

The Future of Psychiatric Diagnosis lies in Space

and is so off from DSM that you probably don't want to know.

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Psychologist, Lucas Derks (1950) works as researcher and psychotherapist in the Netherlands. Over the last 3 decades he was involved in the application of spatial cognition on problems with relationships. This work, called *social panorama*, resulted in a paradigm named *mental space psychology*. Since 2000 he travels the globe lecturing about this development.

Abstract:

Mental-Spatial Psychodiagnosis can be an addition or even an alternative for symptom based statistical diagnosis, like the DSM. The view, that all thought and experience is projected in the imaginary space in and around the body, gave way to an analysis of how mental issues appear in the sphere around the patient: where is your trauma? It takes interviewing techniques and another view on what is happening among patients. The foundation for mental spatial diagnostics is made in the multidisciplinary field of spatial cognition. However the link to psychiatry has never been made.

Introduction

Mental ailment is one of mankind's major afflictions. Do you devote your career to remedying them? In that case, you have probably invested long hours in linking psychological symptoms with the categories of the DSM. It is logical, since in medicine every treatment should be based on a diagnosis. Consider psychiatry without diagnostics? Then you and your patients would stay incognisant of what they suffer from. Then psychiatry would float in empty *space*!

Space?

From the 1990s, Stanford psychology professor Barbara Tversky¹ pioneers the role of *space* in cognition and behaviour. The 2018 conclusion from her work: *Space is the primary organizing principle in the mind*. Harvard's flamboyant professor Steven Pinker expressed a similar view when he wrote: *Space is the medium of thought*². What we will call *mental space* in this article is the area in and around a person where all imagination, thinking and feeling takes place³: as if the brain projects it there. For instance, when I now suddenly write '*a green chicken*,' you will automatically think of such an animal, and an image –however faint, subliminal and brief– will appear somewhere in the space in front of you. This very phenomenon, was first captured by linguist Gilles Fauconnier⁴ in 1998, in his *mental space theory*. For instance, when I command you *to kill the purple chicken*, this will probably make you aware of an image out in space and also of an associated feeling in your body. In contrast to what some old school philosophers

believed, most thought can do without words – as proven by the intelligent behaviour of babies and speechless animals⁵. Human thought, for a large part, is accompanied by inner speech – but quite often it is not. So what is speechless thought made of?

Concepts can appear in all sensory modalities: as visual images, imaginary sounds, smells, tastes and feelings. But apart from its sensory quality, what all manner of thought always needs is some location in mental space. This means, for instance, that, when a person considers a choice between the items X and Y, the actual considering may be done by inner speech (reasoning), which is noticed somewhere (in the head and vocal chords) and then goes together – albeit subliminary – with the mental-spatial manipulation of X and Y in the shape of images, tastes, smells, feelings and sounds. These X and Y may go from left to right, up or down or can be moved closer or further away; all in this area of awareness called *mental space*. For another example: when you decide to continue reading this very article, you may shift “it” closer and to a more central position in your mental space. However, if you decide to stop reading, you may move “it” away and out of sight... But then you will miss out on being informed about some revolutionary developments!

In the mid-80s the influential linguist George Lakoff⁶ proposed that all experience is 3-dimensional, but language is only 1-dimensional. That is why a lot of grammar serves the purpose of transcoding our 3-D experience into 1-D language and back. And it is obvious that the inaccuracy of this very process causes misunderstandings. It does so in psychotherapy and in everyday life.

Consider the following conversation:

A says: *I had a crash with another customer at McDonalds; we both held a tray of colas, fries and burgers.*

B responds: *Did the McDonalds people give you new food?*

A reacts: *No, we both juggled successfully.*

B says: *Oh?*

B’s misunderstanding is caused by the inability of verbal communication to accurately represent 3-D events. During a conversation, it is often the adjacent non-verbal communication that helps the other 2 or 3 dimensions to come to life: over gesture and gaze. Can you imagine what gestures and looks in the above example would have made clear to B that all drinks and food were saved?

Barbara Tversky also explored the crucial role of gesturing in communication. And she noticed that to re-establish the 3-D character of experience by means of language, gesture is paramount, often in combination with spatial metaphors, like in: *My life was an uphill battle but now I bridged the abyss.*

The gap between theory and therapeutic practice closed

The Society for Mental Space Psychology was established in 2010, after it appeared to the founders that there was a huge overlooked potential in psychology. They noticed the fast expanding field of research called *spatial cognition*, in which neuroscience, cognitive psychology and linguistics join their interests. Fully disconnected from *spatial cognition*

research, a number of psychotherapy schools exist that use *spatial interventions*. This avant-gardist development operates mainly outside of more accepted forms of psychotherapy. However, the *spatial cognition* researchers in the lab know nothing about applications in practical spatial psychotherapy. And vice versa, these *spatial therapists* tend to use a wealth of farfetched, intuitive and metaphorical theories to explain their (often very successful) work. However, the theory they never adhere to is that *space is the primary organizing principle in the mind*. The practitioners of these spatial therapies may even fully miss the fact that, by changing the locations of the problem concepts in their client's mind, they actually work directly with the brain's operating system. The founders of the society for mental space psychology believed to have found the missing link between theory and practice in psychology. Currently they make big leaps by explaining the immediacy of spatial interventions from *space being the primary way of organizing meaning in the mind*.

Now let's look at somatic medicine for a moment. A general practitioner hears his patient coughing wildly while telling him he coughs up blood sometimes. This patient also reports weight loss, difficulty in breathing and the stethoscope makes a scratching sound. "I need to send you to a lung specialist for further investigation." The diagnosis *lung cancer* is on the one hand based on the patient's symptoms (a list), but on the other hand becomes definitive when the bio-medical analyst, the radiologist and the surgeon find traces of tumors (making the initial diagnosis an anatomical, biochemical, fact).

In comparison, the DSM provides us only with the lists of symptoms as our single means to come to diagnostic conclusions. Only in some occasions psychological symptoms are caused by brain disfigurements, intoxication or a malfunctioning endocrine system. When the latter is the case, doctors are at home. But when nothing physical can be found, a definitive diagnosis remains hard. Even though the medical desire to work with physical illnesses pushes a stream of (always "very promising") research to find the neuro-anatomical correlates of psychiatric symptoms, little has been delivered in comparison to all the means and effort put into it. Therefore, we must consider that the brain is maybe not the only place to confirm a psychiatric diagnosis. Now here comes the main message of this article: the alternative place to look for to verify a psychiatric diagnosis is *mental space*.

Mental spatial diagnosis

The prediction is, that one day, in the (far off) future, the concept of *mental space* will be embraced by psychiatry. Psychiatrists will explore *where* in mental space clients locate and create their issues. And on the base of what they will find, they will diagnose and do psychotherapy. It will lead to a far more potent and immediate form of psychotherapy than most of the current "pills" or "talking about" therapies. When psychiatrists will start to work with spatial interventions, their priority will shift from symptoms described in *language* to exploring aberrations in *spatial imagination*. That shift will automatically reduce the amount of time spent *talking about* the issues.

Let's look at the current examples on which this vision is based. Therapist Christine Beenhakker⁷ in the Netherlands tells us: "When I diagnose a depression, I look for specific areas of darkness in the client's mental space. These zones of darkness, noticeable at the moments the client feels their typical depressed sadness, seem to be what depressions are all about. These dark clouds interfere with perception, and they obstruct someone's outlook on a more pleasant future. These areas of darkness hide the

things (like failed career, family, love, fame, health, respect) that people had to give up in their lives. Or the things they worked towards to, for many years and then had to conclude that this will be out of reach. These things were slowly repressed in the psychoanalytical sense: blocked out of awareness, kept out of consciousness. The inhibitory synapses used for keeping something repressed, consume lots of inhibitory neurotransmitters, which is probably at the root of the sensation of darkness, impaired concentration and fatigue. And bad sleep may arise from keeping the repression going at night, to prevent worrying and nightmares. And since the cause of the issue is hidden this way, the clients cannot tell what they are depressed about.”

Momentous complaints like phobias come with brief phenomena in mental space: one image that comes up at a certain spot followed by the strong emotions. Symptoms with longer duration, with semi-permanence, like depression, narcissism or borderline, must come with a permanent state of affairs in mental space. Now, mental space explorers found that persons diagnosed as borderline on the authority of the DSM, tend to keep several images of other people within (or very close to) the space of their body. And narcissism comes with a constant small and large self-image represented near the person. Antisocial personalities coincide with having the image of all other humans at great distance (20 or more meters) and often low and small. PTSD coincides with the representations of traumatic clusters at close range, large and up front, as a cloud of confusing unfinished associations. However, when the traumas are resolved these clusters shrink in size and move to the back. And similarly, when a person is in love a “pink cloud” may do the same. Asperger autism appears to come with an enlarged left hemispheric awareness field in front of the person. This provides the person with extra “calculation space,” which often goes at the cost of the more intuitive and faint background cognition from the right hemisphere. Also, some other insecure clients represent all people as larger than themselves, while, on the other hand, grandiosity results from having made the others small and far away and the self-image super large. In a similar way, people create social isolation: You just need to think of all other humans as very far away and also as disconnected from yourself.

Level of proof

Although some of the above mental spatial psycho diagnosis has been used (and clinically verified) for several decades now, the scientific traditions will very much slow down the testing of, the acceptance of, and implementation of these insights. Research in this area is not always so easy. However, it has been shown to be possible⁸. The mental spatial paradigm in psychology first needs to become more established before studies can be done that will make the real difference for psycho diagnostics. In the meantime, some “alien” clinicians are building a structure for spatial diagnosis that will finally make what is still science fiction today a reality. Don’t worry, this process is slow, spatial diagnosis (and psychotherapy) will probably not bother you during your lifetime.

When you want to get a better taste of what mental spatial therapy is about, then check out “Clean Space,” as developed by the British psychotherapists James Lawley and Penny Tompkins⁹. Older examples are Time-Line Therapy developed in the 1980s by Steve and Connirae Andreas¹⁰, Tad James and Whyatt Woodsmall¹¹, and the Social Panorama¹², developed in the 1990s by the author (Lucas Derks). Instead of asking the client to describe their problem with a “difficult someone,” in the *social panorama* approach I ask: ‘While you feel this tension with him, where in your mind appears the

image of the perpetrator?' And the client may point with their hand at a location somewhere in front and up as the answer. And then I know: As long as this image is at this site, the problem of the client is not yet resolved, but when it has moved and shrunk, this means significant therapeutic progress. So I then use specific psycho therapeutic tools to make it move away from its problematic location.

Nowadays, psycho-diagnostics, is based on lists of criteria and symptoms. These are statistically supported descriptions. The research program to test spatial psycho diagnosis in a similar way has just started. To give that more momentum, it will take many people in academia and in the world of psychiatry that see the relevance of that.

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