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 -

Christine Beenhakker*[i], Alexandru Ioan Manea[ii]**
*Society for Mental Space Psychology, The Netherlands
**Faculty of Psychology and Educational Sciences, Department of Psychology, University of Bucharest, Romania

Abstract

Introduction: *The introduction presents some statistic figures about depression, the perspective of the DSM model of depression, an overview regarding a new emerging paradigm, called "Mental Space Psychology" and its connection with a hypothesis regarding lowering symptoms of depression.*

Objectives: *The main goal of this pilot study was to investigate the measurable effect of the experimental treatment method Depression in Awareness Space (DAS).*

Method: *The practical suitability of the DAS method was tested with five clients in psychotherapeutic context; five other subjects did not follow a DAS intervention and constituted the control group (n=10). Preceding the pilot investigation, the clients were subjected to a so-called Four-Dimensional Symptom Questionnaire (4DSQ, Dutch: 4DKL/Vier-dimensionale Klachtenlijst) in order to determine to what extent they experienced depressive feelings.*

Results: *After four weeks, the five clients that followed the DAS methodology were re-examined with the 4DSQ and for four out of the five clients, their scores on the "Depression" scale significantly lowered. Also, their subjective feelings regarding depressive states were recorded, and they reported that they found a positive coping strategy for their problem.*

Conclusions: *The success of this pilot study gives enough confidence to start a more ambitious project in using the Depression in Awareness Space (DAS) methodology for a larger study involving at least 100 subjects.*

Keywords: Mental Space Psychology, Depression, Social Panorama, Psychotherapy, Depression in Awareness Space

[i] Corresponding author: Christine Beenhakker, Society for Mental Space Psychology, The Netherlands. Website: www.somsp.com E-mail: c.beenhakker@reflectacoaching.nl.

[ii] Corresponding author: PhD student Alexandru Ioan Manea, Faculty of Psychology and Educational Sciences, Department of Psychology, University of Bucharest, Romania. Website: www.fpse.unibuc.ro. E-mail: alexandruioan_manea@ymail.com

I. Introduction

"Nobody understands it, including myself. My life is running smoothly. I am surrounded by loving and caring people. I have nice work, completed two studies and I make interesting trips. Yet the feeling rankles that my life is not complete. As if I lost a few puzzle pieces of who I am, of my identity, which cannot be found. As if everybody else manages to capture the sun's rays, but a dark cloud is permanently hovering over my head" (Wit de, J., 2017, Eindhovens Dagblad).

During the depression gala in the Netherlands in January, Dutch celebrities as actress Karin Bloemen and journalist Sophie van der Enk gave an impressive account of their struggle with depression. For many people depression constitutes a big problem in daily life, and the diversity in the subjective experience of a depression is great. Some people are reduced to inability to do anything, whereas others still manage to drag themselves to work. However, the feeling of desperation and repression is hard to deal with for all depressive people.

Figures about Depression

In the Netherlands about half a million people suffer from a severe depression nowadays. Feeling depressed is more than having an "off day". It is a feeling of "being chronically unhappy." Depression is an "illness" which is an unhealthy continuous feeling of normal gloom and sorrow; however, the dividing line where sorrow or gloom stops and turns into a depression is often hard to draw. Yearly, about 285.000 adults in the Netherlands get a first depression (Hersenstichting / Brain Foundation, 2016). More than 6% of the adult Dutch population up to 65 is suffering from a depression or had a depression a short time ago (Fonds Psychische Gezondheid / Psychological Health Fund, 2011). There is an incidence of depression as twice as high amongst women than amongst men. Amongst the 12 to 16 year-olds we are talking about a figure 0.7%. These data are from the health survey (CBS, 2016); the figures relate to s*elf-reported* feelings of depression and not to formal diagnosed depression.

In many cases the treatment of depression consists of a combination of medication and talking sessions. In case of a diagnosed depression, an intensive treatment is often proposed, consisting of talks with a psychologist or antidepressants or a combination of both. The psychologist draws up a treatment plan (a so-called Diagnose Behandel Combinatie / Diagnosis Treatment Combination), listens to the complaints and how the client experiences these complaints. In most cases the treatment does not exceed a few supportive and illuminating "talk sessions." The general practitioner/family doctor often prescribes antidepressants for medication and in serious cases the patient is referred to the psychiatrist.

DSM thinking: Depression is a Disease

According to the DSM 5 – the international manual for psychiatric disorders – depression is a disease: a so-called mood disorder. A state of mind is called a depressive disorder or clinical depression in case of a continuous depressive mood that is present almost daily and during the greater part of the day. A depression can succinctly be described as unusual sombreness and/or not being able to enjoy anything, for two weeks or longer, in combination with problems like decreased appetite, insomnia, little energy, weariness, concentration problems, indecisiveness, physical restlessness and thoughts about death or suicide. Characteristic of a depression is that the symptoms impede daily functioning and that psychological suffering is apparent (Fonds psychische gezondheid / Psychological Health Fund, 2011).

During the last few years there have been critical voices about the DSM. Ever more deviations from the norm are branded as psychological disorders. Even mourning and coping with bereavement are now included in the DSM classification whereas mourning is in fact a normal situation after a sorrowful experience of loss. The DSM describes the symptoms and relates the classification to medication. In other words: DSM-thinking notably homes in on finding and supplying medicines as a solution to the person's suffering (Zafiris, W., 2016). However, underlying causes of the psychological and emotional problems that trouble people are not investigated in the manual.

Without us realizing it, DSM-thinking has deeply penetrated our collective unconsciousness (Zafiris, W., 2016). The DSM manual lies on the family doctor's desk, and when you visit the doctor with a psychological-emotional problem he virtually resorts to the DSM and tells you what is troubling you. Our manner of thinking about depression appears to be strongly influenced by *unconscious assumptions* that we have adopted from the DSM. These assumptions have caused us to look for the wrong solutions and methods of treatment in a medical framework. To be sure, the symptoms in the DSM do describe the external features of the depression, but they do not tell us what the underlying problem is, or how depressed people think,

what they experience, how they look at the world and on what grounds they draw their conclusions.

Mental Space Psychology

In November 2016 Lucas Derks PhD, a social psychologist and noted NLP trainer, obtained his doctorate at Nicaragua University with a dissertation on Mental Space Psychology. The question that is answered by *Mental Space Psychology* is: How do we represent inter-human relationships in the space around us? After more than 25 years of research, Derks reached the conclusion: We represent our relationships *unconsciously* in a three-dimensional mental map: “Where concepts (cognitions, thoughts, mental representations or experiences) are located, largely decides about their emotional and rational impact” (Derks, L.A.C., 2016).

Together with two partner friends of the Laboratory of Mental Space Research, Wolfgang Walker in Germany and prof. Walter Ötsch, PhD, in Austria, Derks has investigated the principles of mental space in depth. Jointly they have concluded: *Space is the primary organizing principle in the mind* (Derks, L.A.C., Ötsch, O.O., Walker, W., 2016). This means that all manner of thought – however concrete, abstract, conscious or unconscious – is located somewhere in the space in and around the person. After all, you always think something “somewhere.” Other scientists, as Julian Jaynes (1976), Edward T. Hall (1966) and Barbara Tversky (2005), endorse this principle. The american psychologist Julian Jaynes (1976) postulates: “Everything we think, we are thinking somewhere in the space around us. When I am thinking of a cat, then, in my thoughts, that cat may be at a 5 metres distance and 2 metres up to the left”. Likewise, methods like Hellinger’s Family Constellations and Derks’s Social Panorama and *Time Line Therapy* can be explained by the principles of mental space (Derks, L.A.C. & Manea, A.I., 2016).

According to Derks, the negative emotional impact of objects in mental space increases when, in the client’s experience, they are positioned nearby and centrally (straight in front) and are big, high or tall, dark, louder and hotter (Derks, 2002). In his doctoral thesis “*Clinical Experiments in Mental Space*” (2016), Lucas Derks describes a great number of clinical experiments, including the method “Depression in Awareness Space” (DAS). By working with mental space Derks wants to give a huge boost to developments in the therapeutic field. Frequently, therapists aren’t even aware of working with mental space. When, for instance, we lay little notes on the floor to structure personal meanings for the client, we are automatically activating the client’s spatial sense of direction and, consequently, you are working with mental space psychology. For the client, it is often quite natural to “occupy” such a space or to go through a time line.

Mental Space and Depression

Clients with a depression often speak in terms of gloom, heaviness or darkness to describe their depression. The experience of depression is often psychologically associated with “*dark matter*”, or darkness. Psychologists take this to be a metaphor, but the client often undergoes his or her depression as something “tangible.” Winston Churchill, for example, described his own depression as a “black dog” (Attenborough, W., 2014). Others experience their depression as a “dark cloud”, like the person in the example above. These metaphors indicate a three-dimensional “image” of a depressive feeling. If we take these metaphors as something real we can start working with them and make them “lighter.”

According to Lucas Derks (2016) the experience of “darkness” in mental space suggests a process of repression, or suppression, that clients are unable to handle; of something they have given up in their lives and about which they feel hopeless. Just “being aware” of these so-called “dark zones” has no therapeutic value in itself. It is a matter of retrieving the repressed feeling that is hidden *behind the client’s dark zones*, and to transform it. That is what the therapy must be directed at.

Darkness disappears when light shines on it, so the proverb goes. By shedding light on the metaphorical darkness of depression, as on a dark cloud, mental space is affected in such a way that people can better handle their “dark zone” of depression because it often gets smaller and lighter and changes place and shape. Consequently, it becomes easier for the client to look “behind the black cloud of darkness” in such a way that the true problem behind the depression becomes perceptible. So, the gist of the treatment is to discover and transform the repressed feeling hidden behind ‘the dark zones,’ so that people can experience relief and “enlightenment.”

Objectives

The main objective of this pilot study is to investigate the measurable effect of the experimental treatment method Depression in Awareness Space (DAS) in working within a psychotherapeutic context with clients who suffer light to mild depressive complaints.

Hypothesis

Hypothesis 0: The Depression in Awareness Space (DAS) method will not reduce the client's symptoms of depression.

Hypothesis 1: The Depression in Awareness Space (DAS) method will reduce the client's symptoms of depression.

II. Method

A Pilot Investigation into the Effectiveness of the DAS Method

In practice, this therapy form for the treatment of depression has not yet been researched. Therefore, as part of the final project of this present study we have set up an experimental pilot investigation into the effectiveness of the DAS method in order to ascertain whether this therapy method is effective and can be implemented in the psychological therapy practice.

In order to get maximally reliable results in this pilot investigation, the candidate subjects for the research had to satisfy a number of criteria for selection. They should not be knowledgeable about NLP or related techniques, not use anti-depressive medication and not suffer from a serious pathological depression. All subjects knew that this was an experimental treatment and volunteered to participate.

The practical suitability of the DAS method was tested with five clients in the psychological therapy practice; five other subjects did not get a DAS intervention and constituted the control group (n=10). Preceding the pilot investigation, the clients were subjected to a so-called Four-Dimensional Symptom Questionnaire (4DSQ, Dutch: 4DKL/ Vier-dimensionale Klachtenlijst) in order to determine to what extent they were troubled by depressive feelings. The 4DSQ consists of 50 different items spread over four dimensions, namely: distress, depression, anxiety and somatisation. The maximum score on the depression dimension is 12. Because in this pilot study only people with a light or moderate depression were eligible for treatment, the score on the depression dimension was not allowed to exceed 6. Thereafter an appointment was made with the test subjects concerned for a treatment by the DAS methodology.

At the outset of the treatment session these clients' subjective experience of depression was "scored" on a 10-point experience scale, 0 meaning not depressive at all, and 10 always depressive. The respondents were not granted perusal of the DAS treatment protocol in order to test the intervention as reliably as possible. The DAS treatment protocol was strictly followed to guarantee the reliability of the DAS model as much as possible. Afterwards a short report was made of each session. After four weeks, the respondents filled in a 4DSQ questionnaire once more to measure the effect of the DAS intervention. In addition, the respondents were called to score their feelings and their subjective experience of (the intensity of) the depression on a 10-point experience scale.

To exclude external factors as much as possible, the control group, likewise consisting of five subjects with light depressive complaints, filled in a 4DSQ questionnaire twice: at the outset of the investigation and four weeks later. The research criteria of the control group were equal to those of the intervention group.

The DAS Intervention

The *Depression in Awareness Space* model, briefly called the DAS model, has a specific fixed structure and roughly comprises three phases.

In the first phase the client indicates how badly he or she is experiencing the depression right now on a 1 to 10 scale. Then we have the client associate with the dark feeling of depression and point out where it is localized in space. The client often uses a metaphor of his or her own. Subsequently we have the client imagine that this dark zone is shone upon exuberantly by sunlight and that the dark region moves to the centre of his or her attention, right in front of the eyes. Give the client sufficient time to visualize this and to experience and describe exactly what is happening. The expectation is for the dark area to slowly become smaller or melt and/or become considerably lighter. When this has sufficiently come about ask the client if he/she can find out what the problem is behind the dark zone.

In the second phase of the process the real problem is taken in hand. The central question that can be asked here is: *"Do you know a person, or do you believe a person exists who can cope with the problem lying behind the dark area?"* This question serves to find a coping strategy for the actual problem. If the client can imagine this he/she starts working with it: first from a dissociative situation (from a distance) and then in an associative position (being in the experience). Please note that the client has first to be completely sure of the suitability of the coping strategy supplied, before he/she sets to work with it. It is also important to test the

ecology of this new helpful behaviour carefully so that no objections to executing it are left.

After the session, the client is asked how and to what extent the depression is still present in his/her life (on the 1 to 10 scale) in comparison with the beginning of the session. The difference between these two values denotes the degree of "relief/enlightenment" experienced.

The last and third phase takes place after four weeks. Then the client is asked once more how and to what extent the depression is still present and/or is experienced in his/her life on the 1 to 10 scale of personal perception.

As an objective post-measurement, the 4DSQ is again filled in by the client in order to measure how and to what extent the depression has decreased and/or to what extent the complaints are still present.

If, after these four weeks, the client is still experiencing insufficient "relief/enlightenment" and a less than two points difference on the ten-point scale of experience, the steps of phase 1 and 2 can again be passed through to diminish the pressure of the suffering and to enhance the feeling of relief. In this case another intervention technique might be called for to solve the problem in an ecological manner, like the family panorama model (Derks, L.A.C., 1997) or re-imprinting (Dilts, R., Hallbom, T. & Smith, S., 1990).

III. Results

All five clients were able to localize their depression within or around themselves by means of a metaphor, such as "grey fog", a "big stone" or a "black zone around the throat". By shining sunlight on these dark zones the various metaphors of their depression became lighter, more transparent or less heavy, so that "the fog lifted", or "lighter spots appeared in the dark zone", whereby the problem behind their depression became "visible."

All five clients appeared to be able to see what problem was lying "behind the dark zone of depression", like loneliness, problems in youth, lack of confidence, anxiety or grief.

Four of the five subjects could find a helpful coping strategy to tackle the underlying problem and to tap new resources in themselves, like "kicking back", overcoming anxiety, being more purposeful, enter confrontations with the outside world and exhibit courage.

Table 1 shows the subjective experience of depression immediately before the DAS intervention and after four weeks. Immediately after the DAS intervention the *mean* decrease of subjective feelings of depression on the 10-point scale was 1.6. After four weeks it was even higher, to wit 2.4. In conclusion, all clients experienced "relief/enlightenment" of their depression after four weeks.

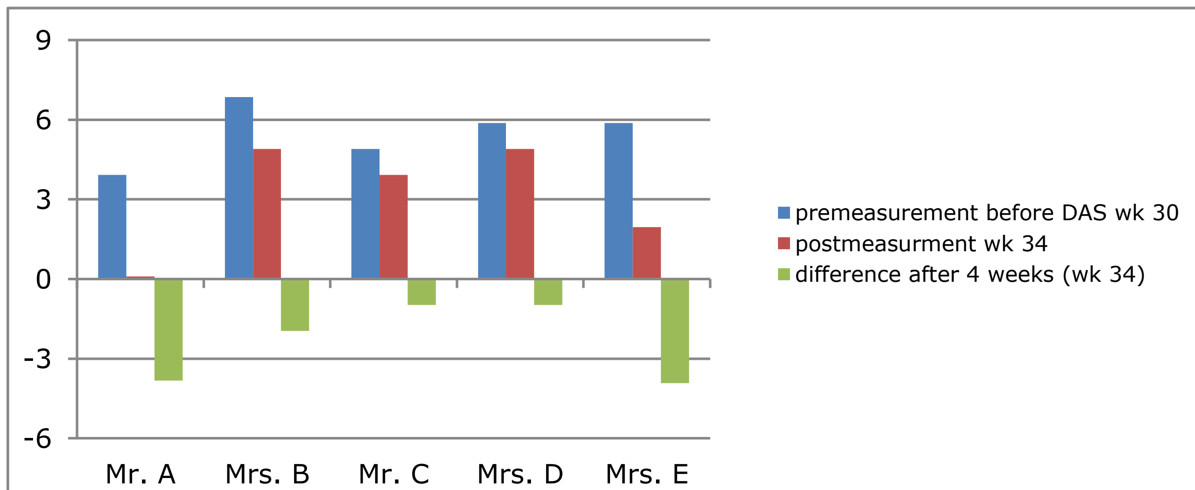

Table 1: representation of the subjective experience depression before DAS (week 30) and after 4 weeks (week 34)

The blue columns represent the degree of subjectively experienced depression before the DAS intervention on a scale of 1 to 10. The red columns represent the degree of subjectively experienced depression four weeks after the DAS intervention. The green columns represent the decrease of subjectively experienced depression (relief) after four weeks.

IV. Discussion

From the 4DSQ scores it was clear that with four of the five respondents after four weeks a positive effect was still measurable after the DAS intervention. With four of the five persons of the control group no big differences were measured on the Depression dimension. With one test subject, as well as with one person of the control group, there were strongly changed circumstances of life due to external factors. On the basis of the results of the investigation we can conclude that Hypothesis 1 is supported and that Hypothesis 0 is rejected. Thus, we can postulate that the DAS method contributes in a positive manner, and that the degree of depression and, as the case may be, the pressure of the suffering decrease.

V. Conclusion

Summarizing, we may conclude - with due caution - that the DAS method is effective with people having light to mild depressive complaints.

However, this investigation was conducted by only one therapist, namely the authors of the present study, with a very limited research population. In order to really prove the relevance of the DAS method and to give it a scientific basis, we would like to expand our research with more therapists and a bigger research population.

Future Research

The follow-up research will take place under the auspices of the Society for Mental Space Psychology, www.somsp.com. Lucas Derks, PhD, and the authors are members of this platform. For this follow-up research, we are recruiting qualified therapists in the Netherlands who are sufficiently conversant with the theory and practice of mental space. The therapists concerned are screened and trained in advance in order to perform the DAS intervention as carefully as possible.

In October 2017, a one-day workshop will be held for all screened therapists, in which the research protocol and the DAS method are explained and practised.

References

American Psychiatric Association APA (2014). *Beknopt overzicht van de criteria DSM-5*. Amsterdam: uitgeverij Boom

Attenborough, W. (2014). *Churchill and the 'Black Dog' of Depression: Reassessing the Biographical Evidence of Psychological Disorder*. London: Palgrave Macmillan

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.* NCOI Hogeschool: Eindscriptie HBO Bachelor Toegepaste Psychologie

Beenhakker, C. (2016). *Society for Mental Space Psychology slaat een brug. Therapiepraktijk en psychologisch onderzoek verenigen.* NVNLP INzicht: jaargang 16, nr. 4

Derks, L.A.C. (1997). Family Systems in the Social Panorama. *NLP World*. (4)1

Derks, L.A.C. (2002). *Sociale Denkpatronen. NLP en het veranderen van onbewust sociaal gedrag.* Utrecht: Kosmos uitgevers/Servire

Derks, L.A.C. (2016). *Clinical Experiments in Mental Space*. *What cognitive psychotherapies reveal about the workings of the mind.* Promotieonderzoek Dr. Lucas Derks. Nijmegen: International Laboratory for Mental Space Research

Derks, L.A.C., Manea. A.I. (2016). On the Emergence of Mental Space in Psychology: Interview With Lucas Albert Charles Derks. *Europe's Journal of Psychology*. 12 (2). Accesed at: http://ejop.psychopen.eu/article/view/1186

Derks, L.A.C., Ötsch, O.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), 3-16

Dilts, R., Hallbom, T., Smith, S. (1990). *Beliefs, Pathways to Health and Well-Being*. Portland, Oregon: Metamorphous Press

Does, van der W. (2005). *Dat moet mij weer gebeuren. Zwartkijkers, zeurpieten en pechvogels.* Amsterdam: Scriptum uitgevers

Hall, E. T. (1966). *The Hidden Dimension*. New York: Doubleday.

Jaynes, J. (1976). *The Origin of Consciousness in the Breakdown of the Bicameral Mind*. Boston: Houghton Muffin

Tversky, B. (2005). Functional significance of visuospatial representations, in P. Shah & A. Miyake (Eds.), *Handbook of higher-level visuospatial thinking* (pp. 1-34). Cambridge: Cambridge University Press

Williams, M., Teasdale, J., Segal, Z., Kabat-Zinn, J. (2010). *Mindfulness en bevrijding van depressie. Voorbij chronische ongelukkigheid*. Amsterdam: uitgeverij Nieuwezijds

Wit de, J. (2017). *Maar jij lacht toch altijd?* Persgroep: Eindhovens Dagblad, Hart & Ziel

Zafiris, W. (2016). *Geluk is deprimerend. De gids naar duurzaam geluk*. Amsterdam: WAAS Publications