

The Future of Psychiatric Diagnosis lies in Space: and is so off from the DSM-5 that you probably don't want to know

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Abstract

Introduction: *Mental Spatial Psycho-diagnosis can be an addition to, or even an alternative for symptom-based statistical diagnosis, like the DSM-5. 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 psycho-trauma? It takes interviewing techniques and another view on what is happening among patients. The foundation for mental spatial diagnostics was laid in the multidisciplinary field of research called "spatial cognition". However, the link to psychiatry has never been made.*

Objectives: *The purpose of the present article is to propose an alternative model of psycho-diagnosis and intervention to be used both in psychotherapy and in the psychiatric field, a model based on the space occupied by the symptom in the mind of the patient and how spatial interventions can effectively identify and address it. It starts from the premise that space is the primary organizing principle in the mind.*

Methods: *The article uses qualitative methods, specialty literature is reviewed to interconnect multi-sector findings on spatial cognition, interventions, linguistics, as Mental Spatial Psycho-diagnosis, Clean Space, Social Panorama, Time-Line Therapy, and the more recent Wholeness Process, and further link them to psychiatric diagnostic.*

Results: *The article prediction is that, sometime in the future, the concept of mental space will be consolidated in psychiatry.*

Conclusions: *Both psychiatric and psychotherapeutic interventions will explore where in mental space clients place and create their issues, this leading to improved interventions. However, the mental spatial paradigm needs to become more established before studies can be done so that a difference for psycho-diagnostics is made.*

Keywords: *Mental Spatial diagnosis, spatial cognition, mental space, clean space, social panorama, psychiatric diagnosis*

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I. 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 incognizant of what they suffer from. Then psychiatry would float in empty *space*!

Why space?

From the 1990s, Stanford psychology professor Barbara Tversky (1999) pioneers the role of *space* in cognition and behavior. The 2018 conclusion from her work: *Space is the primary organizing principle in the mind*. Harvard's flamboyant professor Steven Pinker (2007) expressed a similar view when he wrote: *Space is the medium of thought*. What we will call *mental space* in this article is the area in and around a person where all imagination, thinking and feeling takes place (Groh, 2014), 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 Fauconnier in 1998 (Fauconnier & Turner, 2002), 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 behavior of babies and speechless animals (Emmorey, 2001). 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 throat, head and vocal cords) and then goes together – albeit subliminal – 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 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 Lakoff (1989) 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 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 rapidly 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-garde 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*.

Psychiatric diagnosis

Now, let us first look at somatic medicine. Suppose a general practitioner hears his patient coughing wildly while he is also telling to cough up blood sometimes. This patient reports weight loss, difficulty with breathing and the doctor's stethoscope makes a scratching sound. The doctor now has a **list of symptoms** and comes to an **initial diagnosis**. "I need to send you to a lung specialist for further investigation." Later, the **differential diagnosis** *lung cancer* is based on the one hand on the patient's symptoms (the 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 into an anatomical, biochemical, fact).

In comparison, the DSM-5's 900 pages provide us only with lists of symptoms as our single means to come to diagnostic conclusions about its 350 mental disorders (Frances, 2019). Only in some occasions psychological symptoms are caused by brain damage, disfigurements, intoxication or a malfunctioning endocrine system. When the latter is the case, medical 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 so far 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 a differential psychiatric diagnosis is *mental space*. One could say: mental space is as it were the body of the mind.

II. Method and results

Mental spatial diagnosis

The prediction of this article 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 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 us look at the current examples on which this vision is based. Therapist Christine Beenhakker (2016) in the Netherlands tells us: "When I diagnose 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 about. These dark clouds interfere and shade perception, and they obstruct someone's outlook on a more pleasant future. These areas of darkness hide very difficult things that people had to give up striving for in their lives (like a failed career, no offspring, broken off love, years wasted, missed opportunities, lost health, lost identity, guilt, shame, lacking respect). Or the things they worked towards to, for many years and then had to conclude that this will be out of reach. After concluding that it was hopeless, 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

neuro-transmitters, which is probably at the root of the sensation of darkness, impaired concentration and fatigue (Singer, 1997). 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 us what they are depressed about.” And Beenhakker uses psychotherapeutic protocols that aim at “lighten up the darkness in mental space, by retrograde coping with the repressed issue.”

Momentous complaints like phobias come with brief phenomena in mental space: it may consist of 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 permanent states of affairs in mental space. Now, mental space explorers found that persons diagnosed as borderline, on the authority of the DSM-5, 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 images of all other humans at great distance (20 or more meters) and often low and small. PTSD coincides with the representations of traumatic clusters of memories 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 tend to move to the back. And similarly, when a person is in love, a “pink cloud” may block and filter the outlook on the world in a similar fashion as a dark cloud does: with however the opposite effect on one’s mood. 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 consider that you image all other humans as very far away and also as disconnected from yourself.

III. Discussion and conclusions

Level of proof

Although some of the above mental spatial psycho-diagnoses have been used (and clinically

verified) for several decades now, the scientific tradition slows down the testing, the acceptance, and implementation of these insights. To get funding, academic support and ethical acceptance of research in this area is not easy. However, to test spatial diagnostic patterns over clinical studies has been demonstrated possible (Derks, Oetsch, & Walker, 2016). But it appears that the mental spatial paradigm first needs to become more established before studies can be done that will make the difference for psycho-diagnostics. In the first edition of the Mental Spatial Diagnostic guide (MSD-1, 2019), authored by the Society for Mental Space Psychology (www.somsp.com), the above is made accessible. 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. But have no worries, the process of acceptance 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 Tompkins (2003) (<https://youtu.be/PNNPtcaJ2I>). Older examples are *Time-Line Therapy*, developed in the 1980s by Steve and Connirae Andreas (1989), Tad James and Whyatt Woodsmall (1988), and the *Social Panorama*, developed in the 1990s by the author (Lucas Derks) (2005) (see on YouTube & <https://vimeo.com/540141115>). 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 psychotherapeutic tools to make it move away from its problematic location. The newest spatial form of psychotherapy is developed since 2010 by Connirae Andreas (2018), called *Wholeness Process*.

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 just started. To give that more momentum, it will take people in academia and in the world of psychiatry that see the relevance of that.

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