

DEPRESSION – A GESTALT THEORETICAL PERSPECTIVE

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Jan Roubal

Abstract: Gestalt therapy with its focus on the process of ongoing therapeutic relationship can contribute to both the theoretical understanding and the treatment of depression. The diagnosis of depression is explained as a relational phenomenon in this article. Depression is seen as a pathological fixation of an initially useful mechanism of creative depressive adjustment. Fixed interpersonal patterns of depression manifest in the therapist-client relationship and there are also accesable for exploration and possible changes.

Key words: depression, psychotherapy, gestalt therapy, therapeutic relationship

Introduction

An unhealthy lowering of mood, seen as a disease, was described over 2500 years ago. The World Health Organisation rates depression as the fourth most urgent global health problem. It affects hundreds of millions people worldwide. At least 20% of women and 12% of men experience depression during their life and 15% of depressed people end their life by suicide. (Akiskal, 2000) Despite the widespread use of antidepressants, their efficacy remains unsatisfactory. 15% - 30% of depressed people do not show a response to antidepressant medication.

Psychotherapy, on its own or with combination with antidepressants, is now known to be an effective treatment for depression. According to the majority of relevant studies it is clear that various psychotherapeutic methods are similarly effective in treating depression.

Surveying the major psychiatric literature, we find that only Cognitive Behavioural therapy (CBT) and Interpersonal psychotherapy (IPT) are widely used and supported by research for the psychotherapeutic treatment of depression. The publication rates of our CBT and IPT colleagues should inspire us. However, the impression the psychiatric literature gives actually differs significantly from common practice. There is, in fact, a huge spectrum of psychotherapeutic approaches, which look at the treatment of depression from many different theoretical and practical angles.

As Gestalt therapists we are interested in how Gestalt therapy can contribute to both the theoretical understanding and the treatment of depression. Before we look at depression from a Gestalt perspective, I will briefly survey other approaches. Different psychotherapeutic approaches focus on various aspects of depressive illness.

For example psychodynamic therapy emphasises the role of aggression, and of dependency on others. CBT focuses on negative ways of thinking, depressive convictions and depressive behaviours. Interpersonal psychotherapy emphasises the role of limited social abilities and impaired communication in interactions with others. Systemic therapy works with the patient's whole family system where the isolation and misunderstanding of the depressed person is one element, alongside narratives about patienthood and caring roles as perpetuating factors.

We can see that particular psychotherapeutic approaches are trying to influence different factors connected with depression. I believe that Gestalt therapy can considerably enrich these theoretical concepts and practical approaches by its focus on process in the here-and-now as it is manifest in the therapeutic relationship

What is depression from a Gestalt perspective? Can a Gestalt therapist squeeze the problems and sufferings of his individual clients into one diagnostic category – depression? Is there some particular therapeutic approach, which is suitable for clients with depression? I have been dealing with these questions both theoretically and practically over the past five years while working with depressed people at a psychiatric institution.

In this article I will focus mainly on descriptions of depression from a Gestalt theoretical perspective. Therapy and research will be mentioned only very briefly here. These topics are described thoroughly in other texts (e.g. Greenberg & Watson, 2005) and deserve more study.

When I talk about depression in this article, I mean psychotherapeutically accessible states of moderate depression. Very severe depressive states can be seen as manifestations of extreme forms of self-organisation described further in the text, but a psychotherapeutic approach is not sufficient as an early therapeutic intervention.

A Request for Collaboration

I want to share some of the pitfalls I was confronted with while I wrote this article and I would invite you to read this in the spirit of collaboration. Writing this article, memories of my clients came to me; memories of the time we spent together, memories of common experiences. Feelings I had with them came back to me – fear, doubts, excitement, hope and disappointment. I was touched again by the memory of rare and precious moments of real meeting. And as my body recalled those times, I arched my back, I felt heaviness in my shoulders, tension in my stomach, weakness in my legs and also exciting itching in the tips of my fingers. There were tears in my eyes. Then I looked back at the PC monitor, I straightened up, blinked and held the tears back, relaxed my shoulders. I started to think about diagnosis, depression, Gestalt... In that moment people in my memories faded, flattened, and my experiences were gone. I am afraid this can happen to you, as you read, as well. How can we write or read, and experience at the same time? Maybe a poem would help – but in a professional article? This might be a reason why Gestalt therapists do not write much – they work mostly with experience and experience is only partially held by ink and paper...

In relationship with the client the therapist has to be able to turn smoothly from the I-It professional level to the level of a real human I-Thou meeting. I am aware that writing here about depression reduces the richness of the therapeutic relationship and stays at the I-It level.

I also find myself struggling with language a lot. Our language can point at something and put it into its place. But it cannot encompass a process happening in the moment between people. I can talk about myself as a therapist and then about my client, but how can I describe what is changing in every moment between us?

When I talk about depression and a depressive person, please imagine you are meeting such a person. Take a moment to recall how you experienced contact with them. For myself, I imagine a client I saw yesterday. She has been depressed for almost two years. I feel my hopelessness once more, my tendency to want to change something with some urgency (but I do not know what!). I feel my stiff back and in my legs I feel an impulse to run and escape...

Please, take the word *depression* not as a label that makes a person an object, but as something required for communication. It will help us talk about similar personal experiences of our therapeutic work. When I use the label 'depressive client', I am talking about fixed gestalting that I co-create together with my client, which has specific characteristics that are amenable to phenomenological examination. For practical reasons I borrow the word depression from a psychiatric context.

Diagnosis and the meanings of the word 'depression'

I am a function of a field. Also words I use are functions of a field. When I as a medical doctor use the word *depression*, it means something different then when I as a Gestalt therapist use the same word. In that other configuration of the unified field I am someone different and words I use mean something different.

Traditional medicine considers depression and its symptoms to be a disease, a malfunction that needs to be fixed. According to psychiatric diagnosis the depressed person suffers low mood, decrease of energy and activity, reduced ability to feel pleasure, poor concentration and increased tiredness. The depth of depression is measured according to a list of criteria.

This kind of phenomenological description can be very exact and can be useful for Gestalt therapists as well. But only up to a point. It stays static, still; it does not describe the rich dynamics of the relationship between the depressed person and his environment.

Gestalt therapists also diagnose. We can create a diagnosis from two components. The first component corresponds closely with modern psychiatric diagnostics, which do not look for the origin of the mental illness but are based on phenomenological observation of the patient. Similarly Gestalt therapy is also functionally oriented, as opposed to aetiologically orientated (Delisle, 1991). The Gestalt therapist describes: "The client is stiff in his face and in his whole body, his speech is not accompanied by gestures. He looks down, doesn't establish eye contact. He speaks with a quiet, dull

voice...” Gestalt therapists should have enough clinical experience to recognize symptoms of depression and their seriousness.

From a Gestalt perspective symptoms are products of a creative self and display human uniqueness (Perls, Hefferline & Goodman, 1990). Symptoms such as low mood, suicidal thoughts, increased tiredness etc. are phenomena that accompany depression. Gestalt therapy focuses more on the specific generating process of depression (Greenberg, Watson & Goldman, 1998). In Gestalt therapy the symptoms are viewed not as discrete items but as a narrowed spectrum of functions (Zinker, 1978).

The symptoms indicate limited flexibility of reactions of the client. He is then limited in his ability to stay in conscious contact with his environment here-and-now. He is not able to react in accordance with his actual need but his behaviour and present experiencing are determined by fixed patterns. He follows a habit, not a conscious choice (Yontef, 1993). Depression is a fixed gestalt.

Medical diagnosis keeps a distance and views a client as a static structure. The Gestalt approach on the other hand does not perceive self as an independent structure but as a process at the contact boundary. Self is a function of a field. A person constantly creates himself by synthesizing and adding personal meaning to the biologically based information of his emotions and cultural knowledges gained from the environment (Greenberg & Watson, 2005). Identity is formed by fixed ways by which person relates to his surrounding. Personal identity does not lie in the center of a person but happens at his contact boundary.

The second component of Gestalt diagnosis is the therapist’s awareness. The therapist curiously observes what is happening to himself or herself in contact with a depressed client. For example this is how one therapist describes his awareness: ‘I am sitting opposite the client and I feel tension in my shoulders and in my jaws. I want to swing my arms and shout but I am afraid to do so. I am ashamed of myself, I feel powerless, my stomach lurches and I can’t move...’. This mode of diagnosis already works therapeutically. The therapist realizes his contribution to a depressive organisation of the here-and-now field in contact with the patient. The therapist is a part of the specific field. He or she is a part of the diagnosis and so can directly influence it. Diagnosis becomes a therapeutic possibility (Baalen, 1999). If the therapist stays with his awareness, he is then not caught in out-of-awareness reaction to the fixed gestalt of the client. The therapist’s awareness opens the space for a change that occurs in the present, in the therapeutic relationship.

In Gestalt theory we diagnose the relationship. We describe the way the client relates to his environment and diagnose the process occurring at the contact boundary. In healthy contact there is a smooth cycle of forming a contact and withdrawing from it. If these processes are blocked, the contact is considered unhealthy (Korb, Gorrel & Van de Riet, 1989). For example the therapist may describe his awareness: ‘I am trying to help a client and I am forgetting about myself. My effort seems to be falling into a deep well. My impression is that the client reacts to me as if from obligation. He permanently accuses himself of not coping with anything. I am tired by it and I am looking for where I am making a mistake. Then heavy silence follows, each of us fall into ourselves’. Here we can already notice the typical features of a depressive

relationship – retroflexion and interruption of the contact cycle before action – which I will describe later in detail.

We diagnose how the client and the therapist together create a depressive relationship. We would not say that the client is depressed but rather that the client and his therapist are here-and-now depressing together. This kind of diagnosis is the first step of the therapy. Through this comes awareness of those rigid patterns by which the client relates not only to his therapist but also to his environment and himself. Diagnosis serves as a tool for change (Melnick, Nevis, 1998).

The way a Gestalt therapist creates a diagnosis has the advantage that it acknowledges the inevitably subjective point of view of the one who diagnoses. He even makes use of it. The Gestalt therapist uses his awareness and makes a diagnosis of the relationship that he creates here-and-now with his client. The same deformations of relationship that the client experiences with other people appear in the present therapeutic relationship.

Let us now look at the use of diagnostic category more closely. If we say that some people are depressed, we label them collectively and we stop seeing the suffering of the individual. Is it possible to apply the label of depression and still at the same time work in a Gestalt way, which gives such a value to individual experience?

There are certain clients that contribute to the organisation of the relational field in certain similar stereotypical ways. For example people in psychotic states or people with various personality disorders. When we use formal diagnosis, we make a specific reference to a recurrent pattern of figure/ground formation of an individual. (Melnick, Nevis, 1998).

We can then group people with a similar patterns into a diagnostic category knowing at the same time that there is a continuity of transition between a particular diagnosis and so-called normality.

Depressive disorder can also be seen as a certain kind of fixed organisation of the relational field. As a Gestalt therapist I ask myself in those cases: “How do I experience this relationship, what is happening to me?” While meeting a hopelessly depressed client I, as a therapist, often have a tendency to care for him, to give hope, to try to support and increase his self-confidence. Depression is sometimes considered to be analogous to a child’s cry. It is a signal, calling and longing for care. But if the need of the client is extremely urgent, I as a therapist feel a tendency towards anger, to refuse him. I may try to avoid this client. People in the environment of the client experience this kind of polar reaction – caring and refusing – regularly. Awareness of these reactions of one’s own is a part of Gestalt diagnosis for the therapist. With people who deform their contacts in other fixed ways – for example by a process that we might term borderline – the therapist’s awareness is fundamentally different.

Depressive adjustment.

If we view depression as a fixed gestalt we suppose that in the client's past they had a functional way of relating (given the field conditions which existed) that became fixed. From a Gestalt perspective the way a depressed person relates to his environment and to himself is not a disorder. We can only call it a disorder if a client uses a depressive way of relating in a rigid and stereotypical way in his life which significantly limits his capacity to creatively adjust.

So we can question what kind of Gestalt 'got fixed' in the case of depression. Every emotional state affects the functioning of the whole organism and in a certain way regulates the interactions between the organism and the environment. The basic function of an emotion is to create a specific state within an organism that enables it to handle a situation effectively (Nesse, 2000). The functional emotional state, which resembles depression, can be called low mood (Nesse, 2000). It is not only a change of mood but also a switch of the organism to a standby mode. It leads to limiting activity level, lowering of energy, and a limiting of the intensity of experiencing. These symptoms are similar to those of depression. However, this is not a pathological disorder but an adaptive mechanism.

There are situations when the depressive pattern of contact is of benefit for a person in interaction with their environment. If a person uses a depressive way of relating as a kind of creative adjustment, we can speak about *depressive adjustment*. It is not a malfunction but a specific form of creative adjustment. Depressive adjustment is one way of dealing with certain life situations. A person, when sad, conserves personal resources (Nesse, 2000). Take a situation in which a person cannot satisfy his needs, and an effective action is impossible. This can happen for example after loss of a partner or a job. In that case the depressive adjustment leads to an economy of effort and a conservation of resources. Depressive adjustment enables the person to stop, consider the changed situation and make a decision on alternative strategies.

Optimism usually helps deal with difficult situations. But there are certain situations where an optimistic attitude makes things worse. Then to inhibit striving and signal submission may be profitable. An example is a situation in which a challenge needs to be made to a dominant figure that cannot be overpowered (Price, 1967). The depressive adjustment economically regulates the personal investment and prevents activity that would be wasted. The depressive adjustment helps to let go of the drive towards unproductive effort.

The depressive adjustment is important not only for the individual but also for society. A social biological perspective presents the depressive syndrome as an adaptive mechanism within a society (Hoschl, Libiger & Svestka, 2006). It arises from an ethological theory according to which aggression is an integral part of emotional equipment of animals (Lorenz, 2003). In a dense population aggression can become destructive and that is why there are mechanisms that can moderate and manage potential dangerous consequences. One of these mechanisms is dominance hierarchy (Price, 1967). Four basic types of emotion direct the experience of every member of the society:

1. Anxiety caused by superiors
2. Irritation caused by inferiors
3. Feelings of delight while climbing up the hierarchical levels

4. Feelings of sadness and depression when losing position in the hierarchy

The loss of position in a hierarchy is usually caused by an injury, illness, aging or after the loss of someone close. In these moments symptoms close to those of depression appear. Depressive adjustment serves as an adaptive mechanism during the times of social decline. It might seem that a sad person is sentenced to failure and is not contributing anything to the society. But a depressive style of relating is common and pervades the history of the human race. So it must be obviously somehow profitable.

What is the function of the depressive adjustment? What selective forces helped maintain this mode of interaction during our evolution? Low mood provides a protection for an individual and a benefit for the whole society. When an individual loses interest in the next step in his or her destiny, he does not fight for it and is not hurt or killed. Moreover, if he gives up his social position voluntarily, that saving in energy which comes from avoiding a fight is an economy for the whole society (Price, 1967).

So we can conclude that depressive adjustment serves as a mechanism for coping in unpromising situations. It inhibits dangerous and worthless action at times when an organism lacks inner resources or a viable life strategy. It saves energy in situations that lead to inaccessible goals. These advantages have preserved depressive adjustment through evolution because it is a profitable adaptive mechanism.

Fixed depressing: When depressive adjustment becomes a fixed gestalt

If depressive adjustment has a role in a human's life and in the life of a society why do we try to influence it in a therapy? If we try to treat depression, we consider it as a manifestation of a disease. Generally, there are three manifestations of disease. (Nesse, 2000).

Firstly, its direct harm; for example bodily injury. That requires urgent treatment. In a psychotherapeutic context this would be crisis intervention.

The second manifestation of a disease is a defence of the organism; for example, pain or vomiting. What we consider to be pathology actually prevents more significant harm to the organism. Elimination of this protection can be dangerous for the organism. For example, if we intervene to stop vomiting artificially, our patient will not get rid of poisonous food. If we anaesthetise the pain, we are switching off the signals with which the body lets us know that something is wrong. The depressive adjustment described above fits this category. In the case of a natural mourning over the death of someone close, the depressive adjustment works as an adaptation and defence. Trying to work therapeutically to generate a more optimistic reaction can actually be harmful. The patient may not have sufficient inner resources to cope with demanding situations at that moment. The depressive adjustment serves as a protection, as a survival mechanism.

The third kind of manifestation of disease is dysregulated or extreme defence. The mechanism deployed by the patient that originally prevented greater harm gets fixed

and stops meeting its original function. The pain signalling harm becomes a chronic paralysing pain. Vomiting that helped the body get rid of the poisonous food remains, and exhausts the organism by causing dehydration. Also initially natural depressive adjustment gets fixed and manifests itself as a dysregulated defence. At that moment it loses its original usefulness for the individual and society and turns into depression. Depression represents a pathological fixation of an initially useful mechanism.

From a Gestalt theoretical perspective we speak about a fixed gestalt. During repeated situations when the actual need of an organism was not met a certain stereotypical way of behaving and experiencing got determined. In case of depression it would be appropriate to talk about 'fixed depressing' when a person becomes rigid in his approach to the environment and loses flexibility in meeting his actual need in the situation here-and-now. In the following text I use the term *depressive adjustment* for a functional adaptive mechanism, and the term *depression* for a limiting fixed Gestalt.

The formation of depression: How does the gestalt get fixed?

What is the pathway through which an originally useful adaptive mechanism of depressive adjustment becomes over-determined and turns into an exhausting and devastating form of depression?

The fixed ways of reacting develop during the course of life. They are influenced by both biological and socio-psychological factors. In the formation of depression genetic predisposition undoubtedly plays a role. However, they alone do not create depression. They are responsible for a certain specific vulnerability of a person, who in a demanding situation reacts in a depressive way. It is interesting that modern biological theories of depression talk about a deficit of neuroplasticity. The central nervous system loses the ability to react flexibly to the present situation. The brain then functions in a rigid and stereotypical way and shows characteristic changes in activity and neural transmission. This theory is actually describing a fixed Gestalt at the biological level. Scanning studies show that the use of antidepressants, and also psychotherapy, leads to unblocking of such a rigid state and to restitution of a flexible plasticity of connections between nerve cells (Gabbard, 1997)

Psychological and social factors play an important role in the formation of depression as well. Greenberg *et al* (Greenberg, Watson & Goldman, 1998) suppose that a person who experiences a significant loss in the early stages of their life, particularly if it also involves humiliation or helplessness, preserves this experience in a form of so-called *depressogenic emotional schemas*. If he later finds himself in a situation that is similar to the early traumatic experiences, his emotional reaction can activate these schemas. Such schemas represent a rigid fixed pattern that affect both perceiving and experiencing. A person feels an absence of love, feels humiliated, trapped and powerless, and is not able to mobilise an alternative reaction. These schemas often include introjected negative evaluations such as: 'I am worthless'. Greenberg describes this state as a depressive organisation of self. A depressed person is overwhelmed by feelings of fear, loneliness, insecurity and shame. He develops a negative conviction about himself and others.

Greenberg and Watson's contribution to the Gestalt theoretical view of depression is highly valuable and helps establish experiential therapy within the mainstream clinical

approaches to depression. However, they do not place so much stress on the mutual (client-therapist) cocreation of a depressive organisation of the therapeutic field as it emerges between therapist and client. Within their concept of *depressogenic emotional schemas* they also do not describe depressive adjustment as a form of an adaptive mechanism as I have suggested, they focus more on the pathology.

In depression self stops reacting flexibly to the present situation and starts organizing itself in a rigid and stereotypical way as hopeless, powerless and insecure. Depressive person then tries to cope his emotions by withdrawing from contact with others and by blocking his experiencing. This way he intensifies his depressive difficulties even more and the fixed Gestalt of depression becomes more rigid.

Interruption of a contact cycle: Typical manifestations of depression

The loss of the creative adjustment manifests in a particular withdrawal of contact. A depressed person lacks the self-confidence, will and motivation to contact. We can watch the repeating pattern of an interruption in the contact cycle (Mackewn, 1999). The therapist will see and experience this during the process of therapy. The depressed client usually reaches a good level of awareness. However, he stops at the transition point before entering the next phase of the contact cycle. As soon as he starts mobilising his energy, he stops himself before the action that could satisfy his present need in relation to the surrounding world. The client has insufficient energy to go on; he remains depressive. He is spinning around in a vicious cycle; he can't see any future in front of him, and he becomes resigned. If he actually succeeds in mobilising energy, he might try to commit suicide.

One of my depressed clients, the mother of a little child, left a note on my office door soon after the beginning of her therapy: "Dear doctor, I am really sorry. I apologize but I am not able cope with it. I want to thank you for everything. I regret all the time you wasted with me. I can't change, it will be always same."

If the clients survive their suicidal attempts, as this young woman fortunately did, they are usually treated by hospitalisation and with drugs and returned to the state they were in before the phase of action. So the rigid depressive pattern is actually reinforced by medical methods.

When I write about depressed clients stopping themselves during the *mobilisation of energy* and before *action* I am aware of two points that are open to debate.

First, I am simplifying what is in fact a variety of clinical forms of depression. Depression is not a monolithic disorder and only some people are classically depressed, with low mood and loss of energy. Many appear anxious, angry, abusing substances or present with a chronic pain condition (Greenberg & Watson, 2005).

Second, blockage before action is the first stage that is clearly obvious to the therapist. So blockages in the preceding stages of contact cycle (that might influence the clinical variability of the presentation of depression) will most likely be evident in the blockage before action. (Melnick & Nevis, 1998)

The Role of Retroflexion

The variety of depressive phenomenologies suggests there are several contact styles involved. From my experience the main mechanism by which depressed people disturb smooth and healthy contacting is retroflexion. The contact style of retroflexion is an economical mode of contact in energetic terms. A person does not give out his energy but turns it back to himself. Retroflexion is not a disorder. There are situations when it has a vitally healthy role. Generally those situations are moments of decision, either at a big life crossroads or perhaps in everyday life. Retroflexion becomes disorder when the retroflexive pattern gets fixed and is used rigidly with the environment without regard to the organism's current need in the here-and-now situation. This is so with depression.

A depressed person doesn't manifest his impulses and demands visibly but turns them back to himself. He doesn't express openly his needs concerning the environment and instead of that tortures himself by unrealizable demands. That causes another frustration of his unsatisfied needs, another decline of self-confidence, will and motivation. The depressive organisation of self is strengthened and subsequently the person is even more unable to make contact.

Therapy

In the next two sections I introduce a brief picture of practice and research of Gestalt therapy for depression, which I do not claim to be comprehensive.

In practice Gestalt therapy differentiates between sadness and depression. We can find this differentiation already made clear in the early psychoanalytical work of Abraham (1912) and then of Freud (1917) in his classic article "Sadness and melancholy". Depression and sadness can both have similar symptoms but in practice it is very important to differentiate between them. To work psychotherapeutically with depression and sadness using the same approach can even harm the client (Smith, 1985).

Sadness is an emotion that accompanies an adaptive mechanism, which I have called a depressive adjustment. In case of the depressive adjustment the therapist encourages the natural process of mourning. He does not try to prevent, interfere in it or avoid it.

But in the case of depression the therapeutic approach is different. Gestalt therapy does not focus primarily on healing the symptoms of depression. The goal is, as with other disorders in which fixed Gestalts are central, to restore the ability of self to adjust creatively in accordance to the present needs of the organism and to establish the ability for fluent and flexible contacting and withdrawing.

While working with depressed people the therapist has to emphasise security, structure, and learning. The principle of the therapist's approach is support and appreciation of the effort more than frustration. Depressed people frustrate themselves permanently (Roubal, 2004). During therapy clients first learn how to accept support from their surroundings and then they create a system of self-support by themselves. The work centres around a primary task of creating a safe environment, a safe

relational field, in which the patient's self-healing powers can be activated. These are the capacities that the patient has not been able to activate in a repeating uninviting uninviting and dangerous interpersonal situations in which the depressive adjustment became a fixed Gestalt.

In case or repeated experience of limiting, threatening or misusing environment the person can not acquire the whole spectrum of self-functions. He needs to create them during the process of ongoing therapeutical relationship (Zinker, 1978).

It is important to highlight again that a Gestalt therapist doesn't see the depressed client as an object which he researches and on which he applies the therapeutical procedures. Gestalt therapist works with the relationship between the client and the therapist.

The therapist's task is to ask himself: How do I co-operate on creating the present form of our relationship with the client? So in the case of the depressive client the therapist asks: How do I contribute to the fact that the client who is sitting in front of me is retroflecting and stopping himself before action? How are we depressing together? The therapist then investigates these patterns of relating in the here-and-now therapeutic relationship. Moreover, in this relationship he also experiments with new, and for the client unusual, ways of behaving and relating.

Accepting the current emotional state of the client can serve as an example. The therapist takes seriously all of the client's complaints about low mood, inefficiency, and low self-confidence. But the therapist does not console and does not become resigned. He does not, as far as possible, repeat the reactions the client has been familiar with in his environment and which again and again supported him in a fixed Gestalt of depression. The client's family tries to console him: 'It's not as bad as you say. Don't worry, everything will be fine soon.' But when the depressed person continues retroflecting and withdrawing from the contact, his close ones resign and send him to a specialist. By doing this, they again strengthen his rigid depressive pattern.

The therapist works to avoid repeating any of these patterns. Of course, during the course of therapy he will be seduced by the client to console him or to become resigned. He uses himself as an instrument of the therapy. Based on his awareness he liberates himself from reacting automatically to the client and he creates a free space with the potential for a different way of relating. That enables the client to step out of the rigid depressive pattern. The female client, who I mentioned earlier, returned to therapy after the suicide attempt and after some time she was able to say: 'I found out that things can be resolved by ways other than by killing myself'.

In the therapy of depressed people who are unable to establish good contact with their surroundings, the work with retroflection is very specific. The depressed client turns against himself the feelings and tendencies which he would like to direct at his surroundings – for example anger or criticism. The therapist examines these relational patterns directly in his present relationship with the client. And in this relationship he also experiments with new ways of behaving and relating. The therapist's task is to enable the client, even in the most incremental way, to express the energy which experiences within himself (Zinker, 1978). It is important to find, highlight and

appreciate even the briefest moments during which the client mobilises his energy for an action which leads to interpersonal contact, for example when he directly looks into the other's eyes or expresses his own opinion. The therapist points these moments out and then leads the patient to the awareness of the process. How has the client mobilised his energy in that particular moment? What did he need to make that possible? The client can come to an innovative experience: 'This little thing is something I coped with. I am not completely incapable of action.' Slowly and gradually he finds his own way to confirm himself, to mobilise energy and move to action. He learns how to moderate expressions of his energy. The therapist helps to disrupt the retroflective pattern by his own example and he openly shares his experiences and emotions.

While working with retroflection it is necessary to direct the energy of an internal fight to the relationship with the surrounding world (Polster & Polster, 2000). The Gestalt therapist is usually used to working with deflection and projection; he brings the clients back to themselves and to a deeper experience. With many clients this actually supports the retroflection. But the depressed clients know this way too well. They spend most of their time by tormenting themselves and turning against themselves anything that happens to them. It makes no use to strengthen the rigid pattern of retroflection.

The depressed person needs to learn how to protect himself in ways other than by isolating himself. He needs to learn how to direct his experience into contact with his environment. If we work with retroflection this way we can re-orientate the client's rigid contact style in the opposite direction; we direct it outside. The contact cycle that was stuck before the action by the retroflection can now continue. In the safe relationship with the therapist the client relearns the ability of flexible contacting and withdrawing. Later he gradually uses the support of the therapeutic relationship to try out these new abilities in other relationships as well.

Research

Gestalt therapy progressively finds its place in clinical practice. But there is still a lack of research studies that are dedicated to the Gestalt therapy of depression. It seems that the effectiveness of Gestalt therapy is comparable with the other therapeutical methods, for example with Cognitive Behavioural therapy (Rosner, Frick & Beutler, 1999, Beutler, Engle & Shoham-Salomon, 1991). The effect of a therapy based on a supportive therapeutic relationship may be increased by the use of specific interventions focused on emotions in ways that are typify Gestalt therapy (Greenberg, Watson & Goldman, 1998). Greenberg presents the evidence base for emotion-focused therapy (EFT), which he describes as a dialogical form of Gestalt therapy (Greenberg, 2004). In three separate trials a manualized form of EFT for depression was found to be as effective, or more effective, than a purely relational empathic treatment and a cognitive-behavioral treatment. EFT was more effective in reducing interpersonal problems than both, and promoted more change in symptoms. EFT was also highly effective in preventing relapse. (Greenberg & Watson, 2005)

Other research indicates the Gestalt approach is especially effective in the therapies of internalizing clients who deal with depression in intrapunitive ways (Beutler, Engle & Shoham-Salomon, 1991).

The research studies mentioned above highlight only an objectively measurable result of psychotherapy. What is clearly needed are further studies (both quantitative and qualitative) that show that Gestalt therapy is a coherent mode for treating depressive disorders.

Conclusion

Work with a diagnosis is a creative process, one which encompasses a hidden healing potential. From the beginning there is a contract – one person needs to receive support and inspiration; he organizes himself as a client. The other person organizes himself as a therapist; the one who provides support and inspiration. Even this fundamental configuration has a healing effect for a depressed person. It organizes the field, sets rules about the borders of the relationship.

But still the experience of the actual relationship is uncertain, inconstant, shapeless and chaotic. This is the nature of experience and it is our basic human tendency to organize experience in order to make meaning. Diagnosis is an important part of the process of making meaning. The client experiences relief: ‘Now I know what is happening with me. I have a depression, this expert has recognised it. I orientate myself’. But the other person – the therapist – also feels relief: ‘Finally I know what is going on here; he has depression ... and I am OK’.

Both sides feel relief and there is a risk they will be satisfied with this. They might fix their relationship in this form. But the diagnosis is not a goal, merely a tool. It is a tool supporting the therapeutic process, which must go on. The therapist encourages the client to take responsibility and look for self-support. Instead of: ‘I have a depression’, the client learns to say: ‘I do my depression’.

Again, at this stage the process might come to a halt and the client might be blamed for production of his symptoms. The client has to resist the temptation to hide himself in the safety of his diagnosis. And the therapist has to step out of the safety that the expert position gives him and embrace his part in the diagnosis.

In the next step the therapist has to take back part of the responsibility and learns to say together with the client: ‘We are making the depression together. We are depressing’. They examine the ways in which they create the depressive way of functioning together. Fixed patterns that happen in the present relationship as well as in other relationships become available to awareness and thus at least partly a matter of free choice.

The therapist prevents the creation of another fixed form of a relationship: *depressive client – diagnosing expert*. The therapist re-establishes the original chaos and fluidity of experience, which was obvious in the beginning of the diagnostic process. But there is a difference. This time the chaos is a shared experience. Both client and therapist take their responsibility for the process and are therefore open to the possibility of

change, to a different, nondepressive kind of creative adjustment. The process of diagnosing becomes therapy.

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Jan Roubal MD, is a psychiatrist, Gestalt therapist and supervisor. He is a member of the training staff of the Institute for Gestalt Therapy in Prague and he works in his private practice as a Gestalt therapist. He teaches psychotherapy, clinical psychology, psychiatry and Gestalt therapy at Masaryk University in Brno.

Address for correspondence: Zeleznicarska 554, Havlickuv Brod, 580 01, Czech Republic

Email address: janroubal@centrum.cz