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## POSTTRAUMATIC STRESS DISORDER

### Bio-Psycho-Social Aspects, Eye Movement Desensitisation and Reprocessing and Autogenic Training in Persistent Stress\*\*

#### Case Study, Part 2

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‘There is one more thing I would like to add:  
It wouldn’t be bad if for once truth and love  
prevailed over lies and hatred.’  
(Václav Havel, 1997, our trans.)<sup>1</sup>

In our case study, we illustrate the use of Eye Movement Desensitisation and Reprocessing (EMDR) and Autogenic Training (AT) in PTSD treatment. EMDR was used to manage the acute symptoms, while AT was used to enhance the resilience in persisting stress. Using the bio-psycho-social model of mental illness, we discuss the socio-political and socio-psychological aspects of this case that has put a burden on the relationship of two neighboring nations (Slovakia and Hungary) as well as on the relationship of the national majority and a minority within our country (Slovakia). Our patient consented to this report being published, and we hope that it will contribute to a more realistic evaluation of this event in society.

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<sup>1</sup> Original text: ‘Pravda a láska musí zvítězit nad lží a nenávistí.’ In a speech at a demonstration in Prague on 10 Dec 1989, shown live on the Czechoslovakian TV, Václav Havel said, ‘Truth and love must prevail over lies and hatred’ (our trans.). Later, it became one of Havel’s most famous remarks. His critics, however, ridiculed it for being naive, simplistic and childish. Years later (on 1 Jan 1997), Havel self-ironically alluded to this quote in another TV interview when his last words to the camera were: ‘There is one more thing I would like to add: It wouldn’t be bad if for once truth and love prevailed over lies and hatred’ (our trans.). Original text: ‘A ještě jeden pocit bych chtěl říct. Vůbec by nezaškodilo, kdyby tu a tam zvítězila láska nad lží a nenávistí.’

**Keywords:** posttraumatic stress disorder, bio-psycho-social model, therapy, psychotherapy, Eye Movement Desensitisation and Reprocessing, Autogenic Training, case study

**Posttraumatisches Stresssyndrom: Biologische und soziale Bezüge, Desensibilisierung durch Augenbewegungen und Erlebnisumstrukturierung sowie autogenes Training bei Dauerstress: Fallstudie, Teil 2:** In unserer Studie beschreiben wir die Anwendung der Desensibilisierung durch Augenbewegungen (Eye Movement Desensitisation and Reprocessing – EMDR) bzw. des autogenen Trainings (AT) in der Behandlung des posttraumatischen Stresssyndroms (PTSD). EMDR dient der Milderung der akuten Symptome, AT der Verbesserung des Widerstands gegen Dauerstress. Unter Anwendung des biopsychosozialen Modells der mentalen Probleme untersuchten wir die sozialpolitischen sowie sozialpsychologischen Aspekte eines Falles, der die Beziehung zweier benachbarter Länder (Slowakei und Ungarn) und das Verhältnis zwischen nationaler Mehrheit und einer der Minderheiten beeinträchtigt. Der Patient hat in die Veröffentlichung des Berichts eingewilligt, und nun hoffen wir, zu einer objektiveren Beurteilung des Falles in der Gesellschaft beitragen zu können.

**Schlüsselbegriffe:** Posttraumatisches Stresssyndrom, biopsychosoziales Modell, Therapie, Psychotherapie, Desensibilisierung durch Augenbewegungen und Erlebnisumstrukturierung, autogenes Training, Fallstudie

## 1. The case

We are going to describe the case of the university student Hedviga Malinová, a citizen of the Slovak Republic of Hungarian nationality. She read Hungarian and German at the university. At the time of traumatisation, she was 23 years old. At the time of publication, she is 30 years old. She graduated from the university and obtained a Master's degree, is married and a mother of two children. On account of this case study being public knowledge, and in order to prevent further complications, we do not withhold the patient's identity. The patient has given us written and oral consent to publish information on her medical state and her history. Consent has also been given by her legal attorney. An overview of the case has also been published (in Slovak) by Marie VRABCOVÁ (2009, 2010) and can be presently found at the web-sites [www.tyzden.sk](http://www.tyzden.sk) and [www.fair-play.sk](http://www.fair-play.sk).

In order to make the information more transparent, we first briefly outline the traumatic events. Later we describe the case in more detail. Hedviga Malinová has suffered three serious mental traumata. Furthermore, several other long-term stressors resulted from these. First, she was attacked by two unknown men while walking to the university to take an exam in her course on Hungarian. The second traumatisation was the police interrogation regarding the attack. Finally, a stranger entered the apartment where Malinová and her partner lived, and thereafter she was threatened by a woman who presented her photographs of their messy apartment and a photograph of their car from below. Additionally, she was subjected to the pressures of ruling politicians, groundless prosecution and the media.

## 2. Traumatic events

On the morning of 25 August 2006 the patient was walking through a park by a road to take an exam in her course on Hungarian. In the park, she was assaulted by two bald men. Their first words were: 'In Slovakia, in Slovak!' She was violently dragged off the road; she was being abused and beaten. The last thing she remembered was that the men punched her stomach and she fell, hitting her head. She regained consciousness when the assailants had left. She felt nauseated and weak; she had a headache and difficulties realising what had happened and what she should do. When she arrived at the university, her colleagues and teachers discovered a sentence written on her blouse: 'Hungarians behind the Danube, SK without parasites'. They called for medical help and the patient was treated at the hospital. On 9 September 2006 she was summoned for an interrogation and told it was for the identification of the offenders. However, this did not happen. During a strenuous six-hour interrogation, she was being pressured to falsely confess that she had lied and made the whole thing up. She did not give in. On 12 September 2006 the Prime Minister and the Minister of Interior Affairs gave a press conference claiming that 'the incident did not occur'. The case was a subject of intense media interest. However, the media failed to note that the Prime Minister, the Minister of Interior Affairs and the Chief of Police publicly concluded Hedviga's guilt before the investigation was legally closed.

The last of the three main traumatic events happened while the patient was receiving psychotherapy. On the night from 20 to 21 November 2006, unknown persons broke into the apartment where she lived with her partner. They left the furniture doors open, the drawers pulled out, and the entrance door was left open, too. The keys that were originally in the lock from inside were placed on the doormat. The door of the car of Hedviga's partner was left open, too. He reported the event to the police; Hedviga took a bus to school. On the bus a woman sitting next to her was looking at A4 size photographs showing the apartment as they had found it that morning as well as photographs of the car taken from below. The woman was accompanied by another female person standing in the aisle, and after a while both women got off the bus. Hedviga was scared and uncertain how to react. Should she shout? Stay quiet? She was afraid something might happen to her partner. They might have done something to his car. He was about to travel. She tried to reach him on her cell phone, but it did not work although the battery was functioning. Later she tested it, and the phone was neither able to send text messages nor to receive texts or phone calls. It remained in this condition until 3 p.m. of that day when it started working again, without being repaired.

On 10 November 2006 the prosecutor formally opened a case against the patient. On 14 May 2007 the police accused Hedviga Malinová of false testimony and perjury. The case is still open as of November 2011, though the trial has revealed many abuses and falsehoods on the part of the police and the political representatives, as has been repeatedly emphasised by the patient's attorney. Hedviga Žáková-

Malinová has since married, but kept her maiden name in the hope that the case will be favourably resolved and her name cleared.

The public has been largely misinformed about the case, which has subjected Hedviga to further long-term stress. Instead of receiving support as a victim of violent crime, she has been ridiculed by a large part of the public. In our opinion, three factors have contributed to this public misperception: First, a mistrustful attitude towards Hungarians living in Slovakia; second, the energetic and misleading commentary by political representatives; and third – and this is perhaps the most troubling –, circumstantial DNA evidence against Hedviga's telling of the events. Several days after the assault, Hedviga received an envelope from an anonymous sender containing stolen documents. The biological traces from under the postal stamp were analysed and the patient's DNA was found. Hedviga provided the following explanation: After she was told by the police to bring the envelope in its original state, she discovered that the stamp had fallen off. To comply with the police's order, she pasted the stamp back on the envelope with her finger and saliva. This explanation was not widely reported in the media. The suggestive strength of DNA evidence was consciously misused by the media, and several otherwise critically thinking individuals gave in to its power. We are going to discuss this and further misunderstandings in the conclusion in more detail. A comprehensive summary of the case can be found in VRABCOVÁ (2009, 2010).

### 3. A short overview of the diagnosis and treatment

The patient received outpatient psychiatric care from 2 November 2006 to 5 May 2008. Overall she had 47 diagnostic and therapeutic sessions, and each session lasted between 75 minutes and 3 hours 50 minutes. The intervals between the sessions were 4 to 38 days. Hana Vojtová MSc, a clinical psychologist and the co-author of this study, was present at the sessions as an observer and recorder. She also assessed the patient using several psycho-diagnostic tests and scales. First, we appointed a working diagnosis. After several hours of clinical interviews and psycho-diagnostic assessment, this working diagnosis was confirmed.

#### *Diagnostic conclusion:*

Posttraumatic stress disorder F43.1 (ICD-10, WHO); 309.81 (DSM-IV, APA).

#### *Factors influencing health status and contact with health services*

(‘Z codes’ according to ICD-10):

Z65.4 Victim of crime or torture (Freedom of movement restricted by physical violence; being forced into unwanted behaviour – taking off her clothes and handing in her documents; punches into her face and other body parts; participating in a situation where the consequences of her actions on further violence could not be foreseen; risk of potential rape – memory loss due to a concussion and a fresh haematoma on the thighs.)

Z65.8 Other specified problems related to psychosocial circumstances (Libel from high political representatives, e.g. from Prime Minister Dr Robert Fico, Minis-

ter of Interior Affairs Dr Robert Kaliňák, and Chief of Police Dr Ján Packa, and media pressure including disparaging disinformation and attacks in online discussions.)

Z65.3 Problems related to other legal circumstances, e.g. prosecution (She is being prosecuted for ‘false testimony’ by the Chief Public Prosecutor’s Office of the Slovak Republic, although the nature of her false testimony has never been specified. At the same time, the investigation of the assault was suspended with the explanation that it ‘did not happen’.)

Z60.5 Target of perceived adverse discrimination and persecution (Verbal and physical assault on account of speaking Hungarian; the statement ‘In Slovakia, in Slovak’; the sentence ‘Hungarians behind the Danube, SK without parasites’ found on her blouse after regaining consciousness; the stressful police investigation while she was still in the role of a victim; the role changes from ‘victim’ to ‘perpetrator’ according to the Chief Public Prosecutor’s Office and the police; disparaging statements from the public; sophisticated intimidation from the unknown trespassers; invasion of her privacy and the hint that her partner might be in danger.)

Z60.8 Other problems related to social environment (She witnesses the suffering of her beloved ones, especially of her parents and partner, because of the problems she has to face but has not caused.)

*Degree of disability* according to the WHO scale (WHO-DS): A = 0; B = 2,5; C = 1; D = 2.

*Therapy*: supportive psychotherapy using specific methods of trauma processing (EMDR – Eye Movement Desensitisation and Reprocessing) and later autogenic training according to J.H. Schultz to increase and enhance resilience in persistent stress (Z65.3; Z60.8 and partially Z65.8).

#### 4. Details of the diagnostics, therapy and catamnesis

The patient was referred to one of the authors (J. H.) with the aim of establishing a diagnosis and considering therapeutic options. She was referred by psychiatrist and psychotherapist, senior consultant Peter Breier, M.D. who is also President of the League for Mental Health. He on his part had been consulted by Dr Roman Kvasnica, the patient’s future attorney.

##### 4.1. Beginning of the therapy

During the first examination, we learned that on 31 August 2006 the patient had visited an *outpatient psychiatrist* close to her domicile. According to the medical report she stated that she had been assaulted, threatened, and beaten. She could not remember certain events, she was afraid, was repeatedly being contacted by the media, although she only wished to forget everything. ‘I never thought I would need a psychiatrist.’ The psychiatrist noticed a higher anxiety level and attention focused

on the given event, and he diagnosed anxiety and depressive disorder. As for therapy, he recommended psychotherapy and prescribed 10 mg of the antidepressant Cipralex (s-citalopram) in the morning and 0.5 mg of the anxiolytic Xanax (alprazolam) twice a day, in the morning and in the evening. During her second visit on 9 September 2006, the patient stated that on Saturday morning at 7 a.m. she had been summoned by the police to identify the perpetrators. At the police station, however, this was not even mentioned. Instead, six policemen interrogated her, claiming that her story was a fabrication and that she would be taken into pre-trial custody. The psychiatrist observed decompensation due to the 'police terror' in the city of N. He described insomnia and anxiety. He augmented the pharmacotherapy by the hypnotic Stilnox (zolpidem). On 9 September 2006 the psychiatrist wrote that according to the patient, she had experienced the worst week of her life. 'It is very difficult for me to cope with the lies I am being accused of, I know I am right, and I am trying to prove it, but the majority is against me, they claim I wasn't beaten... I believe the truth will overcome, that is my only hope.' The psychiatrist described depressive mood, fleeting lachrymosity, feelings of uncertainty, distrust, and disappointment. He also described ongoing insomnia and tension.

During our first informative *psychiatric examination* (2 November 2006), we found clear symptoms of posttraumatic stress disorder (PTSD). The patient suffered from flashbacks with very unpleasant emotional (anxiety, helplessness) and somatic (heart racing, uncomfortable feeling of warmth in her back and in her stomach, tremor, headaches and pain in her thigh) responses. These were usually triggered by situations resembling the assault. The patient later described these situations in detail, for example walking alone and seeing male figures behind her, especially if they were bald, or going from the bus stop to the university through the park. Other situations included leaving the house alone, entering the dormitory, as she imagined the assailants could be hidden there, or speaking among people, either in Slovak or in Hungarian. The patient also complained of irritability that she was not quite able to control. The irritability occurred in communication with close people, for example with her father and her partner, Peter, with whom she had had a good and stable relationship. Her sleep was fragmented, and she had problems concentrating, for example while studying. She tended to avoid all thoughts and situations resembling the traumatic event, and she could not remember some parts of the traumatic situation. When hearing misinformation on TV, radio, or online, she felt restless and had an impulse to run out on the street and shout: 'People, for God's sake, don't believe it, it is a lie!' According to Malinová, this misinformation concerned questions of whether she did or did not make a phone call, whether her ATM card was or was not blocked, when and how the accident happened, the way her biological material got on the envelope, the manner in which the sentence was written on her blouse, and more. All misleading information was either released by the Ministry of Interior Affairs or resulted from 'findings' of experts appointed by the police, and such statements could be easily identified as false. It is interesting to ponder whether the campaign of misinformation was produced deliberately, for political benefit, or whether wishful



thinking (PETERS 2011; CIOMPI 1997; CIOMPI & ENDERT 2011), hostility and other motives played a role. We are going to consider this subject in more detail and in a broader context in the concluding remarks.

During the first examination in Trenčín (Trencsén) on 2 November 2006 the patient said: *'I want to be strong, but I am not, when I am alone, I cry a lot... I keep living in stress, I especially hate the town and don't go there very often... On Saturday I already feel stressed that I have to go there on Monday... Yes, before the attack, it was normal... I am afraid to go there, I am afraid to go out on the street, I might meet those two men, I don't feel safe there, I am terribly afraid to go there... they might be waiting for me in the dormitory... I am always with a friend, I never go anywhere without her... a very good friend... I don't feel safe there, I don't go there alone... it has been like this for 9 weeks (from 8 August 2006). When I am going with my friend through the park, I try to think of something else, or I start singing, only in my head... sometimes it helps, but usually it doesn't.'*

We asked the patient to evaluate the distress caused by the negative emotions when remembering the event, using the Subjective Units of Disturbance Scale (SUDS). It is a scale of 0 to 10, where 0 means 'no distress' and 10 means 'maximal distress'. The patient's response was 7–8. The *clinical symptoms* included: anxiety, helplessness, the memory of the assault coloured by anger and disgust, unwanted reliving, repeated intrusive memories of the traumatic situation, mental distress in situations resembling the trauma as well as uncomfortable somatic symptoms when remembering it. There was a tendency to avoidance behaviour, conscious avoidance of thought and emotions connected to the traumatic event as well as conscious avoidance of activities and situations evoking memories of the trauma. Furthermore, we found inability to remember details of the traumatic event even apart from the memory loss due to the concussion diagnosed by a neurologist, ongoing hyper-arousal, difficulties falling and staying asleep, irritability, and attention and concentration deficits. Episodically, there was sadness and crying. The patient had full amnesia regarding the strikes which led to wounds on her nose and her left cheekbone, as well as the subsequent events over the next 15–20 minutes. For example, she could not remember why she had a haematoma on her thighs or how the assailants wrote on her blouse, nor did she remember her assailants leaving. Considering the PTSD diagnosis, we recommended further diagnostics and psychotherapy, since pharmacotherapy is seldom effective. We informed the patient that there were several options. She could either continue her treatment with her previous outpatient psychiatrist, or, in case he did not specialise in psycho-traumatology, she could find another psychiatrist or clinical psychologist specialised in psychotherapy and psycho-traumatology close to her domicile. Travelling 127 kms from Dunajská Streda (Dunaszerdahely), her hometown, to Trenčín (Trencsén) might be difficult. After considering her options, however, the patient preferred to continue her treatment in Trenčín (Trencsén). She agreed with her father and Peter, her future husband that they would drive her.

During the first ten sessions, we focused on detailing the patient's history and refining the diagnosis and symptomatology. We evaluated her premorbid personal-

ity, degree of disability, intelligence, and her truthfulness and credibility. Simultaneously with the diagnostic process, we offered the patient stabilising interventions to compensate the uncontrollable traumatic memories.

#### 4.2. Further medical findings and reconstruction of the traumatic event

The following findings of physicians from the University Hospital in Nitra (Nyitra) come from *medical reports* or from *deposition under oath*. The emergency physician who cared for the patient on the day of the assault later testified, on 18 June 2008, on the basis of her medical records. She stated that on 25 August 2006 she came by ambulance to the patient who ‘was very scared and distraught, she had a full body tremor . . . her pupils . . . were widened to 4 mm’. The physician also found increased blood pressure (150/80) and increased heart rate (150/min). She noticed a wound on the patient’s face and a haematoma on her thighs. She administered 10 mg of diazepam intramuscularly.

Physicians at the Department of Traumatology of the University Hospital in Nitra (Nyitra) found ‘facial oedema in the left zygomatic region and in the nose radix, pain on palpation of the oedematous areas . . . oedema and a small laceration of the lower lip left . . . dried blood from the earring holes on the earlobes, mild oedema bilaterally, pain on palpation in the jaw left, pain on palpation of the molars left . . . Extremities: reddening and sensibility on palpation of anteromedial thighs.’

A *neurologist* who examined the patient found increased tension, anxiety, anterograde amnesia of approximately 15–20 minutes, oedema in the left zygomatic region. Diagnostic conclusion: *Commotio cerebri, contusio faciei, contusio auriculae bilat, neurologically acute stress disorder of a mild degree, and further traumatological diagnoses.* (Our comment: The patient had already been tranquilised by Diazepam 10 mg i.m.)

In the discharge summary from the Department of Traumatology on 25 August 2006 the following diagnoses are stated: *Commotio cerebri, Contusio faciei l.sin. et nasi, Contusio mandibulae l.sin., Contusio et excoriation auriculae bilat., Contusio par. abdominis et reg. femoris bilat.*

The *computer tomography* (CT) of the brain, thorax and abdomen was done on 25 August 2006 at 10.42 a.m. It showed ‘no clear signs of traumatic changes’. Specific CT projections focused on the soft facial tissues were not done, since the injury was clinically unambiguous. However, further analysis of the CT scan showed that ‘there is an oedema of the soft subcutaneous structures in the left zygomatic region – the thickness of the cutis and subcutis in this area is 21 mm and 17 mm collaterally. Similarly, there is an oedema of the soft cutaneous and subcutaneous structures in the nose radix and facial regions.’ These findings come from a CT evaluation by a highly qualified radiologist, and are fully concordant with the clinical findings.

Based on the patient’s anamnestic information as well as on the findings from the University Hospital in Nitra (Nyitra) – especially the injuries of the left zygo-



matic region and nose radix captured also on the CT scan –, we can hypothetically reconstruct the most probable course of events. The patient remembered that the men slapped her left cheek twice. This is probably how her lower lip got wounded. The patient also remembered seeing blood on her finger, falling to the ground after the second slap, and being punched in her lower abdomen. She did not remember what happened next. The next thing she did remember was getting up from the ground. The assailants had already left. We can assume that after being punched in her abdomen, the patient still stood up and got two other punches on her left cheekbone and her nose radix, probably with a fist. The other possibility is that she remained on the ground and was kicked twice in these areas. These last two punches probably led to the concussion and the short retrograde and anterograde amnesia with the estimated duration of 15–20 minutes. We can assume that it was during the time the patient suffered from a consciousness disturbance that the assailants wrote the sentence ‘Hungarians behind the Danube, SK without parasites’ on the back of her blouse. Even in free associations during the trauma processing, the patient could not remember anything about the assailants writing on her blouse. Neither was she able to recollect anything about the haematoma on her thighs. It is possible that in that transitional stage when her consciousness, which she was about to regain, was still in an altered state – LOC: level of consciousness (MALEC 1999), clouded consciousness (PETERS 2011) –, she spontaneously resisted a manipulation with her lower extremities.

For completeness’ sake we conclude this section with thoughts on differential diagnosis. A disturbance of consciousness followed by amnesia might also be caused by dissociative amnesia or by a vasovagal syncope. However, the persistence of the amnesia even during trauma processing indicates against dissociative amnesia. A vasovagal syncope might have been caused either by an emotionally induced parasympathetic hyperactivity or reflexively by the punches to the lower abdomen. If this was the case, the patient would have suffered the slaps to her left cheekbone and her nose radix while already unconscious. In our opinion, however, the global clinical findings as well as the results of the CT scan indicate rather the simplest explanation which is concussion. As mentioned previously, the neurologist shared this view, too. This does not exclude a combination of a vasovagal syncope and a consecutive concussion caused by further punches.

### 4.3. Further diagnostic procedures

The clinical assessment of the patient confirmed the PTSD diagnosis according to the International Classification of Diseases (ICD-10) (SMOLÍK 2002) of the World Health Organisation (WHO). In the course of the first sessions, we also used the Structured Clinical Interview for DSM-IV (MARGRAF 1994). On 2 November 2006 we found 9 out of 17 possible symptoms, the diagnostic threshold being 6 symptoms. We also administered the Impact of Event Scale – Revised (IES-R) (WEISS & MARMAR 1996). On 10 November 2006 the patient’s total symptom score was 44;

on 9 February 2007 it was 45, the maximal score being 88. The cutoff score is 35. On 2 November 2006 we evaluated the degree of disability according to the WHO scale (WHO-DS) where 0 means 'no disability' and 5 means 'serious disability'. The evaluation included the past 9 weeks. The patient's scores were 0 for 'self-care', 2.5 for 'work', 1 for 'family and household', and 2 for 'broader social context'. We also administered the Raven Progressive Matrices Test measuring general intelligence. The results indicated above average intelligence.

Apart from the common clinical evaluation of the premorbid personality and of the personality development (KIND 1997; DÜHRSEN 1998), we administered the Structured Clinical Interview-II (FYDRICH et al. 1997). No premorbid personality disorder was found. The pedantry criterion was partially fulfilled, indicating an accentuation of this personality trait rather than its abnormal form or intensity. When assessing the *family history*, we did not find any neuropsychiatric conditions among consanguineous relatives. The patient's father works in masonry, her mother is a clerk at the city council. Considering the *personal history*, the patient described her relationship to her parents as loving. She has many nice memories of her time with her grandparents. She has a 1.5 years younger sister who is a university student specialising in education. The relationship between the sisters is good. The patient has a stable relationship with her partner, Peter. The patient is a university student and studies Hungarian and German at the Faculty of Central European Studies at the University in Nitra (Nyitra). She likes studying, does not have any difficulties passing her exams, as she is always well prepared. She was also well prepared for the exam she should have taken on 25 August 2006, on the day of the assault. In the past, after graduating from high school, she worked as an au-pair in Germany. She had a positive relationship with her host family; they kept in touch and wrote each other postcards for holidays. They suggested she stay in Germany and go to university there, and were ready to help her out financially.

In the post-pubertal period she had aesthetic earlobe surgery. At university she went through a period of epigastric pain, and a peptic ulcer was diagnosed. She had to interrupt her studies. At no point of the diagnostic and therapeutic process did we have reason to doubt the patient's credibility. On the contrary, all the subjective and objective information including direct observations during face-to-face meetings were concordant and contributed to the impressions of the patient's veracity.

#### 4.4. Stabilisation phase of the therapy

During each of the first seven sessions, we used the guided mental imagery method, specifically establishing the reassuring image of a 'safe place' and that of a 'helper'. The patient was frequently reminded that it would be necessary to relieve the traumatic situation, including negative emotions, at a later stage of the therapy, but that this would happen in a radically different and safe context. The aim was to process the traumatic memories so that they do not lead to severely disturbing emotions, as

though the trauma was happening again – activation of a ‘hot memory trace’ according to FISCHER & RIEDESSER (1999). Instead, the memories ‘cool down’ and become just memories of a past event without interfering with the present life. We also explained in detail the procedure of EMDR exposure therapy. The patient agreed to the exposure method. This was then used during sessions 8–10.

From the professional point of view, therapeutic treatment in conditions of *on-going threat* – for example, the tendency of state institutions to distort reality, ‘to present the beating as a lie’ (ZAJAC 2007) – is controversial. However, due to her numerous internal and external (social) resources, the patient was quickly able to acquire the stability needed for the confrontation therapy phase. She quickly obtained the ability to calm herself down and break away from traumatic memories whenever they were too overwhelming, and to maintain contact with the present safe environment when recalling the traumatic event.

#### 4.5. Confronting the trauma

*Trauma reprocessing* using EMDR – sessions 8–10 (SHAPIRO 1998; HOFMANN 2006).

The eighth session lasted 3 hours and 50 minutes, the ninth 2 hours 35 minutes, and the tenth 93 minutes. During the first exposure session we worked with the trauma of the assault. The patient was asked to imagine herself standing in the weeds after her face had been slapped, seeing blood on her fingers and discovering her blouse was torn. While imagining this scene, her gestures became more agitated, her facial expression was visibly tense, and her posture was rigid.

Negative cognition is: ‘I am a victim; I am disappointed, helpless and angry.’

Positive cognition: ‘I am strong and balanced; what happened is the past.’

Emotions: uncomfortable feeling, fear

Somatic sensations: sweating of the palms, unpleasant sensation warmth in the back, constricted stomach, heart racing

For trauma reprocessing we employed rhythmic bilateral stimulation. First, the stimulation happened via eye movements (20–40 eye movements in one set), later, we used bilateral tactile stimulation of the palms. In the short breaks between the sets the patient described the spontaneous appearance of memories, thoughts, images, emotions and somatic sensations.

Here we describe an excerpt from a recording of the session on February 23, 2007. At this point, the patient was vividly recalling memories of the traumatic event as though it had been happening at that moment. In this transcription three dots (...) signify application of bilateral stimulus, at which time the patient is silent and observes the spontaneous development of associations, images, sensations etc. ‘*On the way to the university... a weird sensation in my hands... chill; only trees and bushes; as though I was holding something in my hands, cold feet* (she is moving her feet)... *a head, then a tree, then a head again, then hands... I am standing in grass,*

*it is chilly, I see a head, a face, eyes, but also a whole face, but the eyes are shining, I looked at my hands and there was blood on them, not on my hands, but on my fingers... My head hurts, my hands are cold, so are my feet, my toes, I might take off my shoes (she is taking her shoes off)... My head hurts, my head is full of thoughts... I want to leave... I want to leave, but I don't know how, I am thinking how... there, I see the smaller one, a round face, big eyes... I am standing in front of him, I am cold, my head hurts, I see his mouth, he is telling me something, but I can't hear him... the surroundings, that place, exactly, I saw that place from above, the trees, the bushes, the trail... I take my shoes off and start running on the trail, but I fall down and the two faces... a backpack... a woman with short hair who had that backpack... the faces again, round faces, big eyes... slap my face... he is standing in front of me, my head is so heavy that it threatens to fall, it is so heavy; I am terribly warm... they are pulling at my hair; terrible – I can't move, it hurts and I see the hands, I see my shoes, but that is already on the trail... the fabric rips and that moment when they seize me... I take off the clothes he ordered me to, the jacket, the stockings, the earrings, I see earrings, my head is heavy, I have thousand thoughts in my head... how to get out... he is standing in front of me, who is the other one? I don't know, probably behind my back, I can't go right, I can't go left... so many thoughts in my head, not thoughts, but images; the surroundings, the pit, the leaves, the trees, the bushes, it is so closed, I am warm and I am chilly, my head hurts, I want to cry... big eyes, it is not even possible for a human to have such big eyes, then my hands with blood on them, my head hurts so much... I feel my head, I feel them pulling at my hair, I can't move, the trail, the woman with the backpack; my feet so cold, bare, dirty, I can see my feet walking on the concrete... an unpleasant sensation in my nose... as though my nose was broken... unpleasant warmth in my neck, cold feet... an unpleasant feeling in my mouth, like iron, it is disgusting, I am climbing out of the pit and my nails are so dirty, very-very dirty... my nails are disgustingly dirty... very cold feet, cold hands, my colleagues... they are telling me something, but I can't hear them again, everyone is looking at me... slap in my face... something is itching... I probably bit my lip... because I can feel the itching... here, like this... the slap, I can't see the slap, but I can feel it, it is unpleasant, something unpleasant in my mouth, it might be blood... they seize my hands, I am trying to slow down with my heels, but they are strong... the one with the short neck is standing in front of me, and I don't know where the tall one is, he is certainly behind my back... I am just standing there... I am thinking... I want to do something and I am thinking... and I can't think of anything... helplessness... I can't go right and I can't go left... I want to cry, I am thinking that it is better not to cry, it will be better if I don't cry (her voice is weepy and there are tears in her eyes)... I feel my heart racing, I can feel it in my head, and I am terribly, terribly stressed out, and I keep looking for a way out... he is standing there and I can't go there... I am thinking that if they want to rape me, I will fight back... I am losing my stability and I fall on my butt... something here in my underbelly on the left side... some pain, not very strong, I just feel sick... I can hear: in Slovakia in Slovak, a deep voice, a male voice... I am considering throwing my purse away because*

*they certainly want my purse... but here they are next to me... I want to stay calm because it might help, it might help to stay calm, the same voice again, asking where I am going... to the university, to take an exam... I can hear today: you are not going anywhere... and suddenly I feel very, very unpleasantly warm around my heart, and I can feel the warmth going to my head, my stomach is constricted, my hands started shaking, I feel pain in my head... he is pulling at my hair, I can't see anything but the trees and the sky, I can't move because they are holding me, and I am trying to slow down with my heels as much as I can... I don't know how to get out... if I started screaming, someone might hear me, can I scream or not... (tears in her eyes), then I decide not to scream, I will give them everything I have... I have a lot of money in my wallet, over two thousand crowns, if I give it to them, they will certainly leave me alone... I am standing there, there is a lot of trash all around me, I want to tell them that I have money, that I will give it to them, I am so stressed out that I can't think of the words in Slovak (tears) and I hear again my blouse ripping... it is that feeling of tears drying on your face, this time, I didn't see anything, I just felt it, the same feeling of tears, of dry tears... I can see the girls... Štefi comes to me, and, and, they are stroking me and I am crying, I can't say anything... I saw the ambulance, there I felt good, I certainly got something there (Diazepam intramuscularly – note of the authors), I am so calm, my head still hurts, but I am so calm.'* In this phase, the subjective distress measured by the SUD scale decreased from 9 to 3.

In the course of further EMDR treatments, feelings of disgust, anger and distaste appear. The patient remembers seeing one of the assailants on TV. Later there are feelings of fatigue and sadness. The subjective distress (SUD) decreases to 1–2. When relaxing and imagining a 'safe place', the patient feels at ease, the headache fades, her hands and feet are warm, and the calm feeling lasts also after the relaxation. Considering the types of EMDR trauma reprocessing (HOFMANN 2006), this is mainly an associative course of trauma reprocessing.

The ninth session was postponed for a week later than the original appointment. Subjective information from the patient: On the way here last week, their car broke down at a gas station. During the week, she felt more relaxed; there were few disturbing thoughts and images. The patient's mother, Mrs Irena Malinová, who was present at the beginning of the session, said that her daughter was more balanced. The second week before the session, however, the patient had an unpleasant experience. In front of the dormitory in Nitra (Nyitra), two bald men sitting in a car shouted 'Hedviga, Hedviga... bitch!' She was already feeling better, she also sent a text message to her therapist saying she started feeling better, and something like that happened again. The unknown people broke into her apartment and threatened her in the bus 'accidentally' after the session during which she regained much of her stability. She texted her therapist that she was able to relax imagining a 'safe place' (her boyfriend's room) as was her 'homework'. When we learned about this further harassment, it became clear that the therapeutic process can be seriously hindered by continuing intimidation. Furthermore, it was not clear how far the threats could go. During the session we returned to what



remained from the traumatic event. The degree of subjective distress measured by the SUD scale while imagining the assault was 1–2. We continued to process the traumatic memories via EMDR. In the course of several EMDR sets (tactile stimulation) the emotion of anger appeared. ‘I don’t know why me, why it had to happen to me... it makes me sad, too.’ The anger was followed by a feeling that it is useless to be angry. ‘Emptiness, as though I’ve got rid of all the disgust, I am tired and empty... a pleasant tiredness.’ The degree of subjective distress temporarily increased to 2–3. After the desensitisation, the patient did not feel any tension at all; the subjective distress measured by the SUD scale was 0 meaning ‘no distress’. The patient gradually started experiencing positive cognition (‘I am strong and balanced; what happened is the past’). On the Validity of Cognition Scale (VoC) of 1 to 7, where 1 means ‘completely false’ and 7 means ‘completely true’, the patient repeatedly estimated the validity of her positive cognition 7. At the end of the session, following relaxation coupled with an imagination of a ‘safe place’, she feels great: ‘I am so light . . . I feel really good.’

During the tenth session, the patient said she had no troubles sleeping and was able to concentrate on studying ‘almost as well as before’. The memories of the police interrogation were not disturbing anymore. ‘It is over, at that time I was angry and humiliated... but it is over now.’ The interrogation made it clear to her that she was not considered a victim of a violent act but an offender, and that the two assailants were protégés of the police. She remembered one of the policemen telling her in private: ‘Girl, it doesn’t really matter whether you are lying or telling the truth, you are doomed anyway.’ However, when remembering the strangers breaking into her partner’s apartment and being threatened on the bus, the patient still felt nervous and uncomfortable. We focused on processing this experience using EMDR. The patient described the most disturbing image in the following way: ‘I am sitting on the bus, that lady is sitting next to me looking at those photos... the car from below?’

Negative cognition: ‘I am a victim again; not only me but also Peter is in danger.’

Positive cognition: ‘They want to make my life unpleasant, it is a game, but I can handle it, I am sure it will end well.’ (VoC = 4).

Emotions: anger, disappointment, ‘when is it going to be over?’, nervousness (SUD = 3–4).

Somatic sensations: unpleasant warmth around the stomach, stress, warmth in the face and around the ears.

This time, we used tactile bilateral stimulation. There is a stream of memories, images and emotions; the patient is reliving the event and showing new attitudes: *‘everything is open... what does it mean, what happened... I am sitting in the bus and I see these photos... now I feel terribly warm, it is a very unpleasant feeling, I don’t know, I don’t know what to do, should I scream or should I stay silent or should I tell her something, what would be the best?... I would prefer to get off the bus... thousands of thoughts... how should I solve this... I don’t know whether she had something with her, whether she would want to harm me... she could have a knife,*



*if I screamed, I am not sure what she would do... a big problem and I don't know how to get out, how to solve it... helplessness... I will call Peter to tell him not to get into his car, not to travel anywhere and they get off the bus and I can't make a phone call... now I am truly desperate... I am running to the university... find some friend who could lend me a cell phone... call Peter to tell him not to get into his car... fear that there is an explosive in his car... what if it is too late... terribly cold hands but at the same time unpleasant warmth around my stomach and shivers down my spine... I think I'm getting crazy... my cell phone doesn't work (SUD score increased from 4 to 7)... the image of me sitting in the bus and seeing those photos, now I am angry, but at that time, I wasn't angry... a feeling that my head bursts... terrible warmth in my head, terrible warmth and a feeling that I am getting crazy, that I can't handle this, it is simply too much... I am trying to look at everything from above... a huge anger and disgust and filth, what people are able to do to each other; I am terribly angry... the helplessness mixed with anger... tiredness and anger... but the tiredness is stronger... I am thinking about the fact that it can happen anytime again (she moves her feet uneasily)... all I can feel is disgust... my head doesn't hurt anymore... a little funny... when I am thinking of them (of the two women in the bus), I can see myself standing above them, they are under me, and what they did is very low, beneath dignity... I feel pride, energy and composedness, probably because it is so funny and childish... peace and composedness, self-certainty, an absolute peace... I know they wanted to intimidate me... but they didn't succeed, and now it is funny, what they did... what did they want to achieve, did they want me to get crazy or commit suicide?... I feel strong, I could run a marathon... now a pleasant warmth (SUD = 0)... the whole body.'*

Body scan: We asked the patient to bring the original target image to her mind coupled with the positive cognition. She still felt calm and energetic. SUD = 0; VoC = 7. Thus, the reprocessing of the traumatic event was optimal.

In the following conversation Hedviga mentioned that her boyfriend had gone through a period when he could not sleep in his apartment. Now, however, it is all right. A policeman told him it was a 'game'. During these EMDR sessions, the patient successfully processed all of her traumatic memories that had been the source of discomfort and posttraumatic stress symptoms. Now, we planned the next therapy phase focused on strengthening the resilience and stress coping strategies. The patient still had to face many stressors, for example the accusing and humiliating statements of the Prime Minister, the Minister of Interior Affairs, the Chief of Police and their speakers as well as of the Chief Public Prosecutor's Office. There was still widespread misinformation in media, public verbal assaults and a risk of further physical assaults. Furthermore, the patient had to cope emotionally with the distress of her relatives caused by problems she did not choose to face.

#### 4.6. Integration and further development phase

Sessions 11–25 were dedicated to strengthening and deepening the therapeutic effect. The aim was to enhance the patient's emotional stability and resilience, and to improve her stress coping strategies. In case of facing new stressors, she should be able to recognise and stop the stress reactions. Therefore, the patient was taught the basic stage of autogenic training (AT) according to J.H. Schultz (HAŠTO 2006). She enjoyed the method and was progressing fast.

After she mastered all the six steps of the basic stage, we continued with teaching her the higher stage of autogenic training. It consists of meditation and imagination exercises, some of which focus on certain themes. – This training is strongly reminiscent of the mindfulness method (KABAT-ZINN 2005). During the exercises of the basic stage, she felt calm and composed. Her arms and legs were heavy and warm; her heart rate and breathing were calm. She described a pleasant sensation in her abdomen and feeling of a clear head. During the sessions, we used various interventions aiming at increasing her self-efficacy and self-confidence (WINSTON et al. 2006). Furthermore, we imaginatively modelled future possible 'catastrophic' situations and their management. We discouraged both the patient and her mother from reading online discussions of her court case, much of which included brutal and aggressive content. (After reading these discussions, the patient's mother felt tense and had trouble sleeping. For a short period, we recommended her hypnotic medication.)

Since the patient became pregnant, we instructed her to further employ the calming effects of autogenic training and to enhance contact with the foetus. We taught her to use autogenic training during labour to increase the chances of an uncomplicated and natural childbearing. (This happens through the dismantling of the negative emotions that could disturb endocrine regulation mechanisms during labour.) A video appeared on YouTube showing a policeman shooting at a figure labelled Hedviga, but the patient was able to cope with it. Both pregnancy and childbirth progressed without complications.

#### 4.7. Conclusion of therapy

Following the trauma processing, the patient's mental state was stable. Clinical evaluation was concordant with the results of the diagnostic scales. In March 2007 the patient showed almost no PTSD symptoms. According to *Mini DIPS* (MARGRAF 1994), she did not fulfil the PTSD diagnostic criteria. On 16 March 2007 her Impact of Event Scale (IES-R) (WEISS & MARMAR 1996) was 8; on 23 March 2007 it was 4. (The maximum score is 88; the patient's score at the beginning of the therapy was 44). On 16 March 2007 the degree of disability (WHO-DS) score was 0 on all the scales. The patient managed to integrate the psychological traumata into her life.

After the therapy ended, the therapist met the patient during several informal meetings. Hedviga Žáková-Malinová, her husband Peter and their daughter Emma

(born in 2008) gave an impression of being content and happy. After breaking the ice, the baby started exploring the therapist's office. Hedviga talked to her daughter in Hungarian; her husband Peter in Slovak. The couple agreed on this since they wanted Emma to learn the mother tongues of both her mother and father.

During the therapy we had several short therapeutic and counselling sessions with the patient's parents and her partner (future husband), since they were also subjected to great stress and experiencing feelings of helplessness and anxiety.

#### 4.8. Concluding remarks to diagnostics and catamnesis

The retroactive analysis of all the medical findings and the patient's statements confirms the logical coherence of the objective and subjective information. In our opinion, the PTSD diagnosis was valid according to the criteria of both ICD-10 and DSM-IV. Direct observation of the patient's behaviour during both the diagnostic and therapeutic sessions granted objective phenomena confirming her credibility. (The complex evaluation takes into account not only the content of the words, but also the mimics and micro-mimics, the conjunctiva, the pupils, the voice, the movements of various body parts, the bodily sensations, the context and time consecutiveness, and so on.)

On 6 October 2010, I (the author, J.H.) had an unstructured *follow-up* telephone conversation with the patient. I learned that Hedviga Žáková-Malinová was feeling completely healthy. She was not experiencing any symptoms she had been treated for. She did not have any flashbacks of the trauma and described herself as happy. In 2008 she got her Master's degree. She successfully defended her Master's thesis on the subject of Hungarian slang originating in Slovak. She is confronted with common everyday problems of a mother of already two children. Her daughter is at the time of publication 5, her son 3 years old. Both children are healthy. Besides temporary heartburn, the second pregnancy and childbirth were uncomplicated, too. She continued employing the methods of autogenic training. Her husband continues to work for the same company. Her mother helps with the household and the two children. Her father, who owns a construction company, has built a house for the young family. Since Hedviga has always enjoyed learning foreign languages, she has started learning English. She continues to be sensitive to subjects connected to the traumatic event. When she speaks about the suffering she and her family had to face, she is usually worried, but able to let go and return to her everyday concerns. She is disconcerted about the fact that during the past 7 (!) years, her court case has still not been fairly resolved. She understands the political issues influencing her case, but her wish is to leave it behind.

She appreciates the fact that she was able to spend time with people she values, and that she had a chance to understand the phenomena of individual and social life. She feels that during those years, she gained the experience of a 50-year-old person, although in reality she is only 30.

## 5. Discussion

### 5.1. Diagnosis

In our opinion, the diagnosis of PTSD is not difficult, if we take into account the reported feelings of shame, guilt and fear. The strong emotions and fear can prevent the patient from describing the traumatic event and his or her symptoms. Both authors have specialised in psycho-traumatology and gained experience in both diagnosing and treating traumatogenic disorders.

In Hedviga's case, however, we had to be particularly careful and alert, and consider simulation, artificial or personality disorders. We even had to consider the possibility that she was an agent of a secret service. After all, the police had claimed that the 'incident had not occurred' and that Hedviga's story was false. The Prime Minister (R.F.), the Minister of Interior Affairs (R.K.) and the Chief of Police (J.P.) appeared in the media and strongly suggested that the incident was a hoax. They presented many emotionally manipulative arguments. These statements were later revealed to be distorted or false, consistently ignoring hard facts confirming Hedviga's version of the events. The social and political context of Hedviga's case is described in the book titled 'National Populism in Slovakia and Slovak-Hungarian Relationships' (PETŐCZ 2009; PETŐCZ & KOLÍKOVÁ 2010). A summary of the case (in Slovak) can be found in the text of the journalist VRABCOVÁ (2010). Social and political aspects of various segments of Slovak society are captured in comprehensive reports on the state of the society published by the Institute for Public Affairs under the leadership of the sociologist Martin Bútora and the political scientist Grigorij Mesežnikov (KOLLÁR et al. 2008, 2009, 2010; STREČANSKÝ et al. 2010). Practically all questions that arose due to misleading statements by political representatives, were easily resolved in conversations with our patient. We gained an increasingly sound impression that she was credible and veracious, and the symptoms she was describing and those we found during the targeted exploration clearly confirmed the PTSD diagnosis. An experience of a traumatic event is a condition of PTSD. The patient's description of the traumatic situation sounded fully credible. More than usually, we paid attention to every movement of her facial muscles, eyes, pupils, to the skin on her face, gestures of her hands, to her feet and her whole body. In various contexts we asked about her bodily sensations and were alert to our own feelings and emotions possibly reflecting our perception of her micro-mimics (EKMAN 1989, 2004). Based on all this information, we concluded that the patient was describing events she had really experienced, as she remembered them and how they still interfered with her present life.

Furthermore, we saw Hedviga's photographs shortly after the assault, as well as the CT scans confirming the oedema of the left zygomatic region and of the nose radix. These were in accordance with the local findings described by the traumatologist. We received some of these findings only later, during the diagnostic and the treatment. In the course of the whole diagnostics and therapeutic process and after

each session, we asked ourselves whether we had noticed anything contradicting the credibility of our patient, or anything conflicting with our knowledge and our hypotheses. Yet we did not find anything of the sort. On the contrary, we were discovering more and more information about the attempts of the police and the Chief Public Prosecutor's Office to distort reality and prove that the 'incident had not occurred'. This was reflected also in the expert evaluation (MUDr. Š.K.) requested first by the police and later by the attorney's office (Prof. MUDr. P.L.).

We considered the possibility of simulation, aggravation or artificial disorder (PRAŠKO 2008). However, Hedviga's descriptions of the event were short and dispassionate. She visibly feared strong emotions. Details and strong displays of emotions only appeared during the trauma exposure, and the patient experienced them as obviously disturbing. We noticed a certain tendency to dissimulation in connection with the patient's attempts not to burden her relatives and other people by her suffering.

To increase the probability that the patient would be telling the truth, we informed her of our commitment that everything we would learn from her would be subject to the patient-doctor confidentiality as legally ensured. We made sure she understood that without her consent and knowledge, we would not inform anyone of anything she mentioned. She understood we would not inform the police, the state organs, her parents, her partner, or her lawyer. We also asked her to warn us of facts she did not want us to include in her medical record. Later it became clear that for the sake of her safety, it was better to publish all the information she had given us. This happened with her consent.

## 5.2. Risk and protective factors

Considering the first and the third traumatic events (the assault and the stranger entering the apartment), the most important risk factors are the *type* and *intensity* of the trauma. The patient was losing her control over the course of the events; she was feeling fully *helpless* and *desperate*. For about 15–20 minutes, she lost consciousness, and later she found bloodstains on her garments. Therefore, she could not know what had happened to her; she might have been sexually assaulted. During the therapeutic process, we encountered the themes of disgust and filth. Hedviga's cognitive unpreparedness for this type of assault represents another risk factor. She did not expect to be humiliated on account of her mother language, or to be physically attacked, nor was she able to predict the extent of the violence and to know what had happened during the period of unconsciousness. Her upbringing and the relationships in her elementary family have all developed her attitude that she could trust people, and that people would not want to hurt and threaten her intentionally. After the first traumatic event, the police turned against her, she was being intimidated and had to face hostile information from the media and online discussions. This was probably the reason why the traumatogenic symptoms did not spontaneous-

ly disappear after the first trauma. It is questionable whether the benzodiazepines administered shortly after the assault contributed to the unfolding of the symptoms. Some findings in the literature suggest that benzodiazepines might have a calming effect in the acute phase, but have a negative effect on the global symptom course (HELLMANN et al. 2011).

Otherwise, there were several protective factors. Hedviga had support from her family and her partner. According to our clinical judgement, the patient, her parents and her partner had a safe attachment. In her early childhood, Hedviga did not experience a separation from her primary caregivers. If we do not consider the peptic ulcer, she had not suffered from any mental disorder prior to the assault. She had not been traumatised before. In her positive, warm and calming memories her grandparents played an important role, particularly her grandfather. The importance of a good relationship with grandparents for health is supported by empirical research and highlighted, for example, by Peter Tavel (TAVEL et al. 2007; TAVEL 2009). Her personality was stable; she had plenty of experiences of success and self-efficacy. Obviously, we know nothing about the presence or absence of predisposing genes. Considering the family history as well as the positive course of the therapeutic process in spite of the persisting stressors, however, we estimate that the role of these genes was small or none. Although there were massive and persisting stressors, the PTSD symptomatology did not culminate to its maximum. This is yet another proof of the patient's premorbid resilience. Furthermore, the degree of disability in various areas of daily life was not paralysing.

### 5.3. Problem of therapeutic relationship and working alliance

A trustful relationship with the patient was formed optimally. Our curious interest was combined with human sympathies towards her. Our own Slovak national identity did not represent an obstacle in forming a positive counter-transference towards a patient of Hungarian nationality living in Slovakia. On the contrary, we strongly identify ourselves with the concept of a free citizen. We perceived the primitive nationalism and populism of Robert Fico's government as humiliating for our quiet patriotism, sensitivity for human and civil rights and liberties. The more Hedviga's credibility was being confirmed, the more stable our positive counter-transference and our readiness to help her reduce the PTSD symptoms became. Our positive concordant transference (WÖLLER & KRUSE 2011) enabled us to empathise with the whole spectrum of the patient's emotions, including anxiety, helplessness, loss of control over her life, fear from the future, but also anger, disgust, contempt and the wish to live a normal, safe life.

From the beginning of the therapy, we realised the possible *transference* risks of the patient. She could have perceived the therapist as a potential aggressor, transgressor of her sacred boundaries, untrustworthy traitor, investigator, judge or controller on one hand, and as an indifferent witness or even as a potential victim of her ag-



gressive impulses on the other. The transference tendencies are known from supervisions and literature of psychoanalytically oriented psychotherapists (e.g. LEVENSON et al. 2005, 106). Therefore, three people were present in each of the sessions. Apart from the patient and the therapist (psychiatrist and psychotherapist), there was a co-therapist (clinical psychologist and psychotherapist) who administered some of the psycho-diagnostic tests and otherwise functioned as a rather passive recorder. This also increased our capacity for reflecting the diagnostic and therapeutic processes.

There are several reasons why these transference risks did not complicate the therapy. The patient had a good sense of reality, positive relationship experiences in her early childhood (with her parents, grandparents and her sister), a stable relationship with her partner and a good relationship with her lawyer, who had originally consulted one of our colleagues and referred Hedviga to our care. Based on the patient's general communication style we concluded that her premorbid attachment was safe, and that she was able to ask for help, support, advice and therapy and to use them optimally for her own benefit. She perceived her communication partners as integral human beings with their real roles, not as partial objects.

We believe we were able to avoid the problematic intense counter-transference reactions. These could have included hostility, feelings of being emotionally overwhelmed and helpless, indifference or an exaggerated tendency to 'save' the patient (HOROWITZ 2003; LEVENSON et al. 2005). The most difficult emotionally was to endure the confrontation with the negative emotions during the exposure to the first trauma, the assault itself. This lasted for several hours, and for a long time the patient did not feel any relief. Finally, the expected relief came. Coping with the third traumatic event – a stranger entering Peter's apartment and intimidating him – was also emotionally exhausting. We were experiencing mixed emotions. Anger towards the perpetrators, the organisers in the background and the politicians misusing their power was mixed with realistic concerns of how to accelerate the healing process, reduce the patient's symptoms and enhance her resilience in case of further stressful events. We considered the idea of informing the public about our findings. We evaluated whether it could protect the patient from further assaults, or whether we could put ourselves at risk. We based our decision of 'civil courage' (DAHRENDORF 2008; VORLÄNDER 2010) on the bio-psycho-social model of health, illness and therapy (ENGEL 1977, 1980; HAŠTO 2005), as well as on attitudes of those we trust. Connections to several publicists, intellectuals, and the professionalism and civil courage of Hedviga's lawyer facilitated our decision.

We attempted to avoid an exaggeratedly idealising transference towards the therapist coupled with disappointment from unfulfilled expectations. Therefore, we were continually harnessing the patient's own healing resources we either anticipated or directly identified. We aimed at supporting the patient's experiences of self-efficacy. We pointed out that a good lawyer is more important for the future development of the case than therapists are. We also paid attention to the patient's family and her partner. We were aware of the burden the case represented for them as well as of their importance for the patient's stability. At the beginning of each session, we

talked to them for at least a few minutes. Their cooperation was excellent. We also felt frustration at persistent flaws in our society. The state continues to be directly responsible for crimes or for protecting criminal perpetrators, starting from the first Slovak State in World War II, through the communist regime, up until the current post-communist government (MIKLOŠKO et al. 2001; TAKÁČ 2001; BÚTORA 2010; HRADSKÁ 2010).

#### **5.4. Therapeutic interventions**

After confirming the diagnosis, the patient was repeatedly educated about the logic of her symptoms, about her disorder, the possibilities of coping with them, therapeutic options and spontaneous courses. She accepted our suggestion to continue psychotherapy without pharmacotherapy. This decision was based on our positive experience with this option in case of traumatised adults. Self-relaxation exercises using imagery (safe place, inner helpers, etc.) were part of each of the sessions and represented an important stabilising intervention. We agreed on the content of each of the sessions. We pointed out that we would only start the EMDR trauma exposure after she began to feel strong enough. We also stressed that she could interrupt the exposure at any time by lifting her arm, and we would immediately understand that as a signal that she needed a break. We signalled to her, both verbally and nonverbally, our understanding and empathy as much as possible. We offered her the option to express herself in German (she majored in German) or Hungarian (her native language) in case she had difficulties finding a Slovak expression. As none of us speaks Hungarian, we were ready to note the Hungarian expressions phonetically and assess their meaning later. Although Hedviga never used this option, we considered it important as a display of our tolerance and regard towards her cultural and national identity. It was crucial to create a safe therapeutic framework as much different from the traumatic situation as possible. (Before the assault, she heard 'In Slovakia in Slovak!') Later, we discovered that she was using the autogenic training formulas in Slovak, although we encouraged her to translate them into Hungarian. We understood it as a sign of a good therapeutic relationship, and of Hedviga's ability not to generalise her negative emotions towards all Slovaks. This was important as her partner and future husband was Slovak.

In literature, trauma processing via exposure in case of persisting threat is considered relatively contraindicated (SHAPIRO 1998; HOFMANN 2006). Nevertheless, with this patient we risked it, assuming it would be possible to create a clear differentiation between healing the symptoms caused by a former trauma and a rational and realistic avoidance of future risks. For the patient it was crucial to be able to free herself from the older traumatic memories in situations when new stressors arose. This plan was confirmed as realistic both for the patient and the therapists.

### 5.5. Therapeutic setting and process

When we agreed on approximately 15 sessions, each lasting 90 minutes, we first considered a frequency of one session a week. However, during the exposure, we had sessions lasting several hours in order to reduce the negative emotions and avoid symptom exacerbations between sessions. These sessions turned out to be successful; the patient showed her strong will and perseverance. It was worth investing the effort. After each of the exposure sessions, the patient's state improved. As the patient had obligations at the university and the distance of 127 kms between her city and our office made the commuting difficult, it was not possible to have one session a week as originally planned. At several occasions, there were several weeks between the sessions. In the second half of the therapy, the longer intervals between the sessions were intentional.

According to HOFMANN (2006), there are 6 possible courses of EMDR trauma processing. These can be *associative* (successions of various, mostly retrospective associations where the time sequence does not have to correspond with the real sequence of events), *imaginative* (spontaneous imaginations), or *bland* (empty, with no marked changes). Hofmann considers these courses positive. Another possibility is *abreaction* that can be either positive or negative. Finally, there are two rather negative courses. These are *flooding* (the intensity of the emotions exceeds the patient's capacity for information processing), and *circularity* (the same answers are being repeated, and the process does not lead to stress reduction). Hedviga's therapy can be described as associative. A short phase of flooding could be controlled by ego strengthening interventions.

Already at the beginning of EMDR therapy it became evident that the patient preferred rhythmical alternating tactile stimuli to eye movements. According to our experience, this is not rare. Tactile or auditory bilateral stimulation is being used in EMDR as an effective alternative to eye movements (SHAPIRO 1998). Although their effectiveness has not yet been sufficiently studied, it has been confirmed in clinical practice. In spite of this, EMDR keeps its original historical name.

Even after trauma processing and symptom reduction, the risk of re-traumatisation remained high. There were still instances of misinformation in the media, verbal attacks in online discussions, discrediting statements by politicians, and the prosecution of the Attorney General's Office under the leadership of LL. D. Trnka. Therefore, in the next phase of the therapy, we aimed at increasing the patient's stress tolerance.

From Hedviga's history we knew that she had been able to experience inner peace, to see problems in broader context and to analyse them. These characteristics had been present, but were covered by the symptomatology and the existing stressors. First the basic and later the higher meditative stage of autogenic training helped her to revive them and to develop them further. Hedviga accepted this method with interest and she was able to make quick progress. She exercised systematically two to three times a day, usually for about 15 minutes. Although we had originally

planned 30 sessions, there were 47 of them, as we added sessions aiming at prevention and personality development. Hedviga shared her view of the therapy and her experience with the journalist VRABCOVÁ, and they were published in a book titled *Hedviga* (2010).

## 5.6. Misinformation as a work method?

The strong and loving support the patient was getting from her close surroundings compensated the negative attitudes of the broader social environment. If this strong support had not been present, the lack of public understanding and the hostile reactions might have seriously complicated the course of the patient's PTSD. It might have led to the chronification of the symptoms, to depression or other mental disorders. It was mainly the media that influenced public attitudes. Even before the legal closing of the investigation of the assault, the Slovak Prime Minister, LL. D. Robert Fico, said during a press conference: 'The Government of the Slovak Republic has to waste a huge amount of energy to uproot deceptions, manipulations and maybe even the fact that some lady wasn't able to pass her exam, so she sacrificed the name of the Slovak Republic just to save her own name.' (our trans.)<sup>2</sup> As the Prime Minister was immensely popular with a major part of the population, such a statement influenced the public opinion of Hedviga as a victim of a violent crime negatively, and it made it easier to spread misinformation further. 'We Slovaks are endangered by them, Hungarians (polarisation between *us* and *them*), therefore we have to unite under the leadership of a strong leader' – this hypothetic statement interpreting the mentality of the former Prime Minister expresses the atmosphere influencing the public understanding of the case. It is a known phenomenon described by human ethology and social psychology. Some politicians seem to misuse it intentionally and cynically to gain the voters' support. 'The logic of affect' (CIOMPI 1997; CIOMPI & ENDERT 2011) plays a role here. In another context, we will mention Stanley MILGRAM's (1974) socio-psychological experiments enabling us to understand the suggestive strength of an authority.

At a press conference of the Minister of Interior Affairs and of the Chief of Police held before the legal closing of the investigation, the public and the media learned about the DNA found on the envelope with Hedviga's documents. In our opinion, this argument strongly influenced the public opinion as well as the opinion of the media. It suggested that the documents had not been stolen, and that Hedviga had put them into the envelope herself. Hedviga was able to explain it. After obtaining the envelope, she handled it with her hands. After receiving the instruction to

<sup>2</sup> Original text: 'Vláda Slovenskej republiky musí mŕňať také obrovské množstvo energie, aby vyvracala podvody, manipulácie a možno aj to, že nejaká dievčina nebola schopná urobiť skúšku, tak obetovala meno Slovenskej republiky len preto, aby si zachránila svoju vlastnú kožu...' This statement is shown in a film made by Anna Kratochvilová, *Občan Hedviga (Citizen Hedviga)*, retrieved 30 Sept 2012 from <http://video.tyzden.sk/redakcia/2010/06/08/obcanhedviga/>.

bring it to the police 'as she got it', she took it out of the trash and noticed that the stamp had fallen off. Therefore, she put her own saliva on her finger and used it to glue the stamp back on the envelope. The Minister of Interior Affairs claimed that the stamp was glued onto the envelope in a way that the part of the postal seal on the stamp and the part on the envelope constituted an uninterrupted line. However, according to the investigation file, this had never been examined.

In our opinion, the reference to the DNA analysis confused the critical thinking ability even of otherwise educated intellectuals, until they learned about the context. The 'DNA proof' functioned as an 'emotional attractor' in the sense of Ciompi's 'affect logic': 'She is guilty', 'a liar', 'an anti-Slovak Hungarian'. This further influenced the evaluation of all other pieces of information and misinformation connected to the case. The expert evaluation was done by a physician ranking high in medical hierarchy. He is a professor of surgery and the dean of the medical faculty. His expert opinion verifying that 'the assault did not happen' and 'she was not hurt' has similar strength of authority. A CT scan is a similarly highly valued proof. As a matter of fact, however, the CT scan on the day of the assault confirmed a cranial trauma.

We describe two instances of the misinformation in more detail. During her hospital stay after the assault, after a commotion, when she suffered from an acute stress reaction and had been administered benzodiazepines, she was interrogated and asked why she had been attacked. This happened in spite of the fact that the doctors had advised against her interrogation for the time being. At that time, Hedviga attempted logical reasoning. Since the assailants kept repeating 'in Slovakia in Slovak', she assumed that the reason for the attack was her speaking Hungarian. The next question was with whom she spoke. She answered that she either talked on her phone or she met someone. Later, she remembered that two people asked her how to get somewhere. When she was describing the situation to us she came up with an explanation why she thought of a phone call. She was already being late and considered calling her colleague to tell her she was on her way. Just as she was thinking that, she had been addressed by the two assailants. Since the police discovered that her phone was not used at the time of the assault, they used the uncertainty of Hedviga's memory against her.

Another example: Hedviga said that after her documents including her credit card had been stolen, she contacted her mother and asked her to block the card. According to the police, the card had never been blocked. The truth is that it had been blocked, but the police used an invalid, false confirmation that it had not been blocked. This confirmation is in the first investigation file. It is a request of the police to disclose the data about the bank account with a hand-written note that the card had not been blocked.

High state representatives publically described Hedviga's case as an attempt to discredit the Slovak government or as an act of the Hungarian secret service. This belief, whether it was a self-deception or a conscious decision to deceive the public, subjectively justified their behaviour towards Hedviga as though she had actively

participated in some anti-Slovak conspiracy. They oversaw that it was their reaction ('Hedviga is not a victim; she is an assailant!') that created the problem.

### 5.7. Socio-political aspects

I am often asked what, in my opinion, is 'behind this case'. There are sufficient indications allowing us to formulate certain hypotheses. Again, I am referring to the book of VRABCOVÁ (2010) containing interesting information from LL. D. Roman Kvasnica. Here, I will add only some thoughts helping us to understand the seemingly incomprehensible failure of the state structures.

Considering the assault itself, there are, in our opinion, two possibilities. The first is that the assault was planned. On that day, about ten students of Hungarian nationality were supposed to come to the university to take an exam. This could easily be found online on the university website. The second possibility is that the attack was random, perpetrated by several extremists who happened to encounter a woman of Hungarian nationality. Subsequently, the police, the prosecution, and the government followed the principles of nationalistic populism, and the victim became the culprit. The official version sounded like this: 'She was not beaten; she is a liar; the incident did not occur; she is trying to discredit the government of the Slovak Republic.' Here, we can ask several questions: What role did 'intoxication by power' play here? Were there feelings of narcissistic triumph and grandiosity (HENSELER 1976; KOHUT & WOLF 1980) on the part of representatives who had won the election thanks to their populism and deceiving of the public? How much did the attitudes of the Prime Minister and the Minister of Interior Affairs influence the police and the prosecution? What was the role of the inborn tendency to obey high authority (EIBL-EIBESFELDT 2005)? This tendency, studied experimentally by Milgram, allows us to comprehend the psychological mechanisms which allow the arbitrary and undeserved abuse of a citizen. If we consider the human tendency in Milgram's experiments to give up our own superego as well as the whole spectrum of intrapsychic and interpersonal defence mechanisms (KAŠČÁKOVÁ 2007), we see the human potential to self-deception. In his experiments, Milgram was trying to answer the question how common people could participate in the killing of civilians during World War II (BROWNING 2002). In his experiments, Philip ZIMBARDO (2007) divided healthy volunteers into two groups: a group of criminals imprisoned for a crime they committed, and a group of guardians overseeing the order of the prison. He showed the effects such a polarisation between 'us' and 'them' have on human behaviour. Such a polarisation of roles with no other controlling mechanisms quickly leads to destructive behaviour, to misuse of power and to violence.

Then there is the other possibility. There are several indications that the assault was not incidental but planned. Furthermore, someone in the background did not have to rely on the aforementioned dynamics, but could beforehand indoctrinate the key representatives with the misinformation that the claimed assault



was an attempt to discredit the government by ‘evil Hungarians’. When the relationships between Slovakia and Hungary deteriorate, the Slovak nationalists can thrive. We can naturally ask who among the Slovak nationalists has connection with persons capable of such a massive campaign of misinformation and propaganda, on the level of a graduate from the ‘KGB University’. And who was interested in deteriorating the relationships between Slovakia and Hungary? Possible answers can be found in a book analysing the post-Soviet development in Russia (LUCAS 2008). But is it possible that even the physicians who had been asked for an expert opinion allowed to be pulled into this fraud? It is difficult to believe it. The figure of a physician or a healer represents a positive archetype. In our opinion, however, if physicians had participated in Milgram’s experiments, they would have acted in the same way as other healthy subjects. Although Milgram did not specifically examine the behaviour of physicians, we know that during the Third Reich (SCHNEIDER 2011; CRANACH & SCHNEIDER 2010), all Jewish physicians were excluded from the Medical Chamber, and this decision was made by German physicians. Protests against this decision are not known. When Hitler rose to power, a law about prevention of hereditary illnesses was passed. Schizophrenia and manic depression, among others, belonged to this group. The healthy ‘body of the nation’ was not allowed to be burdened by these and other ailments. All physicians were obliged to report so-called hereditary illnesses to the officials. Based on this law, more than 360 thousand citizens were selected and forcefully sterilised. More than 6 thousand people died during these medical interventions. On 1 September 1939, Hitler ordered the so-called ‘Euthanasia’ action. It was an order to kill patients who were mentally or physically ill or mentally retarded. At least 250–300 thousand people were murdered by injections of Phenobarbital, morphine, or scopolamine. Furthermore, they served as test subjects in experiments with starvation and the deadly effects of gas. All of these processes were controlled and carried out by physicians, often psychiatrists. About 50 selected experts, some of them well-known psychiatrists, evaluated the reports, and made decisions about life and death. Experiences with the action named ‘T4’ were later used in concentration camps during the murdering of millions of ‘Untermenschen’. There was a certain resistance against the injustice in medicine and especially in psychiatry. However, more than 50% of the physicians were members of the national socialist organisations (NSDAP, SA, or SS). Formulated positively, almost half of the physicians were not members of these organisations. This shows that there were some possibilities of resistance, and it did not always have private consequences. Some of the physicians did resist. But they were few. Very few (SCHNEIDER 2011). The way German psychiatrists nowadays deal with this failure during Hitler’s regime deserves our admiration. It is very instructive for physicians worldwide.

The current (2010) President of the German Society for Psychiatry, Psychotherapy and Neurology (DGPPN) said: ‘Except for several individuals, the majority of German psychiatrists and members of our community including its leaders participated in research, planning, executing and scientific legitimisation of selection,

sterilisation and murder' (SCHNEIDER 2011, 31). At a different place and after apologising to the victims, Professor Schneider says:

Wir Psychiaterinnen und Psychiater sollen keine Werturteile über Menschen fällen, wir lehren, forschen, behandeln, begleiten und heilen. Die unantastbare Menschenwürde ist immer die Würde des einzelnen Menschen und kein Gesetz und kein Forschungsziel dürfen uns dazu anleiten, diese zu missachten.<sup>3</sup> (37)

We see that the archetype of a doctor, a healer, of a powerful and well-meaning figure helps strengthen the hope and increases the placebo effect of a treatment, but it should not prevent us from thinking critically and acting assertively (ALBERTI & EMMONS 2011).

The winning party in the 2006 elections, the social democratic 'Smer', formed a coalition with the Slovak National Party known for its primitive nationalism. The Socialist International uniting socialist parties criticised this move and suspended the membership of Smer. News about the attack on a student of Hungarian nationality must, at the time, have been unpleasant for the Smer leaders. The Prime Minister and the Minister of Interior Affairs started to deny the reality of the attack and to claim that 'the incident had not happened'. They interpreted the assault as an attempt to discredit the government. Even if top politicians had been mistaken, after discovering the real nature of the case, they should have been able to apologise. They should have apologised to Hedviga, to her relatives, to Hungarians living in Slovakia and to the Slovak public. There are several possible reasons why they failed to do so. Some of them might be political (fear from losing the admiration of the nationalists); some of them are probably connected to group dynamics (we must hold together). Personality structures of the main protagonists certainly play a role too.

### 5.8. Socio-political context of psycho-traumatology

In the history of scientific research of mental trauma, the attitudes of the society towards mental trauma as well as towards its victims are remarkably ambivalent. There are helpless victims on the one side and powerful assailants on the other. In psycho-traumatology, the question of power is crucial. The power rank of the assailant, either his/her political or parental influence (MILLER 1998) strengthens the tendency of the witnesses to draw away from the victim. Due to the character of the posttraumatic symptoms (fragmentation of memories, emotional overload, and the neurobiologically based 'indescribable' nature of the trauma), victims of trauma might make an untrustworthy impression. According to J.L. HERMAN, one of the modern pioneers of psycho-traumatology research and co-author of the definition of complex PTSD, these socio-political aspects complicate the status of both mental

<sup>3</sup> 'We psychiatrists cannot judge the human value; we teach, treat, accompany and heal. The untouchable human dignity is always the dignity of a specific human being. There is no law and no research goal that can mislead us to disrespect it.' (Our trans.)

trauma victims and experts helping them. In her book subtitled *The Aftermath of Violence – from Domestic Abuse to Political Terror*, she writes:

In order to escape accountability for his crimes, the perpetrator does everything in his power to promote forgetting. Secrecy and silence are the perpetrator's first lines of defence. If secrecy fails, the perpetrator attacks the credibility of his victim. If he cannot silence her absolutely, he tries to make sure that no one listens . . . The perpetrator's arguments prove irresistible when the bystander faces them in isolation. (2001, 8)

A witness dealing with the trauma must 'combat the tendency to discredit the victim or to render her invisible', fight the doubts whether 'patients with posttraumatic conditions . . . are genuinely suffering or malingering, whether their histories are true or false and, if false, whether imagined or maliciously fabricated' (8). This might be observed in victims of political terror as well as those of domestic abuse. We must realise that not only the traumatic event itself but also the reactions of the social environment contribute to the symptomatology and PTSD chronification. The victim's isolation and the inability to share his/her experience strengthen the suffering. Our clinical experience confirms that victims of violence often do not receive support in their social environment, and are often described as untrustworthy, inadaptably and overly complicated. The victim might be proclaimed an assailant by those in power if there are not enough witnesses able and willing to intervene.

F. NEUNER, M. SCHAUER, and T. ELBERT, the authors of narrative exposure therapy, a new promising psychotherapy method for treating traumatogenic disorders, also stress the socio-political aspect of psycho-traumatology. 'For therapists of victims of political violence, political attitudes protecting human rights and the victims of state violence might be helpful. The meaning of the therapy might then be interpreted as targeted support of human rights' (2009, 39).

This therapeutic attitude corresponds to Václav Havel's quote that is the motto of this article. During the communist regime, the attitude of many psychiatrists was that they should not get publicly involved in social and political issues. Such an attitude was understandable, but often exaggerated. Psychiatry was expected to deal only with its narrow specialisation. Bio-psycho-social understanding of psychiatry was therefore reduced, and some psychiatrists contributed to the status quo of the totalitarian regime out of fear. Sometimes they cooperated when a person with anti-communist attitudes had to be hospitalised because he/she might disturb, for example, the celebration of May Day. The Psychiatric Section of the Slovak Medical Society also hindered the free development of psychotherapy in Slovakia. Therefore, psychotherapy was developing among semi-illegal conditions and in various camouflaged ways. Luckily, there were several psychiatrists who were readily helping those persecuted and threatened by the regime. And many of them also found ways of educating themselves in the newest trends.

Using the terminology of transactional analysis, Hedviga was lucky because positive interactions with her parents and grandparents allowed her to interiorise the figure of a good parent. This component of her personality became a source of

strength, stability and resilience at the time when the state represented by specific people treated her and her homeland as a controlling parent with no respect towards her need of safety, justice, dignity, and freedom.

## 6. Conclusion

In the last two decades, the therapy of posttraumatic stress disorder has substantially developed. As a result, effective help is now available for PTSD patients. This includes both pharmacotherapy and specific psychotherapy, and, in more serious cases, their combination. The diagnostic classification of PTSD in the American classification system of mental disorders as DSM III, 30 years ago, has helped therapy development. In our opinion, diagnosing PTSD is not especially difficult if the therapist is adequately trained and does not have an unconscious tendency to avoid the diagnosis resulting from dramatic experience and from strong negative emotions. At the same time, the patient may have the tendency to avoid certain topics, too. This means that the therapist has to respect the patient's fear from strong emotions, his/her embarrassment or irrational guilt that can burden spontaneous communication.

Therapy of PTSD requires a specific attitude. It has to take the main characteristics of PTSD into account: the central nervous system's disturbed capacity to process information adaptively, dysfunctional traumatic memories, and inability to experience safety. Therefore, the therapy of a mental trauma has three phases: stabilisation, exposure and integration, and new orientation. In all of the phases, it is crucial to strengthen the patient's own resources.

In our case study, we describe EMDR therapy of PTSD as well as AT in enhancing the patient's resilience in a persisting stress condition. The case study of the patient who gave us her consent to disclose her real name tells a lot about the socio-political dimension. The philosopher Nicolai Hartmann understood people as beings with several 'levels'. In order to study them, several scientific disciplines are needed: physics, chemistry, biology, psychological and social sciences (HAŠTO 2005). The bio-psycho-social model formulated by ENGEL (1977, 1980) adequately describes this complex attitude towards diagnostic and treatment in medicine and psychiatry.

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ted individuals. We cannot name them all; it would be a long list. It would begin with the journalists Eugen Korda and Štefan Hríb, the musician, journalist and promoter Michal Kaščák, the literary theorist Peter Zajac, the activist Zuzana Wienk, the sociologist Martin Bútor, the psychologist Gustáv Matijek, the philosopher Egon Gál, the psychiatrist László Sárközy, and the journalist Marie Vrabcová. It would then continue with names of other great people working in various professions including journalists, physicians, psychiatrists, psychologists and psychotherapists, sociologists, political scientists, lawyers, philosophers, university teachers and critically thinking citizens.

*Translated by Svetlana Žuchová and Ted Erler*

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