HYPNOTIC RESOURCE GRAFTING MANUAL

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Introduction

First it should be made clear that HRG is a strategy and not a protocol. The trauma and schema protocols described in this manual are a subset of an infinite number of viable variations. However, there is a core within the HRG strategy that should ideally be replicated for each protocol:

1. A fear-laden target memory is first activated.

2. A negative cognition is associated from the target memory

3. A desired contradictory positive cognition is chosen by the patient for possible replacement of the negative cognition.

4. Positive resource memories are located by the patient in which the positive cognition felt true.

5. The patient experiences the resource memories and associates the evoked emotions into body locations and colors.

6. The patient reactivates the initial target memory while body associations from the resources are maintained.

7. Hypnotic placebo techniques are used to catalyze associations between the resource body associations and the target memory.

In addition to the afore mentioned core elements, the following protocols incorporate several factors that are designed to enhance therapeutic effectiveness:

- The patient is taught how to use body posture and syntax to facilitate a sympathy meta-motivational state (joining with) instead of a mastery state (acting upon). The sympathy state is a meta-motivational dimension from Reversal Theory. The current authors theorize that such a sympathy state can facilitate contextual learning during HRG. The initial Sympathy State Protocol prepares the patient to use these methods in later HRG steps.

- The patient is guided to use requests when dialoguing with resourced parts of his/her mind. This is designed to avoid inducing internal reactance to commands. The unconscious seems to relish choice and abhor commands.

- A heavy emphasis is placed on color to represent the resourced part of the unconscious mind. The importance of color has been learned from patient reactions both during and after treatment.

There is a strong similarity between the trauma and schema protocols. One difference is that the schema protocol focuses on increasing the felt validity of the desired positive cognition. The trauma protocol focuses on reducing the trauma disturbance instead. Another difference is that the schema work will almost never require a titration procedure to reduce hyperarousal. In contrast to traumas, schemas are most often embedded in the unconscious by less intense repetitive experiences.

Some detective work is often needed to discern the target schema and most appropriate templating memories. The best way to locate a target schema is to first look for unbalanced behavior. The person who can never play or the person who can't ask for what he/she wants would likely have buried schemas. Another way to uncover a schema is to ask the patient to play with syntax. For example, saying "I want ….. you?" or " I refuse to pretend that I agree with you" can provoke intense discomfort in some patients. By following such verbal discomforts back to their origins, one can uncover the templating memories.

Sympathy State Protocol

1) The therapist first asks permission to guide the client through the training procedure. The client is then asked to follow the therapist's suggestions and replicate the therapist's arm and hand positions.

2) Therapist holds out his/her arms toward the client. Elbows are slightly bent, hands balled in fists with the fingers underneath and back of hand on top. The therapist waits until the client has replicated the posture. If the client's elbows are resting on the lap or on a chair arm ask the client to lift his/her arms so that the arms aren't receiving any outside support.

3) Therapist says: **"Notice how this position feels. Ask yourself, what attitude or feeling is this hand posture sending to the unconscious. If the hands had a face what facial expression would they have? If they had a voice what tone of voice would they have? Notice the attitude."** (Therapist waits about 7 seconds so that the client can experience the felt sense of the posture)

4) Therapist says: **"Now try doing this."** The therapist then shifts hand position so that his/her hands are completely open, palms up, fingers only slightly bent and arms still extended. (Therapist waits until the client replicates the position.) Therapist says **"Notice how that feels. Notice the attitude."** (Waits another 7 seconds for the client to experience it).

5) Therapist then reverses hands back to the first position of fists facing down. **"Do this again.....Notice how it feels."** (Therapist waits about 7 seconds for the client to replicate and experience it."

6) Therapist says: **"Now do this."** (Therapist reverses position again to open palm up position." **"Notice how it feels."** (Waits 7 seconds)

(The therapist keeps his/her own arms extended for the rest of the whole protocol to encourage the client to keep the same arm position). Therapist's hands start off in neither of the two positions but rather in an ambiguous position of palms facing each other.)

7) Therapist asks: **"Which position is controlling?"** (Therapist waits until the client gestures with his/her hands to indicate his/her choice. The client always indicates the closed fist down position.)

8) Therapist asks: **"Which one is accepting?** (Therapist waits for client's choice, always palms up.)

9) Therapist asks: **"Which one is rejecting?"** (Therapist waits for client's choice.)

10) Therapist asks: **"Which one is connecting?" (**Therapist waits for client's choice.) This

sequence of questions will lead to open palm up posture in almost every case. If not, then the client's associations should be explored.

11) Therapist replicates the open palm posture and says with positive emphasis **"That's right! It's this position isn't it? It's not this."** (Therapist gestures with the closed fist down position).

12) Therapist then reverses hand position to open palms up and says: **"We feel we are ready to connect when we're ready to receive, not when we have to be in control."** (Waits a few seconds for any questions or discussion)

13) Therapist says: **".....Now I'm going to ask you to keep your hands up and do this."** **(**Therapist starts slow beckoning movement in the fingers of both hands and waits for the client to replicate.)

14) Therapist says: **"Now notice how the movement keeps sending a stream of information to your brain about your posture. If you kept still and didn't move then your mind would habituate and after a while it wouldn't get much of a message. If you keep moving very slightly it adds kinesthetic information to keep reminding your brain that you're ready to connect."**

15) Therapist (with arms still up and with open palms beckoning) says:: **"Now let's play with some words to go along with the posture. Let's see how it feels.... Would you try saying this right after me? ….....** (Waits about 3 seconds and pair the next words with the open palm posture) ..... **"Help me."** ….. (Waits until client replicates the words) **"OK. Notice how that feels."** (Waits about 7 seconds for the client to experience the felt sense.)

16) While still holding arms out with open palm poster, the therapist says **"Now say this."** (Waits 3 seconds.) **"<u>Will</u> you help me?" ….....** (Waits about 7 seconds for the client to repeat the words and experience the felt sense.)

17) Therapist asks: **"Which one is more respectful?"** (Client will invariably say "Will you help me?"

18) Therapist emphasizes **"That's right! The unconscious is hungry for choice. It loves to be asked and hates to be commanded…..so this is what we do. We ask politely."**

19) With arms still up with open palms, the therapist says **"OK, now let's try this. …... Say…...'Will you help me?"** (Therapist waits for client to repeat.)

20) Therapist then says: **"Now say…..... Will you help us? "** (Therapist waits for the client to repeat."

21) Therapist asks **"Which one implies more connection? Help me or help us?"** (Therapist waits a few seconds and then says this: **"Notice this"** (Therapist holds hands

vertically about 6 inches apart and then says the following while simultaneously moving the hands further apart a few inches) **"Help <u>us</u>"** (Therapist moves hands closer together again while saying:) **"Help <u>me</u>"** (Hands moving apart again:) **"Help <u>us</u>"** (Hands moving towards each other again:) **"Help <u>me.</u>**"

22) Therapist says **"Notice that when you say "us" it implies in the frame of the question that you're already connected to a larger group. Can you guess who 'us' is?"** (therapist waits for the client to guess. The therapist then discusses how the "us" is the conscious self and all the little unconscious parts of self that are listening in.

23) With arms still up and hands beckoning, the therapist says **"Now let's try saying this: ..... Will you help us by lending your wisdom and perspective to this difficult experience? "** (Therapist waits for the client to repeat and experience the felt sense for a while.) Therapist explains **"..... and this is what we will be using in our future work. One part of your mind will be asking another part of your mind to make an unconscious connection. It's a very useful technique to heal painful or traumatic memory.**

HRG Trauma Protocol

The following is one of many ways that HRG can be performed. HRG is a strategy and not a specific protocol. However, the following is but one example of a derived protocol that has been successfully applied to trauma cases.

Step 1: Preliminary Sympathy State Invocation Training:

(See Sympathy State Protocol) The patient should be shown the Sympathy State induction procedure before performing other HRG steps. It can be taught in a preceding session to reserve more time in the main HRG session.

Step 2: Initial Exposure:

Today we are going to be working on that disturbing experience_____ and we are going to be focusing on the worst part of that experience.

Let's begin by having you create a memory story like a movie clip of the most disturbing part of that experience. Let go of the room, let go of me and locate a logical starting point and natural stopping point. Would you be willing to do that? Ok, let me know when you have finished reviewing the memory.

NC: **What negative words go best with this experience that express the momentary negative belief about yourself? I am what?**
_____ *(NC)*

PC: **When we are finished, and you feel differently, what would you like to believe about yourself instead? I am what? _____** *(PC)*

(Note – If the patient becomes hyper-aroused at the start of this step, it is best to alter the procedure with titration. See the Box Titration method following this procotol.)

Step 3: Resource Memories

Let's go ahead and put this movie clip aside for now and I would like for you to identify 3 memories from adulthood when you really felt _____ *(PC)* (strong, safe, brave, lovable, etc.). **Let me know when you have them.** (Client gives the resource memories titles)

1. _____
2. _____
3. _____

Would you pick which one of your resource memories is most inspiring to you? (Make note of the memory to use throughout the protocol)

Step 4: Pre-exposure to Trauma Memory

Now, I am going to ask you to go back and play the disturbing movie clip that you created earlier and locate the worst 10 seconds of that experience. Let me know when you have it. (Wait for client's signal.)

Would you describe what is happening? (client describes visual details)

In addition to _____ (described picture)**, what other sights, sounds, smells do you find most disturbing.** (client describes). **Take a moment to notice all of these sensory details as you focus on the movie clip that you created.**

Right after you bring up this experience, how true to the words _____ *(PC*) **feel to you right now? ..... On a scale 1-7, with 1 meaning it feels completely false and 7 means it feels completely true.**

Now, I am going to ask you to pair the negative words _____ (NC) **with the disturbing memory. Hear them echoing in the back of your mind as you play the memory one more time and see _____ and hear _____, and smell _____. Tell me when you have it.**

What emotion are you feeling right now? _____ *(emotion)*

Where in your body do you feel this disturbance? _____ *(location)*

Go ahead and play all the sensory details of the disturbing experience as you hear the negative words _____ *(NC)* **and notice the disturbance in your body.**

On a scale 0-10, how disturbing does it seem to you right now? _____ *(SUD Level)*

Step 4: First Exposure to Resource Memory

Now, I would like for you to bring up the first resource memory that we identified earlier:

_____ *(title).*

Play the memory for about a minute and create a visual story like a movie clip as if you were a movie producer.

Now locate the moment where you feel most strongly that you are *(PC)* _____. (Wait until the patient locates it.)

Would you be willing to step into the moment as if it's happening now? (Get patient's consent) **OK, go ahead and step into it now.**

What emotion do you feel in this situation? _____ *(defined emotion)*

Would you be willing to let that emotion grow stronger from this experience? (Get patient's consent**) Good, just let me know when it's real strong.** (Wait until the patient signals)

If your _____ *(emotion)* **were to resonate to your body, where would it resonate the most? Go with your first association. _____** *(body location)*

If your _____ *(emotion)* **were to have a color, what color would it have? Go with your first association. _____** *(color)*

If your_____ *(emotion)* **were to have a temperature, would it be hot, warm, cool or cold?" _____** *(temperature)*

Would you be willing to let your _____ *(body location)* **serve as a conduit so that it can absorb and spread these feelings throughout your entire body?** (Get consent). **…. So, keeping a dual attention on this inspiring experience and your body, let the _____** *(color),* **_____** *(temperature)* **feeling in your _____** *(body location)* **start to spread to other parts of your body** (Therapist guides client very slowly to various parts of the body**) Going up your neck, head, face. Moving down your arms, hands and fingers. Making its way down your chest and torso. Moving into your legs and feet.**

(Therapist continues) **Let yourself feel the _____** *(color)* **knowledge that you are _____** *(PC*) **throughout your entire body, seeping deeper and deeper into your muscles, filling every cell of your body, allowing it to resonate even in your bones. You can let me know when it's really with you.** (Wait for signal from the patient)

Now, I have an important question to ask you: If your _____ *(color),* **_____** *(emotion)* **feeling in your body could act like an unconscious medicine to help you heal your other disturbing memory ……. would you let it?** (Get the patient's consent)

And for this to happen would you be willing to let your _____ *(color),* **_____** *(emotion***) stay in your body while the scene changes around you and you remain constant so that you're still feeling those feelings in your body while you are also in the scene of your disturbing memory?** (Get the patient's consent)

So, letting that happen…… Tell me when you are in the challenging memory. (wait for confirmation) **Are you still connected to the _____** *(defined color***) in your body?**

Step 5: First Interactive Exposure to Trauma Memory

Now, I am going to measure out about 6 minutes and I am going to ask you to do 3 things at the same time:

First hold your arms with your palms up like you learned before.

Second, notice as much detail in your challenging experience as if you are in it and it's happening now.

Third, you can ask the _____ (color) **part of your mind for help by using your internal voice as you make a series of respectful requests. You can start with:**

- **Will you help us by painting your _** *(color)* **wisdom into this experience?**

And I will give you another one in about a minute or you can let me know if you need it sooner.

Ready? Go ahead and start. (Repeat the starting request if necessary.)

(The therapist makes catalytic requests designed to stimulate curiosity. The best requests ask for help to uncover some relationship between the target memory and the resource memory. Examples are as follows:)

- **Will you help us to find the hidden meaning that is common to both our positive and challenging experiences?'**
- **Will you help us to notice the most important difference between our positive experience and our challenging experience?**
- **Will you help us to discover how our positive experience can act like a friend to our challenging experience?**
- **Will you help us to appreciate how our positive experience has something in common with our challenging experience?**
- **Will you help us to discover the important message we have probably overlooked in both our positive and challenging experiences?**
- **Will you help us to notice the way the world is different between our challenging experience and our positive experience?**

(After about 6 minutes**) Okay, lower your hands and take about a minute to meditate on your experience. Let thoughts, images and sensations flow freely without any effort at all. Just be curious and receptive to anything that wants to come.**

After about 3 minutes of the meditation, give the client a chance to share his experience.

Step 6: First Assessment of Residual Disturbance in Trauma Memory

I'm going to ask you to replay the original challenging movie clip again for about 30 seconds. (Silently time out about 30 seconds.) **When you play the movie clip now, how disturbing is it to you right now? (0-10)**

SUD Level: **_____**

(If SUD greater than 0:) **What sensory details contribute most to your disturbance now?**

Step 7: Second Exposure to Resource Memory

Okay, Let's put this movie clip to the side and go back to your most inspiring moment of your resource memory _____ *(title).* **Let me know when you're there.** (Wait for confirmation)

Now would you be willing to let your (body location) again drink in more of the _____*(temperature)(color)* **from this experience?** *(Wait for confirmation)* **Good. So as you experience this again let the _____***(color)* **spread out through your body, flowing…..and deepening…….as you notice and accept that you are _____***(PC)***.** (Wait about 30 seconds) **. Let me know when the feeling has gotten quite strong.** (Wait for confirmation)

Now would you let your _____*(temperature)(color)* **remain in your body while the scene changes around you and you are back in your challenging memory like before?** (Wait for confirmation) **OK. So letting that happen …….. Let yourself see the scene as of it's happening …… Are you there?** (Wait for confirmation) **…….. and is the _____** *(color)* **still with you?** (Wait for confirmation)

Step 8: Second Interactive Exposure to Trauma Memory

(Repeat Step 5 with new catalytic questions. Then repeat Step 6 up to the point of having obtained a SUD level.)

If level is higher than 1, repeat steps 6 and 7. If 1 or lower, check if the PC seems true now.

If residuals remain then another session may be required. It is best to guide the patient to thank the _____ **(defined color)** part of his mind for helping him in the session.

Optional Box Titration

The HRG trauma procedure may be adapted for clients who hyper-arouse during initial exposure to the target memory. The following is a general description.

After a resource memory has been fully anchored into body associations the patient is asked to stay in his/her resource location instead of suggesting that the context will change. The patient is asked to place his box somewhere in his/her imagined resource location so that he/she can occasionally glance at it when instructed. He/she is subsequently asked to pendulate between noticing the resource events and occasionally looking at the box. Exposure to the box may be gradually increased from very brief exposures to prolonged exposure. The patient is also instructed to use the open-palm sympathy state posture while making processing requests to the colored resource part of his/her mind. When making the processing requests, the patient is guided to make his/her requests with reference to "what's in the box". Two important features pertain to the box titration method. First, it keeps the patient associating his/her self as if the patient is in the resource context. Second, it implies a spatial contextual relationship between the resource context and the trauma scene. There are many other methods that can also be used for titrating exposure to the trauma memory. In HRG these titration methods are usually not required except for the most traumatized cases.

Start Time: _____ **HRG Trauma Worksheet** **End Time_____**

Name: _____ Date: _____ Memory: _____

Picture: What picture represents the worst part of the experience? What sight, sound and scent aspects were most disturbing in that moment?

SUD Scale: On a scale from 0 to 10 where 0 is neutral, no disturbance and 10 is the highest disturbance you can imagine, how disturbing does the picture (or experience) feel to you now?

0	1	2	3	4	5	6	7	8	9	10
No disturbance										**Highest dist.**

Negative cognition (NC): What negative words go best with this experience that express the momentary negative belief in yourself that this experience stirs up? (If previous sessions: What negative words go best with this experience that express any residual momentary negative belief in yourself? Is there any momentary negative belief about yourself that gets stirred up by the memory today? Do the words ….....still fit or would the words be different today?)

Positive cognition (PC): When you bring up that picture (or experience), what would you like to believe about yourself now?

Resource memories: Will you locate three memories from adulthood when you've already experienced feeling (Pt's positive belief) was true of you in that moment? We need three moments or scenes that you can recall and visualize. I don't need to know the details, just give me a title for each memory:

1)_____ Body Assoc. _____

2)_____ Body Assoc. _____

3)_____ Body Assoc. _____

Ask the patient to re-experience all the sensory elements of the negative picture again.

Validity of cognition (VoC) (PC only): As you bring up that picture (or experience), how true does the (PC) **feel** to you **now** on a scale of 1 to 7 where 1 means it feels completely false and 7 means in feels completely true?

1	2	3	4	5	6	7
Completely false						**Completely true**

Emotions from picture and NC: When you bring up the negative picture (or experience) and the words (NC), what emotions do you **feel now**?

Location of body sensation: Where in your body do you feel it?

(Now ask the patient to hold the negative picture, the NC and the body sensations all together)

Defining Schemas

Defining schemas requires a bit of detective work. The process is to find out how to define the elements and origins of the following unconscious rule:

If X then Y so I MUST always do Z

Where X is some adaptive behavior or action that is NOT happening; and

Where Y is some feared consequence or negative self-perception that would occur if X did in fact occur; and

Where Z is an automatized defensive action that counteracts and prevents X

Example: If I enjoy having fun or pleasure then I will be targeted and hurt so I must always stay responsible and take care of business.

X = Enjoy fun or pleasure Y = Be targeted and hurt Z = Stay in responsibility mode

The reason patients develop such an unconscious rule is because of classical conditioning in the unconscious. During childhood, an antecedent behavior/action X becomes over-coupled with some painful consequence Y. This is usually learned via Pavlovian conditioning without the patient's awareness. The child may then learn to use a defensive action Z to avoid the anxiety-evoking antecedent behavior/action X. The behavior/action Z prevents the toxic X - Y chain from happening. The whole sequence becomes unconsciously automatic so that behavior/action X is routinely avoided without the patient even being aware of it. The reason why "action" needs to be considered and not just behavior is because internal actions can become over-coupled with toxic consequences as well. For example, patients can become conditioned to avoid trusting or hoping.

Initial clues:

There are two ways to initially detect maladaptive schemas. The first is to observe an imbalance in the patient's behaviors. This is often indicated by an overemphasis on a class of behavior or actions so that other behaviors or actions are NOT happening. The therapist and patient need to discuss the best descriptions of both antecedent X and defensive action Z. The patient's judgement is the final verdict of what fits.

The following examples illustrate how some actions are avoided by counteracting them with somewhat compulsive reactions.

"I must always give others what they want" (Not happening: Setting limits to sometimes protect an equitable balance between self-interest and generosity to others)

"I must always do a task perfectly" (Not happening: Acceptance of limited resources such as time and effort; also, self-compassion and forgiveness of normal human imperfection)

"I must always make sure that others are happy" (Not happening: Respecting others' responsibility for their own happiness; allowing others to be frustrated; protecting equity or personal boundaries)

"I must always be pleasant" (Not happening: Constructive confrontation of irresponsible behavior to seek a correction in a relationship)

"I must always give a task 100 %" (Not happening: Setting limits in order to budget reasonable time and effort and avoid stress)

"I must always keep things in order" (Not happening: Sometimes allowing relaxing states to enjoy receptive experiences)

"I must always be on guard" (Not happening: Trusting in others to allow friendship or intimacy)

The second way to detect maladaptive schemas is to ask the patient to evaluate his/her comfort with saying certain expressions out loud. For example, the patient may be asked to say one of the following expressions several times and then assess his/herr feelings immediately afterwards.

"I want……will you?"

"It's my turn. It's time to enjoy myself and have some fun."

"I refuse to pretend that what you just did is OK with me."

"I'd like to spend some time with you…Would you like that too?"

"I deserve to have some fun and pleasure in my life."

"I was speaking. Let me finish what I was about to say."

"I know you're frustrated but you don't have the right to expect that of me."

Negative emotional reactions to verbalizations such as these may range from mild discomfort to nausea or even full abreactions. Strong reactions are usually confirmation of significant maladaptive schemas. The therapist needs to be creative in devising a fitting verbalization to test out ferret out the hidden anxiety. It will depend on what the therapist has observed where the patient is avoiding adaptive functioning in his/her life. Is the patient avoiding fun and constantly staying in a responsibility state? Is the patient avoiding constructive confrontation and always complying with expectations of others? Is the patient avoiding asking for others' choices and gives commands instead? These are the types of questions the therapist needs to be asking him/herself.

Step 3: Define the feared consequence if the patient were ever to execute the adaptive action

The therapist can simply ask the patient to imagine executing the adaptive action and to freely associate to what would happen next. Examples:

"Imagine saying to your partner 'It's my turn. I want to enjoy my choice now.' What do you imagine would happen next?"

"Imagine holding up your hand when someone interrupts you and saying 'I was speaking. Let me finish what I was about to say.' What do you imagine would happen next?"

"Imagine that you're letting yourself do something fun and not carrying out some responsibility. What do you imagine would happen?"

From the patient's associations, the therapist needs to tease out the irrational imagined consequence. (e.g. "That would mean I'm 'selfish and bad.'"; "I feel like I'd be rude because I wouldn't be nice."; "I feel like I'd be targeted and attacked.")

Step 4: Define some typical templating memories that trained in the schema

Once the patient has associated an irrational and unrealistic consequence, the therapist needs to ask the patient **"When did you actually experience consequences like that when you were much younger?"** The task is to obtain memories when the currently maladaptive schema originally fit the patient's younger environment. For example, the parent may have reacted sadistically at the sight of the younger patient having fun. Another example may have been that siblings may have reacted negatively if the younger patient were to ask for any attention of an overwhelmed single mother. It's best to obtain several templating memories that fit the maladaptive schema.

HRG Schema Protocol

The following HRG-Schema protocol closely parallels HRG-Trauma desensitization. The biggest difference is in the target. HRG-Trauma targets a traumatic memory that has generated a shameful negative belief. HRG-Schema targets one of many similar templating memories. The templating memories usually involved caregivers who repetitively trained the patient to expect toxic consequences to a class of behavior. For example: If I ask for what I want I will be painfully ignored or punished. Another example: If I let others see that I'm enjoying myself I'll be targeted and hurt. It is important that the therapist help the patient to accurately define his schema before starting HRG work. One can usually start defining a dysfunctional schema by noticing a patient's maladaptive defensive behavior. For example: The patient may give commands instead of asking others for what he wants. He may focus on work and chores instead of enjoying himself.

The second major difference between HRG trauma and schema protocols is that HRG trauma work focuses on reducing the disturbance to a traumatic memory. HRG schema work focuses on increasing the felt validity of an adaptive replacement rule (PC) to take the place of a negative schema.

Step 1: Preliminary Sympathy State Invocation Training:

(See Sympathy State Invocation Protocol) The patient should be shown the Sympathy State induction procedure before performing other HRG steps. It can be taught in a preceding session to reserve more time in the main HRG session.

Step 2: Define the Negative Schema and Desired Replacement Rule:

Therapist asks: **"What negative pattern usually knocks you off balance? A negative schema usually takes the pattern of 'If I do behavior X then some toxic Y consequence will occur.' For example: 'If I don't meet another's expectations then I'll be unbearably hurt.' You usually have some maladaptive defense Z that your unconscious has designed to avoid the consequence. For example: "'If I don't meet another's expectations then I'll**

be criticized and unbearably hurt ……so I must always obey what I think the other person expects.'

Can you define the schema that's been knocking you off balance?"

If X:

_____

Then Y:

_____

Now can you define a replacement rule that you would like to have operating instead of the old negative schema? For example: "If I don't meet another's expectations then I may or may not be criticized and if I'm criticized then I can focus on my core values and keep myself safe."

If X (Same as before):

_____

Then Y (New):

_____

This replacement rule has now defined the replacement positive cognition (PC)

Now can you find a childhood memory where you were likely taught your negative schema? It could be one of hundreds of similar memories. It could also be very subtle but because there are so many similar memories the schema got buried deep.

Templating target memory:

_____

_____

Step 3: Resource Memories

Now can you find 3 <u>adult</u> memories when you really felt that your replacement rule was true at and applied at that time? (Repeat the defined replacement rule for the patient.) **Let me know when you have them.** (Ask the patient to give each resource memory a very brief title.)

1) **_____ (Title)**
2) **_____ (Title)**
3) **_____ (Title)**

Would you pick which one of your resource memories is most inspiring to you? (Make note of the memory to use throughout the protocol)

4: Preliminary Exposure to Templating Memory

Now, I am going to ask you to go back and play the templating memory for your negative schema. Can you locate the worst 10 seconds of that memory? Let me know when you have it. (Wait for client's signal.)

Would you describe what is happening? (client describes visual details)

In addition to **_____** *(described picture***), what other sights, sounds, smells do you find most disturbing?** (client describes) **Take a moment to notice all of these sensory details as you focus on the movie clip that you created.**

Right after you bring up this experience, how true to the words_____ *(PC)* **feel to you right now? ..... On a scale 1-7, with 1 meaning it feels completely false and 7 means it feels completely true.**

Now, I am going to ask you to pair the negative words _____ *(NC)* **with the disturbing memory. Hear them echoing in the back of your mind as you play the memory one more time and see _____** *(described picture)* **and hear _____** *(described sound),* **and smell _____** *(described scent).* Tell me when you have it.

What emotion are you feeling right now*?* **_____** *(emotion)*

Where in your body do you feel this disturbance? _____ *(location)*

Go ahead and play all the sensory details of the disturbing experience and notice the disturbance in your body. (Let the patient play the disturbing memory for about 20 seconds) **OK. Can you pause the memory now like you would on a DVD player so we can come back to it later?**

Step 5: First Exposure to Resource Memory

Now, I would like for you to bring up the first resource memory that we identified earlier: _____ *(title).*

Play the memory for about a minute and create a visual story like a movie clip as if you were a movie producer.

Now can you locate the moment where you feel most strongly that your desired replacement rule is true? (Repeat the patient's PC to remind him. Wait while the patient locates his PC moment.)

Would you be willing to step into the moment as if it's happening now? (Get patient's consent) **OK, go ahead and step into it now.**

What emotion do you feel in this situation? _____ *(defined emotion)*

Would you be willing to let that emotion grow stronger from this experience? (Get patient's consent) **Good, just let me know when it's real strong.** (Wait until the patient signals)

If your _____ *(emotion)* **were to resonate to your body, where would it resonate the most? Go with your first association. _____** *(body location)*

If your _____ *(emotion)* **were to have a color, what color would it have? Go with your first association. _____** *(color)*

If your _____ *(emotion)* **were to have a temperature, would it be hot, warm, cool or cold?" _____** *(temperature)*

Would you be willing to let your _____ *(body location)* **serve as a conduit so that it can absorb and spread these feelings throughout your entire**

body? (Get consent**). …. So, keeping a dual attention on this inspiring experience and your body, let the _____** *(color),* **_____** *(temperature)* **feeling in your _____** *(body location)* **start to spread to other parts of your body.** (therapist guides client very slowly to various parts of the body**) Going up your neck, head, face. Moving down your arms, hands and fingers. Making its way down your chest and torso. Moving into your legs and feet.**

(Therapist continues) **Let yourself feel the _____** *(color***) felt sense that _____** (Repeat the patient's **PC** out loud:) **_____throughout your entire body, seeping deeper and deeper into your muscles, filling every cell of your body, allowing it to resonate even in your bones. You can let me know when it's really with you.** (Wait for signal from the patient)

Now, I have an important question to ask you: If your _____ *(color),* **_____** *(emotion***) feeling in your body could act like an unconscious medicine to help your desired replacement rule to replace your obsolete negative schema……. would you let it?** (Get the patient's confirmation.)

And for this to happen would you be willing to let your _____ *(color),* **_____** *(emotion)* **stay in your body while the scene changes around you and you remain constant so that you're still feeling those feelings in your body while you are also in the scene of your disturbing memory?** (Get the patient's confirmation.)

*S***o, letting that happen…… Tell me when you are in the challenging memory.** (wait for confirmation) **Are you still connected to the _____** *(color)* **in your body?**

Step 6: First Interactive Exposure to Templating Memory

Now, I am going to measure out about 6 minutes and I am going to ask you to do 3 things at the same time:

First hold your arms with your palms up like you learned before.

Second, notice as much detail in your challenging experience as if you are in it and it's happening now.

Third, you can ask the _____ *(color)* **part of your mind for help by using your internal voice as you make a series of respectful requests. You can start with:**

- **Will you help us by painting your _** *(color)* **wisdom into this experience?**

And I will give you another one in about a minute or you can let me know if you need it sooner.

Ready? Go ahead and start. (Repeat the starting request if necessary.)

(The therapist makes catalytic requests designed to stimulate curiosity. The best requests ask for help to uncover some relationship between the target memory and the resource memory. Examples are as follows:)

- **Will you help us to find the hidden meaning that is common to both our positive and challenging experiences?'**
- **Will you help us to notice the most important difference between our positive experience and our challenging experience?**
- **Will you help us to discover how our positive experience can act like a friend to our challenging experience?**
- **Will you help us to appreciate how our positive experience has something in common with our challenging experience?**
- **Will you help us to discover the important message we have probably overlooked in both our positive and challenging experiences?**

(After about 6 minutes:) **Okay, lower your hands and take about a minute to meditate on your experience. Let thoughts, images and sensations flow freely without any effort at all. Just be curious and receptive to anything that wants to come.**

After about 3 minutes of the meditation, give the client a chance to share his experience.

Step 7: First Assessment of Positive Cognition

I'm going to ask you to replay the original challenging movie clip again for about 30 seconds. (Silently time out about 30 seconds.) **Right after you bring**

up this experience, how true to the words _____ *(PC)* **feel to you right now? ..... On a scale 1-7, with 1 meaning it feels completely false and 7 means it feels completely true.**

Step 8: Second Exposure to Resource Memory

Okay, Let's put this movie clip to the side and go back to your most inspiring moment of your resource memory _____ *(title).* **Let me know when you're there.** (Wait for confirmation)

Now would you be willing to let your (body location) again drink in more of the _____*(temperature)(color)* **from this experience?** *(Wait for confirmation)* **Good. So as you experience this again let the _____***(color)* **spread out through your body, flowing…..and deepening…….as you notice the felt sense that _____**(Repeat the patient's PC out loud and then wait about 30 seconds) **. Let me know when the feeling has gotten quite strong.** (Wait for confirmation)

Now would you let your _____*(temperature)(color)* **remain in your body while the scene changes around you and you are back in your challenging memory like before?** (Wait for confirmation) **OK. So letting that happen …….. Let yourself see the scene as of it's happening …… Are you there?** (Wait for confirmation) **…….. and is the _____** *(color)* **still with you?** (Wait for confirmation)

Step 9: Second Interactive Exposure to Templating Memory

(Repeat Step 6 with new catalytic questions. Then repeat Step 7 up to the point of having obtained a new validity measure for the desired PC)

If level is less than 7, repeat steps 6 and 7.

If PC remains retarded then another session may be required. It is best to guide the patient to thank the _____ (defined color) part of his mind for helping him in the session.

Start Time: _____ # HRG Schema Worksheet **End Time: _____**

Name: _____ Date: _____ Age When Occurred:_____

Negative Schema: What negative schema is still causing problems in your current life? (If X then Y so I must always do Z)

Desired New Rule: What new rule would you like as a replacement so that you **CAN** do something more productive or adaptive?

Templating memory: What childhood memory is strongly associated with your negative schema?

Picture: What picture represents the worst part of the experience? What's the location? What sight, sound and scent aspects were most disturbing in that moment?

Validity of new rule: As you bring up that picture (or experience), how true do the words (New Rule) **feel** to you **right now** on a scale of 1 to 7 where 1 means it feels completely true and 7 means it feels completely false?

1	2	3	4	5	6	7
Completely false						**Completely true**

Emotions from picture and NC: When you bring up the negative picture (or experience) what emotions do you **feel now**?

Location of body sensation: Where in your body do you feel the disturbance?

Resource memories: Will you locate three memories from adulthood when you've already experienced feeling (Pt's positive belief) was true in that moment? We need three moments or scenes that you can recall and visualize. I don't need to know the details, just give me a title for each memory:

1)_____ Body Assoc. _____

2)_____ Body Assoc. _____

3)_____ Body Assoc. _____