to change the overall personality. It is directed at one specific problem at a time with attention being devoted to solving that problem. For example, if a patient comes in with a number of complaints such as migraines, obesity, and insomnia, we ask the patient the following: *"If you could solve only one problem right now, which would it be?"* All the succeeding questions in the intake are built around the initial question, *"Tell me about your problem."*

We do this so that we can have a goal by which we can measure success. Frequently in the process of getting to this goal, some of the coexisting problems clear up too.

A useful metaphor for this approach is a computer metaphor. The patient comes in with a complaint or series of complaints that, unbeknownst to the patient, are driven by a pathogenic fixed idea. This is analogous to a bad line in a computer program that gives an error message every time the program is run. The cure is to find the bad line and to correct it.

Milton Erickson said "the symptom is a solution" (Erickson, 1986). We need to find the very FIRST time the patient subconsciously got the idea that the headache, cough, etc., (whatever the symptom is) was a solution, rather than the problem that it is now. The goal is to help the patient accept on a feeling level that even though it may have worked at a time in the past, it now has outlived its usefulness and no longer has any value.

ACKNOWLEDGMENTS

We gratefully acknowledge our patients who have entrusted us with their secrets in the hope that we might help them obtain relief from their symptoms. In our efforts to help them, we continue to gain valuable experience that we can pass on to our students. We also thank our students whose questions continue to stimulate our search for more efficient and compassionate ways of helping. Teaching and doing therapy and hypnosis keep us young. We are grateful to our students and our patients for teaching us.

Bringing a good book to fruition requires the help of a good publisher. We gratefully acknowledge Michael Thomas of Charles C Thomas for recognizing the value of this work and continuing to support this project.

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We both express our heartfelt appreciation to David B. Cheek, M.D., the father of modern ideomotor hypnoanalysis techniques, for his kind and gentle guidance as a mentor and friend to both of us.

Last but not least, we thank our families, my (DME) wife Marilyn, and my (BNE) wife Andrea, and my (BNE) mother Cecile, for their loving support and encouragement.

Disclaimer

The clinical evaluation and treatment methods described in this book are NOT intended as substitutes for appropriate, individual, medical, psychiatric, or psychological, evaluation and care. This book is NOT intended to replace the professional recommendations of licensed physicians and other licensed health professionals who are familiar with a given case. If expert medical or psychological assistance, counseling, therapy, or hypnosis are needed, the services of a competent health professional should be sought.

This book is designed to provide accurate and authoritative information in regard to the subject matter covered; clinical hypnosis and hypnoanalysis. It is intended to offer usable information that can enhance the effectiveness of the reader/clinician in helping his or her patients.

However, it is written and sold with the understanding that no book can replace attendance at live workshops, individual supervision and consultation, clinical experience, and therapy.

Although this book is intended primarily for experienced health care clinicians, as a source of practical, usable information about how to do hypnoanalysis using ideomotor methods, we recognize that this book may be of interest to the intelligent layperson with an interest in hypnosis.

However, we do not support the *lay* practice of hypnosis, or the training of *laypersons* in the use of hypnosis. By "practice" we mean providing hypnosis, or offering to do so, to individuals or groups, whether for a fee or for free. By "layperson" we mean a person (a) with NO accredited professional education or clinical training in a licensed health care discipline, and (b) who has NOT pursued a degree, from a regionally accredited institution, in a recognized, professional health care discipline.

Note that the identities of all patients described in the case examples and transcripts presented in this book have been disguised to protect and preserve patient confidentiality.

For simplicity, throughout this book, instead of using "he/she" and "his/her" to refer to a single patient, we will use the male pronoun.

Dabney M. Ewin
Bruce N. Eimer

CONTENTS

IDEOMOTOR SIGNALS FOR RAPID HYPNOANALYSIS

PART I
BASIC CONCEPTS

Chapter 1

IDEOMOTOR SIGNALS: THEIR VALUE IN HYPNOTHERAPY

One of the casualties of the limited time in our basic workshops is that we must gloss over the remarkable value of ideomotor (IM) signals, noting only that they can be useful, giving a short demonstration, and admonishing participants to read about the details of the technique. It is easy, the uses are many, and the time use is efficient.

IM signals are body language, and anyone can read the "yes" and "no" language of ideomotor signals, as opposed to the complicated art of reading body language in general, which is a science unto itself. In the diagnosis and treatment of nearly every patient, there is a place for this form of nonverbal communication.

Insight-Oriented Therapy. Insight-Oriented Therapy is often much more effective and permanent than direct or indirect suggestion. We know that when we can change an idea, we change an illness. But what is the fixed idea that the patient clings to that makes him sick? Often, it is NOT what seems apparent to the therapist or the patient's family, and it is not consciously available to the patient.

Repeating for emphasis what we said before, our first request for an ideomotor response is to ask, *Is it all right with your deepest feeling mind for me to help you with this problem?* The usual (sometimes hesitant) "yes" response to this seems to seal the therapeutic alliance, and in our experience, therapy goes more easily than it did before we started using this as an opening question.

After this, we can start right into questioning about the seven common causes of psychosomatic illness so well described by Cheek and LeCron (1968). These are conflict, organ language, motivation, past experience, identification, self-punishment, and suggestion. The opti-