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SPECIAL ISSUE PRACTICE PAPER: CO-PRODUCTION IN ART THERAPY PRACTICE, RESEARCH AND PUBLICATION

Dual perspectives on art therapy and EMDR for the treatment of complex childhood trauma

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ABSTRACT

Background: This article explores art therapy and EMDR for the treatment of complex PTSD caused by childhood sexual abuse, from the point of view of both client and therapist. It was co-written with a former client who wishes to remain anonymous.

Context: The therapeutic work took place in an NHS community setting. The idea of writing together – emerged organically as therapy came to an end, with both client and therapist feeling they have learnt from the process and that sharing these ideas could be beneficial for other practitioners.

Approach: While psychodynamically informed, much of the intervention followed the main principles of a trauma-focused approach with an emphasis on embodied processes – both in art therapy and EMDR.

Outcomes: The client made a great deal of progress during therapy and both writers explore the changes and insights that were gained as part of the article, with a particular emphasis on using interoceptive skills to enhance emotional processing.

Conclusions: When working with clients who have complex PTSD it is important to be aware of trauma-informed approaches and the role of grounding, stabilisation, embodied experiences and trauma processing. At times, this might be essential in order to help clients manage high levels of emotional arousal in the room, learn to contain their distress and improve their symptoms.

Implications for Research: More research is required to establish ways in which trauma-informed thinking can be incorporated into art therapy, the link between visual and emotional processing, and whether art therapy can improve interoceptive ability.

Plain-language summary

This article contains the summary of three years of art therapy and Eye Movement Desensitisation and Reprocessing (EMDR). It was co-written with 'Rob' (pseudonym), a male client in his mid-thirties who has a history of childhood sexual abuse and who wishes to remain anonymous. In the paper, Rob provides his account of the intervention while I explain my process as a therapist. I had limited experience of complex trauma work before I met him, and in many ways the journey was transformative for both of us.

In my writing, I briefly outline the theoretical basis of my thoughts and choices within our art therapy sessions. I reflect on the way my practice has expanded and changed, in order to incorporate an understanding of the way trauma affects the body and how we can work with the body in art therapy. As an EMDR therapist, I often combine EMDR and art therapy with clients who have complex trauma and believe that these two approaches can complement each other.

Therapy with Rob was often difficult to contain and there were times where his risk – of self-harm, substance misuse and suicidal urges – had to be carefully considered and managed. The principles of trauma-informed interventions were crucial for our work together. This includes explaining the current research about trauma to the client, so that the client understands his/her experiences better. It also involves helping clients to feel as calm and safe in the room and in their own bodies as possible, and maintaining an emphasis on body sensations in the here-and-now.

The article considers the idea of 'interoceptive imagery' as a way of working with the body in art therapy with traumatised clients. Some of Rob's images are explored and a link is provided for a video we co-produced, where he discusses more of his journey and his artwork.

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EMDR; PTSD; abuse; complex trauma; interoception; embodied; CSA

Introduction

This article is the culmination of three years of art therapy and EMDR – Eye Movement Desensitisation and Reprocessing – with 'Rob' (pseudonym), a male client in his mid-thirties who experienced childhood sexual abuse. It seems important to acknowledge and think together about his journey and the ways we might be able to use the material to enrich our understanding and practice in this field of art therapy. Due to publishing ethics, authors are not able to publish under a pseudonym with authorship details kept confidential. It was therefore not possible for 'Rob', who wishes to remain anonymous, to be fully credited as co-author of this paper in the official title. However, it was very much jointly written and our contribution is equal. I would like to take this opportunity to credit Rob as my co-author and to thank him for undertaking this journey together.

Rob was enthusiastic about writing this piece and has also made an AIR video (audio-image recording) about his images and experience of therapy. Although I will be discussing my perspective and providing some theoretical context in the second part of the article, I believe it is best to start with

*Rob is the co-author of this paper. He has chosen to use a pseudonym in order to protect his confidentiality.

Rob's words, as he shares his journey and his insights with powerful clarity.

Rob's account: my time with Art Psychotherapy and EMDR treatment

'This is amazing! I can't wait to get involved and play in here!' is from what I remember the first thing I said as I walked into a room that is wrapped in a whole galaxy of bold colours from the art materials surrounding a large table with big windows that looks out onto an emerald green lawn flanked by old, bold oak trees. The room I had been accompanied into by my Art Psychotherapist Nili was to become the playground I was going to tell my only trusted friend in the whole world about the horrors that went on behind closed doors. It was the playground I was going to try and find, then perhaps love, my child self that I had discarded, hated and did my best to forget for 25 five years.

My journey to this NHS playground was 20 odd years of, frankly, a shit show.

The first memory I have in this world was being sexually abused which continued on and off until I was about ten or eleven, with that came nightmares, interruptions to my thoughts, triggers from people or certain smells, even vertical blinds would set me off!

It's miserable that even vertical blinds would give me flashbacks of sweaty, hairy, blubbery flesh rubbing into each other, tobacco-stained teeth with equally yellowing fingernails going in and out, up and down, clammy heat, textures, smells and wetness of sex.

When I say sex it wasn't sex that I had discovered in my adult life – it was confusing, disgusting, nasty, and deeply sad. This is just the tip of a very miserable iceberg and because even seeing stupid vertical blinds would make me think of my abuse let alone meeting a man or woman that may look similar, smell similar, speak similar it would send my thoughts back to those torments. I would hear but not listen, see but not understand, always behind, never feeling a part of something, always feeling alone in the world.

From that I would not be able to sleep properly, I felt disconnected from people and had to create a version of myself I thought people would like but I wouldn't look after myself – I wouldn't wash, brush my teeth, a lot of the time I would just lay in bed.

Discovering drugs for me was like when Harry met Sally and I scoffed my way through the market of illegal narcotics like I was late for an important meeting with a lot of other successful substances. My illicit remedies of choice was either my old mate Ketamine which was fantastic because it removed my mind from my body, scrambling my thoughts. A very important tool if you need to basically kick your consciousness into the long grass and not think about things too clearly. I was an addict to K for at least five years, I really liked the way it would allow me to run on auto-pilot and not have to be with my dark inner self much. Another choice would be opiates like Methadone or Morphine which does another wonderful thing for me but in a totally different way in that I'm so mellow I don't really give a shit about what happened, all the triggers happen it's just that I mentally just shrug my shoulders and move on with my day.

Benzodiazepines, Alcohol and MDMA are also very useful but for me Ketamine, Methadone and Diazepam are the drugs that helped the most because they jam that signal of the abuse. I have tried SSRI's and frankly they do nothing other than make me feel a bit strange, they do not help at all with the ugly reality of complex PTSD, at least not for me.

Years and years would layer upon each other and it just felt like no matter what I would do the symptoms of my trauma would not go away or at least ease no matter how much I tried with over working, binge drinking, sex, drug use, over eating – almost any bad habit and some good I tried to get my mind away from the memories. What was left to try? Perhaps knitting? Stone skimming? Scientology? And since I've already done one of the two things I would never, ever want to do (Morris dancing and incest) I decided to try something much more inviting. Self-harm and the serious contemplation of suicide.

The self-harm part of this had been going on for years anyway, I had cut my arms since I was young and since then I've sliced, burnt, smashed and even electrocuted myself, so it seemed that the natural next step was one of the things that ironically saved me – the idea of suicide.

I had just had enough of the never ending nasty feelings that were overwhelming, within a constant spiral of crap, where everyone got along but me, neither good or bad whatever I did resulted in everything going wrong somehow. I hated feeling stuck and I hated myself.

So with all that chaotic, infuriating torment corroding away at me, which I really whipped up with some vodka and just being desperately unhappy, I found myself at about three in the morning at the edge of a wet, dark bridge overlooking the motorway.

Just as my hands touched the slippy, wet metal railings to pull myself over all I could think of at that moment was the profound love I had for my daughter and that I couldn't and wouldn't let her be another victim of all of this. So with that I stepped away from the side of the bridge, walked back home soaked through and although I felt like I couldn't even kill myself properly, something else happened to me – I had got to a point where I had to ask for help. The next day, I booked an appointment to see my doctor.

After an intense but very important appointment with my Doctor a plan was forming, it felt good – in fact it felt fantastic! It was the first time in my entire life I had decided to actually approach the traumatic effects of my abuse in a positive way and trusted other people to be involved, but how on earth I am going to do it? I could tell that this was going to be really very hard, would it even be possible? I wasn't sure but at least there was traction and that's immeasurably better than the edge of a motorway bridge. I started with hour long per week appointments with a lovely therapist that went on for over six months but in that time I wasn't even able to talk fully about the abuse or who did it to me – it wasn't my therapist's fault, but it was not working. I was diagnosed with Complex PTSD from the years of sexual and mental abuse, and another thing we find out together is that as a child the way I managed to cope with what was happening to me was art.

I copied comic books and got so absorbed in the storylines and bold style of British Comics, Japanese Manga and American Graffiti that I would lose myself in the pages of beautifully created graphic novels and imported magazines. Because of this it was decided that Art Psychotherapy could be a better form of therapy than the traditional talking style. I didn't even know creative therapies existed let alone art therapy, I was so enthusiastic with the idea of it and

again another positive movement with my stars aligning I managed to get a place at the art therapy department – a large, beautiful early nineteenth-century house with equally beautiful gardens that is run by the NHS – I was to see Art Psychotherapist Nili once a week and it was as I entered for my first session, the moment that I had found my playground and my future 'bestie' or confidant with Nili, I just needed the courage to be able to talk about what had happened to me and how it affects my life. That process began with a drawing.

Therapy included art, talking, EMDR, safe place exercises, even breathing and play to study my mental geology that lasted three years. It took a long time for a clear, strong bridge of trust and security to be built between myself and Nili – It was very difficult for me to be able to let go of so much conditioning and pain, I still feel that perhaps it might take me a long time to fully break down some of the walls I have built although writing this is another step for me within the healing process. The main work was a lot of drawing and a lot of talking, not just talking but understanding, sometimes it felt like two people speaking different languages making huge efforts to try and come to an understanding of my hardships, how my life has been forever altered, how hard it is to be understood and through all those drawings, paintings, conversations and tears we did it.

By year two the trust was very strong between us both, there were some breakthroughs during this period of time that I never thought I would ever be able to tell anyone, even a Therapist – Nili was more than a Therapist, she became someone I trusted. Most of the subjects I spoke about with Nili will never be spoken about again, far too painful, far too dangerous for my own health both mental and physical, but through those very important sessions we arrived at the next cornerstone of the work – EMDR.

Eye movement desensitisation and reprocessing, or EMDR, felt for a long time for me like a waste of time, I even nicknamed it the '*MKULTRA Machine*' after the CIA mind control cold war project – a name that in reflection was kind of dumb and without much thought.

It also was a response to a change in our work and the name calling was an attempt to give expression to that inner feeling of moving from my comfort zone that had been built with our first stage of work together. It took quite a while for the EMDR to take effect, I started and ended with one of the most positive memories of childhood I had and in between the traumatic memories and imagery was pushed to an incrementally intense place as the sessions went on. It started to feel like not only was the positive memory folding in on the traumatic ones, but with the combination of talking and feeling where the mental pain links to a physical pain, we reached a much broader understanding of how these very dark and deeply cutting traumatic memories influenced me and my day to day life.

A note on trust

A factor of this process for me, which I have mentioned in the piece – however, I think it's crucial to mention here – is trust, and the trust between myself and Nili. It blows my mind to think I have written a piece like this and also remember a time where I did almost anything to move away from the realities of my past. The most I will mention here is that there was a disclosure within a disclosure; Nili will understand what I mean, although I won't go into any more details here or ever again with anyone other than myself. The point is that there was a bridge of trust built between us over time that, like all bridges, had to begin with the skeleton of it and more would be added until we could meet at the middle.

Importantly, this was the same bridge where I was able to meet that little boy who had been through so much, abandoned by even himself and with Nili we attempted to repair the deep and very complex fractures within me. I would imagine almost everyone that went through something similar to what I did understands the dark art of manipulation, it's a cliche but I was given a strict rule as a child – 'Don't tell anyone else about this, this is our secret' – a commitment I kept right up until Nili guided me to my child self. I was then finally able to embrace him and stop trying to throw him back into the darkness of drink, drugs and self-harm; it became possible for me and that little boy to find each other and look at the ugly realities of our past for what they were, and as a man with Nili's guidance to be able to make positive movements into a future of acceptance, strength and hope. Without trust, none of it would have been possible.

So what did I learn through my journey of Art Psychotherapy and EMDR?

That I was really hard on myself and that not absolutely everything that goes wrong in my life is all my fault. That taking a moment to allow myself to be more compassionate not just to others but to myself is really important, especially if I mess up because things can be really bloody hard … The days are still filled with serious challenges, the nights can still be hard to get through with the nightmares and if I make mistakes – it's okay.

Being creative, just like I did as a child, still helps me and always will do and having the courage to accept what happened and be able to communicate about it if needs be.

I'm trying to be a better person and manage my PTSD one day at a time. I've also found that joining a gym has helped and physical exercise – even though sometimes I don't want to do it – really breaks down those sharp edges.

My monster, My Babadook has been taken in and not told to leave because it is experience that sculpts the brain, my monsters are now part of myself and I am not going to scold, bash and try to remove or lock away my inner child any more because that little boy has had an entire lifetime of suffering so now I'm committed to being a survivor and with that I'm trying to love myself.

Thank you Nili and thank you to the NHS – you saved me.

> Wisdom. We do not receive wisdom, we must discover it within ourselves, after a journey through the wilderness which no one else can make for us, which no one can spare us. (Marcel Proust)
>
> (By an anonymous survivor of childhood mental and sexual abuse)

Nili's account: the shadow of trauma and the power of creativity

I had just started a new NHS post when a message was received by Rob's GP asking when he could be seen, as he'd been on the waiting list for quite a while. There was therefore a sense of urgency about the work before we

Figure 1. The room where the abuse happened. Soft pastels on A3 paper.

even started. This was reinforced in our first meeting, where Rob was both extremely enthusiastic about art therapy and the room (looking around the room with excitement and saying 'I can play here!') yet clearly very vulnerable, terrified and grappling with intense emotions he did not know how to express safely. He took to the materials immediately and the image he made in our first session was one of the abuse – a powerful and expressive depiction of his first memory: the eyes of his abusers looking at him in a dark room (Figure 1). I remember being drawn into the work and yet feeling anxious; I had done some work with survivors of childhood sexual abuse and was undertaking my EMDR training, but I never worked with someone where the traumatic material was so raw, so overwhelming, so unprocessed.

Rob had only recently started talking about what happened to him and said he had never thought he would disclose it, that he believed he would take it to his grave. Yet it took a huge toll and he was referred to therapy after a near suicide attempt. The urgency was real, and we needed to find a way to contain the distress. I tried to stay grounded and make sense of it with him. I experienced him both as a caged animal who could erupt with rage at any moment, and as a terrified child who was very vulnerable and who felt very small. Over time, we explored the way he also experienced himself in these ways. My countertransference reaction was wanting to protect him, yet I knew this work was going to be painful and that I would not be able to protect him from his own pain.

Theoretical considerations: the role of the body

While my art therapy training was non-directive, psychodynamic, and emphasised the importance of open exploration, I have found that working with traumatised clients can require different tools and an awareness of different approaches – in particular, embodied and trauma-focused approaches. As the purpose of this paper is to reflect on the experience of the therapeutic work, this is only a very brief overview; for an in-depth exploration of the theories and approaches mentioned in this section please see my book chapter, 'The Story of the Body' (Sigal, 2021).

Many specialist trauma-focused interventions follow a three-part model, based on Herman's (1992) three stages of recovery. The first stage involves stabilisation and establishing safety, in and out of the therapy space. Stage two is remembering, mourning and emotionally processing the trauma, while the third stage involves re-integrating the trauma into a new and more cohesive sense of self and reconnecting with relationships. According to this model, some initial work must be undertaken before commencing direct work with the trauma material, in order to enable clients to do so safely and without becoming overwhelmed or destabilised (Van der Kolk, 2014).

According to Craig (2015) and Damasio (2000), emotions arise as physical sensations in the body, before they emerge into conscious awareness. The awareness of one's own physiological state – of knowing what is happening inside our body – is called *interoception*. Interoception encompasses our ability, for example, to sense whether we are tense, hungry, tired, hot, cold, or if our heart is beating fast. It also makes us aware of the range of uncomfortable sensations related to difficult emotions, such as the chest constriction or abdominal discomfort often linked with anxiety. Interoception is crucial for self-awareness and for our ability to meet our own needs effectively; if we do not realise we are cold, we will not look for ways to increase our body's temperature and might become distressed. If we do not realise we are becoming anxious, we might not seek out support or engage with self-soothing before we become overwhelmed.

Interoceptive processes are increasingly seen as key to our understanding of emotions (Critchley & Garfinkel, 2017) and poor interoceptive ability has been linked with a variety of mental health difficulties (Sahib et al., 2018). We know that traumatised clients can have difficulties with the mind–body relationship – which would suggest higher likelihood of poor interoceptive ability, and therefore potential difficulties around becoming aware of, and meeting, their own needs. We also know that they often feel disconnected from their body, betrayed by it or even hostile towards it. Many traumatised clients use their bodies to evacuate, numb, redirect or act out unwanted feelings – through substance abuse, addiction, self-harm, over- or under-eating, impulsive behaviour, distorted body image, dissociation, self-neglect, somatic symptoms, and medically unexplained conditions (Van der Kolk, 2014).

Trauma is held in the body and the nervous system, in the form of 'body memories' (Rothschild, 2000); working with Rob showed me the importance of helping clients to be present with their intense, extreme, overwhelming sensations and physiological experiences. Thanks to Rob and to clients like Rob, embodied practices have become an increasingly central part of my work. Trauma psychoeducation was also something Rob seemed to find very useful, as it helped him to understand many of his physiological reactions when he was triggered. Again, this is something that has been

shown to be beneficial in trauma-focused therapy (Rothschild, 2000). Additionally, we used movement in the sessions when I would invite him to move freely and expressively in the space, which he said he found liberating.

Elbrecht (2013) explores, from a sensorimotor art therapy approach, the way body, mind and hands are connected through a variety of senses including the skin, kinaesthetic experiences, sense of balance, and sense of depth. Thinking in this way can be expanded to the whole body, and to the parts of the body where distress might be held. Talking about his drugs of choice (something Rob also addresses in his writing) was a useful way for us to understand what he was trying to self-medicate for: why this drug and not that drug? What experiences are being enhanced and what experiences are being numbed? What does the dysregulated brain seek in order to find temporary relief?

Art therapy can support clients to re-attune to their bodies in a safe way by paying attention to the physicality of the materials, and to sensations in the body in the here-and-now; there is a growing body of literature addressing ways a trauma-focused understanding can be used as part of art therapy practice (King, 2016). As mentioned later in this article, interoceptive imagery helped Rob to become aware of a deeply felt emotion which he said had always been there – but he was never able to truly *feel* it, as he was too busy trying to escape or avoid it.

With so much being experienced through sensations, it was important to work with the physicality of Rob's experiences. EMDR – which I sometimes use in conjunction with art therapy for clients who have PTSD – was a way to give Rob tools to access his embodied experiences in a safe and structured way. We used attachment-focused EMDR (Parnell, 2013), which has a strong focus on safety, resourcing and the creative imagination. Rob used guided visualisation to connect with safe, wise, protective, and nurturing figures which we brought into the trauma material to support and help his 'child self'. This increased his self-compassion and ability to see his inner child in a new light. Instilling this previously unfamiliar sense of safety (first in the room, and then when working through the trauma material) was one of the things Rob said he found especially helpful.

Therapist self-care and vicarious trauma

It is important to note that working with complex trauma can be deeply upsetting for the therapist. It can bring up feelings of anger, helplessness, fear and terror. Due to the very nature of trauma-focused work, we are accompanying our clients on a journey into the darkest, most difficult times of their lives. Good supervision and feeling held by an organisation (if the therapist is working in one), or joining a group of clinicians, can help to maintain balance and provide an outlet. This was the reason I set up the Complex Trauma, PTSD and Dissociation Special Interest Group for the British Association of Art Therapists (BAAT), for art therapists in this field to share practices and have a supportive forum where they feel a sense of belonging, as isolation can play a large part in traumatisation. Research on secondary trauma suggests that therapists are at risk of developing similar symptoms to their traumatised clients, namely hypervigilance and anxiety, re-experiencing of clients' trauma, insomnia and nightmares, hopelessness, emotional numbness, irritability, avoidance, and gaps in memory (Bride et al., 2004).

Becoming dysregulated or ungrounded as therapists can have damaging implications for our clients; an analysis of fitness-to-practice cases involving harm caused by art therapists (Springham & Huet, 2020) suggests that failure of the therapist's capacity for self-reflection can result in damaging and abusive behaviour towards clients, especially in the context of art therapists seeking to meet their own needs through the therapeutic relationship. While it was only a small minority of art therapists who faced such proceedings, it nevertheless demonstrates the importance of staying aware of changes to our physiological and emotional responses and remaining grounded and reflective. Alongside supervision and professional considerations, I would recommend that therapists working with trauma utilise the same strategies we so often recommend to our clients: using art-making and creativity, developing a physical practice, engaging with activities which are soothing and enjoyable, and seeking support and connection with others.

The therapeutic process

The first challenge was getting Rob to slow down. He arrived at sessions in the way I would imagine someone might turn up to a parachute jump without being quite sure the parachute worked; anxious and somewhat agitated, as though he had to do it all immediately. After a few sessions he began to miss appointments and it became clear that the pace of the work was too overwhelming – as though he believed he had to dive straight into the trauma material, or perhaps he thought it was what I expected. I had a sense that he was re-traumatising himself by doing this, so we began to slow things down by working with the first stage of trauma-focused therapy: establishing safety. I reassured Rob and reminded him that we had time, that he did not have to spend all of our sessions immersed in the trauma material, and that we could gradually work towards it. He made artwork about the abuse before we developed a therapeutic relationship of trust, in that first session and during the first part of our work together. It was difficult to find a way to engage with the grounding and stabilisation work so important for trauma-focused therapy, when there seemed to be such a strong need in him to express it in an urgent and immediate way.

His life was very chaotic at the time and there were issues around accommodation, finances, self-harm and substance use which we also needed to attend to, some of which seemed to be a direct response to the therapy. We continued to move between the here-and-now and the there-and-then over the next year or so, during which time trust grew and Rob was able to share more about what had happened to him without becoming so overwhelmed.

Because of the coping mechanisms he had built to protect himself, details of his childhood were expressed in chunks; in non-linear, incomplete ways. Sharing this would at times make him extremely agitated and at times led to self-harm or impulsive behaviours between sessions, but he was always clear that he wanted to address this time of his life and that it was important. It was only towards the end of our work together that he was able to put together the entire narrative of the horrific things that had happened to him, to make sense of the way he dealt with them and the way they affected him. This included his complex relationship with the perpetrators, who were major attachment figures

(please note: for the purpose of this paper Rob chose not to disclose more about this relationship, however, this was an important part of the therapeutic work).

During the three years we worked together Rob suffered devastating losses as well as the joy of a new child, struggled with opiate addiction, and agreed (for the first time in his life) to accept support from addiction services and the community mental health team. He missed some of our sessions but he never disengaged. I had a sense that I needed to stay constant and not discharge him, although there were times when this nearly happened. We worked flexibly to help him stay engaged through the pain, fear and anger. Sometimes we would have phone sessions when he was too distressed to come in, although the boundaries were clear and this was important. Luckily it was a long term intervention – this seemed to enable Rob to work through, and learn to tolerate, his own ambivalence about the therapeutic process.

Rob was aware he was carrying a great deal of guilt and shame and that he had a tendency to blame himself for everything that happened to him, including things he knew were not his fault (a coping mechanism he developed in childhood, in order to avoid blaming the perpetrators). This was reflected in his transference to me, where he was often apologetic or self-critical, and seemed to expect punishment from me, believing that I was angry with him or that he was failing me somehow. It was hard for him to believe that this was not the case. We explored the reasons behind this, looking at the beliefs he had internalised about himself and others and the way his actions sustained these beliefs. I could tell that Rob was able to be more assertive and less frightened in the room when he jokingly started saying 'oh shut up Nili!' if I brought up something that was difficult or that seemed to 'hit a nerve' for him. This playful challenging of my perceived authority in the sessions was a sign that he was becoming more confident and felt more able to be fully himself. Humour and laughter were a helpful way to bring playfulness and joy into the therapeutic journey.

Imagery, video and the use of metaphors

Rob had a background in, and a passion for, art. His creative process was visceral with a great deal of movement and expression, which was palpable while he worked. As already mentioned, his art therapy journey began with imagery about his abuse; another early drawing (Figure 2) depicts the abusers as two monstrous creatures with one wrapped around the other like a snake. The eyes are blacked out, and Rob depicted himself as both the faceless person at the bottom of the image and the puppet on a string. This drawing, he realised, was similar to a poster for a horror film called 'The Babadook', which he said was meaningful for him (the poster can be viewed here: https://bit.ly/3rmjHDB). The Babadook storyline, about a woman who seeks to ignore and deny her grief, only for it to haunt her as a monster until she finds ways to process and manage it, became an important reference point in our work together. The idea of learning to tame or live alongside the shadow – and even to learn to look after it, rather than seek to control or destroy it – became instrumental in Rob's understanding of his feelings about his abuse.

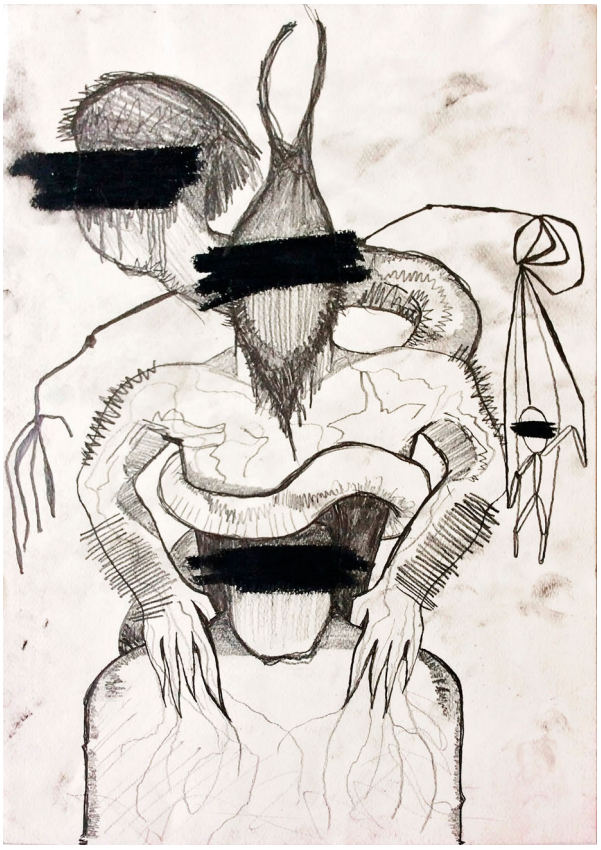

Figure 2. The snake and the puppet. Pencils and graphite sticks on A3 paper.

As therapy progressed, Rob's images became more varied and the characters he depicted became more human and closer to real life, as well as more embodied. Figure 3 expressed his feeling that his mind has 'exploded', yet despite showing a great deal of distress it included some clear features of an outline of a person, not a puppet. A later drawing about the abuse (Figure 4) no longer portrayed the perpetrators as monsters; instead, it showed some aspects of their body parts and physical presence which Rob found the most disturbing: the hand, eyes, chest and stomach. One of Rob's final images (Figure 5) depicted him as a whole person with a less fragmented sense of his own body, showing a clear connection between body and mind (including movement, and the brain being connected to the body) with a sense of integration.

Figure 6 is an interoceptive image which was especially significant in our therapeutic work: Rob painted it while working with EMDR, to express the feelings and body sensations associated with his trauma. He said he often felt overwhelmed by these sensations and described them as 'a moving ball of blood and shit' inside him, most strongly felt in his abdominal area. He named this painting 'the shit pumpkin' and said that expressing it visually allowed him to truly understand and feel these sensations and emotions. While there is only scope to include a few of Rob's powerful art therapy images in this paper, more of them can be seen in a 13 min AIR video where he discusses his experience of art therapy and EMDR. It is available at: https://www.youtube.com/watch?v=PxIb0jWcrMg

We started using EMDR after the first year of therapy. This was the time when Rob began to move away from imagery of monstrous perpetrators and the language of 'killing off' his traumatised part, towards a stance of increased self-

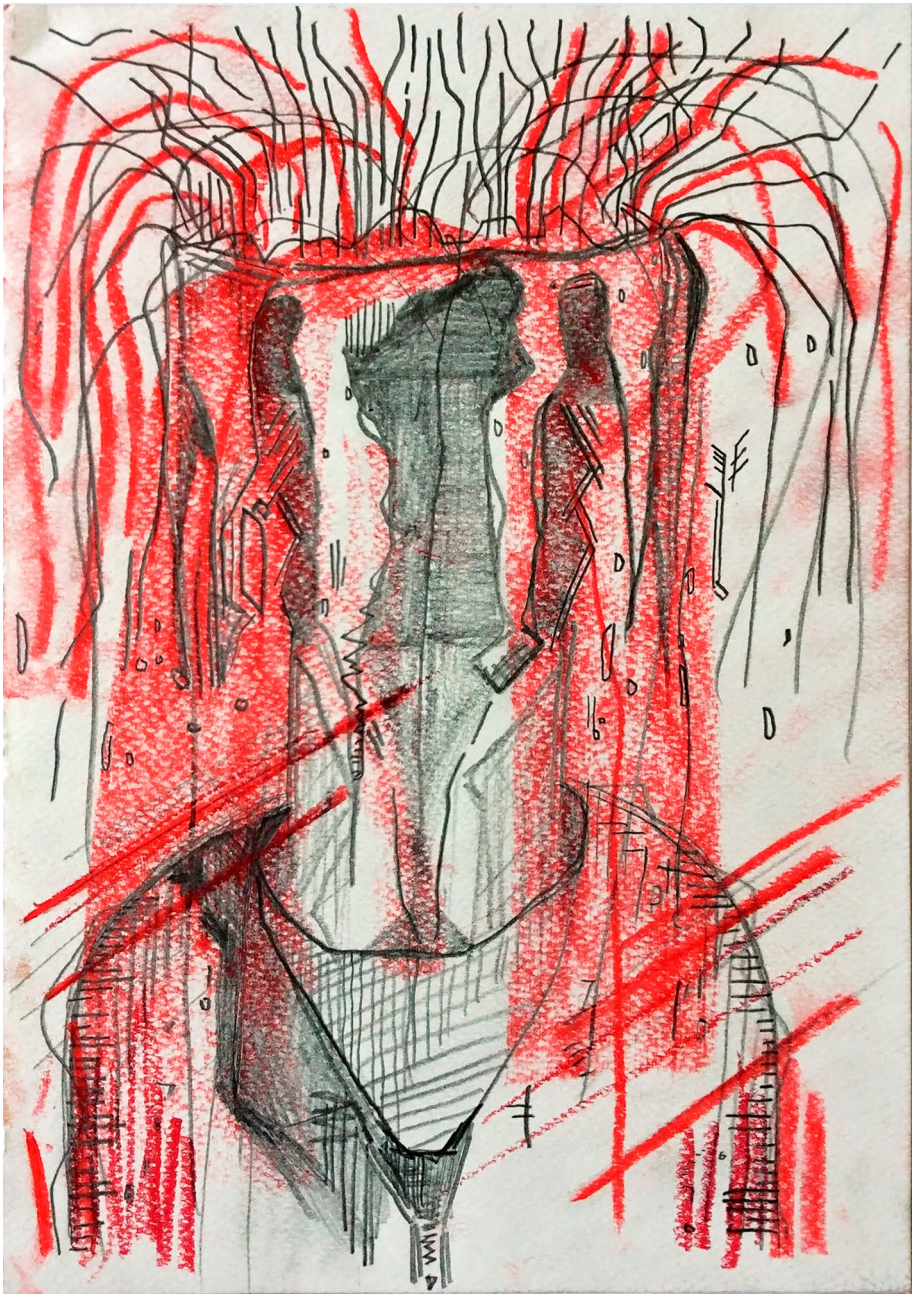

Figure 3. Exploding head. Pencils and oil pastels on A3 paper.

compassion. This was perhaps the most important change in his understanding of what happened to him, as his need to fragment, dissociate and 'split off' from his pain shifted towards increased acceptance, and therefore integration. He shared a realisation that wanting to destroy 'it' had led to him wanting to destroy himself and said, 'it wasn't just them. I was also seeing myself as a monster … ' This is sadly so often the price of the fragmentation and dissociation emerging from the reality of abuse and the survivor's feelings about the abuse. Towards the end of our work together, Rob said he was learning to take his child self to the beach, where he could play. He has been trying to stop punishing that little boy, to learn to love him and to see that he is lovable. He has also been taking his 'shit pumpkin' to the gym, where the anger and the powerful feelings could be expressed in non-destructive ways, channelling the energy into something constructive instead.

Telling me about the abuse was a very important first step, but I knew a deeper change was happening when Rob found a way to tell others, including his partner and keyworker, and was then keen to make the video and to engage with this co-writing process. It was no longer a shameful secret Rob had to keep hidden at all costs. Instead, it became something – one of many things – that made him the creative, kind, caring person he is today and an experience, however horrific, that could be shared, learned from, integrated and understood.

The process of co-production

Nili: After our final session and completing the AIR video, Rob told me he still felt he needed to process our work together; I suggested he could try to do this by writing about his experience in therapy. When he sent me his writing, mostly as it appears in this publication (with more swear words, which we were advised to edit out!) I felt that it was a powerful and important piece of work and asked if he would consider sharing it with others – and if so, whether he would like to keep it as it was, or if he would prefer to collaborate. Rob

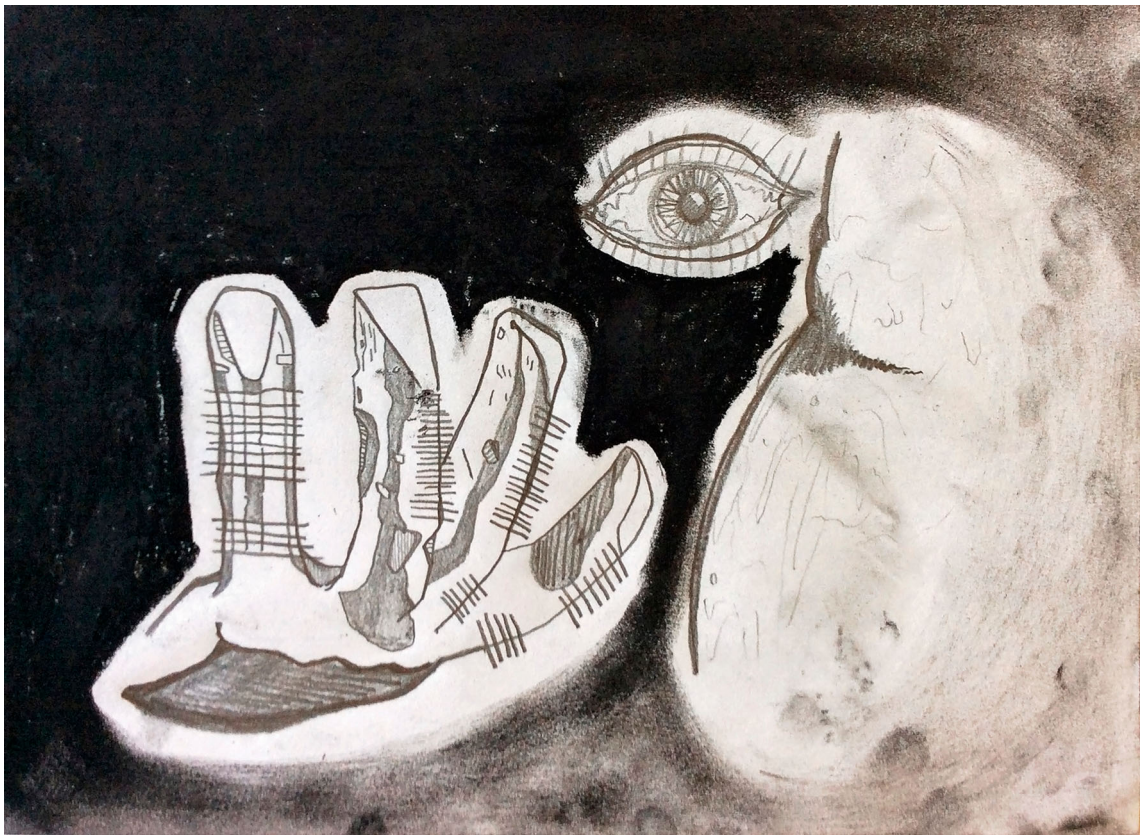

Figure 4. Body parts. Pencils and charcoal on A3 paper.

said he was keen to do anything that might help others and he was also curious about my experience and reflections on working with him. Since then, he said that writing this article gave him the confidence to write more.

While I am aware of the potential ethical implications of co-production, I felt it was an organic process which happened after therapy had ended and which was part of Rob's journey of recovery – as much as it was part of my

Figure 5. Becoming real. Pencils and oil pastels on A3 paper.

Figure 6. 'The Shit Pumpkin'. Acrylic paint on A2 paper.

journey of learning and growth as a therapist. I cannot think of a better way to include clients in the research and development of the interventions that are meant to be tailored for their benefit. In fact, when we met with *IJAT*'s guest editors for this special issue on co-production, both Rob and I were surprised to learn that co-writing in this way is not common practice. I believe that excluding the service user's voice stops us from having a fuller view of why, how, and whether what we do is helpful. On a personal note, having grown up in Israel – where a nationally promoted single narrative leads to an entrenched viewpoint and an inability to see the position or understand the experiences of the 'other' – I have concerns about the 'othering' of people in the mental health system. If this is the story of two people in a room trying to make sense of the unfathomable, then both of their voices should be heard.

Rob: At first the suggestion from Nili to write about my experience within therapy felt like a puzzle; I wasn't quite sure how I would do it. Would I frame it as a list of some sort, perhaps like a timeline? After some thought I decided to just write creatively and allow myself to not be restricted in any way, hence the colourful language of the first draft. I really enjoyed my part of this co-production as a creative process. Unlike painting or drawing, the only material available is language – most of the artwork I made with Nili was abstract and we would interpret the work together. I found writing to be much more focused and it was a refreshing way of exploring my 'mental geology', as I put it in the piece. The process was extremely fast, and I realised that for me, in this form, it became an extension of the art therapy and a joyful coda as opposed to some kind of stiff record of events.

Like Nili, I was very surprised that co-production is a rare practice. It seems to me that there are many positive and progressive outcomes that are available to both parties with a co-production piece like this. With the amount of trust built between us it felt to me like a natural conclusion, a way of dovetailing our experiences of those difficult and very emotional sessions and increasing the level of therapy in a massive way. I learnt more about Nili's process and with that I understand better how we got to the places we did and it reinforces Nili's guidance – it has been an interesting and creative way of learning even more that ultimately helps me be able to interact with my trauma on a daily basis.

Conclusion and implications for research

Nili: In this paper, Rob and I shared our experiences of art therapy and EMDR. Rob openly and courageously described his therapeutic journey, feelings and insights. I sought to share my practice, guiding theoretic principles and the choices I made in our work together. I hope this has helped to demonstrate the importance of trauma-informed, embodied work with clients who have developmental trauma and complex PTSD. Future research could consider the use of image-making to express body sensations (e.g. interoceptive imagery) in trauma-focused art therapy.

Rob: Personally, I don't think I can comment on any implications for research – I can only give my side of this process for observation by professionals in the field. However, my overall conclusion of the process of co-production is that it's been a positive thing; I learnt much more about how Nili helped and guided me through the therapy, something that just would not have been possible with the time and resources available to us other than through this co-production. I think the best example of this is Nili's focus on body sensations, through which we discovered a concentrated knot of stress that I was able to represent through art and then begin to try and relax and heal this hot ball of tension in the pit of my stomach, most of which has been done out of the sessions. Understanding that it is called 'interoceptive imagery' has helped me research the topic more and understand better how experiencing one's own body is incredibly important. I would self-harm, which was a physical process to attempt to change a mental interference – so not only is it important to try and understand trauma mentally, but also to try and understand how trauma interacts with us physically. It has definitely helped me be able to make improved choices on how I move forward in my life with my trauma and what I do when I have bad days.

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No potential conflict of interest was reported by the authors.

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Nili Sigal is an art psychotherapist, supervisor, accredited EMDR therapist and the founder (and previous coordinator) of the Complex Trauma, PTSD and Dissociation BAAT Special Interest Group. Nili has a background in fine art and psychology, and an ongoing fascination in the way creative expression reflects internal processes. Originally from Israel, Nili lived and worked in London for many years with a variety of marginalised communities and hard-to-reach client groups. Her experience includes working in forensic settings, community organisations, acute inpatient wards and crisis services. She ran a blog for the London Art Therapy Centre, wrote several articles for BAAT Newsbriefing, and published book chapters about art therapy in private practice and embodied processes in trauma-focused art therapy. Nili is currently based in Devon, where she works for the NHS in a community setting. She specialises in working with adults who have complex trauma.

Rob is the co-author of this paper. He has chosen not to share further biographic details beyond what we have written, in order to protect his confidentiality.

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