**A Comparative Look at the Effectiveness of Adlerian Therapy versus Gestalt Therapy for Major Depressive Disorder**

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**Abstract**

Major Depressive Disorder (MDD) is a serious and consuming mental illness that affects a large portion of the population. As such, extensive research has been dedicated to finding effective methods for its remission. Throughout this body of work, researchers have not only identified the most effective, but least effective methods as well. There are numerous benefits to studying why and how a particular treatment works, but even more so for studying why and how it does not. This approach can illuminate inconsistencies between treatment and patient needs, allowing already effective methods to increase their applicability. Countering flaws in this manner can improve therapy methods in general, by providing another technique with which treatment information can be gathered and used. Adlerian and Gestalt therapy are two methods which meet these requirements. Discussing each treatment’s ineffectiveness as well as its comparative effectiveness will shed light into the nature of MDD. This discussion demonstrates that Adlerian therapy (AT) is more effective than Gestalt therapy (GT), thereby suggesting that people with MDD respond to a slow, sensitive, and mental therapy that allows for a world-view restructuring well.

*Keywords*: Adlerian Therapy, Gestalt Therapy, Major Depressive Disorder

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Major depressive disorder (MDD) affects and disables many adults throughout their lives (Jakobsen, Hansen, Simonsen, & Gluud, 2012). Considering MDD’s global, individual, and economic impacts, it is not surprising that much research has gone into finding which is the most effective way to cure the disorder. Even though antidepressants are most common (and believed to be most effective) (Grobler, 2013), it is still worth inquiring into less effective therapies or methods. The goal of this is to assist in understanding the nuances of MDD treatment. Firstly, being familiar with MDD is required. Then, detailing the techniques and theories of both therapies will occur, followed by comparison between AT and GT on MDD effectiveness. Together, this will demonstrate that although AT and GT are rather ineffective in helping remission of adult depression, the former is more effective than the latter. These results have interesting implications for general methods of treatment for the disorder.

**Major Depressive Disorder**

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) defines MDD as the presence of five out of seven predetermined symptoms for a period of at least two weeks. Out of the five symptoms, one has to be either depressed mood or the loss of interest and/or pleasure. The other symptoms experienced could be: (1) change from the individual’s previous manner of functioning, (2) change not caused or attributable to another medical condition or the use of narcotics, (3) significantly distressing and/or cause impairment in daily life (socially, occupationally, etc.), and (4) not better explained by another condition (e.g., psychotic spectrum disorders). The individual must, furthermore, never have had a manic or hypomanic episode.

Various other examinations are required before an individual is diagnosed with MDD (Grobler, 2013). A general medical and psychiatric history of both family and client are amongst some of the suggested assessments (Grobler, 2013). Once diagnosis is made, treatment strives for remission. There is no one way in which this is accomplished since goals and plans tend follow the needs of the client as defined by the severity of their disorder and any personal factors. However, in terms of treatment, cognitive-behavioural therapy (CBT), cognitive therapy (CT), and interpersonal therapy (IPT) are often recommended with or without the addition of antidepressants (Grobler, 2013).

Although CBT, CT, and IPT are most commonly prescribed (Grobler, 2013), this does not mean other psychotherapies cannot be used. DYN has become less significant in the treatment of MDD (Schwartz and Petersen, 2006), but several meta-analyses have shown that it can help in remission (Driessen et al., 2010; Jakobsen et al., 2012; Braun et al., 2013; Cuijpers et al., 2008). Other research also shows that GT is an effective treatment for depression (Cook, 1999; Yoo, 2011; Greenberg & Watson, 1998). Both are, therefore, viable therapies for MDD. However, before comparing them on their effectiveness in the treatment of depression, two things are required. First, analysis of why AT and GT are ineffective and, second, a basic understanding of both therapies.

**Ineffectiveness**

Both AT and GT assume a lot about the nature of a client’s depression. In focusing on only the social effects influencing a person’s MDD, not all possible causes are identified. This is most obvious from the multitude of medical and biological models available as explanation for depression onset and cause. As such, differences in treatment can often come down to the explanations of MDD presumed to be correct. Environmental approaches, for instance, lead to theories like the Chronic Mild Stress (CMS) model (Venzala, Garcia-Gacria, Elizalde, & Tordera, 2013). Social conflict approaches, on the other hand, lead to theories like the Chronic Social Defeat Stress (CDSC) model (Venzala et al., 2013). The former posits that depression is caused by stress from the environment and the latter, by social subordination. It is intuitive how treatment for MDD would differ depending on the explanation of disorder causation and perpetuation. This, however, is precisely the drawback with AT, GT, and the use of different models.

The very fact that different explanations, approaches, treatments, and subtypes of MDD exist makes the statement that depression has many varying causes, sources, stressors, and pressers; which depend on the individual themselves rather than the disorder. As such, a model of MDD causation and onset has to be flexible in both method and application. Depression with anxiety, for instance, is related to genetics and the (5-HTT) serotonin transporter gene (Lichtenberg & Belmaker, 2010). Restructuring beliefs about the world or getting back to your basic desires will not change how the 5-HTT gene works and will unlikely treat the disorder. Furthermore, an inflexible approach can result in a degree of victim blaming. If a patient is in a healthy situation according to the principles of AT or GT, then the suggestion is that no depression should be present. Yet individuals with healthy families, lifestyles, and social lives can still be depressed.

Thus, the ineffectiveness of both therapies originates from the very nature of their theories about the causes of MDD. These theories are simply not inclusive. Appreciating and recognizing that ideology restructuring is not applicable in every case would increase each therapy’s effectiveness.

**Psychodynamic Therapy**

Since the focus here is AT—which belongs in the DYN category of treatment—it’s important to understand AT’s therapeutic ‘family’ (i.e., Psychodynamic Therapy). DYN is a Neo-Freudian approach to treatment whose core concepts are similar to psychoanalysis’ (PSA; Prochaska & Norcross, 2010). The most relevant theory they share is that psychopathologies are subconscious responses to faulty ‘ideologies’ (e.g., habits, beliefs, and values), which have been influenced by early experiences. However, even with this similarity, DYN still takes relatively less time and tends to focus more on the individual’s future. This is achieved through concern with directly pressing issues, interpersonal conflicts, coping strategies, social forces (Prochaska & Norcross, 2010), and client-driven discovery.

Understanding these fundamental aspects of DYN provides insight about the general nature of this therapeutic family. This has one important consequence; if subtypes of DYN (like AT) are effective for MDD remission, then DYN in general (and its other subtypes) should be as well. Therefore, being aware of the theories shared within the DYN family can be a great asset for MDD treatment.

**Adlerian Therapy**

As sexual conflict is to humanity in Freud’s work, so is superiority to mankind in AT. Superiority is understood as the striving for perfection or completeness and can be achieved in a variety of ways (Prochaska & Norcross, 2010). Pathologies, for instance, are one such way. Born from early experiences, they develop into negative ideologies and coping behaviours. This often occurs when people make errors in their development of a world view. One example is by generalizing certain relationships from their early experiences. Such that an aggressive and unloving father from childhood turns into the belief that all men are aggressive and unloving. These maladaptive life patterns allow individuals to play various excusatory roles and it is these roles which help one achieve superiority. However, many people are unaware that they are in engaged in these roles or behaviours.

The point of AT therapy is to make clients aware of these destructive forces. Therapists reveal these truths by employing techniques like family constellation analysis, dream analysis, early memory analysis, bibliotherapy, and lifestyle evaluation. Each technique serves a different function. Family constellations (birth order), for instance, provide the therapist with a view of family dynamics, shedding light on how and why negative ideologies are developed. Adlerians —here understood to refer to any therapist practicing Adlerian therapy at any particular moment—are not overly concerned with past experiences though. These are only important as far as they are relevant to understanding basic life structures and their connection to the future.

Of more concern to Adlerians is social welfare. Therapists help direct their client’s destructiveness (e.g., acting sick so others are forced to take care of them) towards behaviour that embodies social interest and selflessness. This is, of course, only if the individual chooses to do so; one can either continue their old life pattern—with full awareness of the excusatory and destructive behaviour they engage in—or take up the Adlerian philosophy. Hostility, control, anxiety, compensation, and a host of other defenses are often problems during this time of change. Especially since an irresponsible and selfish lifestyle is easier and more secure than one of social and personal responsibility. During this redirection is when individuals finally gain a sense of self-esteem, proper superiority, and the ability to be intimate and communicate properly.

In summation, AT is the process by which a therapist uses their relationship with clients as the basis for the development of a healthy lifestyle. This is achieved through the positive regard, genuineness, faith, and encouragement they show their clients; and it allows a therapist to direct and help individuals transcend their old, selfish, irresponsible, and empty life. The therapeutic environment itself can assist this process since it often provides the client with a basic experience and relationship that undermines earlier life events. Compounded, these mend an individual’s view of the world. An unsupportive family is thus undermined by the therapist who shows faith in a patient’s abilities, giving the client an opportunity to break away from old habits. In transcending this behaviour, one can embrace gemeinschaftsgefühl (i.e., “social interest with which we add to the world”; Prochaska & Norcross, 2010). In the end the client becomes a responsible individual with a meaningful life and healthy self-esteem.

**Gestalt Therapy**

In a general respect, GT is very much antipode to AT. Although, they do share in the importance placed on personal responsibility, awareness of excusatory behavior, the role of early experiences, and dream analysis (whereby one is required to act their dreams out rather than talk about them). Still, GT is very much action-oriented rather than mind-oriented. As such, Gestaltists—here understood to refer to any therapist practicing Gestalt therapy at any particular moment—would criticize Adlerians for telling their clients to; (1) adopt yet another role; (2) teaching them to endlessly rehearse for it with thought processes; and (3) forcing on them responsibility for others (i.e., social responsibility).

In the Gestalt ‘philosophy’, the individual is a biological being who lives around their daily goals (i.e., end goals). These goals are primal forces such as hunger, survival, shelter, breathing, and sex. The healthy being is, thus, engaged in the circular pattern of fulfilling the body’s basic needs and desires. Satisfying this pattern is also how the human being (e.g., their identity, personality, or personhood) develops and pathologies are born when this development is stunted. Usually that occurs when one’s lifestyle is focused on everything and anything but the physical self and its natural urges.

Unfortunately, the nature of our social world prohibits such basic satisfaction; and for this reason Perls believed that only the sick assimilated to and lived there. In his view, the entirety of society ignores the basic biological body and forces people to assimilate to a rigid existence and personality. The process of healthy growth and existence is interrupted by this kind of life. Thus, all those within the social world are left sick and stunted. To be a healthy, responsible, and mature individual is to rely on and be responsible for oneself, leave other to their own lives, disregard habit and routine, and live—whilst allowing others—by one’s own expectations (Prochaska & Norcross, 2010). All this is, unfortunately, against the tenets of social existence.

Therefore, pathologies are developed by those who remain in society, creating a breeding ground for the sick, childish, irresponsible, and dependent. Many tend to stay in this reality because early experiences and relationships give them the impression that there are no other options. An overbearing parent, for instance, gives their child the impression that they are incapable of supporting or taking care of themselves (i.e., catastrophic expectations; Prochaska & Norcross, 2010). This experience results in the development of an adult who fears independence. These psychopathologies—of which dependency is only one—are deeply ingrained, existing in the person in five different layers (see Prochaska & Norcross, 2010, Chapter 6 for discussion).

The therapists’ job is to employ various gestalt techniques in order to break these layers. Empty chair dialogue, frustrating the patient, preventing avoidance, and refusing to accept responsibility are some of the available options (Prochaska & Norcross, 2010). By employing these techniques, a therapist raises awareness and breaks the constructs of each psychopathological layer. For instance, Maya is found in the first layer (the phobic layer) and embodies the unrealistic and inauthentic self (Prochaska & Norcross, 2010). By focusing on the reality of now (instead of the fantasy of ‘should be’) and in acting out or releasing frustrations individuals break out of this pseudo reality and role. This forces them to embrace their authentic and independent selves. The entire process of GT is, thus, client-driven because clients are often their own source of feedback and responsible for the continuation and content of therapy (Prochaska & Norcross, 2010). The therapist’s only role is to set the stage for emotional release and offer methods with which people can progress towards authentication.

The Gestalt approach is, thus, an active one. It views society as destructive, pathological, and the core of human disorder. Treatment seeks to tear people away from the unhealthy ideas, expectations, and habits that the world at-large has forced on them through assimilation to society. This break is best achieved through movement and activity rather than thinking. Since continuous mental repetition and internal focus is the root of all psychopathologies, in taking the focus away from the internal and putting it on the external, clients rid themselves of social teachings and revert to their intended and natural form; the biologically-driven being.

**Effectiveness of Adlerian Therapy**

Clinically and empirically speaking, AT tends to be just as effective as other forms of psychotherapy. Braun, Gregor, and Tran (2013) found that at the end of treatment, DYN was just as effective as other therapies in the sample. Although no statistically significant superiority between CBT, DYN, IPT, or behavior activation therapy (BA) was found; patient self-ratings, clinician ratings, and their clinical significance were significantly worse for DYN than all other therapies. Furthermore, the effectiveness ratings of DYN were found to be impacted by reporting bias. As Braun, Gregor, and Tran (2013) pointed out, this does not mean that DYN is not as effective as other therapies; just that studies of higher quality are required. Similar results regarding the effectiveness of DYN on MDD in adults were obtained in a meta-analysis of 53 studies (Cuijpers, van Straten, Andersson, & van Oppen, 2008). A variety of data, thus, support the conclusion that DYN is as equally effective as the other psychotherapies.

Evidence also points to the fact that DYN and anti-depressants work effectively on the treatment of MDD. A meta-analysis—consisting of 365 participants with a primary diagnosis of MDD—found that DYN in conjunction with antidepressants reduced symptoms of depression more than medication alone (Jakobsen, Hansen, Simonsen, & Gluud, 2012). As such, DYN consists of aspects which have positive effects on the symptoms of MDD. However, this meta-ana lysis did not include data on effects of DYN after treatment. It is therefore not clear how beneficial DYN was in the long run.

Adding to this data is Driessen and colleagues (2010) who—in their meta-analysis—showed that short-term psychodynamic psychotherapy (STPP) is an effective treatment for depression in adults. STPP is not exactly DYN, but the two still share many tenets and practices. Thus, the meta-analysis in question is a valid addition to the body of empirical evidence on the effectiveness of DYN. Of particular interest in this research was the inclusion of a 3-month, 6-month, and 1 year follow up. Data from these follow-ups showed that STPP was more effective than no treatment in post-treatment depression levels of community and clinically recruited patients of various age, depression levels, and gender. These results suggest that DYN does have positive effects on MDD symptoms in the long run.

The data of the reviewed literature suggest that Adlerian approaches to therapy can be effective, but are likely to be dependent on individual preference and the nature of the disorder itself. For instance, AT may not be beneficial to those whose MDD is largely sourced by their over concern with the mental. Techniques of raising awareness and directing change would be useless for someone who is far too ingrained in their repressive ideologies and doesn’t notice their destructive behaviour. In this case, one instance of being contradicted would simply lead to another excuse and so on and so forth. For this individual however, participating in Gestalt role play (e.g., taking the role of their parent in a discussion about themselves) could promote a cathartic release of emotion. Helping the client realize what they have been repressing all this time. However, AT could be helpful for a client whose MDD is largely sourced by perfectionism (see Blatt, 1995 for discussion). Having the opportunity to restructure a world view based on an example of a healthy relationship can, for example, help one get rid of childhood anxieties about not being good enough or living up to parental expectations. In the end, AT applicability can largely be a question of who the patient is and the nuances of their depression.

**Effectiveness of Gestalt Therapy**

The effectiveness of GT is severely under-tested. As Prochaska and Norcross (2010) point out, Gestaltists have not taken to the scientific method of empirical research. This does not mean, however, that studies on the effectiveness of GT for MDD do not exist.

Yoo (2011) makes several compelling arguments about the potential of GT for the treatment of depression in adolescent Korean males. Specifically, this research found that Gestalt techniques are effective in remission of depression (Yoo, 2011). The suggestion is that using dream work, I – Thou, and two chair interventions are useful in treating symptoms of MDD, since either techniques would allow individuals to disclose personal concerns in a safe and active environment. Similar evidence suggests that GT is also effective for lowering depressive symptoms in adolescent girls (Cook, 1999). Unfortunately, only sixteen participants took part in this research and depressive symptoms were self-reported. However, the most essential conclusion this evidence helps draw out is that the techniques of GT are useful. Regardless of sample or methodology, these methods of treatment appear to be supportive of the changes and needs encountered during the healing process. GT achieves this by providing a safe and powerful method with which one can explore their internal dynamics and concretely examine abstract personal issues. In general then, this treatment targets the source of the developmental problems which cause and are a part of depression as a whole (Cook, 1999).

Although not directly assessing GT, research looking at the effects process-experiential psychotherapy (PEP) has on MDD is relevant. PEP is not fully Gestaltian in nature, but it does include Gestalt techniques (such as two-chair dialogue and empty-chair dialogue). Looking at symptoms of depression during treatment, termination, and 6 months post-treatment, Greenberg and Watson (1998) found that PEP—at mid-treatment and termination of treatment—had superior scores on the total level of symptom reduction. Thus, GT can have a positive effect on the symptoms of MDD at particular points of treatment.

As in the case of AT, literature on GT suggest that Gestalt approaches to MDD may largely come down to the nature of the disorder and a patient’s personal preferences. Gestaltists, for instance, tend to work in a group setting, but on an individual basis. A client is, generally, expected to sit in the hot seat and enact a gestalt exercise in front of a group. GT is, in addition, very active; often including dramatic exercises like role play and ‘acting out’. Someone who isn’t comfortable around others or dramatic activities might not, as such, benefit from this type of approach. GT has also been critiqued on its exclusion of the cultural and social sources of pathologies (Prochaska & Norcross, 2010). If someone suffering from MDD had a recent traumatic event occur, for example, offering anything other than support would unlikely be helpful. On the other hand however, someone with MDD caused by perfectionism (see Blatt, 1995 for discussion) could benefit from the gestalt tenet of not living up to anyone else’s standard but one’s own.

**Conclusions and Discussion**

Research suggests that, for the remission of adult MDD, AT is more effective than GT. Although DYN is the empirically supported therapy, it is not a stretch to claim that the results are applicable to AT. As per earlier discussion, although there are many variations to DYN, they share core principles, techniques, and ideas. This makes the differences between DYN and AT miniscule in the broader sense. Furthermore, studies testing DYN likely include AT, EP, and others since DYN is the broader therapy category. Meaning that, indirectly, results of studies on DYN are also results about AT. Thus, AT is just as effective as other psychotherapies and is, additionally, more effective in the long run. GT is, on the other hand, unfortunately largely unsupported by evidence. Most literature, instead, asserts that various GT techniques—not the therapy itself—are useful. As a whole, therefore, GT may be ineffective even though it employs particular exercises that can help some cases of MDD.

These differences in effectiveness may be largely explained by the contrasting techniques each therapy employs and how these techniques help heal the underlying forces behind adult MDD. For instance, adults with perfectionistic qualities tend to be susceptible to MDD and suicide (Blatt, 1995). Perfectionistic qualities include, amongst many other characteristics, being highly self-critical. An Adlerian therapist faced with this type of case could help a client restructure their belief about the necessity of always being one hundred percent perfect. In showing compassion, acceptance, and respect for their client, the therapist would provide the necessary personal experiences a client would need to begin their world-view restructuring. Knowing that there are people out there—or even just one—who believes your effort are enough could sufficiently help a client change how they relate to other individuals. By taking the time to construct proper examples of what relationships are like, a therapist can help their client analyze personal experiences using a different schema. If a client feels that they are capable of having a normal human relationship (e.g., with their therapist), they may begin to get the sense that their efforts and achievements are enough. The simple knowledge that a proper and supportive human relationship is possible, can thus, help someone re-evaluate how they experience the world and the people around them.

A Gestalt therapist might achieve these exact results, but with a different route. Instead of using the therapeutic relationship as grounds for re-building the client’s world the Gestalt therapist would make their client act everything out. For example, the therapist would ask the client to talk to an imaginary form of the parent, communicating the repressed feelings. This role-playing exercise should conclude in a cathartic release. If this is achieved, the therapist would demonstrate that the client does not have to live up to the expectations of others; that only they are responsible for how life progresses.

Both methods sound effective, especially if they achieve the same goal (e.g., changing ideas about perfection). Individual preferences could, however, make a difference. This may make it appear as if no concise conclusion about treatment for depression could be reached; and it may make the idea of inquiry seem pointless. However, the saving grace is that MDD can be generalized while still keeping to certain particularities. Earlier discussion emphasized the importance of flexibility in treatment. This particular fact continues to be the case even if depression is defined or understood, more generally, as a mental disorder. Disorders of this nature are, quite obviously, internal, with treatment looking to assist in the inward concerns of patients (e.g., feelings, thoughts, impressions, or brain mechanisms). In line with this sense, MDD can also be considered a ‘sensitive’ disorder.

This is not to say that people with MDD need to be handled as if they are fragile objects. However, depression—like other mental disorders (e.g., phobias or anxiety)—does need to be approached with a certain finesse. A therapist who presents the object of a patient’s fear at the very first session is unlikely to do any good. There is a degree of support and easing-into that is required of a treatment for MDD. Those suffering from a particularly sensitive disorder, then, are not likely to be supported by Gestalt ‘philosophy’. The feeling that one is unloved by parents who have abused and stolen from them, for example, isn’t something that can alleviated by being put in front of a group of strangers and told to take responsibility. In the case of depression particularly a therapy that’s more sensitive and that doesn’t blame the victim (Prochaska & Norcross, 2010) would be more effective.

Restructuring a client’s view of the world and self is also an important goal for treatment (even though it may not always be necessary). This too, however, seems to be more easily achievable by AT rather than GT. With an Adlerian therapist, a client has the chance to slowly build up a reassuring relationship, which they may then use to change their beliefs. This type of positive and slow change is not very conducive through the Gestalt philosophy. Especially since with AT, not GT, is genuineness and support employed. The Gestalt model thus, in general, makes ill use of concepts and techniques (e.g., support) that could be helpful to a client with a disorder of this nature. The conclusion this discussion forms is that a therapy based on a philosophy which ignores the internal is not likely to assist someone whose problems are, in many ways, internal.

It is clear then that MDD in adults is a mental, internal, and sensitive disorder which likely has roots in negative generalizations about oneself and the world. An Adlerian philosophy and therapy targets these basic principles underlying depression more so than a Gestalt one. Thus, adults with MDD would respond more to AT than to GT.

**Limitations**

Aside from the limitations of each specific study itself, there are several worth noting about the method employed in these discussion. Studies included in support for the effectiveness of AT and GT have drastic differences between them. This may explain the conclusion that AT is more powerful than GT for the remission of MDD in adults. The literature used to support the Adlerian approach to depression were mostly meta-analyses. Hence, in general, quality and quantity were on the side of AT. GT, on the other hand, was supported by various dissertations and singular studies that—although didn’t support the therapy itself—used Gestalt techniques. Therefore, comparing the two therapies using studies which differ so drastically in methodology skews perceptions of effectiveness.

The concern with methodology is, firstly, in content compared. The full procedures and treatments used in AT are substantially more thorough and, therefore, more widely applicable than just a few exercises from GT. If only one or two methods of AT were compared to only one or two methods of GT, the two could have had equally effective or ineffective results. The second concern is with sample populations. Meta analyses include hundreds of studies and can, therefore, consist of data of hundreds of participants. This makes the results of comparison between meta-analyses and singular samples inconclusive. Especially since the former has a higher probability of including more diverse samples and, therefore, results (from the sheer amount of participants). The concern is more pressing when considering the fact that the research included on GT was proposed for and conducted on adolescents. Depression in adults is different than in teenagers or children (American Psychiatric Association, 2013). Therapies and techniques that benefit one age group do not necessarily benefit another. The studies used in defense of AT were, therefore, more diverse and inclusive of the population at large, allowing for a broader investigation into its effects.

Lastly, since Gestaltists have not been taken to empirical research—as previously mentioned—there is the issue of scientific validity. Studies provide a chance for psychologists to present, test, analyze, and report their methods. Without having a concise list of processes, how they’ve been analyzed or used, and what results these tests indicate, there is no objective way for others to validate the techniques in question. Gestalt methods being applied in the literature may not, thus, be similar enough as another’s use of these very same techniques. These small changes in execution from literature to literature could have drastic effects—and not just on MDD remission—thereby skewing the data on empty chair dialogue. Additionally, by studying only some of the techniques available from GT, there could be a chance that a more effective method is being overlooked.

Therefore, if a near equal amount of diverse (e.g., all age groups and different genders) meta-analyses or studies looked at the complete body of GT and AT techniques, data might show that both are equally in/effective. To claim that AT should be recommended over GT to an adult with MDD is, therefore, a tentative conclusion at best. Nonetheless—taking the focus away from logistics—AT may still be a more viable suggestion than GT. If the effectiveness of Adlerian therapy is more tested and understood, it is likely a better (barring any experimental requirements that an individual’s particular case may bring) clinical recommendation than a therapy whose effects are currently hidden to the world at large.

**Future Research**

Considering the inequalities between quantity and quality, GT needs to be applied more frequently to adults diagnosed with depression (although there are ethical considerations in doing so). A body of research comparable to those of other psychotherapies will, thus, be formed. Armed with this type of data, skewing of results is less likely to occur when comparisons between therapies are made. This body of research will, furthermore, allow for thorough analyses into what it is about GT that makes it in/effective for treatment of adult MDD. Since comparative research has implied that GT is more effective in adolescents, further research will also make clearer the differences between depression in children, adolescents, and adults. This could provide fundamental information for the creation of techniques that target specific underlying causes of MDD per age group; thereby assisting general techniques for the treatment of depression. Considering the breadth and intensity of MDD, such advances can help the population, in general, with a much needed release from such a consuming disorder.

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