AP Treatment

10/22/23	Version 1.0	First draft

AP Treatment is a psychotherapy treatment methodology based on NLP.

The therapists who apply AP Treatment lead the patients to a self-healing process of immediate effect, that does not only last for ever in the future, but it lasts for ever even in the past.

Credits

In our societies, most people, including therapists, do not value cheap things. Instead, they appreciate and value what is expensive, regardless of its quality.
Cutting-edge psychology courses are expensive, and this is the way it should be. Therapists pay a lot of money for advanced courses to upgrade their professional profile, expertise, and qualifications, and to learn new skills; and they then charge their clients higher fees. This is the way it should be.

AP Treatment is distributed for free, which is an unprecedented challenge that the Author presents to the psychology industry. The Author is aware that some professional therapists may not value the teachings here because they are free, even if they will eventually use and take advantage of some parts of the teachings.

The main reasons for free distribution are primarily, but not exclusively, the following:

1. Not everybody who attempts to learn AP Treatment will be able to grasp it properly, and consequently, will struggle to treat patients successfully. The Author is not willing to deal with the frustration of unskilled therapists or those unwilling to break out of their orthodox shell.
2. The Author is not interested in dedicating their life to building fame, creating marketing strategies for AP Treatment to gain popularity, establishing teaching schools and certificates, and chasing forgers.
3. The Author has been persuaded by many patients to share the know-how knowledge about this treatment to prevent it from being lost.

The only credit requested by the Author is the acknowledgment of the AP Treatment itself. Anyone who uses AP Treatment, a part of it, or a modified version of it must acknowledge the methodology in their statements, advertisements (physical, digital, or any other form), therapy introductions, speeches (both private and public), and in any other occasion.

The Author encourages professionals, therapists, and patients to report, discredit, disclose, and expose anyone who uses the AP Treatment, a part of it, or a modified version of it without acknowledging the AP Treatment itself.
It is an intellectual dishonesty to use the AP Treatment, a part of it, or a modified version of it without acknowledgment, for example, by calling or defining the treatment in a different way. The Author supports anyone who exposes anyone, any professional, or any therapist who shows such intellectual dishonesty.

Disclaimer

The Author takes no responsibility for any type of damage, both psychological and financial, caused by improper practice of AP Treatment.

The Author discourages anyone from practising AP Treatment without a genuine professional approach and/or without a deep understanding of all the correlated topics.

The Author invites anyone to discredit anyone who sells AP Treatment courses and/or certifications.

About the Author

The majority of discoveries are the result of the hard work of scientists who have dedicated their lives to a specific goal. With the support of enthusiastic colleagues, they eventually achieve what they have diligently worked for.
In many instances, scientific progress occurs unexpectedly through remarkable discoveries...events that happen by chance or through a stroke of genius. This is not unheard of.

AP Treatment emerged from the genuine intuition of an individual whose scientific background was shaped by an accumulation of knowledge in various fields. This authentic intuition arose without a preconceived intention to create a new treatment methodology. The Author, from a young age, harboured a deep interest in psychology and science, accumulating a reputable knowledge base in the origins of NLP and hypnosis research. While investigating unusual mind disorders, the Author began developing AP Treatment, a step-by-step approach aimed at helping people overcome traumas and phobias.

From the outset, the Author never charged any patients and never intended to make a living from AP Treatment. Great things, in this case, sprang from passion.

Introduction

AP Treatment is probably the most difficult treatment that can be found in literature in terms of therapist efforts during the treatment session.

As the name implies, AP Treatment is not a psychoanalytic methodology; it is a treatment. Both the patient and the therapist choosing AP Treatment must have already conducted investigations into the psychological issue, including its origins, causes, consequences, and effects on the patient's life.

AP Treatment is a one-off intervention designed to treat a disease after thorough prior investigation. In most cases, a single session of AP Treatment is sufficient to cure the patient. If a second session is required, it is either for treatment result confirmation or to address any repetition of a former treatment that was not correctly carried out.

AP Treatment is perfectly safe: the therapist does not impose any actions but rather guides the patient toward immediate self-healing. There is no risk of harming a delicate, barely balanced psyche. This treatment is not a form of hypnosis with post-hypnotic control or a forced modification of mental structure. The AP Treatment therapist is not a physiotherapist of the mind manipulating a a back; instead, one who corrects the patient's mental posture.

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The healing process in AP Treatment is a natural self-adjustment that occurs when the patient comprehends the true nature of the issue and its origins.

Treatment concept - Basic knowledge

Hypnosis may be used for certain types of treatment, involving the induction of the patient into a non-ordinary (altered) state of consciousness by shutting down input sensory channels. In this state, the conscious mind is in a sleep mode (hypnos, “sleep” in ancient Greek), and the therapist gives commands to the unconscious mind.
In AP Treatment, a non-ordinary (altered) state of consciousness is induced in the patient. However, in contrast to hypnosis, input sensory channels are active and stimulated.
During the treatment, memories from the past and from the future are recalled. The Therapists applying the AP Treatment guides the patient, who is fully conscious throughout the process, into solving process through questions and thinking.
To facilitate the unlocking of treatment doors for the patient, at a certain point in the treatment, the therapist suggests minor changes to secondary memory details. These changes may involve altering the viewpoint of the memory's action or making minor adjustments to the environment.

Therapist's knowledge requirements

From the most important to the least:

1. The therapist must **know that there is no time dimension**. This requirement is not for “to understand” or “to believe”, it's a requirement for **“to know”**. Some basic knowledge of Holographic Universe theory may help to understand, to believe, and then to know there is no time dimension.
2. The therapist must have knowledge of NLP as created and described by Richard Bandler. Modern understandings of NLP are useless for the purpose of AP Treatment application.
3. The therapist must have deep knowledge of visual, auditory, and kinesthetic characteristics (VAK) of a person's mind structure and of a person's input sensory channels. The therapist must know how to perform tests to identify the VAK of a patient and must have developed conversional skills that allow him/her to formulate any sentence in a way to stimulate properly the particular patient's VAK.
4. The therapist must have good knowledge about hypnosis and clinical hypnosis. This knowledge is essential for avoiding any form of hypnosis status.
5. The therapist must have clinical psychotherapy qualification and extended clinical experience in psychotherapy through different methodologies. In alternative, the therapists must have a very extended clinical experience in psychotherapy with at least 120 patients treated using different methodologies.
6. The therapist must be able to create and maintain an appropriate professional rapport.
7. Basic knowledge of psychoanalysis may help.

AP Treatment – Stages

Following steps outline the foundations of AP Treatments. They could be complemented with other test/exercises, provided as they are aligned with AP Treatment theory and don't impact its foundational steps.
Each following Step has some examples, which are just indicative and briefly explained, highlighting potential challenges for the therapist. These examples are not inventions of the Author, and their detailed explanation, underlying principles, and psychological mechanisms are beyond the scope of this paper. Skilled and experienced therapists can modify, enhance, or replace these examples with equivalent ones, possibly more familiar to the therapist, to achieve the same

therapeutic goals.

Stage 1 - Treatment planning – 12 to 20 minutes

Goal: to explain the treatment to the patient and plan/organise the treatment.
The therapist sits right in front of the patient, nearer than usual treatments, about 1m-1.5m away.
The therapist may mirror the patient gestures and posture, that helps the patient to unconsciously feel closer to the therapist and more comfortable.
The therapist explains to the patient what will happen during the treatment session, highlighting the eventual strong emotions that may arise and, in some cases, unpleasant memories may be recalled.
The patient must be comfortable to release strong emotions during the treatment and to face tough memories.
The patient must understand that will be always aware of each part of the treatment, every single moment, and if he/she wanted, could stand up and walk away; there won't be any moment where the patient is unconscious, and every part of the treatment will be remembered.
The patient must understand that the treatment is an hard mental exercise; he/she may feel uncomfortable at the beginning, then a bit dizzy, or foggy at certain times, and efforts to continue the treatment will be requested even whether it is tiring; at the end of the treatment, the patient will have some time to rest.
The therapist carefully takes exhaustively notes, until the relaxation step begins. Those notes must be exhaustive and clearly readable during the core treatment, as the therapist will need to follow them.
The therapist very shortly summarises the first steps of the treatment: “we will do some relaxation exercises, then I will ask you to look at certain point... you will focus on that point, then that point will become a cave and you will walk into the cave... inside the cave, you will find an elevator that will take you to a room, where you will live again your memories exactly as they were, full of details and emotions” - this statement may be said in 15/20 seconds; it's not important the patient remembers it, it's important that the unconscious mind perceives it and is prepared to accept it.
The therapist should make sure the patient has no issue with caves and elevators, and in case of claustrophobia, the therapist should plan an alternative *journey* or create wider environments.
The therapist asks the patient to identify four remarkable memories, as following; the treatment will be focused on them.

1) A very old memory, a memory almost faded off. That should be a pleasant memory that the patient would wish to live again.
   This memory will be recalled as first regression in order to improve the patient's confidence in the treatment and to make the non-ordinary state of consciousness deeper.
   The therapist has to write down all possible details the patient remembers: what they see from the memory, what is happening in the memory, who is present, the location, the approximate date, and so on. After general memory details, smaller details, if remembered: the clothes of people present, their style, the details of the place, more details about what is happening. The patient must admit to not remembering rather than making up.
   The therapist must write everything down exhaustively.
2) A pleasant recent memory, possibly where the patient was alone. That memory must be of a relaxing moment, serene, in peace with oneself.
   The therapist must write down when that memory is about, what the patient was doing, the feelings of the patient in that moment. Details of this moment are important as it will be not just recalled as second regression, but then this memory will be “projected” into the future, recalling a very similar “future memory”. In other words, the therapist will ask the patient to recall a very similar memory “happened in the future”.
3) The most recent memory when the problem concerning this treatment occurred.
   The therapist writes down the details of the event. This will be recalled shortly as third regression, then again as fifth regression. As the previous memories, the therapist needs to write down all details that are required to recall the memory.

4) The memory of the first time the problem concerning this treatments occurred. The therapist writes down the details of the event. This will be recalled as forth regression. On this memory, the therapist will apply minor changes of secondary memory details. As the previous memories, the therapist needs to write down all details that are required to recall the memory and to handle the memory: no detail should arise as unexpected during the regression.
   The therapist has to plan strategically the above minor changes to apply to the memory, and those minor changes should be in according to the tests explained here below.

The environment where the AP Treatment takes place must be as quiet as possible. Nobody should ever interrupt the treatment. Both therapist and patient must switch off their phones. Landline needs to be unplugged, door bell disable, eventual disturber must be advised, pets must be kept in a non disturbing place. The AP Treatment cannot be interrupted for even one second for any inconvenience.
The patient may want to have a blanket on the laps.

Example:
Once sit, and explained all above, the therapist takes notes of the four situation individuated by the patient.
1) **a far memory** could be the beloved grandmother passed away when the patient was very young; a pleasant memory of the whole family during kindergarten age; a pet the patient had several years ago; and so forth. The memory may be faded, it doesn't matter at this point. The therapist asks to focus on a particular moment, like a photography; from that photography the mind will collect an increasing number of details, until it will build the whole memory as it was used to be.
The therapist also tries themselves to visualise that photography while asking the patient for details, from the patient point of view, starting from the main details, down to the smaller ones: what you "see"? who is in that photograph? What is your location? Who or what is nearer to you? … what's the colour of your dad's trouser? How is the temperature of the floor? How do you feel there, near the big table? - the memory doesn't carry just visual detail.
During the prior treatment planning (in an ordinary state of consciousness), the therapist's questions about the memories to recall were formulated in past tense, being concerning the patient's past. Instead, during the regression, all the questions the therapist asks, must be in the **present tense**: the patient is living again those memories. If the therapist mistakenly uses the past tense, that is not a secondary mistake: that shows there is a fundamental lack in the AP Treatment understanding and execution and that therapist should review all their knowledge before applying AP Treatment again.
<u>More the therapist attempts to actually visualise the same photography the patient sees, and easier is to ask for more details and to use the present tense</u>.
During the prior treatment planning, do not force to ask for details: forcing details out of a faded far memory in a ordinary state of consciousness may cause the patient to unintentionally make up details – no point asking "what cloths did you ware?" as the picture is usually from the patient's point of view and one cannot see own clothes when looking at something else.
The therapist write downs all the details.

2) **The pleasant recent memory** must be very clear for the patient. Ideally the memory should be in a place isolated, alone, and in peace; in case the patient recalls another pleasant situation but in company of somebody else, the therapist should not hesitate to request for fetching another more appropriate memory. The patient must describe some details with high accuracy about the situation of that memory; those description must give a good representation of the situation and the therapist must be accurately write them down as they will be used to recall that moment. The therapist must ask the patient about he/her <u>feelings</u> in that moment: they should be pleasant.

Prior treatment planning:

Patient – I was laying on my bed-. Therapist – what was the date?- , patient – march 29th, 2022-. Therapist – how did you feel on your bed, relaxed? -, patient – yes, extremely relaxed, serene (detail)-, therapist – thoughtful? - , patient – no, peaceful -.

During the regression:
Patient – I am laying on my bed, looking at the ceiling... a warm light is coming through the window- Therapist – enjoying your time on bed... what details do you see in the ceiling? - , patient – A lamp with two bulbs, a blue shade...- . Therapist - is the ceiling paint rough or smooth? Are there any shadows? -, patient - it's smooths... there is a warm shadow projecting the hanger shape ..- . Then, as last, the therapist – how do you feel on your bed, relaxed? -, patient – yes, extremely relaxed - , therapist – thoughtful? - , patient – no, peaceful -. Therapist – how is your breathing like? - , patient – slow....-.

3) **The most recent memory about the traumatic/issue event** we are treating. It doesn't need to be the most recent, but recent enough to still evoking emotions. Here the therapist needs to collect again about 10 details describing the situation and his/her feeling. From those details, the therapist will recall that particular memory and not a generic one. Warn the patient that this memory will be recalled twice. The therapist should seek to get important details: in this case, it's not important what somebody is wearing, although that could be a further detail to anchor the patient into a more vivid experience, but description of location, feelings, and what happened right before, during the event, and right after.
The therapist must be snoopy. If the patient becomes uncomfortable, irritated, emotional, terrified, or any other strong emotion, that means you got the right details on the right memory. If therapist minds about the patient's discomfort, cannot cope with it, or feels powerless, then this is not the right methodology for the therapist and should quit the treatment immediately. The therapist must be professionally cold for the patient's emotions like a surgeon holding a knife. The therapist should keep applying the methodology whatever patient's emotion arises. The second recall of this memory will be with emotions faded off or no emotion at all.

Arachnophobia brief example
Prior treatment planning-
Patient – a few days ago I was in the cellar, when I open that box a spider walked on my hand... ahhhh! It was so painful and scary! I jumped back and fell on my bum, then stood up and ran away, screaming like if I was stabbed!-
Therapist (details before the event) - Tell me about that cellar?- , - how tall was the cellar ceiling? - , - where was that box located? -, - describe me that the box? -, - what were you looking for in the box? -, - why did you decided to look for that now? What date was?-, - what time of the day was? -
Therapist (details of the event) – you approached the box, then what happen? How the spider got on your hand, describe me in details-, - focus on the moment you had the spider on your hand, tell me what you felt (highlight this point is patient is mainly kinesthetic) / what you saw (highlight this point is patient is mainly visual) / listening to your body and emotions and tell me (highlight this point is patient is mainly auditory) -, - while you were running away from the box and the spider, tell me what you felt/saw/listened... -
Therapist (details after the event) – now you had run away, where did you go, what were you doing? -, patient – I went to the kitchen, I stood by the wall, scared to death...- , therapist – describe me what were your emotions in details -, - tell me what you were thinking, there standing by the wall – .

4) **The oldest memory about the traumatic/issue event**. The memory about the first time the issue happened or arose. It's very important that the really first memory is found and described, even in these cases when the memory is faded (for whatever reason). Highlight this importance to the patient.

It might happen that the patient may have the oldest memory blocked/hidden – in that case, the patient won't tell the oldest memory at this stage (before the treatment core) and then during the treatment core the actual oldest memory is recalled: in this unfortunate case the therapist doesn't have details notes about the actual oldest memory and could feel unprepared to deal with this important memory... the therapist must be prepared to face that case too.
Within the oldest memory there is always the triggering event that create/provoke the issue under treatment; if the triggering event is not clear after the memory analysis, it may be that this memory is not the oldest memory and the patient is unintentionally blocking/hiding the really first memory. This inconvenience has never occurred to the Author, therefore there is not precise guideline in this document about how to do deal with that.
A memory block of a short time may be present in the traumatic event of the oldest memory; that could be seen by the patient as a temporal blackout – a brief moment lived by the patient but not remembered because of patient's mind blocks/hides it for any reason. The best solution a temporal blackout during the treatment core is to create an anchor right before the temporal blackout (see below or NLP anchor technique description), make a view shift (see below), and then ask the paient for rewinding the memory and recalling again from the moment right before the anchor – this solution bypasses the memory block and allows the therapist to know the event in full. This anchor solution must be properly planned in advance.
Once the actual memory is fully recalled during the treatment core, the therapist tries to fetch as many details as possible and for each one performs a reflection technique (see below). By properly activating the sensory channels, the therapist will create a good set to work and to follow the regular methodology described below.
The therapist should individuate the issue triggering event while the patient tells about the oldest memory at the preliminary stage and should be able to work out a treatment strategy. The treatment strategy shouldn't be disclosed to the patient, to avoid the patient's mind unconsciously creates defences.

Arachnophobia, brief example no 1:
Patient – I was a kid, eating by the table and suddenly one spider jumped in on my face and I freaked out -. Unless other details of that memory reveal a triggering factor or event, from that first description it seems there isn't an evident reason to create a phobia, in that case that memory could be not the first arachnophobia event.
Arachnophobia, brief example no 2:
Patient – I was very young, and my older brothers brought me to a graveyard. It was almost dark and I was scared. I was walking tight close to my oldest bother as I was scared to death, I was feeling my heart beat in my throat. We stopped by a bush and while I was checking around, the other brother tied me up with a small rope. My brothers pretended to get scared and ran away, and as I attempted to follow them, I fell on the bush... I was frightened to death, but I couldn't scream... as I stood up, my face was covered by a spider web and a spider was right on my nose... I remained petrified. - .
In this memory, the patient was very distressed due to the setting he was put into. The triggering factor likely was that unexpected fall, that could have triggered a certain mind condition which have been linked to the close sight of the spider.

Stage 2 – Personality tests – 5 to 10 minutes

The AP Treatment therapist's most important task is to identify the VAK characteristics and the handedness of the patient and of her/his sensory channels – i.e. one person might be left-handed and being AKV with right-handed auditive input channel. The details of these characteristics are of paramount importance for the treatment, in fact, the therapist has to customise the whole treatment process in accordance with the results of these tests. The outcome of the treatment will depend on the customisation of the treatment. More details concerning that aspect will be highlighted later on.

Note about VAK characteristics test: a deep analysis of this type of tests may take several pages; although its outcome is extremely important for AP Treatment, we let the reader to investigate about this subject in other specialistic texts. For the readers who wish to investigate later on, for the sake of providing some basic details, we mention the following *extreme simplified easy case*:
the therapist seats in front of the patient and asks him to take certain postures, like crossing hands, crossing arms, crossing legs, to see what part of the body is predominant. The left-handed people will place the left part above the right part. Some people may be naturally left-handed but being educated right-handed, in that case discrepancies will show up.
Then the therapist looks at the patient eyes and asks him for reminding what happened 24h ago. When a right-handed patient reminds something truly happened in the past, they eyes will turn left (right side for the therapist), while the eyes of a left-handed will turn to right (left side for the therapist). When the therapist asks the patient for imagining something out of fantasy, the eyes will move to the other side (right side for right-handed, left side for left-handed). Asking about reminding an event of 24h ago may be a visual exercise, as patients tend to remind scenes of the past, therefore patients with just little visual (V) characteristic may not move the eye, or slightly move them and slight turn them down. If the eyes do turn to one side and also slightly move up, that may be a sing of a prominent visual (V) characteristics. The therapist may ask to reminding the taste of chocolate (as past memory) to check the kinesthetic (K) predominance, or a made up taste (as fantasy). Then the therapist may ask to remind the favourite music (as past memory), to check the auditory (A) predominance. Similar tests such these will provide extremely important information about predominant side and VAK characteristics, which are paramount for the outcome of the AP Treatment. In some complex cases, which are not rare at all, patients have physical predominance for one side, while VAK characteristics, or even one of them, have predominance of the other side: for example, a left-handed person who crosses hands, legs, and arms as a left-handed does, and resulted being an AVK (Observer personality type), but has the A and K channels reversed (i.e. eyes turn left when thinking about auditive and kinesthetic real memories). For those complex cases, but also as confirmation of test result goodness, the therapist should perform other type of tests, like graphology, speech analysis (quick speakers are mainly V, slower ones are A, very slow ones are K), reading patient's body language, drawing analysis, and so on. The therapist should always write down test results once they are confirmed and keep his notes easy-to-read during the therapy.

For the experienced therapist, additional psychological details about the patients may also prove useful. However, we entrust their expertise to seamlessly integrate those details into the AP Treatment process.

Another aspect that may be checked at this stage is the seriousness of the patient in finding a solution to the problem and their willingness to pursue it. Sometimes, individuals may seek therapy for various reasons, such as challenging their willpower against the therapist's, passing time, flirting, or seeking attention. Other people go in therapy because recommended but they are not really willing to overcome they problem. Some may be comfortable with their problem, using it to garner sympathy, attention, or compassion from friends and family. Additionally, there are cases of Munchausen's syndrome, where individuals may intentionally or unintentionally fabricate mental health issues, or hypochondriacs who are excessively fearful of diseases. In all these instances, the therapist should kindly refuse to proceed with the treatment and dismiss the potential patient.

The therapist must double check the patient's willingness to achieve the goal of resolving their own issue. Asking questions that project the patient into a future situation with the issue resolved may reveal the healing importance from the patient's point of view..

Stage 3 – Relaxation and induction

All mobile phones must be turn off from now onward; any eventual disturbance should be

prevented. If the environment is cool, a light blanket could be provided to the patient.

Mirroring technique.

At the beginning of this session, the Mirroring technique is an useful technique to adopt while the patient is in ordinary state of consciousness and is seeking for a comfort zone in the new environment of the treatment room. This technique creates trust and a kind of friendly bond with the therapist, and it helps the patient to find relax and more confidence in the treatment.

In the first part of the Step 3, the therapist, usually seated in front of the patient, literally mirror the posture and movements of the patient. The physical mirroring is an exact mirroring or just a slight mirroring, done with almost no delay from the patient's movements. Usually the physical mirroring lasts until the relaxation part takes place.

Later in the treatment, the mirroring becomes verbal, and it will have obviously a slight delay from patient's voice. When the patient answers with one-word response to therapist's simpler questions, the therapist repeats the answer with calm, warm, and reassuring tone. In that way the patient feels reassured, attended, protected, and more relaxed. This can be done during whole the treatment session when the patient is in an alterated state of consciousness (95% of the treatment).

Primordial sounds

When the therapist is taking the patient in a deep state of alterated state of consciousness (see below), the therapist may produce some “primordial sounds”. Those sounds could be guttural or palatal sounds, or any other type, but not vocal (not generated by vocal cords). The Author uses a low-tone and slow-frequency palatal sound, typical for calling cats for food, but any primordial sound may work. There is no scientific explanation for the effectiveness of this technique, maybe they emulate sounds that the fetus perceives during the pregnancy, or they belong to unknown instincts.

Relaxation.

Patients with experience with meditation, yoga, or breathing techniques will find this part easy to go through. Therapists with such patients, will dedicate maximum 3 or 4 minutes for this session.

Meditation neophyte patients, namely patients with no experience with such disciplines may require up to 15 min.

The final goal is to get the patient completely relaxed, with low heart beat rate and slow breathing. The therapist may notice when relaxation takes place, by noticing the patient's muscles relaxation, mostly shoulder, neck, and harms. Patient might change posture to find a more comfortable position for the relaxed body.

A meditation neophyte patient might require a “guided meditation” in order to find a way to relax. Any guided meditation technique is fine: breathing focus, chakra focus, image focus, body parts focus, and so on.

Performing an AP Treatment is very tiring task. All the following parts from now on until the end of the treatment, must be lived in co-participation by the therapist. It's not the therapist who tells a sequence of things, like a father telling a tale to own kid with empathy and emphasis, it must be must more engaging than that; the therapist must imagine and live all treatment events along with the patient: only in that way the therapist can create a truly engaging “trip” for the patient and obtain the wanted result. And not just that. The therapist needs to create such trip and being in that trip event by event just an instant before the event happens to the patient. The therapist customises the trip to the patient's characteristics resulted from previous tests, has to notice the patient's reactions, and has to modify the “trip” according to those reactions. The therapist hasn't got one second break in 120-180 minutes long treatment.

Induction from the meditation.

When the therapist notices the patient is relaxed, they can introduce the Breathing Focus Loop.

The Breathing Focus Loop

While the patient keeps being relaxed and/or meditating, the therapist ask for following the *air path*, namely they ask the patient for following the air that gets in the nose, pass the throat, fill the lungs, pass again through the throat, and finally gets out from the nose.

The Breathing Focus Loop is a kind of guided meditation and it is the first moment when the therapist applies the VAK characteristics of the patient as resulted from previous tests. Shortly, if the patient is mainly Visual, the therapist will use words like "see the air getting in the nose", or "visualise the air going through the throat"; if the patient is mainly Auditory, the therapist will use words like "listen to the air filling the lungs", or "hear the air leaving the nose"; if the patient is mainly kinesthetic, the therapist will use words like "feel the lungs expanding and filling with air" or "feel the warmer temperature of the air leaving the nose".
The Breathing Focus Loop is also a way to verifies the correctness of the VAK characteristics, in fact, if the previous test results were wrong and we highlight wrong VAK characteristic, the results will be poor.

The therapist, when instructing the Breathing Focus Loop, must be clear, slow, using warm and reinsuring tone, always following the patient's breathing pace.

The therapist at this stage can repeat the Breathing Focus Loop about 10/15 times. The first time, the therapist adds a lot of the details to the exercise, in order to make the patient interested in following the Breathing Focus Loop. Loop after loop, the therapist removes details, until obtaining an essential but functional loop exercise, to repeat over the entire treatment.
The Breathing Focus Loop exercise must become an automatic sequence for the therapist to tell, so they can reciting it identical without thinking: that will be particularly useful for the therapist to have a few seconds for quickly recollecting the ideas.

The purpose of the Breathing Focus Loop is to bring the mind in a overworking state, providing different tasks to follow at the same time. As we will see later on, with the mind in that overworking state and with all the patient's input channels activated accordingly own VAK characteristics, the patient is brought into an *Alerted* Alterated State of Consciousness. This State of Consciousness is the opposite state of an hypnosis, where the conscious mind is asleep and the therapist instructs/commands to the unconscious part of the brain.

Guiding to the overworking brain

At a certain moment, the patient will be performing own relaxing/meditation, showing all characteristics of being very relaxed, and following the Breathing Focus Loop as guided by the therapist. The therapist should not proceed any further if the patient is not in that state.

Now the therapist asks the patient to slowly open the eye: when the patient wants and with the desired speed. Once the patient has opened the eyes, the therapist asks him to pick a point in front of him: it could be a detail on the wall, a corner of a poster or of a picture, a details of a furniture, whatever, the important is that should be approximately in front of the patient. The therapist asks what point is (this is useful for guiding the following).

The therapist asks for focusing in that picked point, and then guides the Breathing Focus Loop. Formerly, the therapist asks for analysing details of that point, without speaking them out loudly. Then, according to what point has been picked, the therapist suggests a detail, followed by a Breathing Focus Loop. Detail by detail, the therapist indulges asking always smaller and more peculiar details. Each detail is followed by a Breathing Focus Loop. In the undesired case that the therapist runs out with fantasy, may also repeat a detail suggestion previously asked.

From this point, the therapist starts forcing the vision of details of the picked point by working on patient's imagination. By forcing details that otherwise the patient would not have looked at/imaged, we force the activation of that part of the brain that usually in regular daily routines is not active,

and also we force the brain in overworking mode by asking to follow the Breathing Focus Loop. For example, according to what the patient is looking at, “appreciate the different tonality of the colours”, “look at the details of the texture”, “see the tiny imperfections”.
In this moment the therapist can already notice the patient begins to struggle. Patients who are not genuinely intentioned and convinced to undergo to the treatment will have weird unconscious reactions in this moment, like being uncomfortable, uncontrolled movement, or even emotional reactions. The therapist should be knowledgeable enough to understand the situation and decide whether to continue and guide the patient through the struggling moment, which could also be a regular reaction, or to stop the treatment if it becomes clear that the treatment is not what the patient wants.

In order to bring the patient in an alterated state of consciousness appropriate for the therapy, now the therapist has to active that part of the brain that deals with imagination; to do so, it must be stimulated the right channel accordingly with the VAK characteristics test results.

The therapist begins saying “more you look at that point, more details you keep finding, and bigger that point appears... closer you get”; alternating each sentence with a Breathing Focus Loop. For each detail suggested, the therapist keeps repeating that the picked point “becomes bigger as more details are found”.
The therapist may suggest details activating VAK channels, indulging more on the predominant inputs. For the K channel it could be “you can almost feel the taste of the material” and at the same time making a sound with the mouth like tasting something; for V channel it could be “you can hear the sound of the material molecules that are settling for the temperature” and at the same time making a quiet sound of cracking, and so on. Never forget to alternate sentences with a Breathing Focus Loop.
Bigger the point becomes and tinier details can be suggested by the therapist, till going down to molecular level. In this moment we can notice the patient's eyes blocked, blurred, slightly off focus, or getting tired. Although the brain is overworking, the patient will tend to keep the eyes open because enjoying the moment... but for the next step, we need the eyes closed.

The cave

At this point, the therapist may suggest “you can keep your eyes open if you like, but if your eyes are tired, you can close them at any time, at the speed you like”. Some patients may not do it immediately, but, as it has been suggested by the therapist, eventually the eyes will get too tired and the patient will close them; until that moment doesn't occurs, the therapist should continue with the last previous part, suggesting the picked point getting bigger and closer, and suggesting always more details to see and to imagine.

As soon as the patient closes the eyes, the therapist suggests “now that point is so big... and you come to realise that it actually is the entrance of a cave...” .

It given for granted that the therapist previously enquired about an eventual patient's claustrophobia. If the patient is highly claustrophobic, an alternative to the cave and next closed environments should be found.

The goal now is to take the patient down within. Walking in a cave is a good mental metaphor for proceeding deeper within. Here the therapist keeps guiding the Breathing Focus Loop, but less frequent than before, let's say once every two other sentences.
The therapist should suggest the patient to walk in the cave and, while proceeding, scenarios and events descriptions must fit to the patient's VAK characteristics: “while walking farther in, /see your feet stepping on the cave floor (V) / hear the sound of your steps (A) / feel in your soles your steps (K)”, or “while proceeding deeper in the cave, you / see the typical cave dust in the air (V) / hear louder the sound of your breathing (A) as quiet the environment becomes / feel in your lungs the typical cave air (K)” .

As for many people cave may be scaring, the therapist should suggest an environment peaceful and secure, ie “for each step you proceed into the cave, you feel calmer and more relaxed... for each step you find the cave always more familiar”.

In the case, the therapist should suggest those details that are meaningful for the treatment purpose, like VAK characteristic suggestions, and leave free choice of details for other parts, i.e. “look at the details of the cave, look at the stalagmites and stalactites, if there are any” - here we don't get into details.

Allow a good 5 minutes to this proceeding into the cave part. We want to help the patient to get familiarity with what he perceives and the mind status. It's a very good sign if the patient turn the head while looking at the cave details – you can see eyes activity through the eye lids.

Getting down to the rabbit's hole.

We are going take the patient down to the “centre of universe”; such statement makes no sense, but the patient sees the analogy of going deep to dig out the issue concerning the treatment. The therapy is not about articulating perfect, sensible sentences; it is about ensuring that the patient comprehends what we aim to achieve. The verbal aspect is only a small part of the communication between two individuals.

When the therapist believes the patient has walked into the cave enough, the therapist wants to make aware the patient about the intention to go deeper and wants to induce into the patient such desire.
From now on, until the Memory Room is reached, the therapist will provide suggestions. All those suggestions must be accepted by the patient. If the patient is hesitant or reacts as they are not happy, the therapist may decide either to end the treatment, or to hold the situation and find out what blocks the patient's willingness (strategies how to do that are not described in this document).

At this point the therapist suggests “while proceeding into the cave, a large hole on the floor (or a stair case) appears from the darkness of the cave depth”... slowly, step by step, that hole (or stair) is approached. “Look down in the hole, you can see a soft light, it looks so far”. The therapist suggests then that light comes from a special place, where all memories are stored. “Just looking at that light, you may feel even more peace, a bit of sweet melancholy rises for your old memories stored over there... you really want to go there... but the way down through the hole (or stairs) is dark and dangerous...” . Highlight the inducted desired to wanting to go over there, where the light comes from. If the patient is now relaxed at the idea of reaching that light, proceed.
“ooohh... what? …. / a sound of elevator on the (A) / a feeling suggests you there is an elevator on the (K) / turn the head and look at (V) / DIRECTION”. The elevator is the mental tool that will take the patient to the Memory Room and has to be placed in the side that represents the past for the patient. That DIRECTION (therapist replaces it with left/right) corresponds to either the *left* for a right-handed patient or the *right* for a left-handed patient, accordingly to the former test results.

The elevator

The therapist invites the patient to get in the elevator. The therapist describes the elevator as high-technology and advanced elevator.
For this session, the therapist fully controls the events. The therapist should announce each event beforehand, stating that at the count of “3” (combined with a sound or finger snapping) the event happens. Let's call *Event Control* that announcement and count performed by the therapist. When the therapist wants the patient having time to prepare oneself for a certain event, the *Event Control* can be performed slowly; when instead the therapist doesn't want to let the patient's mind to wonder among eventual alternatives, the *Event Control* can be performed very quickly.

Once the patient is accommodated seated in the elevator, the therapist gives an *Event Control* to

close the doors and another one to start the elevator descending.
The therapist here does an Breathing Focus Loop about every 2 or 3 sentences. A suggestion could be that the air breathed in the elevator could have also a “technological taste”, another no-sense sentence that makes a lot of sense for a kinesthetic patient.
The therapist could spend time to let the patient seeing details in the elevators. A display counting the depth could be an useful details for our purpose. With a series of *Event Controls* the therapist makes the elevator accelerating always more. The above mentioned display could be use as speed indicator. Elevator cable noises for Auditory patient or elevator vibrations for Kinesthetic patients could be interesting details to add when the elevator descends at high speed.
Nice sensations help patients to trust more in the methodology. Usually patients enjoy the body weight loss induction. Suggesting always a faster descending speed with *Event Controls*, the therapist suggests that the body weight becomes always lighter, till, with a next *Event Control*, the patient may find oneself floating in the elevator. “floating like a tree branch in the sea”, “floating like an astronaut in space”, or even better “floating like a little baby in the mother bely” (using the word fetus might be not convenient) are analogies that help the mind associating the moment with something known and pleasant. An *Event Control* could eventually detaches the elevator's cables for a supersonic fall. The therapist could let the patient enjoying the floating moment for a while.
The therapist could even generate *Primordial sounds* to fill some silent moments.

All following stopping steps of the Elevator session can be performed much faster than the previous accelerating steps. A few *Event Controls* to slow down the elevator, to allow the patient to gain back own body weight, to stop the elevator, and finally to open the doors.

Stage 4 – Memory regression and treatment

It shouldn't be necessary to state this, however it's paramount that the therapist NEVER EVER EVER conjugate verbs in past or future tense during the treatment core (from stage 3 onward). Everything happens now. That can be easily achieved only if the therapist is living the trip along with the patient.

The Memory room

Once the elevator doors are open, the patient can see a room in the dark. The therapist shall avoid giving the room details, shall rather let the patient to explore the room. The therapist may just suggest some details useful to the purpose, i.e. an “high-technology air”.
The frequency of Breathing Focus Loop at this stage may vary in according to the moment.

While proceeding walking in the room from the elevator, a sofa is found. The therapist lets the patient approaching the sofa and touching it (and/or smelling it, looking at its features, listening to the fabric sound while touching it), and then suggests the desire to try how comfortable the sofa is. Once the patient is seated, the therapist asks to relax back, and suggests that the sofa is extremely comfortable.

While performing a Breathing Focus Loop with patient on the comfortable sofa, the therapist surprisedly says “incredible... the sofa is breathing too... actually it's breathing with you... try to let your body relax and enjoy this sensation...”

And then, “that is high-tech sofa, it is made to protect your body... you can feel how it gently wraps your body... and it keeps breathing with you...”

The therapist may repeat (or for a few times) a Breathing Focus Loop adding elements of the breathing sofa, like “when the air fills your lungs, the sofa expands...”.

The sofa is a tool for reassuring the patient that nothing will hurt him while re-living past memories.

Now we have to add a large black screen, with a tiny dot on indicating that the screen is turned on.

“While relaxing with this sofa, look around... look up... ah! An huge black screen, you didn't see it because the room is dark...Wow, it looks an amazing screen”. Other screen details may be suggested to highlight how good it is.
“That little dot on means that the screen and all the room technology is on... actually the room technology is already linked to your brain waves.... relax, chilled out... the technology is now collecting details of your memory X”. The therapist will replace X with the first memory of the *Planning Treatment* chapter, providing a brief summary (I.e. “that memory when you are about 5 years old, you are in the mountain cottage with your grandmother”).

Be careful here. The therapist MUST move forward very slow at this point as this is the first regression for the patient. Some patients, mostly who has had AP Treatment before, will be fast in following up the next stages even if the therapist proceeds at fast pace, while others who are not familiar with this methodology will get lost. Therapist here must be very scrupulous and never give for granted the patient is following up. Therapist must be very careful to patient eyes movement under the eye lids: if the patient is not turning the eyes when, for example, is checking the whole screen, it means he got lost somewhere. Therefore the patient interaction must be forced as in following example.

“Check out this amazing high-tech screen while the room technology is collecting the last data of your memories through brain waves... check the top left corner... the top right corner... how large is it? … Very large...” . If the eyes don't move at all, do not proceed (unless the patient is not V at all); go back to the sofa details, then back again to the screen and slowly repeat (using other details and other words).

Still image and first memory recall

From now until the end of the first memory, the therapist stops giving Breathing Focus Loop.
Now the next goal is to project an imagine of that memory on the screen. Some patients get lost and don't project anything, others are too fast and start living the memory, both cases are undesired and need to be recovered if happened.
Very slowly, the therapist does the following *Event Control*: the therapist begins with a very careful and slow announcement, highlighting and repeating more than once what is wanted, as following “now I am going to count to 3, only, and only when I say 3, not before I say 3, an image will appear on the screen... a still photograph... a frozen image. You will look at that frozen and still photograph and will describe it to me as you would show me an old photograph book”. Then, again very slowly, “1... the room technology is collecting the very last details of that memory X..... 2.... the room technology is ready to show you a frozen imagine of that memory X.... 3” along with a finger snapping or similar (replace X with the memory brief summary as above).
Therapist should keep repeating that is a still image “here we go, a frozen photograph is projected on the screen... check all details of that still photograph, check the bottom right... now the bottom left... look at the details”. Therapist has to make sure the patient's eyes are moving.
Now the therapist may enquire about the details in that still photograph. Most of patients here struggle, as they have difficulties in speaking up at this stage; they might take some minutes to speak up. The therapist may help “tell me who is in that frozen photograph, who do you see?”, “tell me some details? Explain them to me”. - Again, all the regression must be done at the present or present continuos tense.
From the notes taken during the *Planning Treatment* chapter, the therapist may ask for some known easy details to help the patient to start to speak up (do not ask “do you see the sky” if the memory is about being indoor in a cottage, such enquiries would trouble the patient at this stage).
More details the patient describes and more the patient will be engaged to that memory. It's a good work approach to enquire like “if you see the grandma, how is she dressed?... what colour are...?”.
Verbal mirroring (repeating patient's words with a warm and soft tone) will help the patient.
The therapist should enquire mostly about memory's details that are linked to patient's VAK

characteristic.

When the therapist sees the patient well engaged in that still image, it's time to get the patient into the action: the therapist gives now a fast *Event Control*, such as “now when I say 3, everything moves and you are in that photograph, and everything occurs, 1, 2, 3, everything moves, what is happening?”. This *Event Control* should be given very quickly.
At this point the patient is in the memory. Rarely patients tell aloud what is happening, usually they just enjoying being in the memory; the therapist has to continuously enquire about telling loudly details and what it is going on, although not that insistently as this first memory purpose is just to let the patient reassure about the AP Treatment technique.
Nevertheless, the therapist should verbally mirroring the patient all the times some descriptions are spoken aloud.
Let the patient enjoying this memory for a while.

A pleasant memory as treatment trick

When the patient has enjoyed the first memory for enough time, the therapist may give a session ending *Event Control*, such as “now I count up to 3, only when I say the number 3, the screen will switch off and you will find yourself seated on the amazing sofa... 1, 2, 3”.
The therapist now starts again with Breathing Focus Loop and describing the high-tech sofa, that has been protecting the patient and kept breathing with the patient. The therapist also highlights the screen is off and the little dot is on (note that no details are given about that dot, no colour, size, brightness, nor location, all is left to the patient to be interpreted; only its states on and off are important).
Few minutes are required for the patient to be recovered from the previous memory and to distract the patient from it. The therapist can double check again the patient's presence, attempting to force turning the eyes by asking to check the screen corners as done before.

After a while, the therapist stops Breathing Focus Loop and begins with all the steps done previously about showing the still imagine on the screen. This time we recall the second memory of the *Planning Treatment* chapter. In this memory the therapist, after having well hooked the patient onto the memory, should inquire mostly about the patient feelings, sentiment, inner energy, and mental status. Again, all the regression must be done at the present tense or present continuos tense.

With this memory the therapist empowers the patient for being in that mental status as he/she was in that memory. The therapist, after collecting memory details for well hooking the patient to this memory, has to highlight and remark the positive mental status the patient had at the time when that memory happened. This is the shortest regression of whole AP Treatment.

The whole treatment mechanism is based in “projecting” this second memory in the future once some NLP techniques are performed (see below), creating a “memory from the future”; in this way the patient self-impose the termination of *something* by the time the memory from the future occurs, which has not a precise date. That *something* we want to terminate is the final goal of the treatment.

State of Art of the issue

Once again, when the therapist believes that the work with the second memory is completed, the therapist may switch off the screen with a *Event Control*.
Once again, the therapist starts with “Breathing Focus Loops” while the patient checks out the screen switched off, the room technology dot on, and the patient is noticing the breathing sofa.
Once again, the therapist repeats all the procedures to project the third memory as a still image, before giving the go to the live memory.

The therapist here shouldn't require too many details from the patient, as they should had been described by the patient during the session *Planning Treatment* chapter, nevertheless the therapist

may double check all those details.

In according to the nature of the issue, the therapist may direct the questions in different ways. The therapist should enquiry also about feelings and emotions occurring during the issue.
While regressing this third memory, the patient may become very emotional, accordingly to he issue. If the issue is a trauma caused by a sexual assault for example, the emotions could be very tough to handle. The patient should have been prepared for this beforehand. The therapist now must show own professionalism: the therapist must hold a cold and professional behaviour, pretending that those emotions are not coming out. No empathy must be shown by the therapist at this moment. **No** comforting words must be said, they might cause a big future issue (making the trauma untreatable), being the patient in a Alternated State of Consciousness. If the patient is a person who seeks for compassion, inappropriate comforting words may even install a further issue causing a dependency from comfort. In this cases, therapist must remain professional and keep performing as there was no emotion at all.

The therapist must carefully co-experience the whole memory, enquiring for more details, even secondary ones, and making the patient more engaged to the memory by using verbal mirroring and enquires featuring patient's VAK characteristics, even when the patient is experiencing strong emotions.

This regression on the third memory will be performed again as the last step of the treatment. The therapist will notice that when recalling again this memory for the second time, those tough emotions will be gone: this is a sign of successful treatment. Also some minor details might be different: that is the effect of future events that affect the past!

NLP techniques for the trauma

We don't describe here again the steps to end the regression, to prepare for the next regression by showing a still photograph on the screen, and to activate the live regression. Those steps are all similar for each memory.

The therapist now works on the memory of the first time the issue under treatment showed up. Many issues have a different origin than the apparent cause of the issue. For example, an arachnophobia could have been triggered by a small traumatic event in the past.

The therapist should have all details of the event already written down.

The purpose of this regression is changing the "map" of a "territory", not changing the "territory". Therefore we are not going to change the memory of the event, but we change the way the patient has experienced/lived/seen that event. The event itself is and will always be the same, the therapist will never change it; with AP Treatment, the therapist doesn't want to force any main change of the memory. By changing the way the patient has experienced/lived/seen that event, we change the past. It's a mind reprogramming about how a certain event was experienced.
The change of that past event interpretation will immediately have repercussions on all the interpretations of similar events happened afterward.
In most of the cases, at the end of the treatment, the patients likely underestimate the outcome of the treatment because they may now believe it was not even required or necessary a treatment: the patients' event interpretation has changed, they don't remember anymore their conditions at the beginning of the treatment.

The strategies to apply in this very first event must be well planned before starting the procedure.

With this memory, the therapist may play with the memory a bit like a DJ, moving the patient back and forward in time. At this point of the treatment, the patient has gotten used to see, analyse, and tell aloud events happening during a memory regression, so it won't be a problem to follow the therapist skipping from one part of the memory to another. Nevertheless the therapist must make sure to not lose the patient somewhere, therefore all procedures must be gradual and have adequate

speed, be seasoned with verbal mirroring, and be anchored with VAK characteristic details.
The therapist may create some pivot moments while the patient is being regressing the whole event: a pivot moment is created by anchoring the patient in a certain moment using some unique details fetched from the memory. When the therapist wants to create a pivot moment, the live memory is stopped with an *Event Control* in still image, like in a frame of a movie, and some questions about a specific details are asked. Then the therapist, during the live memory, can give an *Event Control* to freeze the story into a still frame; and then with another *Event Control* can rewind back to a previous pivot moment or forward to a future pivot moment by specifying the details of that particular pivot moment asked previously (always using present tenses!).

At certain point, the therapist will ask for freezing the memory in an appropriate moment, at the core point of the issue. First the therapist will ask a series of questions that will lead the patient to self-modify the map of the territory, then the therapist will create a fictional addition to the memory to reinforce the new map of the territory, according to the strategy prepared.
Here the therapist's skills come to play. The therapist now has to enquire a series of questions that lead the patient to self-correct the “map” of the “territory”. This questions must be smart and well designed, so the patient's responses can go only in one direction. **Never ask a <u>why</u> question**!
There are several NLP techniques for creating a fictional addition to the map of the territory. The Author uses often the bodies size change: by enlarging the body of the patient and reducing the body size of what causes the issue, the effect of the issue diminishes too.
Let's suppose that the third memory of the cigarette quitter is the first time that he felt the urge of having a cigarette. The questions the therapist may ask could be: “what happens to the smoke that goes to the lungs? Doesn't it goes inside the vein through lung structure? And then? Where do the toxic chemicals go? What do those toxic chemical cause? do you think smocking is healthy?”, “what is actually an addiction? has a cigarette a stronger willingness than you? Isn't all in your brain? Battles make sense between to different entities, does it make sense for the same entity to fight a battle against itself? So, does it make sense to fight a battle against your own brain? Again, what is an addiction?”, “what benefits do you have from smoking? What benefits do you have from quitting smoking?.... so tell me the positive reasons for quit smoking? Aren't those benefits enough for quitting?”.
Once the therapist is happy with the planned questions and their answers, the therapist can start to apply the fictional additions. In case of bodies size change, it could be as following:
“now everything is still stopped, frozen and still... good... now when I say the number 3, another still situation appears, all frozen... with you holding that cigarette, longing for lighting it up... 1, 2, 3” (supposing that this was a situation the patient told us earlier and that the therapist properly created pivots on those frames) “now, in this frozen situation, in this still image, can you feel the weight of the cigarette?... Can you feel its fresh tobacco smell?...”. The therapist may use *Breathing Focus Loop* while using this NLP technique: “now when I say 3, only when I say 3, your body starts to become bigger and bigger and that cigarette becomes smaller and smaller... 1, 2, 3”... *Breathing Focus Loop*, followed by “each time the air leaves your nose, your body increases its size and your determination to quit smoking increase”, *Breathing Focus Loop*, “each time the air leaves your nose, your body becomes bigger, you empower your willingness, and you appreciate more the reasons you don't need that cigarette”. Giving for granted that the therapist has preliminarily talked with the patient about reasons for quitting.
At a certain moment, the therapist checks the NLP technique effect: “now that you are so huge and the cigarette so tiny, what do you feel? What do you feel about lighting it up?”. If everything went correctly, the patient doesn't feel any desire for smoking that cigarette in that memory.

Many other NLP techniques are available in literature, like knocking down walls and ceilings, useful in certain kind of phobias.

Another technique that may be used as additional element, is to ask the patient, once frozen the memory, to create a camera in the same environment, and to see the whole event from that camera point of view. The memory will not change, but it will change its point of view. This technique is

particularly useful in case of extremely strong emotions and distress: in that case the patient calms down when begins to see the scene from another prospective than own eyes.
That technique also is a game changer in case of memory block due to a trauma: sometimes the patient doesn't remember a part of the memory because an event traumatised the mind which built a block. By creating a camera in the environment just a few instants before the blocking event takes place, and from that point onward letting the patient to "play" the live memory from that camera point of view, the memory block is bypassed and the memory appears entirely.

The therapist should remain a bit on the moment when the NLP technique result is obtained (i.e. when the patient confirms there is no smoking urge anymore), and should create some anchors in that frozen image, by verbal mirroring and enquiring some details formulated accordingly to the patient's VAK characteristics.

Then the regression of forth memory can be terminated in this frozen moment.

Memory from the future

Most of readers might think that the AP Treatment just modifies how the patient experiences the issue under treatment, by modifying the map of the territory. If those readers successfully treat patients through the whole process, therefore going through this last part, they will change their minds.
This is the truly magic of the treatment. This magic is what proves the trueness of the Holographic Universe theory. All the time the Author successfully ended an AP Treatment, he reinforced his belief in the Holographic Universe theory.

Once again the therapist goes through those steps to project on the screen another still image. A this point the patient has repeated those steps for four times, so the therapist will not lose the patient on the way if those steps are sped up a bit. We need to speed up those steps because we don't want the patient's mind starts wandering around. This part will be an induction part and the therapist must have well prepared it in advance.
Only in this occasion the therapist conjugates verbs temporally.
The forth part may be something similar to the following, where the memory X is the second memory (along with its brief description):
"when I say the number 3, it appears an still image: it's about a memory similar to the memory X...very similar... but it's a memory in the future, like a future deja vu, a situation where you feel exactly like in memory X.... 1, 2, 3... all its frozen... what do you see in this frozen picture?", ask the patient for details as previously done. Then, as done previously "when I say the number 3, all is moving and you are in... 1, 2, 3" .
Now with the same care for details we had for the second memory, we enquiry about that future memory, using vocal mirroring and VAK characteristic details. The therapist should enquire about the patient mental status, which should be very similar to the second memory. Then the therapist adds something similar to the following induction, with a warm, slow, clear, and reassuring tone: "oh yes, you feel great... you feel relaxed and in peace in this situation... one reason because you feel so good is because you have just thought about that issue that was giving you many troubles years ago..." (mention about that issue) "since long time you have sorted out that issue, and now thinking about it makes you smile... you are grown mature now, you have experienced a lot in life since that issue was sorted... you have enjoyed life much more since you have sorted out that issue... that issue belongs to your past, now it has faded off since years, now you have been enjoying your life greatly without that issue.... it's gone since years...".

Here the regression of the future memory can be ended by an *Event Control*.

Regression for double-checking

The fifth and last regression should be identical to the third one.

Although the therapist might have sped up with all starting procedures of a regression (sofa details and still image projection) for the last regressions, it would be better the therapist performs this regression at the same speed of the third one.
The therapist should also repeat the same enquires already asked for the third regression.
If the treatment has been successful, what was an issue before in the third regression, it shouldn't be any longer an issue in this fifth regression: from the patient's responses, the last event (third memory) of the issue under treatment should cause no distress any longer.

How closing an AP Treatment

Once switched off the screen at the end of the fifth regression, the therapist can add the following: “now you notice that the little dot is off... that means that the room technology has stopped linking your brain waves... you can still enjoy the technological sofa, that keeps breathing with you”, a *Breathing Focus Loop*. Then, “when I say the number 3, the sofa will stop breathing with you and the elevator will open its doors, so you can leave the Memory Room... 1... 2... 3” (still use the VAK characteristics formulations, i.e. “hear the elevator doors opening”).
Therapist should check the patient's reaction at this point. “Now you can stand and walk toward the elevator... look at the details of the room while leaving... you see, the elevator has been waiting for you... approach the elevator... step by step, feel/hear/see your steps toward the elevator... you can get in the elevator and take seated... when I say the number 3, the elevator closes the doors and start its way up...”. The therapist might even ask the patient for nodding when he/she is seated in the elevator and ready to go up; this would be a sign of willingness to end the therapy. “1, 2, 3... the elevator is going up”.
The part of the way up is much faster than the way down, however the patient is still in an Alternated State of Consciousness, so we need to start making the patient aware about the *real* present situation without rushing too much.
“going up...you can relax and start hearing me taping my pen on my notebook”, the therapist taps the pen on the notebook. “you can hear me tapping my shoes on the floor”, the therapist taps the shoe on the floor. The therapist can make the patient aware about any background noise might be (neighbour, road, and so on).
“you can start feeling your body seated on...”, the therapist describes the seating place, and the physical body contact points the patient may feel and getting now aware of.

“you can start now realising that today is xxxx, you are in the studio xxxxx, at the address xxx... you have been under AP Treatment, cared by Dr xxxxx, who happens to be me”.

Now the therapist may change tone “welcome back! Please stay in this position... relax... open your eyes with the pace you feel more comfortable with... if you need anything, please ask”.

The patient may feel drowsy and tired, and usually the therapist as well. Let the patient time to recover, usually within 10 minutes is ready to leave.