Depression treated within the mental space paradigm: effectiveness and training requirements.

Lucas Derks Ph.D., Robbert Masselink Ph.D., Christine Beenhakker MA, Dienie van Wijngaarden MA, Jacqueline Heemskerk, Claudia Wilimsig Ph.D.

Communication to: sociaalpanorama@hetnet.nl

Part Three

This is the third part of the original article *Depression treated within the mental space paradigm* that the authors have split up in three. Part one discussed the existing literature on the mental-space paradigm and gave an overview of two studies into the efficacy of the mental space paradigm for therapy, especially the treatment of depression.

In part two, we continued this discussion by explaining in more detail the first study.

In the present part, the second study is discussed. Whereas the first study aimed to reveal the efficacy of the mental space paradigm in treating depression, this second study shows that a two-day training course equips experienced therapists with the ability to successfully treat depressive clients, using the mental space paradigm.

Study two: Evaluating one day of MSP-D training

In 2017 and 2018 the Society for Mental Space Psychology organized two days of training in the experimental treatment of depression using the method we have called *Depression In Awareness Space,* later abbreviated MSP-D (because our use of DAS was challenged by the lawyers of the insurance company that already used this abbreviation). On both days, held in a venue near Nijmegen, in the Netherlands, about 30 persons were present, among them the researchers, the therapists, the two sponsors and the trainers. The days were sponsored by the NVNLP (Dutch NLP society) and the IEP (Institute for eclectic psychology).

The program consisted of an opening speech, a video that showed the origin of the method with 2 video demonstrations included, extensive explanations of technical details and the set up of the study, a live demonstration of the method and enough time to try the method in a structured exercise.

On this day, the therapists made use of the paper protocol (see Appendix 1) and the questionnaires that were chosen for the study. All technical and procedural questions were answered before the therapists went home with the certainty that they could always get (phone/email) support from the researchers. The idea was that they would find their own, regular type of (moderate) depressed clients, and in case this proved to be too slow, could also acquire clients via social media or local newspapers. The therapists received no payment and had to pay 25 euro themselves for participating in this training (the second batch of therapists only).

The invited therapists were included on the basis of having an NLP-master certificate, social panorama consultant certificate (or some equivalent in hypnotherapy or imagination therapy), having run a private practice for more than 2 years and being members of professional organizations (NVBH, NIP, NVH, NVNLP, SKB accredited, NVPA, NOBCO, VESB).

The time frame for the therapists in which they had to treat 4 clients, was set on 6 months. When after the expiration of this period it was clear that the first training group had not delivered sufficient data, a second training was organized to involve more therapists and prepare them even better for the research protocol. After this training a 6 months of data collection began. Again, the data collection remained below expectations. After an extension of the period and some extra contact with the therapist, the data collection was finally closed, with 47 completed treatments, instead of the 100 aimed for. In the end only 15 therapists produced usable data sets.

One could imagine obvious reasons for the small number of experimental treatments. Firstly, the therapists were not rewarded (paid) by the Society for Mental Space Psychology because of a lack of means. Secondly, the therapist were required not to charge the clients. The therapists were allowed to continue working with the clients after their experimental treatment file was closed on their usual conditions. This happened infrequently and was not interfering with the experimental set-up: it was an ethical necessity.

Besides the lack of financial reward, the researchers could imagine many other reasons why the data collection fell short of expectations. To find out, it was decided to have an independent survey run among the therapist to find out what had made the experimental treatment not as easy as it had appeared. (At the end of the training days there seemed no obstacle left to make it work for all.)

The other rationale was to use this information to improve future trainings for a wider population of therapists. Due to covid19 such a program was postponed to the fall of 2020.

Outcomes of the survey among the therapists: Robbert Masselink Ph.D. took on the role of independent investigator and composed a questionaire of 18 items. This was posted to the 50 therapists and filled out and returned by 17 of them. Among these were 13 who had actually treated 4 clients and completed their data sets. The other 4 were unsuccessful in returning data sets in time.

The low rate of data collection and the low rate of respondents in the survey, were both seen as a consequence of the fact that the invited therapists had not been able foresee the complexity, time and effort of the task. Those who came to the training only knew what was asked of them at the end of this day and later.

It was hypothesized that for many of the invited therapists, the training was just a free opportunity to learn something useful, apart from the scientific goals of the organizers. Since the larger, goal of the project was to familiarize therapist with the new method to treat depression, the fact that most therapist only took the training, still matched with the general mission of the Society for MSP. But the delay in data collection frustrated the project.

The evaluation of the training and project by the therapists: In this section we follow largely the responses on the questions in the questionnaire. The numbers correspond to the numbering of the items. The presented outcomes are an extraction from the 17 responding therapists.

1) Motivation to take part in the research-project training:

The subject of depression was interesting (41%); to learn the MSP-D method (53%); because of the number of depressed clients in their practice (35%); and because of their special ties with the Society for Mental Space Psychology (23%). (More alternatives were possible.)

2) Satisfaction with the content of the of the training:

The explanation of the method: Very satisfied (43%); moderately satisfied (11%).

The explanation regarding how to use the forms and papers: very satisfied (30%); moderately satisfied (55%); neutrally satisfied (25%).

The explanation regarding how to find clients: very satisfied with (27%); moderately satisfied (33%); neutral (75%).

3) Of the responding therapists 13 (=76%) had completed the data collection. Of the respondents to the survey 4 (=23%) had not actively taken part in the treatment of clients within the research project.

4) As a reason for not taking part in the data collection one respondent said finding clients was too hard, two of them stated that they could not use the experimental protocol in a "clear" manner, and a fourth could not do it because of not staying long enough in the Netherlands to follow the time frame of the study (the 2 x 30 days).

5) The evaluation in general when looking back on the project: very positive (23%); mainly positive (46%); slightly positive (23%); slightly negative (7%).

6) How strict did the therapists keep to the research protocol? Without the capacity to video all the therapists the authors relied on the therapists' own judgements. From the 13 therapist that completed the data sets: 58% answered that they strictly followed the protocol; 41% said to have kept it to a large extent. We received 4 descriptions of where there was a deviation from the protocol: One waiting list client was ill at the day of the second test, the test was taken by phone. In one case there was no dark zone found, and the therapist used the reported bodily sensations in the same way as if they had been dark zones. Two clients were tested 2 days before the 30-day target.

7) The satisfaction with the method as a tool in a private practice: 66% were very satisfied; 8% responded to be moderately satisfied; 25% were neutral about the method.

The following comments were given on question 7:
- I make very little use of it, since many depressed clients in my practice are on medication

- The method went to the background, but during the day of training I could use the method well.
- With my autistic clients and with personality disorders it did not work as well.
- I like to work with the method when it suits my clients.
- I am very satisfied. The method is easy to follow and brings us directly to the core of the issue. Clients learn how to do similar steps by themselves afterwards.
- These days I have clients with other issues.
- Clear, people like the concreteness and the action. - What concerns clients in the space around them is already an interesting sensation on its own.
- I used it with several clients with good results.
- Satisfied clients.
- It works very easily and quickly with this method.

8) The responding therapist saw a possible improvement in the protocol, namely to use a printed image that would outline a better 3-D perspective than the current one and as a result would make it easier to sketch the zones of darkness on it. Also, to give suggestions about what to do if no zones of darkness are present. (This had happened twice, when a client knew what caused the depression, so where there was no repression involved. In that case the rest of the protocol can still be very useful.).

9) How satisfied were the therapists with the support they had during the study? 66% very satisfied; 16 % moderately satisfied; 8% slightly unsatisfied; 8% did not use the support.

10) The recruitment of depressed clients: 41% found them in their regular practice; 16% used the suggestions from the training (social media or local newspapers); 41% in other ways, like mobilizing their private network to spread the knowledge of the possibility to take part in the study as a depressed person.

11) How hard was it to assign clients to the waiting list control condition? No problem whatsoever 50%. This question was not clear enough to the other half of the respondents.

12) The usefulness of the standard forms: 66% very satisfied; 25% moderately satisfied; 8% neural.

13) The amount of time that taking part in this study took: 16% not that much time; 25% less than expected; 58% more than expected.

14) Estimated hours: 20, 15, 40-80, 8, 10, 15-20.

17) Estimated use of the method in the years between the training and the present: 43% several times a year; 43% several times a month; 12% otherwise.

18) The practical value of the method was subdivided in:

V= Visible effects on the client.

C= Convenience for the therapist.

E= Ease in combination with other methods.

A= Advantage in relation to other methods.

Distribution of the V, C, E and A answers over a 10-point scale.

																										E					
																										E	A				
																V			A		C	E			C	E	A				
																V	C		A	V	C	E			C	E	A				
				V										A	E	V	C	E	A	V	C	E	A	V	C	E	A				
				V			A		C			V	C	A	E	V	C	E	A	V	C	E	A	V	C	E	A	V	C		

1..2..3… 4 5 6 7 8 9 10

Table 3: From 1 (very low) to 10 (very high).

19) The motivation to make use of the method in the future: strongly motivated 43%; moderately motivated 37%; neutral 6%; and slightly unmotivated 12%.

Conclusions from study two.

It had been relatively easy to find 50 therapists that felt competent and appeared eager to take part in the training in the experimental use of the depression-in-awareness-space method. We could have run two more of these trainings, with a good chance to acquire the data of 100+ clients. But before doing that we preferred to see what was achieved so far with two days of training.

That 15 out of the 50 thus trained therapists produced usable data by keeping the protocol, proved that the training setup can work. The answers given by these 15 therapists in the survey confirmed, that for them the training was sufficient.

Since most therapists who did not produce data, did not respond to the survey, we cannot conclude much about what stopped them from doing so. Only the few (4) who

responded to the survey, but took no part in the study, helped to confirm some guesswork:

1) Probably, before registering for the training, it was not clear for most what was asked of them (research?) before they joined one of the training days.
2) To be trained in a new treatment method was appealing to them, but the complexity and discipline of following and staying within the research protocol was less so.
3) Many had underestimated the complexity and were not able to embark on it for real. It demanded organization, confidence outside of their comfort zone, additional skills and taking the initiative.
4) The excuse that it was hard to find depressed clients was used several times. However, this wasn't necessarily an obstacle, given the ease by which other therapist achieved this.

The main conclusions in relation to the training of therapists in using *Depression in Awareness Space* can be:

1) For about 30% of experienced and well trained (hypnotherapist and master level NLP) therapists, one single day of training can be enough to effectively apply *Depression In Awareness Space* in their private practices.
2) For about 70% of experienced (hypnotherapist and master level NLP) therapists, such as the ones we had invited, taking part in a clinical experiment proves too complex for a variety of known and unknown reasons.
3) Consequently, for those experienced therapists who lack the specific mental-spatial imagination-skills and are less familiar with classical NLP methods, a training with a volume of at least 3 days is recommended to enable them to use *Depression In Awareness Space* effectively. In this training there must be an extra focus on how to access repressed life issues in mental space by exploring zones of darkness, how to support the client in identifying the mental skills and coping strategies (resources) that were critically lacking in their younger selves before the onset of the repression, how to help create these resources with the aid of the *new behaviour generator* techniques and how to help implement these resources backwards in time with the aid of the *change-personal- history* technique.

Overall discussion.

The criterion of "evidence-based" rules clinical psychology today. At the same time depression is a major burden for many people – with a limited range of psychotherapeutic treatment options. A new treatment tool for depression has only a chance to reach these clients when it passes the hurdle of clinical testing. The *Depression In Awareness Space* method, that was central in these studies, showed its effectiveness in a small pilot study and in the hands of a group of well-trained therapists that embraced the mental-space paradigm. The Society for Mental Space Psychology had to take the clinical testing in its own hands, after a lack of interest in any type of cooperation from existing academic institutions. This primarily showed very clearly how hard it is in our current, Dutch, European, landscape of psychotherapy research for a private initiative to satisfy the complex bureaucracy around clinical research. The primary reason is, that

depression is claimed to be a medical condition, and research into its treatment must fulfil the norms of medical clinical research with people. These norms do fit well in academic medical centres where they nevertheless are regarded as a major obstacle. The alternative is investing in the help of commercial, professional research support agencies, for which the society lacks the financial sponsoring.

Be that as it may, executed with the existing means, the data from study one showed support for what had already been found in the practical application of the method for several years. Even though the procedure of *Depression In Awareness Space* was technically demanding by itself and even more in spite of the constrained environment of a clinical trial, well-trained and experienced therapists were able to accomplish a significant number of successful treatments with this approach.

Although the protocol of *Depression In Awareness Space* is presented as a format that should resolve depression in one single go (session), this does not mean that all clients can always be helped in that time frame. Just like other methods that are laid down in the shape of one series of steps that lead to resolution (like EMDR, Re-imprinting or the compulsion blowout), it may be that complications in the form of underlying limiting beliefs, multiple traumas, comorbidities, difficulty in rapport or responsiveness with the client, may extend the work to multiple sessions. This does not take away anything of the value of the tools per se.

Enough success was registered to motivate a training program aimed at a broader group of therapists. Something that promises to make the treatment of *depression with an unknown cause* more efficient. This study holds an invitation to others to do more research in the clinical use of mental-spatial psycho-diagnosis, especially in the correlation between zones of darkness and depression. A larger scale clinical trial to provide more evidence for the effectiveness of *Depression In Awareness Space* needs an academic environment.

References

Barlow, D.H. edit., (2008). Clinical Handbook of Psychological Disorders, A step by step Treatment Manual. Fourth Edition.

Bandler, R. & Grinder J., (1979). Frogs into Princes. Moab Utah: Real people press.

Bandler, R., (1985). Using Your Brain for a Change. Moab, Utah: Real People Press.

Barsalou, L.W., (2012). The human conceptual system. In: M. Spivey, K. McRae, & M. Joanisse (eds.). The Cambridge handbook of psycholinguistics. New York: Cambridge University Press: 239-258.

Basil, B., Mahmud, J., Mathews, M., Rodriguez & C. Adetunji, B., (2005). Is There Evidence for Effectiveness of Transcranial Magnetic Stimulation in the Treatment of Psychiatric Disorders? Psychiatry (Edgmont). 2005 Nov; 2(11): 64–69.

Beenhakker, C., (2016). Black Matter; Depressie en mentale ruimte. Een experimentele pilotstudie naar de psychologische methodiek *Depression In Awareness Space* als behandelmethode voor depressie in een therapeutische context. Eindscriptie HBO Bachelor Toegepaste Psychologie.

Beenhakker, C. & Manea, A. I., (2017). Dark matter: mental space and depression – a pilot investigation of an experimental psychotherapeutic method based on mental space psychology to reduce the distress of moderate depression. Journal of Experiential Psychotherapy, 20, 21 – 26.

Bellmund, J. L. S., Gärdenfors, P., Moser, E. I., & Doeller, C. F., (2018). Navigating cognition: Spatial codes for human thinking. Science, 362.

Bogousslavsky, J., Cummings, J.J., (2000). Behavior and Mood Disorders in Focal Brain Lesions. Cambridge University Press, 2000 – 554.

Brown, P., & Van der Hart, O., (1998). Memories of Sexusl Abuse: Janet's critique of Freud, a balance approach. Psychological Reports, 1998, 82, 1027-1043.

Brewin, C., Gregory, J. D., Lipton, M., & Burgess, N., (2010). Intrusive images in psychological disorders: characteristics, neural mechanisms, and treatment implications. Psychological Review, 117, 210 – 232.

Connor, D. R., & Callahan, J. L., (2015). Impact of psychotherapist expectations on client outcomes. *Psychotherapy, 52*(3), 351–362. https://doi.org/10.1037/a0038890.

Derks, L.A.C., (2005). Social Panoramas; Changing the unconscious landscape with NLP and psychotherapy. Camarthen, Wales: Crown House Publishing.

Derks, L.A.C., (2016). Clinical experiments: what cognitive psychotherapies – like CBT, NLP and Ericksonian hypnotherapy – reveal about the workings of the mind. A theoretical analysis over 35 years of clinical experimentation. Dissertation, Universidad Central de Nicaragua, Nicaragua.

Derks, L.A.C., Oetsch, W. O., & Walker, W., (2016). Relationships are Constructed from Generalized Unconscious Social Images Kept in Steady Locations in Mental Space. Journal of Experiential Psychotherapy, 19(1), March: 3-16.

Derks, L.A.C., (2018). Mental Space Psychology: Psychotherapeutic Evidence for a New Paradigm. Coppelear b.v. Nijmegen, Netherlands.

Dilts, R,, (1983) Applications of Neuro-Linguistic Programming, Meta Publications, Capitola, CA.
Dilts, R., (1990) Changing Belief Systems with NLP, Meta Publications, Capitola, CA.

Dilts, R., (2017). Sleight of Mouth The Magic of Conversational Belief Change. Meta Publications, Capitola, CA.

Dubin, M. J., Llieva, I., Deng, Z. D., Thomas, J., Cochran, A., Kravers, K., Brody, B. D., Christos, J.H., Kocsis, J.H., Liston, C. & Gunning, F.M., (2019). A Double-Blind Pilot Dosing Study of Low Field Magnetic Stimulation (LFMS) for Treatment-Risistant Depression (TRD). Journal of Affective Disorders doi: 10.1016/j.jad.2019.02.039.

Dong, B., Holm, L. & Bao, M., (2017). Cortical mechanisms for afterimage formation: evidence from interocular grouping. Scientific Reports volume 7, Article number: 41101.

Erickson, M. H., (1967). Advanced techniques of hypnosis and therapy; Selected papers, edited by Haley, J.; Orlando, Florida: Grune & Stratton.

Fauconnier, G., (1997). Mappings in Thought and Language, New York: Cambridge University Press.

Freud, S., (1914). Zur Geschichte der psychoanalytische Bewegung.

Gallese, V., (2015). Embodied simulation and the space around us: The perspective of cognitive neuroscience. Keynote at the ICSC Rome, september 9, 2015.

Ganis, G., Thompson, W. L., & Kosslyn, S. M., (2004). Brain areas undelying visual mental imagery and visual perception: an fMRI study. Cognitive Brain Research, 20, 226 – 241.

Graziano, M. S. A., (2018). The spaces between us. A story of neuroscience, evolution, and human nature. New York: Oxford University Press.

Groh, J. M., (2014). Making space how the brain knows where things are. Harvard: Harvard University Press.

Halligan, P. W., Fink, G. R., Marshall, J. C., & Vallar, G., (2003). Spatial cognition: evidence from visual neglect. Trends in Cognitive Science, 7, 125 – 133.

James, T., & Woodsmall, W., (1988). Time Line Therapy and the Basis of Personality. Cupertino, CA: Meta Publications.

Karg, N., Dorscht, L., Kornhuber, J., & Luttenberger K., (2020). Bouldering Psychotherapy Is More Effective in the Treatment of Depression Than Physical Exercise Alone: Results of a Multicentre Randomised Controlled Intervention Study. Free PMC Article, PMID: 32164679 PMCID: PMC7066840 DOI: 10.1186/s12888-020-02518-y BMC Psychiatry Mar 12;20(1):116.

Kaviani, H., Gray, J. A., Checkley, S. A., Raven, P. W., Wilson, G. D., & Kumari, V., (2004). Affective modulation of the startle response in depression: influence of the severity of depression, anhedonia, and anxiety. Journal of affective DIsorders, 83, 21 – 31.

Kikuchi, H., Fujii, T., Abe, N., Suzuki, M., Takagi, M., Mugikura, S., Takahashi, S. & Mori, E., (2010), Memory repression: brain mechanisms underlying dissociative amnesia. Journal for Cognitive Neuroscience, 22(3): 602-13.

Kolk, van der, B., (2015). The Body Keeps the Score : Brain, Mind, and Body in the Healing of Trauma.

Kosslyn, S. M., Shephard, J. M., & Thompson, W. L., (2007). Spatial processing during mental imagery: a neurofunctional theory. In F. Mast & L. Jäncke (Eds.), Spatial processing in navigation, imagery and perception (pp. 1 – 15). Berlin: Springer.

Lakoff, G., (1987). Woman, Fire and Dangerous Things. Chicago: University of Chicago Press.

Lakoff, G. & Johnson, M., (1999). Philosophy in the Flesh. New York: Basic Books.

Levinson, S. (2003). Space in language and cognition: explorations in cognitive diversity. Cambridge, UK: Cambridge University Press.

Matelli, M. & Luppino, G., (2001). Parietofrontal circuits for action and space perception in the macaque monkey. Neuroimage, 14, S27 – S32.

Mckellar, P., (1957). Imagination and thinking: a psychological analysis. Oxford: Basic Books.

Merckelbach, H., Hogervorst, E., Kampman, M. & De Jongh, A. (1994). Effects of 'Eye Movement Desensitization' on emotional processing in normal subjects. Behavioural and Cognitive Psychotherapy, 22, 331-335.

O'Keefe, J., & Nadel, L., (1978) The Hippocampus as a Cognitive Map, Oxford University Press.

Renk, K., Dinger T.M. & Bjustad, K., (2000). Predicting therapy duration from therapist experience and client psychopathology© 2000 John Wiley & Sons, Inc. J Clin Psychol 56: 1609–1614.

Rohan-Rinah, M.L., Yammoto, T., Ravichandran, C.T., Cayetano, O. R., Moralez, D. G., Olson, P., Vitanello, G., Paul, S.M. & Cohen, B.M., (2013). Rapid Mood-Elevating Effects of Low Field Magnetic Stimulation in Depression. Biol.Psychiatry, 2014 Aug 1;76 (3):186-93.

Rijk, de, L., Derks, L.A.C. & Hollander, J., (2019). NLP Conceptual Framework, Tools and Techniques – A Delphi Poll. In Powered by NLP 2, London.

Shapiro, F., (2001). Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures. New York: Guildford Press.

Sheikh, A. A., (2002). Healing Images. Baywood Publishing Company Inc.

Singer, J.L., (1990). Preface: A fresh look at repression, dissociation, and the defenses as mechanisms and as personality styles. In *Repression and Dissociation*. University of Chicago Press.

Stein, D. J., & Young, J.E., (1992). Schema approach to personality disorders. In D. J. Stein & J.E. Young (Eds.) Cognitive science and clinical disorders (pp.271-288). San Diego, CA: Academic Press.

Spivey, M., Richardson, D. & Zednik, C., (2010). Language is spatial, not special: using space for language and memory. In L. Smith, K. Mix & M. Gasser (Eds.), Spatial foundations of cognition and language (p. 16 – 40). Oxford: Oxford University Press.

Thomas, M. & Tsai, C. I., (2011). Psychological distance and subjective experience: How distancing reduces the feeling of difficulty. Journal of Consumer Research, 39, 324 – 340.

Tversky, B., (1991). Spatial mental models. In: Bower, G.H. (ed.), The Psychology of Learning and Motivation: Advances in Research and Theory 27. New York: Academic Press: 109-145.

Tversky, B., (1997). Spatial constructions. In: Stein, N., Ornstein, Tversky, B. & Brainerd, C. (eds.). Memory for emotion and everyday events. Mahwah, N. J.: Erlbaum: 181-208.

Tversky, B., (1999). Talking about space. Contemporary Psychology, 44: 39-40.

Tversky, B., J. Heiser, L. P., & Daniel. M. P., (2009). Explanations in gesture, diagram, and word. In: Coventry, K.R., Tenbrink, T. & BatemanJ.A. (eds.). Spatial language and dialogue. Oxford: Oxford University Press: 119–131.

Vaidyanathan, U., Welo, E. J., Malone, S. M., Burwell, S. J., & Iacono, W. G., (2014). The Effects of Recurrent Episodes of Depression on Startle Responses. Psychophysiology, 51, 103–109.

Wake, L., Gray, R. M., & Bourke, F. S., (2013). The Clinical Effectiveness of Neurolinguistic Programming; a critical appraisal. London and New York: Routledge, Taylor & Francis.

Walker, W. (2014). In L.A.C. Derks, W. Walker & W. O. Oetsch, Mental space psychology. On www.mentalspaceresearch.com.

Whiteford, H. A., et al., (2013). Estimating remission from untreated major depression: A systematic review and meta-analysis. Psychological Medicine 43.8 (2013): 1569-85. ProQuest. Web.

Timimi S., (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished International Journal of Clinical and Health Psychology 14(3DOI:10.1016/j.ijchp.2014.03.004.

Young, J. E., Klosko, J.S. & Weishaar, M. E. (2003). Schema Therapy: A Practitioner's Guide. Guilford Press, New York.

Appendix 1

Guidelines for treating a depression without a known cause

Introduction: Most people who have ever repressed something have not done so in one fell swoop, but the process has proceeded gradually. They have repeatedly come up against a life problem they can't manage and subsequently got stuck on it every time. One can think of problems such as finding out that because of your dyslexia you can never do the work you actually want to do (being a novelist). Or you discover that acne has permanently destroyed your facial skin (you can't be a photo model). At the age of sixteen you become pregnant, and you see your whole future disappear behind a fat belly (you won't be a professor of archaeology). Your parents get divorced, no matter what you try to keep them together (you have failed as a child).

In short, it can be anything, but the biggest common denominator is that you believe you can't change anything, and usually you also believe that no one in the world can. Maybe the best advice you get, is: learn to live with it. Then you're going to try to accept it and efface the problematic stuff from your mind. After a while this goes automatically: you've successfully repressed your problem. Anything that reminds you of it becomes a trigger to spark off the repression mechanism. As a result, you're not consciously paying attention to it anymore, you're not aware of it anymore; but also, you don't remember it anymore.
Stealthily the symptoms of depression begin to appear in your life. First a little, later more, and then as a matter of course: you get used to it and you count on it. And it can very well be that you don't see the connection with where it comes from, thanks to a perfect repression.

After that it's just a matter of time. Then, usually on an evil day, which is actually a very good day, you conclude that something is wrong with you. But what? Some people take a few years to get help. And then it depends on whether the caregiver uses the "depression is a physical disease, a brain disease” model or on the other hand believes in black clouds and does the following:

1) Ask the client to evoke his/her sadness.
2) Have the client indicate where in his/her mental space there are dark areas associated with this sadness.
3) Suggest that the sun shines on the dark areas (like on the beach).
4) Suggest shifting the dark areas to the centre of attention (50 cm in front of the eyes).
5) When the client indicates that the dark areas have become 50% lighter and smaller, it is time for the next question: What have you ever given up in your life because you discovered that you would never reach, learn, be, get, or experience it? Or what valuable things have you ever lost? What important value or conviction have you ever been compelled to let go of? So, what is it that hides behind the dark areas?
6) Help the client determine the age at which this abandonment happened in his life.
7) Help the client translate the answer to point 5 (the thing that was given up) into an ability that would have made the lack of the answer to point 5 manageable. What should someone be able to do in order to deal with this?

Extra technical explanation for identifying the lacking capability:

1) Find the issue behind the zone of darkness.
2) Help the client to remember when in their life, at what age, this started.
3) Now it is essential, to help the client to identify the capability, that if the client at that age would have had this capability available – could have used that skill – could have **made the repression of the issue not necessary**.
4) Thus, the sought for capability is not a means to replace that what was lost that caused the issue, but it needs to be what capability it should have taken to cope effectively with the issue.

Because the life themes that cause people to become depressed are often very difficult to deal with, we must also give unrealistic, superhuman abilities a chance (e.g. "to let go of everything", "to forgive myself and everyone", "universal love", "to be there completely"). In this context, we must also consider spiritual resources.

Extra technical explanation for finding spiritual resources:
Here one can use also the NLP technique called *core transformation.* Or a short cut that goes like this:

1) What was the most beautiful experience of your life?
2) What was the emotional quality in this most beautiful experience that made it so special? Name that.
3) Next, the client evokes a very intense example of this, and re-experiences that in all sensory systems and connected to a colour of light. The whole experience, its name, the colour and all the feelings, voices, breathing and visuals can then be used as the spiritual resource: the capability that could have helped to cope with the issue earlier in life.
4) For the same purpose the *new behaviour generator* technique can be used:

Usually, as soon as the client has described the necessary ability, we look for a role model that has this skill and uses it effectively. Again, we are particularly open to superhuman, supernatural, spiritual beings.

Extra technical explanation of the new behaviour generator:

1) Support the client in finding a role model that the client believes is able to deal with the issue (that was behind de zone of darkness).
2) Name the capability this role model has and help the client to visualize the role model as actively having this capability.
3) When the role model is visualized as having the capability, the client can visualize the role model as coping with a similar issue as the one that was hidden behind the zone of darkness of the client.
4) Only when the client imagines that what the role model does looks effective, the client will change the image of the role model in an image of themselves: same capability but now they see themselves do it, feel it, use it effectively.
5) When the client appears to be convinced that they can see themselves use the capability of the role model effectively, they step into their own image and experience from the inside (associated) how it is to be capable to deal with the issue.

Thus, as soon as a model example has been found, the client will visualize it in detail, until a very good and clear image of this ability is created and then the client changes the role model into himself and now visualizes himself as someone who has the ability.
When the client sees himself performing the ability satisfactorily (dissociated), he can take the image of himself and step into it and feel what it is like to be able to use the ability (associated).
Then the client visualizes his/her younger self, prior to the age where the issue started in his/her life.

Extra technical explanation for changing personal history with a younger self:

1) Have the client visualize their younger self from before the issue started in their life.
2) Only when that image of the younger self looks fine, the client activates the capability (acquired from the role model) as strong and intense as possible.
3) The capability is transferred (or taught) to the younger self until the younger self appears fully capable of applying it in the difficult situations ahead.
4) The client then steps into his/her younger self and senses the presence of the capability earlier in life.
5) From here the client imagines growing up anew, but now having and applying the capability (that stemmed from the role model) everywhere in his life where it could have been useful.

6) The client takes all the time necessary for this before getting back into the present,

The client mentally transfers the ability to his/her younger self.
The client steps into his/her younger self and experiences having the ability as his/her younger self. The client, being associated in his/her younger self, steps into the age before the age when the issue started (point 6, perhaps on the timeline). The client grows up again in his/her imagination and uses the newly acquired skill wherever it was needed.
As soon as the client has arrived back in himself/herself, in the here and now, we can test the effect. To do this, we ask the client to evoke once more his/her sad, depressive feeling. We can also ask where the dark areas are now. The remaining negative feelings of all sorts and the remaining zones of darkness are showing what else needs to be done. So, from here the therapeutic process may be ended or continued, based on this feedback.

When testing the ecology, the main question is whether the client can actually live from the present onwards without depression.

Comment to appendix 1
Change personal history on the timeline, in combination with the new behaviour generator, helps to activate the missing abilities and retroactively implement them in a person's life. This is Old School for most NLP-ers and they can work with it flexibly. Therefore, the novelty of the approach described above is only the search for dark areas in mental space. In addition, changing the sub-modalities of the dark areas is the method that provides access to the repressed and abandoned stuff. Question 5 is the key to being able to identify the missing abilities. The recurrent observation while using this method is that once the abilities are implemented in life, the feelings of depression lose their effect.

Clients are often no longer able to recall the depressive feelings in all their former intensity and usually only report small remains of the dark areas. The NLP-people who use this method report so much success that it seemed worthwhile to start a study into its effectiveness, scope and applicability. Should this approach ever get into the mainstream mental health care, we might witness that the model of depression as a disease is transformed into the broader mental spatial diagnostic category of 'intrusions into mental space' and the diagnosis of ‘depression without a known cause’ will be used more commonly.