

## Clinical Trauma-Correlates and the Motivation for Psychotherapy

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### Abstract

The Operationalized Psychodynamic Diagnosis OPD-2 is a multi-axial diagnostic system based on psychodynamic principles. Axis I (OPD-2 axis I), assessing “experience of illness and prerequisites for treatment”, contains the factors: 1) “psychological orientation” (PSO), 2) “somatic orientation” (SMO), 3) “social orientation” (SCO), 4) “resources and openness” (ROP), 5) “impediments to therapy and secondary gain from illness” (IMP). The experience of illness and the prerequisites for treatment are linked to the subjective suffering, a construct modulated by depression, in theory and clinical practice, and to structure *in a psychoanalytical sense*. The corresponding structural functions are typically altered in trauma-correlates. This study examined the effects of posttraumatic stress disorder (PTSD), borderline criteria (BLC), dissociation and depression on the experience of illness and the prerequisites for treatment in 53 inpatients of a psychotherapeutic clinic using the OPD-2 axis I, the AMDP module dissociation (AMDP-dis), the posttraumatic distress scale (PDS), the SCID II and the Montgomery Asberg Depression Rating Scale (MADRS). Somatoform disorders were linked to SMO, whereas depression and PTSD were linked to PSO. Extracting the shared variances separated single dissociative symptoms from the other syndromes. Specific associations showed between the factors of OPD-2 axis I and dissociative, as well as non-dissociative syndromes. PSO was best predicted by amnesia, as opposed to the prediction of IMP by identity disturbances. These findings indicate a hierarchy of defences within the dissociative spectrum and a mediating function of some dissociative symptoms on the orientation towards therapy.

### Introduction

The operationalize psychodynamic diagnosis 2 (OPD task force, 2006) is a multi-axial system combining the purely descriptive approach of the current classifications DSM-IV and ICD-10 with individualized, psychodynamic differentiation based on psychoanalytical principles. It comprises of the five axes I) “Experience of illness and prerequisites for treatment”, II) “interpersonal relations”, III) “conflicts”, IV) “structure” and V) “mental and psychosomatic disorders”. The OPD-2 axis I capture the manner, in which an illness is experienced and processed. Not only may these issues be crucially important and informative with respect to the planning of treatment and the choice of a certain method, but also as regards the respective outcome [1]. The question of how the individual experiences, presents and conceptualizes his or her symptoms and sufferings is linked to the wish to cooperate with a therapist and to tolerate the stresses which a therapy may give rise to [2]. OPD-2 axis I shares some of the theoretical and heuristic background of [3] transactional model of coping in that it deems intra-psychic and environmental factors relevant for the process of mastering psychological or medical stressors. However, the OPD-2 axis I do not operationalize coping and illness behavior in depth, but focuses rather on trait variables, social aspects and certain features of coping considered relevant for change and the respective indication. In principle, the OPD-2 axis I is governed by psychodynamic theory supposing that facets of personality structure, typical unconscious conflictual themes and relationship patterns would have an impact on the course of illness. Based on these theoretical assumptions, the OPD-2 axis I take emotional, cognitive and behavioral resources into consideration, as it dedicates itself to the subjective appraisal of the burden and of the effects of an illness. This subjective evaluation corresponds to the question as to how the individual perceives, presents and conceptualizes the symptoms on the basis of his or her lay theory. Through the distinction of medical, psychological and social implications, which shape the quality and character of an individual’s perception and appraisal of his or her problems, the OPD-2 axis I stick to the logic of a bio-psycho-social conception of illness. In their factor analysis of the OPD-2 axis I, [4] established five factors, namely the

“psychological orientation”, the “somatic orientation”, and the “social orientation”, as well as the factors “resources and openness”, and “impediments to therapy and secondary gain from illness”, thereby demonstrating the plausibility of the internal structure of the OPD-2 axis I. The factors ROP and IMP influence the orientation factors, and are themselves dependent on personal resources and, as far as the motivation for psychotherapy is concerned, on the openness towards a psychological consideration of causes and meanings. Therefore, the fourth factor ROP specifies health-related characteristics rooted in personality structure (such as experience of self-effectiveness, adaptive relationships, capacity to be on one’s own or to distance oneself, emotional competencies and others), and the willingness to occupy oneself with a psycho-reactive genesis of complaints. Another resource of interest for this factor is the availability of support from the social environment. Finally, the fifth factor IMP refers to the inner resistance against psychotherapy, such as poor motivation to identify and clarify the underlying psychosocial causes of health-related problems, and to the gratification which the individual receives through the illness [5].

Since the structural functions represent important psychological determinants of the process of adapting to illness [6], the OPD regards intrapsychic, as well as interpersonal and conflicting perception, self-reflectedness, regulation of affects, and the ability to relate to others as resources for illness-related psychodynamic as well as coping processes

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and attitudes. Those structural functions co-determine the extent of suffering, which the individual experiences, because that suffering corresponds to the discrepancy between the individual symptoms, on the one hand, and the coping abilities as well as the compensatory resources the individual disposes of, on the other. Freud's [7] view ("the primary motive force in the therapy is the patient's suffering and the wish to be cured from it") is echoed in the understanding of the OPD-2 axis I, which posits, that that suffering would be the driving force to motivate an individual to seek help from a therapist and to strive for changes. The construct of the motivation for psychotherapy is therefore composed of an affective element representing the subjective suffering and the secondary gain from illness, and a cognitive part reflecting the disease-related concept, as well as the expectations of change [8]. These components may have a predominantly psychological, somatic or social connotation - depending on how the experience of the distress is modulated by the structural functions and the availability of resources, on the one hand, and on the explanations for it which a patient declines to adhere to, on the other.

Given the theoretical overlap between the prerequisites of treatment and psychodynamic theory, it seems promising to investigate those prerequisites for treatment in those patients who expectedly display altered functions of their relational, perceptual, interactional and self-regulative capabilities. Typically, trauma effectuates alterations of these structural functions, on which the definitions of PTSD, dissociation and borderline personality disorder are actually based, according to the American Psychiatric Association (2000) [9]. Specifically, dissociation is defined as the disruption of the usually integrated functions of memory, identity, perception and consciousness, and therefore implicitly a disorder of the structural functions to a remarkable extent. It is a central feature to PTSD and borderline personality, and viewed as a trauma-related pathology [10]. However, dissociation is usually depicted as a total score [11], making it difficult to recognize specific aspects of the numerous associations between the dissociative spectrum and other clinical syndromes reported in literature [12]. Borderline personality disorder is a condition of pervasive and enduring instability in moods, interpersonal relationships, self-image, and behavior, and displays elevated rates of severe childhood abuse. PTSD represents a specific fashion of processing a given trauma, and is characterized by re-experiencing emotions, cognitions, and bodily reactions related to the trauma, by avoidance of the stimuli of those reactions, and by an elevated psycho-physiologic reactivity. All these posttraumatic conditions show high rates of co-morbidity with axis I disorders [12-15], in general, and with depression, in particular. A recent study reported co-morbidity rates with depression ranging from 63-77 % in patients with BPD with and without PTSD [16]. Likewise, PTSD as such [16] and dissociative disorders are frequently associated with depression [17].

The high incidence of depressive symptoms in disorders classified as posttraumatic and related to trauma may signify an impaired capacity of self-regulation, and is of special interest as far as the prerequisites for treatment are concerned. The motivation for psychotherapy is often believed to correspond to the subjective suffering, with special importance attached to affective symptoms [18], which along with the secondary gain from illness co-determine that motivation for psychotherapy as a result of the mutual influences between the subjective suffering and the derived cognitions. In-line with this theorizing, depression was shown to give rise to a high motivation for therapy [19], whereas somatoform problems rather constitute a motive for seeking medical therapies, and anxiety disorders take an intermediate position [18]. The few studies undertaken with the axis I further point to relevance of socio-demographic variables for the

prediction of the motivation for therapy, that is to say female gender and older age [18,20] are more likely related to a psychological and a somatic orientation respectively. The present study tests the hypothesis, whether or not dissociative symptoms have a major impact on the prerequisites for therapy guided by the theoretical consideration that the respective constructs share a considerable conceptual overlap. Therefore, the presence of dissociative symptoms, which are a hallmark of posttraumatic syndromes, may contribute to the individual suffering even more significantly than depression. Eventually, single dissociative symptoms may give rise to the specific interest in exploring psychological aspects of the disturbance, as opposed to blaming medical or social factors, as a result of the specific interactions between the respective underlying factors and mechanisms.

## Methods and Participants

The study was approved by the ethical board of the University of Rostock. Voluntary, written, informed consent was given prior to the interviews by all subjects. 53 consecutively admitted participants were recruited in a psychosomatic clinic in Northern Germany. 20 were diagnosed with depressive disorder excluding major depression, 20 with panic disorder, and 16 with somatisation disorder according to DSM-IV criteria.

Admission to this psychotherapeutic ward is typically attained after waiting periods of several weeks. Given this precondition, patients are affected significantly enough by their index disorder to be in need of in-patient psychotherapy, but stable inasmuch as they are able to cope with the waiting period. The only explicitly adopted exclusion criterion was current substance abuse.

## Instruments

Symptoms were assessed in interviews, using the Montgomery Asberg depression rating scale [21], the German version [22] of the Posttraumatic Stress Diagnostic Scale PDS and the AMDP (Arbeitsgemeinschaft Methodik und Dokumentation in der Psychiatrie) module-dissociation [23] by thoroughly trained raters. The AMDP module dissociation comprises of 15 items which are divided into four subscales of 1) symptoms affecting consciousness (lowered vigilance, clouded, narrowed and expanded consciousness); 2) symptoms affecting memory (amnesia, hypermnesia and Déjà vu); 3) symptoms affecting identity (uncertainty of own identity, changing identity, obsession and fugue); 4) symptoms affecting perception (derealisation, depersonalisation, altered perception of space and time, respectively). Its high correlation ( $r=0.8$ ; FDS) with the German version of the dissociative experiences scale [24] suggests strong concordant validity, and the interrater-reliability of the AMDP system is judged to be high, in general [25]. The score for each item is either 0 (not at all) or 1 (mild) or 2 (moderate) or 3 (severe).

The PDS is assigned good to very good internal consistence (Cronbach's  $\alpha=.92$ ) and retest reliability ( $\kappa=.74$ ). Convergent Validity at comparison with the corresponding SCID section is moderate (Cohen's  $\kappa=.59$ ). The present study assessed the full scope of the PDS regardless of whether or not a single criterion was fulfilled. The rationale behind this procedure was to assess posttraumatic distress dimensionally resulting in the count of PTSD-dimensions (PTSD-dim), as opposed to treating it as a category. Borderline criteria (BLC) were assessed using the SCID-II [26].

Axes I-IV of the OPD-2 are based on psychodynamic understanding derived from psychoanalysis, whereas axis V is descriptive in accordance with chapter V of the international classification of disorders [9].

Although these axes partly reflect psychoanalytic concepts (personality structure, intra-psychic conflict, transference) conclusions are to be drawn with reference to the respective operationalization.

The present study made use of **OPD-2 axis I**, only, which describes the factual subjective experience of illness and those aspects of processing it, which are relevant to change and indication for psychotherapy, such as consciously and unconsciously available resources. As a rule, OPD-2 axis I sticks to the taxonomy of the social, psychological and medical dimensions of those experiences and resources. Waage et al. [4] established a five-factor structure of the axis I with Cronbach’s alpha ranging from 0.63-0.86. The subscale SCO reflects the pronounced presentation of social problems, social concepts of the disorder, and the desire for social therapy; accordingly, the factor SMO is characterized by the predominance of physical complaints, the orientation of the concept of illness to somatic factors, and the wish for somatic therapy, whereas the factor PSO is characterized by the presentation of mental complaints, or their attribution to psychological matters. The factor IMP describes characteristic and psychodynamically relevant, unconscious conflicts as well as facets of the mental structure, such as a limited capacity for self-regulation, or for the tolerance of stress. The factor ROP assesses the patient’s openness towards psychological topics or interaction-related contemplation of his or her mental or psychosomatic problems. Also, it refers to personal resources and psychosocial support, that is to say, the capability to adapt one’s behavior in a way, which is beneficial for health, to adjust to disorders and to recruit and use a supporting social environment. Each of the 20 items of the axis I of the OPD-2 axis I is rated on a 5-point Likert scale (0=none or hardly present; 1=mild; 2=medium; 3=high; 4=very high; 5=not ratable). The reliability of the axis I in its first version was considered fair (weighted kappa=0.47). For the latest version, good validity and a plausible internal structure have been reported [4].

### Statistical procedures

Sociodemographic variables were investigated by means of Anova and  $\chi^2$ . Manova was used to compare the mean scores of axis I subscales between the diagnostic groups. As the study question regarded symptoms and their influence on the motivation for therapy, the subscales of OPD-2 axis I were dichotomized into groups scoring above and below the respective mean. Then, MADRS scores and the number of PTSD- and borderline-criteria were compared between those groups by means of MANOVA. In order to explore the shared variances of the variables of interest with the subscales of the AMDP module dissociation, Pearson and partial correlations were used. These procedures were necessary in order to separate dissociative symptoms from the other syndromes wherever possible. Finally, the variables found in linkage with the factors of OPD-2 axis I by the previous procedures were entered into stepwise forward binary regression analyses as independent variables, whereby the definite research goal of the study was reached. Regression analyses were controlled for gender and age, which were entered into the first step as independent variables.

### Results

Age ranged from 19 to 60 years (mean:  $39.79 \pm 11.12$ ). 27 (47.4%) participants (66.7% females) were diagnosed with PTSD according to the PDS, as compared to 29 (75% females), who were not. PTSD was similarly distributed among the diagnoses: 11 (57.9%) cases were identified in depression, 11 (55.0%) in panic disorder and 5 (31.3%) in somatoform disorder ( $\chi^2=2.7$ ;  $p=0.3$ ).

The mean score for borderline criteria was  $5.50 \pm 3.32$ . The mean

MADRS score was  $26.45 \pm 9.04$ . MADRS scores were correlated to BLC ( $\rho = 0.45$ ;  $p=0.001$ ) and to PTSD-dim ( $\rho = 0.50$ ;  $p = 0.002$ ). Means of the factors of OPD-2 axis I were: 1) PSO:  $8.09 \pm 2.30$ ; 2) SMO:  $5.08 \pm 3.83$ ; 3) SCO:  $3.87 \pm 2.82$ ; 4.) ROP:  $6.14 \pm 1.84$ ; 5): IMP:  $1.64 \pm 2.67$ . SCO was related to gender (males:  $5.13 \pm 2.77$ ; females:  $3.67 \pm 2.72$ ;  $T = -2.1$ ;  $p=0.05$ ), and age was correlated to the factor IMP ( $\rho = 0.31$ ,  $p=0.03$ ) (Table 1).

The diagnostic groups did not differ with respect to the factors of OPD-2 axis-I, except for an association of SMO with somatoform disorder (Table 2). T-testing revealed associations between higher scores on MADRS and the dissociative subscale “amnesia”, respectively, and the factor PSO. Moreover, t-testing uncovered relationships between the factor IMP and the dissociative subscales “perception” and “identity” (Table 3).

Depressive symptoms, borderline criteria and PTSD symptoms were highly correlated with the subscales of the AMDP module dissociation, indicating shared variances. However, after extracting these variances by means of partial correlations, only the dissociative subscales “consciousness” and “amnesia” showed an essential involvement in that interplay between those syndromes, whereas “identity” and “perception” could be statistically separated from the non-dissociative syndromes. Specifically, borderline criteria were associated with amnesia, whereas PTSD-criteria were linked to altered consciousness, and MADRS scores were related to both, amnesia and altered consciousness (Table 4).

		n	%
Gender	female	38	71.4
	male	15	28.6
Accommodation	With Parents	2	3.8
	With parents in law	1	1.9
	Own	44	7.5
	Flat-share	4	7.5
	Other	2	3.8
School	8 Classes	3	5.7
	10 classes	31	58.5
	12 classes	19	35.8
education	ongoing	2	3.8
	apprenticeship. completed	29	54.7
	university	12	22.6
	none	3	5.7
	master	3	5.7
	other	4	7.6
Profession	unskilled	6	11.3
	skilled labor	11	20.8
	low qualification	14	26.4
	intermediate qualification	5	9.4
	high qualification	5	9.4
	leading position	2	3.8
	self-employed	4	7.6
	never employed	1	1.9
	unknown	3	5.7
current work situation	full-time	16	30.2
	part-time	9	17.0
	occasionally	1	1.9
	house-wife (-man)	2	3.8
	apprenticeship	3	5.7
	unemployed	13	24.5
	pension	3	5.7

Table 1: Sociodemographic Information.

	Psychological orientation	somatic orientation	Social orientation	Resources / openness	Internal impediments to change/secondary gain from the disorder
depression	8.32	3.37	4.57	6.47	0.89
	±2.00	±3.61	±3.54	±1.71	±2.51
Panic disorder	8.78	4.06	2.72	6.39	1.44
	2.29	2.62	2.07	1.69	2.57
somato form disorder	7.17	9.42	2.92	5.25	2.83
	±2.66	±2.71	±2.07	±2.18	±2.89
F	2.03	14.45	2.17	1.86	1.16
p	0.1	<0.01	0.1	0.2	0.3

**Table 2:** MANOVA comparing the subscales of the OPD-2 axis I (mean ± SD) between diagnostic groups, participants with and without PTSD, borderline personality, and scoring below or above the mean MADRS score.

	consciousness	amnesia	Identity	Perception	BLC	PTSD-dim	MADRS
Low	5.38	2.10	2.45	3.48	5.03	19.95	24.34
PSO	±2.26	±1.37	±1.72	±2.71	±2.81	±12.50	±8.13
high	6.08	3.29	2.75	4.13	6.38	25.15	29.42
PSO	±2.65	±1.63	±1.87	±2.77	±3.57	±11.43	±9.14
T (p)	-1.04	-2.88	-0.61	-0.85	-1.53	-1.22	-2.14
	(0.3)	(<0.01)	(0.5)	(0.4)	(0.1)	(0.2)	(0.04)
Low	5.87	2.40	2.47	3.43	5.33	19.89	25.77
SCO	±2.22	±1.63	±1.55	±2.43	±3.19	±10.78	±8.69
High	5.48	2.96	2.74	4.22	6.04	24.53	27.78
SCO	±2.74	±1.52	±2.07	±3.07	±3.28	±13.74	±9.20
T (p)	0.57	-1.27	-0.55	-1.04	-0.79	-2.1	-0.82
	(0.6)	(0.2)	(0.6)	(0.3)	(0.4)	(0.3)	(0.4)
low	5.39	2.90	2.74	3.97	5.97	24.58	25.77
SMO	±2.42	±1.64	±1.63	±2.95	±2.96	±12.52	±8.28
High	6.14	2.27	2.36	3.50	5.16	18.60	27.86
SMO	±2.47	±1.49	±1.99	±2.43	±3.57	±11.32	±9.75
T (p)	-1.1	1.43	0.76	0.61	0.87	1.44	-0.84
	(0.3)	(0.2)	(0.5)	(0.5)	(0.4)	(0.2)	(0.4)
Low	5.82	2.71	2.71	3.47	5.76	20.54	26.76
ROP	±1.91	±1.72	±1.79	±2.03	±3.19	±11.47	±8.10
High	5.61	2.55	2.61	3.88	5.85	22.65	26.88
ROP	±2.67	±1.44	±1.78	±2.79	±3.27	±13.14	±9.61
T (p)	0.33	0.35	0.19	0.53	-0.09	-0.47	-0.04
	(0.7)	(0.7)	(0.9)	(0.6)	(0.9)	(0.7)	(0.9)
Low	5.88	2.81	3.03	4.19	6.09	24.20	27.38
IMP	±2.39	±1.55	±1.71	±2.39	±2.84	±10.68	±9.14
High	5.10	2.11	1.74	2.42	4.84	17.54	24.84
IMP	±2.42	±1.49	±1.69	±2.24	±3.80	±13.68	±8.74
T (p)	1.11	1.60	2.62	2.61	1.34	1.57	0.97
	(0.3)	(0.1)	(0.01)	(0.01)	(0.2)	(0.1)	(0.3)

**Table 3:** Comparison of the clinical variables between groups scoring high and low on the subscales of OPD-2 axis I\*: t-test (Mean ± SD).

Based on their respective relevance in previous t-testing, MADRS scores and amnesia were then chosen as predictors of the factor PSO, which was best predicted by amnesia. Likewise, the dissociative subscales “perception” and “identity” were used for the prediction of the factor IMP, which was best predicted by Identity. However, the exponential of the beta weight, Exp. (B), was lower than 1 indicating that the odds of belonging to the criterion variable category decreased for increasing scores on the identity subscale (Table 5).

## Discussion

The present study aimed to compare the influence of different posttraumatic syndromes and of depression on the prerequisites for treatment and the experience of illness as operationalized by OPD-2 axis I. This construct is based on the assumption that the burden of affective symptoms would largely contribute to the extent of the subjective suffering. On the contrary, the hypothesis tested was, whether or not dissociative symptoms and correlates of trauma have an additional

Description of procedure		Consciousness	Amnesia	Identity	Perception
Bivariate correlation	<b>MADRS</b>	0.71 <b>&lt;0.01</b>	0.54 <b>&lt;0.01</b>	0.44 <b>&lt;0.01</b>	0.47 <b>&lt;0.01</b>
	<b>BLC</b>	0.42 <b>&lt;0.01</b>	0.43 <b>&lt;0.01</b>	0.49 <b>&lt;0.01</b>	0.32 <b>0.01</b>
	<b>PTSD-criteria</b>	0.41 <b>0.01</b>	0.44 <b>0.01</b>	0.42 <b>0.01</b>	0.29 <b>0.01</b>
Partial correlation (control variable: MADRS)	<b>BLC</b>	0.01 0.9	0.34 <b>0.03</b>	0.3 0.08	0.18 0.3
	<b>PTSD-dimensions</b>	0.43 <b>0.01</b>	0.13 0.5	0.24 0.2	0.29 0.1
Partial correlation (control variables: PTSD-dim & BLC)	<b>MADRS</b>	0.56 <b>&lt;0.01</b>	0.34 <b>0.05</b>	0.20 0.3	0.25 0.12
Partial correlation (control variables: MADRS&BLC)	<b>PTSD-dimensions</b>	0.14 0.4	0.10 0.6	0.18 0.3	0.07 0.7
Partial correlation (control variables: MADRS&PTSD-dim)	<b>BLC</b>	-0.051 0.8	0.31 0.08	0.21 0.3	0.13 0.5

**Table4:** Relationships Between Syndromes and The Subscales of the AMDP Module Dissociation: Shared Variances.

Dependent variable	Total Model	predictor	B	SF	Wald	df	p	Exp. B	c.i. (lower)	c.i. (upper)
<b>psychological orientation</b>	$\chi^2=7.79$ ;df=1;p<0.01; Nagelkerke's R <sup>2</sup> =0.18	Amnesia	0.53	0.20	6.67	1	0.01	1.69	1.12	2.53
<b>Impediments to change</b>	$\chi^2=6.74$ ;df=1;p<0.01; Nagelkerke's R <sup>2</sup> =0.17	Identity	0.47	0.20	5.66	1	0.02	0.63	0.43	0.92

**Table 5:** Stepwise forward Binary Regression Analyses.

impact on the prerequisites of therapy, as the partial overlap of the respective definitions strongly suggests. Consistent with earlier studies [18], the results showed that only somatoform disorders *per se* manifest a specific (somatically oriented) concept and orientation, as regards the experience and the processing of illness and the corresponding expectation of therapy. By contrast, but in concordance with earlier findings by [18], depressive symptoms and posttraumatic distress, unlike borderline criteria, were connected to a rather psychological orientation in the studied sample. However, the syndromes themselves, on the one hand, were strongly inter-correlated and, on the other, also correlated to the four dimensions of the dissociative spectrum, questioning the specificity of their relationships with the construct of OPD-2 axis I. Facing this amalgamation of dissociative and non-dissociative syndromes, one might in fact find that posttraumatic distress, emotional instability, and depressive symptoms form a cloud, which pours a dissociative shower. This notwithstanding, the dissociative subscales identity and perception were statistically separable from the non-dissociative syndromes indicating an independent psychopathological status. Those types of dissociation were also linked to fewer impediments of change and less secondary gain from illness, suggesting the corresponding dissociative experiences to have a beneficial effect on the motivation for psychotherapy. At a first glance, this may seem confusing, as dissociation is often believed to represent a fragmentation of mental processes which would disrupt the consistency and integrity of attitudes, cognitions and plans related to coping with a stressor as well, thereby simultaneously rendering more or less adaptive resources non-cohesive, fragmentary and instable. However, since the days of Freud [7] has the concept of individual suffering been constantly regarded an important motivating factor for change, and the stance, that the individual suffering would correspond to the burden of affective disturbance, may be strengthened by these results inasmuch as identity conflicts and derealisation/depersonalization add to the load of affective symptoms. Derealisation/ depersonalization depict a sense of separation from body, self or environment, and may – even though characterized by gross distortion or wrong attribution of the self or the image of others - signify defensive processes adaptive

enough to still raise the interest in a psychological exploration of the disturbance. Likewise, identity conflicts, representing primarily psychological problems, apparently encourage the orientation towards psychical and interpersonal aspects of the complaints instead of merely repressing the conflicting issues from awareness. To our understanding, this interpretation is also sustained by our finding of a positive correlation between age and IMP. Possibly resulting from the increasing investment in normative social roles related to family, work and civic involvement, the individual identity consolidates over time [27], while the complaints subsumed within neuroticism decrease in the adult life span [28]. What the OPD-2 axis I deems the essential precondition of the motivation for psychotherapy, namely the subjective suffering, is therefore likely to decrease over time, as well, due to the higher risk of depression inferred by higher scores on neuroticism [28]. Given the factual negative correlation between the subscales IMP and PSO [4] and the antagonistic nature of their mutual influence, the assertion of an age-related diminution of the propensity for subjective suffering seems cogent, as a shift towards an inclination for social explanations of complaints could reflect the decreasing significance of psychological aspects of the individual homeostasis with increasing age. Similarly, the correlation between male gender and SCO corresponds to findings of a higher inclination of females towards a psychological orientation [17] possibly reflecting women's greater susceptibility to depression [29] and thereby to greater subjective suffering.

Socio-demography aside, the subscale amnesia, covering the loss of accessibility of biographic information and a faster or slower factual lapse of time than perceived, is linked to PSO, the most favorable pre-condition of the motivation for change, as far as the indication for psychotherapy is concerned. This link was not specific to any of the diagnoses and syndromes, but, on the contrary, amnesia was promiscuous in the sense of not being separable from borderline criteria and depression. Inasmuch as this item reflects blanks within biographic memory, this finding could be an indirect indication of the significance of the corresponding topics for the attribution of a symptom as primarily influenced by psychological factors, regardless of the prevailing clinical syndrome. Therefore, dissociative amnesia may

be worth consideration during the diagnostic phase if one is to arrive at a differential indication for psychotherapy. Moreover, *ecmnesia* and *hypermnnesia* could be significant indicators of an intense settlement with internal experiences and self-directed cognitions taking the form of, for instance, rumination and feelings of guilt or shame. Those symptoms apparently have an impact on the subjective suffering and may be a crystallization of the numerous features and symptoms covered by borderline criteria and the MADRS scale that possibly are of less or less direct impact on that suffering.

Consequently, their association with PSO in the present study is likely mediated by the dissociative subscale amnesia. The authors of the OPD-2 axis I view the subjective suffering as an “indicator for inferring what expectations a patient brings to therapy” and differentiate it into a quantitative, symptom-related, and a qualitative, structure-based part, theoretically. Inaccessibility of biographic memories (dissociative amnesia) is regarded a defense mechanism against adverse memories, serving the regulation of potentially threatening intra-psychic as well as interpersonal conflicts. Constituting an individual mode of defense, amnesia rather corresponds to the structural aspects of the above mentioned operationalization and may functionally increase the susceptibility for more quantitative (affective) suffering, which, in turn, may result in a heightened propensity for *hypermnnesia* and *ecmnesia* as a result of the elevated attention paid to inner processes, emotions and conflicts. If these mechanisms held true, the latter dissociative symptoms could be interpreted as markers indicating internal processes of opening up towards psychological topics. Such functional significance of *hypermnnesia* and *ecmnesia* would be consistent with the theory of a hierarchy of defenses, which posits that the dissociative symptoms map onto a rather highly adaptive level of defense [30].

Contrarily, the present results suggest dissociative experiences of altered consciousness to behave neutrally as regards the effects on PSO, although they may be linked to depression and PTSD. Accordingly, disturbances of consciousness might signify more complex challenges to cope with and be more directly connected to PTSD symptoms, including psycho-physiological reactions, than to matters of personality structure and biography. Thus, altered consciousness could represent comparatively poorly adaptive defenses which do not correspond well with the willingness to enter psychotherapy.

Through establishing a link between dissociative features and the motivation for change, the present results emphasize the significance of dissociative features for treatment-planning. Accordingly, the variety and common incidence of dissociative symptoms in psychiatric disorder might offer the chance to recognize individual differences of the experience of an illness as regards its emotional and cognitive processing. Therefore, dissociation may be a precious source of information, if one is to arrive at a differential indication for therapy.

However, this cross-sectional study is based on a relatively small and heterogeneous sample. The participants were selected for inpatient analytic therapy and may not be representative of all patients suffering from trauma-correlates. Also, the promiscuous nature of dissociative symptoms implies their co-morbid relationship with a variety of psychopathological syndromes, which possibly results in numerous interactions qualitatively different from those examined in the present study. Thus, the present results should not be over-generalized, although this study opens the window on an innovative, differentiated and functional interpretation of dissociative symptoms with respect to their interaction with psychodynamic and cognitive aspects of the indication for psychotherapy. Dissociation may not be as complicating for therapeutic processes, as many clinicians would intuitively suppose,

and some of the corresponding symptoms could even be particularly advantageous for the motivation for therapy.

## References

1. Schneider W, Klauer T, Freyberger HJ, Hake K, von Wietersheim J (2000) [Axis I “illness experience and treatment preconditions” of operational psychodynamic diagnosis (OPD). Experiences in clinical practice]. *Psychother Psychosom Med Psychol* 50: 454-463.
2. Becker P (1984) The importance of the subjective theory of disease of the patient for the doctor-patient relationship. *Psychotherapy and Medical Psychology* 34: 313-321.
3. Lazarus RS, Folkman S (1984) *Stress, appraisal and coping*. Springer Pub Co., New York.
4. Waage M, Vogel M, Hake K, Schneider W (2011) [The Operationalized Psychodynamic Diagnostics System (OPD-2): validity of the Axis I “Experience of illness and prerequisites for treatment”]. *Psychother Psychosom Med Psychol* 61: 154-161.
5. OPD task force (2006) *Operationalized psychodynamic diagnostics OPD-2: manual of diagnosis and treatment planning*. Cambridge MA, Hogrefe & Huber publishers.
6. Heigl F (1977) Permanence and change, structure and process in group psychotherapy. *Practice of psychotherapy* 22: 241-248.
7. Freud S (1925) *On Beginning the treatment. Recommendations on the technique of psychoanalysis I*. (Standard Edn), London, Hogarth Press.
8. Schneider W, Basler HD, Beisenherz B (1989) *Questionnaire for psychotherapy motivation*. Weinheim, Beltz.
9. American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders – DSM-IV-TR (4th edn, Text Revision)*. Washington DC, American Psychiatric Association.
10. Bremner JD (2010) Cognitive processes in dissociation: Comment on Giesbrecht et al. (2008). *Psychol Bull* 136: 1-6.
11. Holmes EA, Brown RJ, Mansell W, Fearon RP, Hunter ECM, et al. (2005) Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clin Psychol Rev* 25: 1-23.
12. Vogel M, Meier J, Grönke S, Waage M, Schneider W, et al. (2011) Differential effects of childhood abuse and neglect: Mediation by posttraumatic distress in neurotic disorder and by negative symptoms in schizophrenia? *Psychiatry Res* 189: 121-127.
13. Sar V, Akyüz G, Kundakçı T, Kiziltan E, Dogan O (2004) Childhood trauma, dissociation, and psychiatric comorbidity in patients with conversion disorder. *Am J Psychiatry* 161: 2271-2276.
14. Grant BF, Chou SP, Goldstein RB, Huang B, Stinson FS, et al. (2008) Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *J Clin Psychiatry* 69: 533-545.
15. Mueser KT, Rosenberg SD, Goodman LA, Trumbetta SL (2002) Trauma, PTSD, and the course of severe mental illness: an interactive model. *Schizophr Res* 53: 123-143.
16. Harned MS, Rizvi SL, Linehan MM (2010) Impact of Co-Occurring Posttraumatic Stress Disorder on Suicidal Women With Borderline Personality Disorder. *Am J Psychiatry* 167: 1210-1217.
17. Mulder RT, Beautrais AL, Joyce PR, Fergusson DM (1998) Relationship Between Dissociation, Childhood Sexual Abuse, Childhood Physical Abuse, and Mental Illness in a General Population Sample. *Am J Psychiatry* 155: 806-811.
18. Schneider W, Klauer T, Janssen PL, Tetzlaff M (1999) Influence of psychotherapy motivation on the course of psychotherapy. *Nervenarzt* 70: 240-249.
19. Weidner K, Zimmermann K, Petrowski K, Distler W, Joraschky P (2005) Psychological existential orientation and health oriented quality of life of inpatients. *Psychother Psychosom Med Psychol* 55: 425-432.
20. Rosenthal D, Frank JD (1958) The fate of psychiatric clinic outpatients assigned to psychotherapy. *J Nerv Ment Dis* 127: 330-343.
21. Montgomery SA, Asberg M (1979) New depression scale designed to be sensitive to change. *Br J Psychiatry* 134: 382-389.

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22. Ehlers A, Steil R, Winter H, Foa EB (1996) German translation of Post Traumatic Distress Scale (PDS). Oxford Warneford Hospital, Department of Psychiatry.
  23. Freyberger HJ, Moller HJ (2004) Die AMDP-Module. Göttingen: Hogrefe Verlag.
  24. Freyberger HJ, Spitzer C, Stieglitz RD (1995) Fragebogen zu dissoziativen Symptomen (FDS). Bern, Verlag Hans Huber.
  25. Bobon D, von Frenckell R, Troisfontaines R, Mormont C, Peilet J (1985) Construction and preliminary validation of an anxiety scale extracted from the French version of the AMDP, the AMDP-AT. *The Brain: Journal of Clinical Psychiatry biological and therapeutic* 11: 107-111.
  26. Wittchen HU, Zaudig M, Fydrich T (1997) Structured Clinical Interview for DSM-IV. Göttingen, Hogrefe.
  27. Donnellan MB, Lucas RE (2008) Age differences in the Big Five across the life span: evidence from two national samples. *Psychol Aging* 23: 558–566.
  28. Matthews G, Deary IJ (1998) Personality traits. University Press, Cambridge, UK.
  29. Bebbington PE (1999) Psychosocial causes of depression. *J Gend Specif Med* 2: 52-60.
  30. Høglend P, Perry JC (1998) Defensive functioning predicts improvement in major depressive episodes. *J Nerv Ment Dis* 186: 238-243.