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The black flame: Traumatic amplification and the nonrecognition of sexual abuse

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Abstract

The traumatic impact of sexual abuse by a psychotherapist is exacerbated by subsequent invalidating care while an inpatient in a psychodynamically oriented psychiatric hospital. I designate the nonrecognition and mislabelling the reality of the original abuse "traumatic amplification." This narrative of my personal history is presented as a professional memoir. In my instance, a long-term open psychiatric hospital systematically misunderstood, misdiagnosed, and clinically mismanaged my care and further consolidated the soul-murdering impact of my original therapeutic abuse. Central to my treatment was the active and collusive denial of my having been raped by a therapist. This space of denial was facilitated by systemic slippage of meaning as an assault against truth. "Abuse" was renamed an "affair" with its accusatory and persecutory implications that culminated in my being misdiagnosed as "psychotic," a diagnosis that displaced the foreclosure of truth on the part of the hospital onto me. Central to healing the damage cumulative sexual trauma inflicts is validation by a symbolic authority to authenticate experience. The open psychiatric experience systemically failed in its provision of care and delegitimised my reality. Validation and, with it, a beginning integration of self, arrived years later in psychotherapy where non-defensive acknowledgement, attunement and mutual commitment were able to be held.

KEYWORDS

denial, institutional countertransference, institutional nonrecognition, sexual abuse, soul murder, therapist transgression, traumatic amplification, validation

1 | INTRODUCTION

In this paper I present an experience of sexual trauma in the context of therapist boundary violation that was subsequently traumatically amplified while I was a patient in an open psychiatric hospital that I shall call for the purpose of this narrative "Bayfield Hospital." Central to the traumatic amplification Bayfield perpetrated was their collective and collusive nonrecognition of the actuality and thus the reality of the original abuse. I describe how the hospital's systemic and orchestrated disregard of my actuality further invalidated my inner reality and in doing so seriously impaired my life. I think of this narrative as something like a professional memoir; that is, I am writing about my own personal experience with an emphasis on core themes that shaped my traumatic history in the context of damaged care. Capacity and reflection afforded by my being a clinical psychologist with over 35 years of experience also inform my narrative.

Psychotherapeutic nonrecognition entails invalidation by omission or inaccurate naming of actuality. It is more than moments of misunderstanding or failures in attunement, as important as these can be in their own right for the fate of psychotherapy outcome. Rather, psychotherapeutic nonrecognition is a form of collective countertransference, a built-in affectively driven ideological bias against the defining shape of lived experience. It is built into the ideational mythos of an institution's self-understanding of its mission and legitimacy in the context of the larger therapeutic culture that shares, however implicitly, in this same myth. By myth I mean the mental structures that organise against what is actual. Psychotherapeutic nonrecognition hollows out meaning as it amplifies pre-existing trauma. Treatment provided in this context deepens and further consolidates the original violation of self. In my case, Bayfield systemically denied the history of my sexual abuse by a psychotherapist whom I had seen previously. Psychotherapeutic nonrecognition voided my reality and, in so doing, colonised my inner reality with their unquestioned "truth" that was in fact a lie. Wilfred Bion (1970) has pointed out that the psyche grows through emotional truth but is poisoned by the lie. The lie entwines with the fabric of self as it implants confusion and doubt, undoing faith in one's own orientation toward knowing and experiencing what is real. The lie feeds on silence and invalidating group cohesion, while the subject of the lie slips into numbing isolation and falls under the spectre of internalised splits in self-continuity. Central to the process of institutional nonrecognition is the authoritative substitution of the lie for the truth. This, of course, is not limited to any one institution or collective organisation but is a common feature of how vested interests with self-preservative loyalties manage reality in order to further their own agenda. Thus there is an inherent political function to this process of nonrecognition where competing agendas vie for salience. When the political function of nonrecognition infuses the culture of a therapeutic treatment process, a kind of insidious terrorism against the self ensues, under conditions in which one is most vulnerable and thus most suggestible. For me, this process and its effects were like a nightmare. It has taken years to begin to process this impact and heal from it. I hope that describing my experience will add another voice on behalf of those who have been sexually abused within a therapeutic context. I also hope that therapists may come to further appreciate the profoundly harmful effects that result from denying the truth of sexual trauma that occurs in a psychotherapy relationship. Transparent and non-defensive acknowledgment of transgressive violation is necessary for accurate diagnosis and restoration of one's full personhood. Psychotherapists have written about the harmful effects of psychotherapist sexual abuse (Disch & Avery, 2001; Lundgren, Needleman, & Wohlberg, 2004; Penfold, 2006). What I wish to add to this literature is a case study in which the author can offer the unique viewpoint of one who both is the subject of this pattern of abuse and is also a psychotherapist.

I have been a practising clinical psychologist since 1983 and only now, despite years of clinical practice and the possession of a doctorate in clinical psychology, can I articulate the traumatic amplification that resulted from the treatment I received at Bayfield Hospital and how it contributed to further disturbances in self-organisation and dismantled a coherent sense of well-being. One central concept in understanding trauma is deferred action (Laplanche, 2006/2017), whereby the original impact cannot be adequately registered and processed. It is too much—too disorganising, too overwhelming. Only years later, and often released by a second activating event, can the psyche begin to more fully register and formulate some sense of what happened in one's being. Deferred action is made more complex through the repetition of therapeutic nonrecognition. The original trauma amplifies under the force

field of systemic nonrecognition into a frozen state of constriction that controls one's inner world through incorporating the toxic authority of an institutional lie. The lie functions as a kind of institutional countertransference, which is to say that it is an imposed emotional template that is blind to its own conditions as it misshapes perception and understanding. So, despite my years of training and practice, I was held under the grip of this form of implanted systemic institutional denial and related to myself the way I had been related to—invalidated, dismissed, and blamed. There are layers and layers of coming into the truth. Impact upon impact must be felt and known. Rhythms of approach and avoidance must be lived through. So much to register, to allow in, so much lost time and self-suspension, so much deferral until conditions ripen to facilitate release.

Relationships thrive through recognition and validation (Schore, 1994). Recognition and validation via empathic attunement and affect regulation build tolerance for processing traumatic memories and their embodied correlates. This process shapes the orchestrated dance between two subjectivities and forms something like a relational unconscious (Zeddies, 2000). The relational process of recognition that takes shape through validation and attunement is core to a generative psychotherapy relationship (Benjamin, 2018). Validation is the lifeblood out of which a sense of self forms. Recognition reinforces a sense of wholeness, feelings of worth, a sense of well-being. I see myself as I am seen. If psychological vision is acute then sense of self takes on contour, richness, and detail. If psychological vision is blurred or, worse, approaching blindness, then one sees oneself through the gaze of lack or absence or accusation. Invalidation replaces the potential for wholeness. Without attuned relational weaving, subtle but corrosive damage to the self takes place, both in the original formative periods of life and in a subsequent psychotherapy process whose project includes disentangling past from present and formation via the relational unconscious space for the actuality of damage to be heard and received. This is especially true when there is early trauma and subsequent derailments of trust into betrayal and deception. The therapy relationship as an ambience in which the rhythms of attunement, failure, and reparation are possible allows recovery of contact with exiled good parts of self-experience. Therapy that is faithful to the centrality of recognition in the growth of self heals developmental and traumatic failures. This truth takes on particular urgency when there has been a sexual transgression that has been held as a secret that then is only further occluded when the therapy bond invalidates the reality of that experience.

2 | HOSPITAL EXPERIENCE

In September 1969, at the age of twenty-three, I was admitted to Bayfield Hospital, a private open psychiatric hospital, in a state of panic a year after ending a three-year psychotherapy during which I had been repeatedly sexually violated and raped until I was able to end the contact at age twenty-one. During the year between ending the abusive therapy and going to Bayfield, my anxiety escalated to persistent episodes of panic, a frequent consequence of long-term unacknowledged trauma. The emotional impact of trauma subsequently builds into states of pressure and reactivity that hold the self hostage. Eventually these states become unbearable. It was in this condition that I entered Bayfield at the suggestion of a psychoanalyst who was a friend of the then medical director.

When you enter a mental hospital, even if you are not locked inside, as you are not at Bayfield, you are isolated from the outside world. You have crossed a threshold into another world with its own culture, ethic, rules, sensibility, and belief systems. Admission to a psychiatric hospital, even one that is an open setting, is a shocking experience. Suddenly, you are labelled a "mental patient." You think, "Only yesterday I was on the 'outside'." Your mind races with thoughts that range from "What is happening to me?" to "This must be a mistake." Panic ensues. It possesses and like a virus begins to replicate itself, colonising in the depths of the mind. Panic freezes. The first stop on the way to my room was the medication closet where the nurse asked me to give her all of the medications I had brought with me. After I gave them to her, she proceeded to search my suitcase. In that instant I learned that here my word did not count. Here, at Bayfield, I was not believed. This was the first sign of what subsequently during my time in hospital I would experience over and over: that I would not be believed and that inside this culture a view would prevail that would deform the symbolic validation that I so hungered for and that would be key to my integration. What I had not learned yet, and what took years to deeply realise, was that it was they who were not to be believed.

Soon after my admission to Bayfield, I began to fear that my doctor did not believe me when I described the sexual abuse by my previous therapist. A patient's first conference occurred six to eight weeks after admission; patients were diagnosed and treatment decisions were made at that time. In preparation for my initial conference the doctor asked me to report in minute detail my family history and personal history, while at the same time he expressed little interest in my report of the sexual abuse. As a psychology graduate student on leave, I knew that the APA Ethical Standards of Psychologists (American Psychological Association, 1968) clearly stated that a psychologist should not have sexual contact with a client, and I had thought that my doctor would express concern that my therapist, a psychologist, had raped me. When he did not, I requested permission to attend my conference so that I could hear for myself whether he and others believed what I had reported. I was also concerned about how they viewed me and if they thought I needed to be a patient at their hospital. Though I was severely anxious, I generally had done well in my life. My father's death, when I was sixteen years old, had contributed to my being vulnerable to my therapist's grooming and abuse, but I had succeeded in college despite the abuse and the following year had gone on to graduate school.

The doctors denied my request to attend my conference and replied that, instead, I could write a letter expressing my concerns, and my doctor would read it aloud at the conference. This I did. In it, I asked if they believed that my previous therapist had had a sexual relationship with me, and whether they believed I needed to be there, or was I, perhaps, hospitalised there unnecessarily. Hoping to hear encouraging words following the conference, I was stunned when my therapist told me that the consensus was that I was "schizophrenic," that psychological testing supported this diagnosis, and that from here on out we would need to use "that word" in talking about my problems. He said that I did, indeed, need to be there and that I was surely in the "best place." He made no mention of the abuse by my previous therapist. None. Not a word. Now the sexual abuse by my previous therapist was not even being identified. In that defining moment, I was eclipsed into the void of nonrecognition and with this into a web of invalidation. As a result, my sense of self was conformed to a new label that was asserted with certitude by this community of experts. I was now "schizophrenic."

We see ourselves as we are seen, and this is especially true when vulnerable and unintegrated aspects of self hunger for the liberation that only validation can provide. Instead of offering me the hope that those who are supposed to know see what was done to me and in doing so initiate repair of split-off aspects of my personality, the outcome of this conference imprisoned me in a definition of me that legitimised a long-term hospitalisation. As the power of collective authority silenced the validating voice of truth, the relational unconscious as the vehicle of healing was shattered and I withdrew into a shell under the toxic force of an institutional persecutory gaze. In that moment I felt that I had, like Eli Wiesel, "become a different person … all that was left was a shape that resembled me. My soul had been invaded and devoured by a black flame … . Surely it was a dream" (Wiesel, 1958, p. 37). The meditations of Eli Wiesel on the horrors of the Shoah especially spoke to me. What he described, with such moving and direct yet humble authority, became for me the mirror missing at Bayfield. This is not to reduce the singularity of that event to my experience but rather to find in it a kind projective realisation of what is desperately needed—validation of the actuality of what had been done to me. Devoured by a black flame.

I, a young woman suffering from the loss of my father and further destabilised by cumulative trauma, sought coherence through validation by a symbolic authority to authenticate my experience. The withholding of validation or active invalidation at this decisive moment turned an opportunity for the beginning integration of self into escalating degrees of dissociation and fragmentation (Benjamin, 2018). The disconfirming authorities invoked rationalisations and acted from assumptions of suspicion within their own closed ideological system, whose impact on me, a susceptible and vulnerable patient, was a kind of soul murder. I had lost my bearings. I did not know who I was in the world. At times I felt that I was falling into oblivion. I longed for the "outside world" where my word was believed and where my integrity was not questioned. Instead, contained in the symbolic perimeter of a system of obfuscations and denials, I watched the staff come and go. I envied their freedom, their ease of entering and leaving. I so wished it was I who was leaving the nightmare of the mental hospital and returning home at the end of the day, as they did, to what I imagined were their calm, productive, loving households. Inside the hospital there was no calm and no love. I was in exile, trapped in a nightmare that continued without remission.

Of course, in my shock and confusion I questioned their diagnosis. But mostly I thought that if a whole staff of doctors at a respected hospital had conferred and concluded that I was "schizophrenic," I must be. Determined to recover as quickly as possible and return to graduate school where I had done well, I consented to their assessment and worked as hard and as cooperatively as I could within their therapeutic programme. This involved four psychotherapy sessions per week, participating in many, many community meetings and ultimately serving as Community Chairperson overseeing all aspects of patient community life.

Early in my hospitalisation, I discovered the extent of staff disbelief of the sexual abuse when I attempted to discuss with them what my previous therapist had done to me. Appallingly, the staff responded by calling the abuse an "affair" though, in fact, it bore no resemblance to an affair. And sadly, I believed them. After all, I thought, if I was "psychotic," if my view of reality was askew, then my assessment that the sexual relationship was abusive must be flawed. In sessions, my doctor asked me to reflect on and explore "my part" in the "affair," and at those times my mind shut down and I could not speak. I wished I could respond, but I was paralysed. I had no words. The staff, considering me "psychotic," completely ignored the reasons underlying my upset and routinely placed me in a hot bath in an attempt to calm me. As a result of being so foundationally misunderstood, my condition deteriorated further.

Descriptions of prisoners in concentration camps offered haunting resonance with my own states and the reality of my experience as a patient at the Bayfield. I felt numb, damned, and completely lost. Continually wracked by anxiety and unable to focus my mind, I could not sleep. I felt tortured. "The days resembled the nights, and the nights left in our souls the dregs of their darkness," wrote Wiesel (p. 100). This reality that echoed my own only further disoriented me because, ostensibly, I was comfortable: I had my own room, three meals a day and a staff who, I believed, in their own way cared for me. Yet at Bayfield I felt I was experiencing a living death. "How could this be?" I asked myself. I would discover the answer only decades later.

Though I had participated in all aspects of the community programme including family therapy, my panic and anxiety persisted unabated. It seemed that everything made me worse. I discussed leaving Bayfield, but the staff convinced me of my dire need to be there. Discouraged after one and a half years of inpatient treatment, my family consulted with a psychiatrist at a state hospital who assured them that if I was admitted to their hospital, with the use of antipsychotic medications, they could have me discharged within three months. The Bayfield staff claimed I needed two more years of inpatient treatment in order to reach and treat my "psychotic core."

3 | RETURN TO SCHOOL

At that time, January 1971, I felt desperate about my survival. I had heard horror stories from fellow patients about treatment in state hospitals. I began considering a return to graduate school because that is where I had felt organised and had been successful. I wanted to move forward with a life.

Returning to school would not be easy because I still felt severely anxious, and I feared that I was "psychotic" given that I had been so diagnosed. I decided to audit three graduate-level courses at a nearby graduate school; and having done well I chose to fully re-enter graduate school where I felt good and hopeful. I was pleased that two highly regarded doctoral clinical psychology programmes offered me admission. The Bayfield senior staff strongly opposed my return to school and in one instance, when I was auditing courses, they actually directed the hospital aides to disconnect the engine wires of my Volkswagen in an attempt to prevent me from going to school. The will to live, however, had awakened, and so, contrary to the dominating and coercive voice of the staff, in the fall of 1971 I formally entered the University of Massachusetts/Amherst doctoral clinical psychology programme. I felt alone and oddly unfamiliar in a familiar setting, but at the same time I felt optimistic. Being able to leave the hospital was an assertion of the life force within me, that part of my being that, despite so much destructiveness, was not destroyed. Light appeared on the horizon. The black flame began to diminish.

Graduate school and my clinical training proceeded uneventfully and even happily. Fortunately, I connected with a psychotherapist who worked with me supportively throughout my graduate school years. Unfortunately, however, I

continued to believe that my rape had been an "affair" and that I suffered from "psychosis" still deeply buried within me. At the same time, though, I also felt myself coming back to life, recovering my bearings and reconnecting with the outside world. Since then I have worked consistently as a psychologist all but the first few years of my children's lives. Committed to service to my community, I spent most of my career working in community mental health clinics. For the past ten years I have maintained a private practice.

4 | EPIPHANY

It wasn't until 1992, while reading an article about post-traumatic stress disorder (PTSD) and rape (Frieze, 1986) that I had an epiphany: I had never been "psychotic," and it had not been an "affair." I had been raped and was suffering with the symptoms of PTSD. My therapist had raped me twice a week in his office over a period of eighteen months. For years after this epiphany, I thought that having come to understand what had really happened—my own recognition—would be healing enough. After all, I had completed graduate school, married, and had a family. However, gradually I realised I needed help to work through the past abuses. I still needed a validating and empathic witness under whose care I could further integrate the pervasive impact this trauma had on so much of my life.

With awareness of the issues that had not been addressed and their growing effect on me, twelve years ago I entered psychotherapy with a psychologist with over 20 years of experience and expertise in working with people who have been sexually abused. In this new and different therapy, I gradually began to realise the extent to which the Bayfield staff had systemically misunderstood, misdiagnosed, and clinically mistreated me. Both the abuse by my first therapist and the lack of appropriate treatment at Bayfield had left a deep and pervasive impact. I realise now that, had I received the kind of treatment I received much later, my life would have taken a different course and I wouldn't have suffered for so long the ongoing symptoms of post-traumatic stress disorder.

In this new psychotherapy, I came to understand that my experience at Bayfield Hospital had exacerbated the symptoms of my already present problems with dissociation. Rather than recognising and helping me to work through the severe abuse, the therapeutic approach provided by Bayfield had only reinforced and magnified my dissociative mind. Dissociation, a common defence mechanism that can emerge in the face of overwhelming complex trauma, was the primary way that I had coped with repeated sexual abuse by my first therapist. My sense of self was partitioned between two worlds: the space of therapy with its degrading violation of my being and the world of academia where I found relief and solace in focused thought. When concentrating on my classes I could suspend the otherwise pressing awareness of having been repeatedly abused. I could not however forget it. In fact, wracked by guilt, shame and the stress of holding the secret alone, I struggled in silence to concentrate on my work.

Because my treatment at Bayfield had centred on their denial of my having been raped and their filling in the space of this denial with renaming the abuse as an "affair," my hospitalisation itself became another molestation. Benjamin (2018), in writing about the importance of acknowledgment of trauma said, "a significant aspect of retraumatization is constituted by the analyst's failure to acknowledge [the original trauma]" (p. 55). Rather than recognising the abuse for what it was, Bayfield ignored the reality of the rape and abuse and used it against me by making me responsible for my rape by calling it an "affair." This defining dislocation of meaning was a global invalidation of my reality. Redefinition of what I felt to be true pushed my already present dissociative states further along the dissociative continuum. Just as the psyche grows through emotional truth, it shifts into states of confusion and fracture when a legitimised lie is systematically substituted for the truth. Persistent misunderstanding and invalidation by all who treated me at Bayfield only deepened and consolidated my trauma. This culture of the lie worked to amplify my susceptibility to dissociation. That the hospital staff reinforced my thinking that I was responsible for my own rape was damaging and disorganising.

At the same time, for the hospital to label me "psychotic" as a way of never acknowledging or clinically addressing the truth of my rape, was a further assault against the integrity of my being. Labelling me "psychotic" led me to doubt

my own capacity to think clearly and to severely doubt my own capacity for agency. One's early twenties is a time of crucial identity formation and this kind of misunderstanding, persistently conveyed by a staff of doctors to a vulnerable and panicked 23-year-old, would devastate her development. It did mine.

As I was preparing to leave Bayfield in 1971, I was haunted by the staff telling me that they had not been able to reach and treat my "psychotic core." Several years after I had left the hospital and while still a graduate student, I was even more perplexed when I was asked by the medical director who knew me as a patient at the hospital if I would consider coming to work at Bayfield as a therapist. He said that he did not recommend getting experience the way I had, but he thought I would have much to offer if I worked there.

After having established a working relationship with my new therapist, she told me with calm clarity that I was not "psychotic" nor, in her view, had I been "psychotic" when I was at Bayfield. She concluded this based on my personal history, a reading of my Bayfield medical chart, and her considerable knowledge of the effects of repeated sexual trauma on the personality. She found that I was showing the symptoms of severe sexual abuse, complex trauma, and dissociation that had been long unrecognised. During my time as a patient at Bayfield it was this complex trauma profile that had been called "psychosis."

Further, long after having left the hospital I had personal communication with the then chief psychologist at Bayfield who, for a brief while, had also been my therapist when I was hospitalised. She told me that she, too, thought that I had never been "psychotic" and that it was clear to her that I had been traumatised and was suffering the effects of trauma. Post-traumatic stress disorder, however, was not a formal diagnosis until 1980. Whether the psychologist ever expressed this opinion to the hospital staff, I do not know. However, she did express this to me in a written communication as well.

It also is the case that traumatised persons can present on projective testing with psychotic-like manifestations while not otherwise demonstrating any clinical indication of psychosis (Van der Kolk & Ducey, 1989). What was presumed to be a "psychotic core" was the result of the traumatisation by my first therapist and the disorganisation I experienced as a result of Bayfield's incorrect diagnosis and blanket denial of the rape I had endured. I came to so identify with being "psychotic" that, even with all the contrary evidence that I had never been "psychotic," it took me years before I believed this truth in my core. Now I understand that my episodes of dissociation and confused, angry, frightened, and panicked feelings were not due to "psychosis," but rather the result of complex trauma and the effects of Bayfield's hegemonic assertion of a presumed superior reality, one in which rape was an "affair" for which, in their view, I was culpable.

Finally, as a result of Bayfield's mystification of truth, I developed a phobia of being a client in a psychotherapy relationship. While I had developed specific trust issues with male psychotherapists following my first psychotherapy, this problem mushroomed during and after my Bayfield experience. I became terrified of psychotherapists, psychotherapy offices, and the process of psychotherapy. When I walked into a therapy office as a client, I instantly and subtly dissociated into what Van der Hart, Nijenhuis, and Steele (2006) called a protector part that kept me from feeling vulnerable in the therapeutic situation, and, therefore, I was completely unable to be "present" in the session. During the therapy hour I could recognise that I sounded different and expressed a different attitude, but I was helpless to do anything about it. I felt I was drowning; things seemed far away and out of reach. Only at the end of the hour when I left the therapy office could I feel my utter terror. This severe phobic and dissociative problem significantly prolonged the psychotherapy process and it took years of attentive and patient psychotherapeutic work before, ultimately, I could be fully present as an integrated adult self.

The Bayfield Hospital did not recognise or acknowledge the abuse by my original therapist. They should have known that a therapist perpetrating sex on a patient is not an "affair" and is totally the responsibility of the therapist. They should have known that it was a violation of the ethical principles as laid out in the 1968 Ethical Standards of Clinical Psychologists (American Psychological Association, 1968). The Bayfield Hospital had a responsibility to tell me this and to ask me if I wished them, the hospital staff, to report my therapist to the Board of Registration of Psychologists. A well-publicised legal case, *Zipkin v. Freeman* (1968), held that a sexual relationship between a psychotherapist and patient was in fact criminal and the therapist criminally responsible. The Bayfield Hospital, being one

of the premier long-term in-patient facilities in the country, should have known this. They should have known that sexual relations between a therapist and patient are both unethical and criminal. They should have known that sexual relations between a therapist and patient is never an "affair." They should have known all of this. They did not treat me responsibly or with credibility.

That Bayfield Hospital held me equally responsible for the sexual abuse that my therapist had criminally inflicted on me left me profoundly alone with flooding anxiety, states of confusion, paralysing guilt and shame, and fragmenting rage. Their denial of my rape led me to feel like a tortured concentration camp prisoner. My already severely traumatised young girl's mind, body, and spirit was retraumatised by the hospital's systemic mismanagement and ideological tyranny. I was suspended in a deadening mythic world of smug meta-psychological fantasising. "Denial of violence", noted Jessica Benjamin (2018), "instigates the reliving of violence and it can seem that the deniers are actually the perpetrators" (p. 67). She further added that,

> *Failed witnessing generates envy; you feel envy when you are deprived of witnessing and left alone, you envy the other person who can escape into her seemingly intact world and not be present and feel with you, who doesn't have to bear that pain and shame … [It is] envy that he is on the other side of the barbed wire while she is in the death camp (p. 64)*

My time at Bayfield was a death camp experience in which their treatment negated the deepest truths of my being. I was caged inside denial and shame and iatrogenic madness. My escape only began when, years later, I found a therapist who could bear what I had lived through and whose sustained care led to the redemption of truth and of my life. In sharing this narrative of descent and emergence from the trauma of toxic psychotherapeutic care I offer witness and testimony that others with similar fates may not feel so alone or so tormented. By speaking the truth, I am not collaborating with the lie. And in speaking the unspeakable I can extinguish the black flame.

In the new psychotherapy I gradually absorbed being acknowledged and validated. My new psychotherapist helped me to understand, from the perspective of the present psychotherapy relationship, previous experiences that I had believed were the truth of psychotherapy. Knowing about the abuse by my first therapist and the misguided treatment at Bayfield, my therapist committed to our work understanding the complexity that this would present. She did not see me as filled with pathology but as someone who had experienced complex trauma, and she understood the complications of my having been both sexually abused by a previous therapist and clinically mistreated at the hospital. She had the ability and compassion to work through the transference that would surely emerge under those circumstances (Freud, 1914/2006). With commitment and deep respect, she helped me find the words for my traumas that had eluded me all those years. In the wake of my terror of my own personal psychotherapy that resulted from both my initial psychotherapy and the psychotherapy at Bayfield, it truly feels like a miracle that I feel grounded and sane and have life as it is now.

In October 2017, I wrote to both the Medical Director and to the Board of Trustees of Bayfield Hospital. I described what had happened to me while hospitalised. I did so with some hope that they would now acknowledge the truth of my experience or at least offer some apology. Their response was a brief letter. In it they stated that, because my experience occurred so long ago, they could not speak to it. Their failure to acknowledge is consistent with their original crime against my psychic reality. But now I know the truth. The truth of what happened is sustenance for my being. I presently live more in the now than ever. What is important to me is that now I can clearly and confidently name what was for what it is.

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