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CASE REPORT

Biopsychosocial approach to psychological trauma and possible health consequences
Part II – The case study

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ABSTRACT

In the case study the problem of reprocessing traumatic experience is described in details, including the diagnostic process and the significance of other psychosocial stressors and sociopolitical atmosphere for the development of trauma-related disorder and further built up symptomatology. The therapeutic process based on the specific psychotherapeutic procedure is depicted. The discussion incudes biopsychosocial aspects.

Motto: "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, 1936–2011

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THE CASE STUDY

We describe the case of the university student M., a citizen of the Slovak Republic of Hungarian nationality. Her university major was Hungarian and German. At time of the traumatization, she was 23 years old. Today, she is 28 years old. She graduated from the university and obtained a master degree, is married and a mother of two children.

Because the case study is public knowledge, and to prevent further complication, we do not withhold the patient's identity. The patient has given us written and oral consent to publish the 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 M. Vrabcová (2009, 2010) and can be presently found at www.tyzden.sk and 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.

M. has suffered three serious mental traumata. Furthermore, several other long-term stressors resulted from them. First, she was attacked by two unknown men while walking to the university to take an exam in her course on Hungarian. The second traumatization was the police interrogation on the attack. Finally, a stranger entered the apartment where M. and her partner lived. Consequently, she was being 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 pressure of the political power, groundless prosecution and media pressure.

TRAUMATIC EVENTS

On the morning of August 25, 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 down from the road; she was being abased and beaten. The last thing she remembered was that men punched her stomach while she fell onto her head. She regained consciousness when the assailants had left. She felt nauseated and weak; she had a headache and difficulties to realize what happened and what she should do. After she came to the university, her colleagues and teachers discovered a sentence written on her blouse: "Hungarians behind Danube SK without

* In a speech at a demonstration in Prague, shown live on the Czechoslovak TV, Václav Havel said "Truth and love must prevail over lies and hatred." Later, it became one of Havel's most famous remarks. His critics, however, ridiculed it for being naive, simplistic and childish. Years later, 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."

parasites". They called medical help and the patient was treated in the hospital. On September 9, 2006, she was summoned for an interrogation and told it was to identify the offenders. However, this did not happen. During a strenuous six hour interrogation, she was pressured to falsely confess that she had lied and made the whole thing up. She did not give in. On September, 12, 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 police president publically concluded M.´s guilt before the investigation was legally closed.

The last of the three main traumatic events happened during psychotherapy. In the night from November 20–21, 2006, unknown persons broke into her apartment where she lived with her partner. They left the furniture doors open, 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 on the car of M.´s partner was left open, too. He reported the event to the police; M. took a bus to school. On the bus, a woman sitting next to her was looking at A4 photographs showing the apartment as they had found it that morning as well as photographs from the car taken from below. The woman was accompanied by another female standing in the aisle, and both women left the bus. M. was scared and uncertain how to react. Should she shout? Stay quiet? She was afraid something might happen to her partner. They could have done something to his car. He was about to travel! She tried to reach him with 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 stayed like that until 3p.m. of that day. At that time, it started working again, without being repaired.

On November 10, 2006, the prosecutor formally opened a case against patient. On May 14, 2007, the police accused M. 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 emphasized by the patient´s attorney. M. has since married, but kept her maiden name in the hope that the case will be favorably resolved and her name cleansed.

The public has been largely misinformed about the case, which has subjected M. 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 contributed to this public misperception: First, a mistrustful attitude towards Hungarians living in Slovakia; second, energetic and misleading commentary by political representatives; and third, and perhaps most troubling, is circumstantial DNA evidence against M.'s telling of events. Several days after her assault, M. received an envelope from an anonymous sender containing stolen documents. The biological traces from under the postal stamp were analyzed and patient´s DNA was found. M. 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. In the conclusion, we discuss this and further misunderstandings in more detail.

A comprehensive summary of the case can be found in Vrabcová (2009, 2010).

A SHORT OVERVIEW OF THE DIAGNOSIS AND TREATMENT

The patient received outpatient psychiatric care from November 2, 2006 to May 5, 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 text, was present at the sessions as an observer and recorder. She also assessed the patient using several psychodiagnostic tests and scales.

First, we appointed a working diagnosis. After several hours of clinical interviews and psychodiagnostic 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 (Her freedom of movement was restricted by physical violence; she was forced to unwanted behavior – 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 couldn´t be foreseen; a risk of potential rape – memory loss due to a concussion and fresh haematoma on the thighs)

Z65.8 Other specified problems related to psychosocial circumstances (Libel from the high political representatives, e.g. from the Prime Minister Dr. R. F. Minister of the interior affairs Dr. R. K., and the police president Dr. J. P., media pressure including disparaging disinformation and attacks in online discussion)

Z65.3 Problems related to other legal circumstances, e.g. prosecution (She is being prosecuted for "false testimony" by the Attorney Generalship 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 in context of speaking Hungarian, the statement "In Slovakia, in Slovak", the sentence "Hungarians behind 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 Attorney Generalship and the police, disparaging statements from

the public, sophisticated intimidation from the unknown trespassers, invasion of the 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 is has to face but hasn't 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 – Eyes Movement Desensitization and Reprocessing) and later autogenic training according to J.H. Schultz to increase the enhance the resilience in persisting stress (Z65.3; Z60.8 and partially Z65.8).

DETAILS TO THE DIAGNOSTICS, THERAPY AND CATAMNESIS

The patient was referred to one of the authors (J.H.) with the aim to establish the diagnosis and consider therapeutic options. She was referred by psychiatrists and psychotherapist, senior consultant and the President of the organization *League for Mental Health* Peter Breier, M.D. He, on his part, had been consulted by Dr. Roman Kvasnica, the patient´s future attorney.

BEGINNING OF THE THERAPY

During the first examination, we learned that on August 31, 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 couldn´t remember certain events, she was afraid, was repeatedly being contacted by the media, although she just 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 the antidepressant Cipralex (s-citalopram) 10mg in the morning and the anxiolytic Xanax (alprazolam) 0.5mg in twice a day, in the morning and in the evening. During her second visit on September 9, 2006, the patient stated that on Saturday morning at 7a.m. she had been summoned by the police to identify the perpetrators. At the police station, however, this wasn´t even mentioned. Instead, six policemen interrogated her, claiming that her story was fabrication and that she would be taken into pretrial 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 September 9, 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 win, 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* (November 2, 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 at the back and in the belly, 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 wasn´t quite able to control. The irritability appeared 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 couldn´t 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 to the street and shout: "People, for God´s sake, don´t believe it, it is a lie!" According to M., this misinformation concerned questions of whether she did or didn´t make a phone call, whether her ATM card was or wasn´t blocked, when and how the accident happened, the way her biological material got on the envelope, the manner in which the sentence was written or 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 consciously for political benefit, or whether wishful thinking (Peters 2011; Ciompi 1997; Ciompi & Endert 2011), hostility and other motives played a role. We consider this subject in more detail and in broader context in the concluding remarks.

During the first examination in Trenčín on November 2, 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 … Already on Saturday I 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 to 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 August 8, 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 (SUD). 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 colored by anger and disgust, unwanted reliving, repeated intrusive memories of the traumatic situation, mental distress in situation resembling the trauma as well as uncomfortable somatic symptoms when remembering it. There was a tendency to avoidance behavior, 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. Further, 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 lead to wounds on her nose and her left cheekbone, as well as the events which subsequently over the next 15–20 minutes. For example, she could not remember why she had 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 are several options. She can either continue her treatment with her previous outpatient psychiatrist, or, in case he doesn´t specialize in psychotraumatology, she can find another psychiatrist or clinical psychologist specialized in psychotherapy and psychotraumatology close to her domicile. Travelling 127km from Dunajská streda, her hometown, to Trenčín might be difficult. After considering her options, however, the patient preferred to continue her treatment in Trenčín. 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 personality, degree of disability, intelligence, and her truthfulness and credibility.

Simultaneously with the diagnostic process, we offered the patient stabilizing interventions to compensate the uncontrollable traumatic memories.

FURTHER MEDICAL FINDINGS AND RECONSTRUCTION OF THE TRAUMATIC EVENT

The following findings of *physicians from the University Hospital in Nitra* 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 June 18, 2008, on the basis of her medical records. She stated that on August 25, 2006, she came by ambulance to the patient who "was very scared and distraught, she had a full body tremor … her pupillae … were widened to

4mm." The physician also found increased blood pressure (150/80) and increased heart rate (150/min). She noticed a wound on patient´s face and haematoma on her thighs. She administered diazepam 10mg intramuscularly.

Physicians at the *Department of Traumatology* of the University Hospital in Nitra found " … facial oedema in the left zygomatic region and of 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 on 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 auricualae bilat, neurologically acute stress disorder of a mild degree, and further traumatological diagnoses (Our comment: The patient had already been tranquilized by Diazepam 10mg i.m.).

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

The *computer tomography* (CT) of the brain, thorax and abdomen was done on August 25, 2006, at 10.42a.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 21mm and 17mm 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 patient´s anamnestic information as well as on the findings from the University Hospital in Nitra (especially the injuries of the left zygomatic region and nose radix captured also on the CT scan), we can hypothetically reconstruct the most probable course of the event. 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 to her lower abdomen. She didn´t 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 other two punches to her left cheekbone and her nose radix, probably with a fist. The other possibility is that she stayed on the ground and was twice kicked in these areas. These last two punches probably lead to the concussion and the short retrograde and anterograde amnesia with the estimated duration of 15–20 minutes. We can assume that during the time

when the patient suffered from a consciousness disturbance the assailants wrote on the back of her blouse the sentence "Hungarians behind Danube SK without parasites". Even in free associations during the trauma processing, the patient couldn´t remember anything about the assailants writing on her blouse. She also didn´t recollect anything about the haematoma on her thighs. It is possible that while regaining of the consciousness and while her conscious state was still altered (LOC – level of consciousness (Malec in Varney & Roberts 1999) – clouded consciousness, *Bewusstseinstrübung* (Peters 2011)), she reflexively 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. According to 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 doesn´t exclude a combination of a vasovagal syncope and a consecutive concussion caused by further punches.

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 Organization (WHO). In the course of the first sessions, we also used the Structured Clinical Interview for DSM-IV (Margraf 1994). On November 2, 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, in Wilson & Keane 1996). On November 10, 2006, the patient´s total symptom score was 44; on February 9, 2007, it was 45, the maximal score being 88. The cut off score is 35.

On November 2, 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 the 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; Dührssen 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 didn´t find any neuropsychiatric conditions among consanguineal 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 college student majoring in education. The relationship between the sisters is good. The patient has a stable relationship with her partner, Peter. The patient is a college student and studies Hungarian and German at the Faculty of Central European Studies at the University in Nitra. She likes studying, doesn´t have any difficulties passing her examinations, as she is always well prepared. She was also well prepared for the examination that she should have taken on August 25, 2006, on the day of the assault. In the past, after graduating from the 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 college there, and were ready to help her out financially.

In the post pubertal period, she had aesthetic earlobe surgery. In college, 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 a reason to doubt the patient´s credibility. On the contrary, all the subjective and objective information including direct observations during the face-to-face meetings were concordant and contributed to the impressions of patient´s veracity.

STABILIZATION 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 will be necessary relive the traumatic situation, including negative emotions, at a later stage of the therapy, but that this will happen in a radically different and safe context. The aim is to process the traumatic memories so that they do not lead to severely disturbing emotions, as though the trauma were 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 the sessions 8–10.

From the professional point of view, therapeutic treatment in conditions of *ongoing threat* (for example, the tendency of state institutions to "overpole" reality, "to misqualify caning as a lie" (Zajac 2009) 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 if too overwhelming, and to maintain contact the present safe environment when recalling the traumatic event.

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 is 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 warmth sensation on 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 short breaks in 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 in the 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 tress, 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 in 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 threes, 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, bear, dirty, I can see my feet walking on the concrete … an unpleasant sensation in my nose … as though my nose was broken … unpleasant warmth on 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 here 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 on 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 crying, someone might hear me, can I cry or not … (tears in her eyes), then I decide not to cry, 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 course of further EMDR treatment, feelings of disgust, anger and distaste appear. The patient remembers seeing one of the assaulters on the 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 has faded, her hands and feet are warm, 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 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. I., 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, two bald men sitting in the car shouted "M., M. … bitch!" She had already felt 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 harrassment, it became clear that the therapeutic process can be seriously hindered by ongoing intimidation. Furthermore, it wasn´t clear how far the threads 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 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 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 desensitization, the patient didn´t 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, 1 means "completely false" and 7 equals "completely true", the patient repeatedly estimated the validity of her positive cognition with 7.

At the end of the session, after the 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 any more. "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 as an offender, and that the two assailants were police´ protégés. She remembered one of the policemen telling her in private: "Girl, whether you are lying or telling the truth, it doesn´t really matter, you are doomed anyways."

However, when remembering the strangers breaking into her partner´s apartment and being threatened in the bus, the patient still felt nervous and uncomfortable. We focused on processing of this experience using EMDR.

The patient described the most disturbing image in the following way: "I am sitting in 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 cry 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 cried, 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 you 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 get 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 any more … 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 M. mentioned that her boyfriend had gone through a period when he couldn´t 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, Police President and their speakers as well as of the Attorney Generalship. There was still widespread misinformation in media, public verbal assaults and a risk of further physical assaults. Furthermore, the patient had to emotionally cope with the distress of her relatives caused by problems she didn´t chose to face.

INTEGRATION AND FURTHER DEVELOPMENT PHASE

Sessions 11–25 were dedicated to strengthening and deepening of the therapeutic effect. The aim was to enhance patient´s emotional stability and resilience, and to improve her stress coping strategies. In case of facing new stressors, she should be able to recognize 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 autogenic training stage. It consists of meditation and imagination exercises, some of which focus on certain theme (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 modeled 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, 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 the autogenic training and to enhance the contact with the fetus. We taught her to use the autogenic training during the birth to increase the changes of an uncomplicated and natural childbearing (This happens through dismantling of the negative emotions that could disturb endocrine regulation mechanisms during labor). A video appeared on Youtube showing a policeman shooting on a figure labeled M., but the patient was able to cope with it. Both pregnancy and childbirth progressed without complications.

CONCLUSION OF THERAPY

After the trauma processing, 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 didn´t fulfill the PTSD diagnostic criteria. On March 16, 2007, her Impact of Event Scale (IES-R) (Weiss & Marmar 1996) was 8; on March 23, 2007, it was 4(The maximal score is 88; patient´s score at the beginning of the therapy was 44). On March, 16, 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. M., her husband Peter and their daughter E. (born in 2008) made a content and happy impression. After breaking the ice, the baby started exploring therapist´s office. M. talked to her daughter in Hungarian; her husband Peter in Slovak. The couple agreed on this since they wanted E. to learn both the language of her mother and of her father.

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

CONCLUDING REMARKS TO DIAGNOSTICS AND CATAMNESIS

The retroactive analysis of all the medical findings and 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 patient´s behavior 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, pupils, voice, movements of various body parts, bodily sensations, context and time consecutiveness, and so on).

On October 6, 2010, I (J.H.) had an unstructured *follow-up* telephone conversation with the patient. I learned that M. was feeling completely healthy. She wasn´t experiencing any symptoms she had been treated for. She didn´t have any flashbacks of the trauma and described herself as happy. In 2008, she got her master degree. She successfully defended her master thesis on the subject of Hungarian slang originating from Slovak. She is confronted with common everyday problems of a mother of now two children. Her daughter is now 3, her son three months 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 is helping with the household and the two children. Her father, owning a construction company, built a house for the young family. Since M. has always enjoyed learning foreign languages, she 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 5 (!) 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 4 years, she gained the experience of a 50 year old person, although in reality she is only 27.

DISCUSSION

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 specialized in psychotraumatology and gained experience in both diagnosing and treating traumatogenic disorders.

In M.´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 M.'s story was false. The Prime Minister (R.F.), the Minister of Interior Affairs (R.K.) and the Police President (J.P.) appeared in 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 M.'s version of events. The social and political context of M.´s case is described in the book titled "National Populism in Slovakia and Slovak-Hungarian Relationships" (in Slovak Petöcz 2009; Petöcz & Kolíková, in Kollár *et al.* 2010). A summary of the case (in Slovak) can be found in the text of the journalist M. Vrabcová. Social and political aspects of various segments of Slovak society is captured in comprehensive reports on the state of the society published by the Institute for Public for Public Affairs (http://www.ivo.sk/3808/en) under the leadership of the sociologist Martin Bútora and the political scientist Grigorij Mesežnikov (Kollár *et al.* 2008; 2009; 2010; Strečanský *et al.* in Kollár *et al.* 2010). Practically all questions which arose thanks 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 PTDS diagnosis. An experience of a traumatic event is a condition of PTDS. 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 M.´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 got some of these findings only later, in course of the diagnostic and treatment. In course of the whole diagnostic and therapeutic process and after each session, we asked ourselves whether we noticed anything contradicting the credibility of our patient, or anything conflicting with our knowledge and our hypotheses. However, we didn´t find anything like that. On the contrary, we were discovering more and more information about the attempts of the police and attorney generalship to distort the reality and prove that the "incident hadn´t occurred". This was reflected also in the expert evaluation (MUDr. Š.K.) requested first by the police and later by the attorneyship (Prof. MUDr. P.L.).

We considered a possibility of simulation, aggravation or of an artificial disorder (Praško, in Seiffertová *et al.* 2008). However, M.´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 certain tendency to dissimulation in connection with 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 a 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 inform neither the police, the state organs, her parents, her partner, nor her attorney. We also asked her to warn us of facts she didn´t want to become part of her medical record. Later it was clear that for the sake of her safety, it is better to publish all the information she gave us. This happened with her consent.

RISK AND PROTECTIVE FACTORS

Considering the first and the third traumatic event (the assault and a 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 blood stains on her garments. Therefore, she couldn´t know what had happened to her; she might have been sexually assaulted. During the therapeutic process, we encountered the themes of disgust and filth. M.´s cognitive unpreparedness for this type of an assault represents another risk factor. She didn´t expect to be humiliated due to her mother language, to be physically attacked, not being able to predict the extent of the violence and to know what happened during the period of unconsciousness. Based on her upbringing and the relationships in her primary family, her attitude was that she could trust people, and that people wouldn´t want to purposely hurt and threaten her. 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 didn´t spontaneously disappear after the first trauma. It is questionable, whether the benzodiazepines administered shortly after the assault contributed to the symptoms unfolding. 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. M. had support from her family and her partner. According to our clinical judgment, the patient, her parents and her partner had a safe attachment. In her early childhood, M. didn´t experience a

separation from her primary caregivers. If we don´t consider the peptic ulcer, she hadn´t suffered from any mental disorder prior to the assault. She hadn´t been traumatized 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 e.g. by Tavel (2007, 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 didn´t culminate to its maximum. This is yet another proof of patient´s premorbid resilience. Furthermore, the degree of disability in various areas of daily life wasn´t paralyzing.

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 didn´t represent an obstacle in forming a positive countertransference 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 R. F.´s government as humiliating for our quiet patriotism, sensitivity for human and civil rights and liberties. The more M.´s credibility was being confirmed, the more stable our positive countertransference and our readiness to help her reduce the PTSD symptoms. Our positive concordant transference (Wöller & Kruse 2011) enabled us to empathize with the whole specter of 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 realized the possible *transference* risks of the patient. She could have perceived the therapist as a "potential aggressor, violator of sacred boundaries, untrustworthy traitor, investigator or judge, controller, indifferent witness or a potential victim of patient´s aggressive impulses" (Levenson *et al.* 2005). 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 psychodiagnostic 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 didn´t complicate the therapy. The patients had a good reality sense, positive relationship experiences

in her early childhood (with her parents, grandparents and her sister), a stable relationship with her partner and a good relationship to her attorney, who had originally consulted one of our colleagues and referred M. to our care.

From patient´s global 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 optimally use them 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 countertransference reactions. These could include hostility, feelings of being emotionally overwhelmed and helpless, indifference or an exaggerated tendency to "save" the patient (Horowitz 2004; Levenson *et al.* 2005). Emotionally most difficult 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 didn´t 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 organizers in the background and the politicians misusing their power was mixed with realistic concerns how to accelerate the healing process, reduce patient´s symptoms and enhance her resilience in case of further stressful events. We considered the idea to inform 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 2005; 2005; Hašto 2005), as well as on attitudes of those we trust. Connections to several publicists, intellectuals, and the professionalism and civil courage of M.´s attorney facilitated our decision.

We attempted to avoid an exaggeratedly idealizing transference towards the therapist coupled with disappointment from unfulfilled expectations. Therefore, we were continually stressing patient´s own healing resources we either anticipated or directly identified. We aimed at supporting patient´s experiences of self-efficacy. We pointed out that a good attorney is more important for the future development of the case than therapists.

We also paid attention to patient´s family and her partner. We were aware of the burden the case represented for them as well as of their importance for 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 to protect criminal perpetrators, starting from the first Slovak State in the World War II through the communist regime and the current post-communist government (Mikloško *et al.* 2001; Takáč 2001; Bútora 2010; Hradská, in Benz 2010).

THERAPEUTIC INTERVENTIONS

After confirming the diagnosis, the patient was repeatedly educated about the logic of her symptoms, about her disorder, the possibilities to cope 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 traumatization in adults. Self-relaxation exercises using imagery (safe place, inner helpers, etc.) were part of each of the sessions and represented an important stabilizing intervention.

We agreed on the content of each of the sessions. We pointed out that we only start the EMDR trauma exposure after she would feel strong enough. We also stressed that she can interrupt the exposure any time by lifting her arm, and we would immediately understand that as a signal that she needed a break. We signalized 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 M. 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 M.´s ability not to generalize her negative emotions on 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.

THERAPEUTIC SETTING AND PROCESS

When we agreed on approximately 15 sessions 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 symptoms 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 km between her city and out office made the commute difficult, it wasn´t possible to have one sessions 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, the time sequence doesn´t 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 patient´s capacity of information processing), and *circularity* (the same answers are being repeated, and the process doesn´t lead to stress reduction). M.´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 yet not 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 retraumatization remained high. There were still misinformation in media, verbal attacks in online discussions, discrediting statements of politicians, and the prosecution of the Attorney generalship under the leadership of JUDr. D.T. Therefore, in the next phase of the therapy, we aimed at increasing patient´s stress tolerance.

From M.´s history we knew that she had been able to experience inner peace, to see problems in broader context and to analyze 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. M. 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.

M. shared her view of the therapy and her experience with the journalist Marie Vrabcová, and they were published in a book titled Hedviga (Vrabcová 2010).

MISINFORMATION AS A WORK METHOD?

The strong and loving support the patient was getting from her close surrounding 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 patient's PTSD. It might have lead to chronification of the symptoms, depression or other mental disorders. Mainly the media influenced the public attitudes. Even before the legal closing of the investigation of the assault, the Slovak Prime Minister, JUDr. R. F., 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 that she sacrificed the name of the Slovak Republic, just to safe her own name." (This statement is shown in a film made by Anna Kratochvílová *Citizen Hedviga*. It can be accessed through the website www.tyzden.sk) As the Prime Minister was largely popular by a big part of the population, such a statement negatively influenced the public opinion of M. as a victim of a violent crime, and it made it easier to spread further misinformation. "We Slovaks are endangered by them, Hungarians, (polarization between us and them) therefore we have to unify under the leadership of a strong leader." This statement 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 intentionally and cynically misuse it to gain voters´ support. "The logic of affect" (Ciompi 1997; Ciompi & Endert 2011) plays a role here. In other context, we will mention Milgram's socio-psychological experiments enabling us to understand the suggestive strength of an authority.

At a press conference of the Minister of the Interior Affairs and of the Police President held before the legal closing of the investigation, public and the media learned about the DNA found on the envelope with M.´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 hadn't been stolen, and that M. put them into the envelope herself. M. was able to explain it. After obtaining the envelope, she handled it with her hands. After receiving the instruction to 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 to the envelope. The Minister of the Interior Affairs claimed that the stamp was glued exactly at the place corresponding to the postal seal. However, according to the investigation file, this had never been examined.

In our opinion, referring to the DNA analysis confused critical thinking ability even of otherwise educated intellectuals, until they got to know the context. The "DNA proof" functioned as an "emotional attractor" in sense of Ciompi´s "affect logic": "She is guilty", "a liar", "an anti-Slovak Hungarian". This further influenced evaluation of all other information and misinformation connected to the case. The expert evaluation was done by a physician of a high rank in medical hierarchy. He is a professor of surgery and the dean of the medical school. His expert opinion agreeing that "the assault did not happen" and "she wasn´t hurt" has similar authoritarian strength. In the same way, CT scan is a highly valued proof. In reality, however, the CT scan on the day of the assault confirmed a cranial trauma.

We describe two 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 hadn't recommended interrogation yet. At that time, M. attempted to logically reason. 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 thought that she was addressed by the two assailants. Since the police discovered that her phone wasn´t at the time of the assault, they used the uncertainty of M.´s memory against her.

Another example: M. 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 clocked, but the police used an invalid, false confirmation that it hadn´t 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 hadn´t been blocked.

High state representatives publically described M.´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 deceit the public, subjectively justified their behavior towards M. as though she actively participated on some anti-Slovak conspiracy. They oversaw that it was their reaction ("M. is not a victim; she is an assailant!") that created the problem.

SOCIOPOLITICAL ASPECTS

I (J.H.) often get 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 M. Vrabcová (2010) containing interesting information from JUDr. 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 a planned. On that day, about ten students of Hungarian 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: "She wasn´t beaten; she is a liar;

the incident didn´t occur; she is trying to discredit the government of the Slovak Republic." Here, we can ask several questions: What role did "drunkenness by power" play here? Feelings of narcissistic triumph and grandiosity (Henseler, in Eicke 1976; Kohut & Wolf in Peters 1980) on the part of representatives who had won election thanks to its populism and deceiving of the public? How much did the attitudes of the Prime Minister and the Minister of the 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 (2007), allow 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 defense 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 killing of civilians during the World War II (Browning 2002). In his experiments, Zimbardo (2008) 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 polarization to "us" and "them" has on human behavior. Such a polarization of roles with no other controlling mechanisms quickly leads to destructive behavior, 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, some one in the background didn´t 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 analyzing 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 didn´t specifically examine behavior of physicians, we know that during the Third Reich (Schneider & Roelcke 2010; 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. Among others, schizophrenia and manic depression belonged to this

group. The healthy "body of the nation" shouldn´t have been burdened by these and other ailments. All physicians were obliged to report so called hereditary ill to the officials. Based on this law, more than 360 thousand citizens were selected and forcedly sterilized. More than 6 thousand people died during these medical interventions. On September, 1, 1939, Hitler ordered so called action "Euthanasia". 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 starvations and deadly effects of gas. All of these processes were controlled and carried on 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 murdering of millions of "Untermenschen". There was certain resistance against the injustice in medicine and especially in psychiatry. However, more than 50% of the physicians were members of the national socialist organizations (NSDAP, SA, or SS). Formulated positively, almost half of the physicians were not members of these organizations. This shows that there were some possibilities of resistance, and it not always had private consequences. Some of the physicians did resist. But they were few. Very few (Schneider 2011).

The way German psychiatrists presently 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 (Schneider 2011): "Except for several individuals, the majority of German psychiatrists and members of our community including its leaders participated in research, planning, executing and scientific legitimization of selection, sterilization and murder" (p. 31). At a different place and after apologizing to the victims, professor Schneider says: "We, psychiatrists, can´t 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" (p.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 shouldn´t stop us from critically thinking and assertively (Alberti & Emmons 2011) acting.

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 criticized this move and suspended Smer´s membership.

Then news about the attack on a student of Hungarian nationality must have been unpleasant for the Smer leaders. The Prime Minister and the Minister of the Interior Affairs started to deny the reality of the attack and to claim that "the incident hadn´t 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 apologize. They should have apologized to M., to her relatives, to Hungarians living in Slovakia and to the Slovak public. There are several possible reasons why they avoided this. Some of them might be political (fear from losing the admiration of the nationalists´); some of them are probably connected to the group dynamics (we have to be holding together). Certainly, personality structures of the main protagonists play a role, too.

SOCIOPOLITICAL CONTEXT OF PSYCHOTRAUMATOLOGY

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 psychotraumatology, 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 the memories, emotional overload, and 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 psychotraumatology research and a co-author of the definition of complex PTSD, these sociopolitical aspects complicate the status of both mental trauma victims and experts helping them (Herman 2001). 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 defense. 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" (p. 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." (p.8) This might be observed in victims of political terror as well as those of domestic abuse. We must realize that not only the traumatic event itself, but also the reactions of the social surrounding 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 don´t get support in their social environment, and are often being described as untrustworthy, inadaptable and overly complicated. The victim might be proclaimed an assailant by those having the power, if there aren´t 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 of traumatogenic disorders, also stress the sociopolitical aspect of psychotraumatology. "For therapists of vic-

tims of political violence, political attitudes protecting the human right and the victims of state violence might be helpful. The meaning of the therapy might then be interpreted as targeted support of human rights." (p.309) (Neuner *et al.* in Maercker 2009).

This therapeutic attitude corresponds to Vaclav Havel´s quote that is the motto of this text. During the communist regime, the attitude of many psychiatrists was that they shouldn´t get publicly involved in social and political issues. Such an attitude was understandable, but often exaggerated. It was expected from psychiatry that it will only deal with its narrow specialization. Bio-psycho-social understanding of psychiatry was therefore reduced, and some psychiatrists out of fear contributed to the status quo of the totalitarian regime. Sometimes, they cooperated when a person with anticommunist attitudes was supposed to be hospitalized because he/she might have disturbed, for example, the celebration of May Day. The Psychiatric Section of the Slovak Medical Society also blocked a free development of psychotherapy in Slovakia. Therefore, psychotherapy had been developing in semi-illegal conditions and in variously 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, M. was lucky because positive interactions with her parents and grandparents allowed her to interiorize 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.

CONCLUSION

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

Therapy of PTSD requires a specific attitude. It has to take into account the main characteristics of PTSD: the central nervous system´s disturbed capacity to adaptively process information, dysfunctional traumatic memories, and inability

to experience safety. Therefore, the therapy of a mental trauma has three phases: stabilization, exposure and integration, and new orientation. In all of the phases, it is crucial to strengthen 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 the condition of a persisting stress. The case study of the patient who gave us her consent to disclose her real name tells a lot about the sociopolitical 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 George L. Engel (2005; 2005) adequately describes this complex attitude towards diagnostic and treatment in medicine and psychiatry.

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We would feel very alone without the professionalism and support from many committed 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 Bútora, the psychologist Gustáv Matijek, the philosopher Egon Gál, the psychiatrist László Sarközy, 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, critically thinking citizens …

Translated by Svetlana Žuchová, MSc., MD., PhD. and Ted Erler, PhD.

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Authors' note

This is a case study. In general, a psychiatrist must respect patient's right to privacy. In scientific publications, we are used to protecting a patient's identity using fake initials and withholding or changing information that could lead to identifying the patient. The logic of medical reasoning remains intact. In our case study, it has been impossible to hide the identity of our patient, and it appears important to publish all our findings. We would like to thank Mrs. M. who gave us a permission to publish all our findings and conclusions.

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