

2017

Trauma Recovery: A Heroic Journey

Brenda Keck

Regent University, Brenkec@regent.edu

Lisa Compton

Regent University, lisacom@regent.edu

Corie Schoeneberg

Regent University, corisch@regent.edu

Tucker Compton

Trinity Episcopal School, tuckercompton@gmail.com

Follow this and additional works at: <https://scholarship.richmond.edu/heroism-science>



Part of the [Psychiatry and Psychology Commons](#), and the [Public Health Commons](#)

Recommended Citation

Keck, Brenda; Compton, Lisa; Schoeneberg, Corie; and Compton, Tucker (2017) "Trauma Recovery: A Heroic Journey," *Heroism Science*: Vol. 2 : Iss. 1 , Article 5.

DOI: 10.26736/hs.2017.01.05

Available at: <https://scholarship.richmond.edu/heroism-science/vol2/iss1/5>

This Article is brought to you for free and open access by UR Scholarship Repository. It has been accepted for inclusion in Heroism Science by an authorized editor of UR Scholarship Repository. For more information, please contact scholarshipprepository@richmond.edu.

Heroism Science, Vol. 2, No. 1, 2017

Trauma Recovery: A Heroic Journey

Brenda Keck

Regent University

Lisa Compton¹

Regent University

Corie Schoeneberg

Regent University

Tucker Compton

Trinity Episcopal School

ABSTRACT: Trauma survivors who choose to enter into trauma recovery may be viewed as individuals embarking on a hero's journey. Historically, many of the coping strategies utilized by individuals who are experiencing post-traumatic stress have been viewed as inherently disordered and personally dysfunctional. An alternative perspective of these behaviors calls for an examination of strengths present within trauma survivors, suggesting a reframe of their symptomology as ingenuity in coping during adverse circumstances and an appreciation for the difficulty of living with traumatic memories. This article highlights the challenging process of trauma recovery as it parallels Campbell's (1949) metaphor of the hero's journey and its stages of departure, initiation, and return. The historical conceptual framework for understanding psychosocial and lingering impacts of trauma is reviewed, an alternative strengths-based perspective in the examination of trauma symptoms is proposed, and potential positive outcomes of post-traumatic growth are discussed. Finally, a trauma survivor's personal story of her hero's journey towards post-traumatic growth is presented.

KEYWORDS: trauma, hero, PTSD, post-traumatic growth, trauma symptoms

¹ lisacom@regent.edu

Imagine a man unwilling to leave a burning building. From one perspective, his choice to linger near danger appears foolish, reckless, and nonsensical. However, if we consider his actions in the context of a self-sacrificing purpose to save a trapped child, our view of him is transformed. Ultimately, our perspective of a person as either a hero or a fool rests on what we understand about the context and the conditions of his or her decisions and behavior.

How, then, are heroic behaviors distinguished from irrational behaviors? How do we define heroism? Heroic action shows a willingness to take on physical or social risks that go well beyond what is expected (Beggan, 2016). In their extraordinary capacity to face and survive seemingly insurmountable circumstances, heroes transcend considerable fear to enter a challenging and precarious situation, despite clear obstacles to engagement and without obvious paths of escape (Franco, Blau, & Zimbardo, 2011).

The Hero's Journey

In his iconic book, *The Hero with a Thousand Faces*, Joseph Campbell (1949) expands the concept of heroism beyond the idea of a single brave action. He lays out a clear, recognizable path to heroism drawn from universal components, distilled from the myths of cultures across the world. In what he calls “the hero’s journey,” or the monomyth, Campbell (1949) describes a process which begins when an ordinary person is called away from a safe, familiar world to a journey on an unknown and dangerous path. Upon stepping across the threshold into the adventure, the traveler is faced with a series of trials, tests, ordeals, and victories through which he is ultimately transformed into a different kind of person – a heroic person. In the final stage of the journey, the hero returns to the world from which he began – changed from ordinary to heroic (Campbell, 1949).

Defined by three stages, the traveler experiences one developmental and transformative milestone after another, each requiring a new level of strength and courage (Campbell, 1949). Despite its fictitious nature, the metaphor of the hero’s journey provides applicable and relevant insight into the personal metamorphosis that occurs within individuals facing adversity and trials. A closer look at the hero’s journey reveals a framework from which we can consider the path of recovery for trauma survivors.

Stage One, *The Departure*, begins with some life circumstance that serves as a “call to adventure” that will require courage to accept. It is not uncommon for the traveler to initially refuse the call due to a fear of potential dangers. The encouragement or inspiration of a “mentor” provides “supernatural aid” in the form of resources and guidance, which is often the impetus needed for the would-be hero to find the courage to leave behind all that is familiar and embark on an unknown journey (Campbell, 1949, p. 49-90).

Stage Two, *Initiation*, is characterized by a series of trials, tests, ordeals, and victories. As the individual wrestles with each new challenge, she learns to rely on new allies and develops personal abilities. Each obstacle serves to strengthen and transform the traveler. This stage is often characterized by a final challenge that feels like a death from which the traveler emerges “reborn” as a hero with enhanced strength, wisdom, and knowledge.

In Stage Three, *Return*, the transformed hero is beckoned to re-enter the ordinary world with gifts of enhanced wisdom and knowledge bought through her experiences. Perhaps reluctant

at first, the hero is summoned from the extraordinary journey back to the life of the ordinary. This return often involves another life and death moment for the hero. Once achieved, she is now the “master of two worlds” (Campbell, 1949, pp. 229-237) as she passes the threshold back to her community.

Campbell (1949) describes the transformed hero’s increased wisdom, strength, inspiration or other resources as elixir which can be used to bring restoration to the world. The hero has come full circle and now serves as an aid to others as they begin their journey. Her personal journeys become an offering of inspiration and hope in the service of others.

Backdrop to a Journey of Trauma Recovery

Survivors of traumatic events are unexpectedly thrust into a storyline they did not choose nor are they offered the option to decline. A journey that begins in the shadows of military combat, large scale natural disasters or chronic childhood victimization can leave individuals carrying deep physical and emotional burdens. Trauma jolts an individual’s understanding of safety and his/her ability to cope with the overwhelming threat and danger within the environment, creating ripple effects of disruptions in physical, emotional, and cognitive functioning processes (Parnell, 2007). For example, after a traumatic event, an individual may experience repeated intrusive thoughts as a form of trauma processing (Briere & Scott, 2015). What began as an external threat begins to feel like an internal enemy as survivors attempt to hang onto tenuous control of their thought processes, emotions, and autonomic nervous system.

In efforts to manage the pain and fear of overwhelming tragic events, the individual’s central nervous system sometimes relies upon strategies, referred to as *peritraumatic dissociation*, including emotional numbing, derealization, and dissociative amnesia for survival (Thompson-Hollands, Jun, & Sloan, 2017). While these mechanisms can be valuable resources for distancing survivors from immobilizing pain and allowing them to continue with life in the aftermath of a traumatic event, over time, these very coping strategies may begin to significantly interfere with their ability to function in intimate relationships, work, and other areas of life. The symptoms are categorized by the label in the mental health world of “disordered” and may meet the criteria for Post-Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 2013, p. 279). However, some mental health professionals, military personnel, and survivors of trauma advocate for changing the conceptualization of PTSD from disorder to injury (PTSI) to reflect the responsive nature of the trauma reaction as opposed to a pathological occurrence (Fisher 2017; Ochberg, 2013). In this article, we propose that many of the “symptoms” identified in current trauma diagnoses could be viewed as evidence of adaptive responses in the face of overwhelming danger, and that the recovery process to work through these traumatic injuries is a heroic journey involving both risk and reward.

Campbell’s hero’s journey has been used as a powerful metaphor and descriptor of the recovery path for survivors of trauma (Bray, 2017; Digati, 2015; Dybicz, 2012; Williams, 2017). From the initial decision to pursue recovery and throughout the process, Campbell’s stages can be viewed as a rite of passage for the trauma survivor to move from injured to transformed. According to Allison (2016), “Rites of passage play a central role in preparing people to become emotionally, spiritually, and behaviorally ready for a heroic life” (p. 3). Moving through the painful passage of trauma recovery may lead to improved functioning, psychological growth, and a deeper level of self-awareness (Bray, 2017). Williams (2017) utilizes Campbell’s metaphor in a

story-based counseling approach to help clients navigate the counseling process, which itself can be emotionally treacherous. The trials of counseling include exposure to the trauma memories and “require the Hero to confront unfamiliar scenarios and engage in previously avoided behaviors, while managing high levels of anxiety” (Williams, 2017, p. 3). Although recovery work can be harrowing, such exposure techniques have demonstrated efficacy in symptom reduction, and the alternative, remaining stuck in avoidant behaviors, poses its own risk to health (Foa & Kozak, 1986).

The Departure

At the point when a survivor begins to recognize the high cost of continuing to rely on avoidant coping strategies and considers whether to transcend substantial fear to enter the difficult, dangerous or turbulent path of recovery, he hears the whisper towards the hero’s call to adventure (Franco, Blau, & Zimbardo, 2011). Consistent with Campbell’s (1949) theory of the monomyth, the decision to turn toward the unknown path requires facing fears that cause some to refuse the invitation. Trauma survivors are challenged to either continue to protect themselves from terrifying memories through potentially destructive coping strategies, or turn and walk back into the pain in pursuit of healing for the sake of themselves and others. Their dilemma is captured by Lawson (2005) who states, “Those who refuse the call, continue to live their lives cast in the role of the victim.” A counselor, spiritual guide or another survivor who has returned from their own journey may be a pivotal mentor at this juncture to give the would-be hero resources, advice or inspiration to step across the threshold into the unknown (Williams, 2017).

Initiation

With the decision to intentionally walk back into the experience of horrific memories through a therapeutic counseling process that confronts the shame, fear, and pain that grip many aspects of life, the survivor crosses the threshold from the ordinary world into a new and unknown territory. The trials, tests, and ordeals of the trauma survivor are made up of facing terrifying memories and overwhelming pain. With the assistance of the counselor, they begin to gain insight and skills to manage their bodies, thoughts, and emotions. In some ways, it can feel like their old life is gone, never to be recovered, and a new life is birthed. The concept of post-traumatic growth parallels the idea of transformation that is a part of the hero’s journey. With courage and strength, trauma survivors relinquish their avoidant, controlling strategies and forge new cognitive schemas that incorporate the traumatic experiences. They are ultimately transformed into a new way of being (Tedeschi & Calhoun, 2004). Old coping mechanisms such as avoidance and numbing through addictive behaviors are discontinued and new skills such as the ability to self-regulate intense emotions through healthy coping behaviors are gained through the heroic journey of recovery work.

Return

As the trauma survivor rebuilds their life, they are able to progressively re-engage in normal activities and relationships, but with a deepened understanding of themselves and the world. As in the hero’s journey, they are now a “master of two worlds,” understanding the path of deep grief and pain as well as renewed joy and peace. The hero has learned the value of pressing into fear and pain.

This final stage of the hero's journey has the hero returning to the ordinary world with newfound resources for the restoration of others. When a trauma survivor has the courage to enter a path of recovery, they not only restore themselves, but they become a beacon of hope for other survivors with a trauma history and perhaps a force for social action. Their willingness to break the silence that so often shrouds trauma may become an encouragement to other survivors to pursue their own recovery. Their heroic choice to confront the pain and refuse to remain stuck in avoidance mechanisms holds the possibility of halting the legacy of multigenerational trauma and changing the trajectory of an entire family (Downes, Harrison, Curran, & Kavanagh, 2012). They may raise a newfound and empowered voice to speak and act on behalf of other trauma survivors. They bring the elixir of hope, courage, inspiration, and knowledge back to the world, serving as a lighthouse for others on their journey.

These ideas are intended to serve as an advocacy effort for the movement away from a one-dimensional categorization, as insinuated by traditional diagnostic measures, and the perception of trauma survivors as "disordered" people. While remaining stuck in maladaptive coping mechanisms may be accurately viewed as disordered in both symptomology and functioning, survivors who accept the call into trauma recovery work and battle for months or even years to gain new skills and reprocess trauma memories, may be understood through the lens of the hero's journey. Utilizing the heroic journey as a paradigm to frame the experiences of trauma survivors is supported by postmodern psychotherapy models that endorse assisting clients to externalize the problem, construct a more life-enhancing and empowering identity, and focus on strengths (Dybicz, 2012).

Historical Conceptualizations of Trauma Survival

Types of Trauma

The Substance Abuse and Mental Health Services Administration (2016) lists several types of trauma that can impact individuals, families, and communities: sexual abuse or assault; physical abuse or assault; emotional abuse or psychological maltreatment; neglect; serious accident, illness or medical procedure; victim or witness to domestic violence; victim or witness to community violence; historical trauma; school violence; bullying; natural or manmade disasters; forced displacement; war, terrorism or political violence; military trauma; victim or witness to extreme personal or interpersonal violence; traumatic grief or separation; and system-induced trauma and retraumatization. Many of these types of trauma are inflicted on the vulnerable section of our society: children. The Center for Disease Control (2015) reports over 23% of adults in the United States have experienced some type of abuse, violence or other adverse childhood experience; over 14% have experienced four or more diverse types of trauma as a child. The implications for the adult functioning of these individuals is profound and results in sometimes severe consequences across the lifespan (Briere & Scott, 2015).

Medical Model

As the field of mental health has developed, the profession has, by and large, patterned itself after the medical model of identifying specific pathologies and seeking treatments to resolve them. Developed by the American Psychiatric Association (2013), the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is currently in its 5th edition. Its diagnostic system originated out of a need for a common vocabulary with which professionals could communicate

with one another when describing patients who displayed common sets of symptoms (van der Kolk & Najavits, 2013). Instead of describing a list of symptoms being experienced by a particular client, a professional can simply refer to a *DSM* disorder, such as PTSD, and concisely communicate the presenting problems to others in the field.

An implication of this succinct system of communication is that one can begin to conceive of a *DSM* diagnosis as referring to a concrete disease entity rather than a list of symptoms without etiological implication. This conceptualization may imply that clients possess an inherent quality of dysfunction, without consideration for the environment, system, family, culture or context from which their symptoms have emerged.

Another perspective is to consider that trauma symptoms may have temporarily served as makeshift coping skills in a resource barren environment. In fact, the behavioral, cognitive, and emotional reactions may have been useful during the time of the trauma and represent a reasonable response to extraordinarily adverse circumstances. While some trauma survivors spontaneously recover to normal functioning after a traumatic event, for many, the responses become maladaptive over time and inhibit recovery without proper intervention (Thompson-Hollands, Jun, & Sloan, 2017).

When one considers the emotional, neurological, and physical implications for a person who has been exposed to traumatic situations, their unusual behavior begins to make more sense. A strengths-based reframe for trauma survivors is warranted and worth examining. As counselor educators, we propose that the reader consider the context from which trauma symptoms arise and subsequently understand that many of the symptoms were once adaptive and possibly life-saving. Long-term use of coping mechanisms such as avoidant behaviors may function as a “refusal of the call” (Campbell, 1949, pp. 59-68) of the heroic trauma recovery journey and cause individuals to remain ongoing victims of the trauma.

Development of Diagnosis of Post-Traumatic Stress Disorder

The dramatic impact of combat on soldiers was noted as early as the American Civil War. In the wake of World War I, the condition was given the name “shell shocked” and followed with “battle fatigue,” “combat exhaustion,” and “war stress” after World War II (Satel, 2011). The prevailing attitude toward soldiers who exhibited a stress response to traumatic exposure was that it was due to a character flaw or disorder of “moral weakness” (Substance Abuse and Mental Health Services Administration, n.d.). In the 1980s, a diagnosis of PTSD was included in the *DSM-III* due to intense advocacy by Vietnam veterans and two psychoanalysts, Robert J. Lifton and Chaim Shatan (van der Kolk & Najavits, 2013). Their goal was to create a diagnosis that captured the distressing experience of war veterans and destigmatize it by directly linking the symptoms to the traumatic experiences of war. For the first time, the etiological agent of veterans’ distress was located outside of the individual and in the traumatic event, rather than as an inherent individual weakness or neurosis (Friedman, 2016). Subsequent editions of the *DSM* have expanded and revised the diagnostic criteria for PTSD, to keep pace with emerging information gained through ongoing research in conjunction with enhanced development and cultural considerations; currently, a trauma-specific category exists as a new revision in the *DSM-5*. Today, PTSD symptoms are commonly accepted as experienced by a broad range of people, resulting from a variety of traumatic experiences (American Psychiatric Association, 2013).

Impact of Trauma

Survivors of Chronic Childhood Trauma

Two vulnerable segments of our population that too often face traumatic experiences are children and adolescents. The Pediatric Journal of the American Medical Association asserts that evidence continues to build demonstrating serious consequences to health, well-being, and society from childhood exposure to violence and abuse (Finkelhor, Turner, Shattuck, & Hamby, 2013). The detrimental effects of childhood abuse and neglect, peer victimization, and exposure to family and community violence have been connected to developmental difficulties, problematic behaviors, neurological development, and physical and mental health effects that extend throughout the lifespan (Finkelhor et al., 2013; Read, Fosse, Moskowitz, & Perry, 2014). Paralleling the initial perspective of combat veterans as psychologically disordered individuals, the resulting behaviors and dispositions of survivors of childhood maltreatment are frequently thought of as disordered and pathological, insinuating some inherent deficit within the person. Herman (1997) challenged the traditional conceptualization of survivors of childhood trauma when she stated,

Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology ... Thus, patients who suffer from the complex aftereffects of chronic trauma still commonly risk being misdiagnosed as having personality disorders (pp. 116-117).

As adults, these survivors of childhood trauma may present with a wide range of complex symptoms often expressed as limitations in emotional, cognitive, and neurobiological development. The ghosts of childhood trauma can manifest as self-hatred, amnesia, confusion, somatization, dissociation, self-harm, and behavioral reenactments (van der Kolk & Najavits, 2013). Clinical observations and research have, indeed, identified that both Borderline Personality Disorder and PTSD share similar disturbances in five core domains: affect regulation, impulse control, reality testing, interpersonal relationships, and self-integration (MacIntosh, Godbout, & Dubash, 2015). Similarly, many symptoms often associated with Attention Deficit and Hyperactivity Disorder very closely mirror the residual effects of hypervigilance and inattention present from traumatic experiences. Efforts to diagnose these survivors with the current *DSM-5* categories can result in multiple comorbid diagnoses to account for the range of symptoms. These diagnoses are not necessarily accurate and could lead to under or over treatment as well as harmful long-term labeling (D'Andrea, Ford, Stolbach, Spinazzola, & van de Kolk, 2012).

Challenges in Mental Health Treatment

There are many factors that complicate traditional mental health interventions for individuals with a history of trauma. These clients may experience a range of symptoms including somatization problems, depression, dissociation, self-harm, and addictions. Very often, clients are unaware that their current problems stem from buried trauma. Metaphorically speaking, a great deal of time in therapy can be lost in attempts to place band-aids on paper cuts when massive internal bleeding is unknowingly occurring. Additionally, the dysregulation of affect and behavior, problems with inattention and attunement, and distorted schemas about

themselves and the world all contribute to interpersonal problems (van der Kolk & Najavits, 2013).

The recovery from an array of symptoms is often slow, and consistent with the pattern of avoidance associated with trauma, the response to standard treatments is very frequently met with resistance. In fact, the survivor's symptoms create obstacles for a smooth therapeutic process. Emotional reactivity, distrust, fear of abandonment, dissociation, and suicidality may threaten the therapeutic relationship and impede progress. The range of somatic problems manifesting as various illnesses may drain a client's energy and even become incapacitating. Reactions such as dissociation may also lead to clients being viewed as psychotic. However, a strengths-based perspective and compassionate conceptualization of trauma survivors looks beyond the symptomatic display of disorientation, defense mechanisms, and dysregulation.

Symptomology through a Different Lens

There has been a growing shift over the last several decades to see the symptoms of PTSD through a different lens. Fisher (2017) describes this paradigm shift from a neurobiological lens: "if the brain and body are inherently adaptive, then the legacy of trauma responses must also reflect an attempt at adaptation, rather than evidence of pathology" (p. 1). Prominent PTSD symptoms may be evidence of survival resources that served as invaluable assets within the context of the trauma (Ogden, Minton, & Pain, 2006). Many of the common symptoms of PTSD, including hypervigilance, dissociation, self-harm, and relational mistrust, may be reexamined as not only potentially maladaptive skills that warrant clinical intervention, but also as previously adaptive resources.

Hypervigilance. Survivors of childhood abuse are often stuck in patterns of hypervigilance. The limbic system, the part of the brain responsible for the hypervigilant response, is shaped by the experiences of early childhood (Read et al., 2014). If a child's environment is genuinely filled with threat, hypervigilance is a critical, potentially life-saving response. Nonetheless, when the child grows into adulthood, the hypervigilant brain, which at one time kept them safe, becomes progressively maladaptive. The pattern of endless scanning of the environment for danger often leads to false positives and results in chronic anxiety and relational difficulties (Fisher, 2017). Individuals stuck in hypervigilance see imminent danger where there is minimal risk. Adults raised under normal conditions react to a threat with temporary arousal and return to a normal physiological state as soon as the threat dissipates. However, adult survivors of chronic childhood trauma may become disproportionately reactive quickly in response to only mildly stressful stimuli and subsequently take significantly longer to return to normal functioning (van der Kolk, 2014).

Dissociation. In contrast to the intensity of hypervigilance, dissociation is a means to cope with an overwhelming experience by splitting it apart and fragmenting the memory of the trauma (van der Kolk, 2014). This splintered and constricted consciousness often results in very low self-awareness of their bodies, emotions, and cognitions. A well-learned dissociative coping style leads survivors to ignore or minimize social cues that would ordinarily alert them to danger and limits their capacity to assimilate new experiences (Herman, 1997). Despite its potential for devastating long-term consequences, dissociation may be considered a protection against unbearable pain that provides the conscious brain distance from horrific events and memories of those events. Dissociation, or an escape within the mind, can create some semblance of safety

and ability to continue functioning in a world where there is no safe haven (Fisher, 2017). However, when the dissociative coping style persists over time, its usefulness is diminished, and the suffering of unresolved trauma is prolonged by problems in current functioning.

Self-harm. One of the more troubling and misunderstood coping mechanisms of survivors of chronic childhood trauma is self-harm. Contrary to common belief, self-harm is rarely used as a form of manipulation or a suicidal action. Instead, it is believed to occur when long-term dissociative coping results in feelings of not being real, disconnection from others or disconnection from one's physical body. These states of depersonalization, derealization, and anesthesia are often accompanied by feelings of unbearable agitation (Rotolone & Martin, 2012). Self-harm occurs when deliberate infliction of injury is used to relieve unbearable emotional pain and invoke a temporary feeling of calm and relief as a way of coping (Guerreiro et al., 2013). While self-harm is no doubt a maladaptive soothing mechanism, it is regarded by some survivors as a form of self-preservation from intolerable emotions of "non-being" (Herman, 1997, p. 109). In fact, a large percentage of individuals who engage in self-harm are survivors of traumatic events – between 40% and 65% represent sexual abuse victims – and despite the consequences and steep costs, survivors engage in self-injury as an attempt to manage their post-traumatic symptoms (Brown & Kimball, 2013; Favazza, 1996).

Relational mistrust. Trauma may alter personality development and negatively affect interpersonal skills and interactions involving trust and boundaries. Children are especially vulnerable to traumatic and adverse experiences, because their brains are at the peak of development through the constant, rapid construction of neural pathways, associations, and learning (Gaskill & Perry, 2012). Due to the impact on the developing brain, the reactivity and suspiciousness in relationships persists for years after the actual events. To survive their environment, children are forced to exert control by disconnecting from social relationships, acting coercively, and are unable to appropriately discern the intentions of others (Teague, 2013). These coping mechanisms are critical tools for gaining access to vital relational needs.

When these patterns persist into adult relationships, however, they affect the development and maintenance of healthy, intimate relationships. Trauma survivors' relationships are often marked with ambivalence, intense anxiety, controlling behavior and a propensity to misinterpret others' behavior (Teague, 2013). A desperate longing for connection and nurture may cause difficulty in maintaining safe and appropriate boundaries. Alternatively, survivors can work through relational mistrust issues within the context of the therapeutic relationship (and other healthy relationships) and experience post-traumatic growth.

Post-Traumatic Growth

The transformation and return of the traveler on a hero's journey parallels the idea of post-traumatic growth. When a person's world is shattered by trauma, they are often unable to return to life as it was before. Their cognitive schema simply cannot allow for the integration of such horror. Initial reactions of disbelief and numbness are followed by intrusive thoughts or a variety of unpleasant physical reactions resulting in fatigue, muscle tension, aches, gastric symptoms, and general physical discomfort (Tedeschi & Calhoun, 2004). In addition to surviving the original trauma, many survivors make the courageous decision to embark on a journey of recovery – the hero's journey. They bravely turn back towards the terrifying memories and walk willfully into the unknown. They understand that in order to defeat their

demons, they must look the monster in the eye. The journey is difficult, painful, and life-changing. Successful traumatic work requires that they experience, once again, the agony and pain of their trauma story in order to integrate it into a new story for their lives. As Bray (2017) highlights, “In this difficult journey, individuals begin to adopt new beliefs and values, view themselves and the world differently, acquire wisdom, and have an increased appreciation of life” (p. 5). The idea of post-traumatic growth goes far beyond an ability to resist the damage of highly stressful circumstances. The difficult process of trauma recovery transforms survivors into heroes, who have developed new skills and become a more authentic version of themselves. After overcoming the personal demons bred from trauma, these battle-worn heroes are then ready to return and offer the world something richer and deeper than they ever could have before (Williams, 2017).

A Story from a Hero’s Journey

Throughout history, heroic stories have imparted wisdom and gifted us with powerful inspiration in our own quest towards personal growth and courage (Allison & Goethals, 2015). Stories offer us the hope we need to courageously take the first steps of recovery in our own lives, and they powerfully illustrate what we collectively and intuitively know about redemptive pain. We end this article with the story of one trauma survivor who poignantly illustrates the heroic journey of trauma recovery.

Vicky: A Hero’s Journey

Story backdrop. If you were to have met Vicky² as a young girl, you would have seen a spunky, creative girl who grew into a beautiful, high functioning, intelligent young lady. She excelled in high school and college, and by her early 20s, she had signed with a modeling agent, began developing a singing career, and launched a creative business with a partner. She appeared to reflect the American ideal of happiness and success.

But this highly competent life was the overlay for a less visible storyline. Her early memories were splintered with gaps and holes. The recollections that were available to her were marked by several instances of sexual abuse and the ongoing threat of her father’s repeated suicide attempts. As a young child of only eight years old, she had personally bandaged her father’s bleeding wrists, but Vicky ultimately could not stop him from taking his own life three years later. Her mother’s subsequent marriage to an abusive, alcoholic man continued to wreak havoc in their family and propelled her mother into a decade long battle with alcoholism. In an effort to manage the overwhelming emotions of these memories and the encroaching shadows of other stories she could not yet remember, Vicky protected herself through intense overachievement and an escalating eating disorder.

Departure. Vicky’s first call to adventure arose when it became apparent during college that her anorexia and bulimia were growing out of control. She made the courageous decision to check herself into an inpatient eating disorder program. For the first time, she was challenged to bravely reexamine her painful family history. Vicky, however, refused this initial invitation to the hero’s journey. Something in her knew that the staff at this specific hospital and her post-

² Name has been changed to protect privacy.

treatment therapist were not skilled enough to handle what she held inside her. They did not probe or explore the half-remembered stories, nor had any understanding of the level of dissociation that Vicky utilized in order to cope. Subsequent reviews of her medical records many years later confirmed her intuition, as there was only one small reference to possible trauma in over 100 pages of notes.

A second call to adventure came to Vicky when her children were born. Being responsible for the care and safety of two small children unleashed a torrent of nightmares, flashbacks, and terrorizing emotions. By the birth of her third child, she was frantic with fear for her children's safety and terrified she would not be able to protect them from harm. Her eating disorder began to escalate once again, this time accompanied by alcohol and cutting. By now, she knew something was seriously and dangerously wrong. Parts of her experience that she struggled to keep locked away could not be contained anymore, and it was absolutely terrifying. She continued to battle her fears and cope in the way she always had until the physical ramifications of starving herself and her record low body weight convinced her that she was close to dying. She made the courageous decision to reach out for help again. For Vicky, crossing the threshold into her hero's journey was defined when she sought out the care of a new psychologist and medical doctor. The departure stage of her hero's journey reflected what Campbell (1949) refers to as being "in the belly of the whale" (pp. 90-96) – a part of the journey in which the traveler becomes disconnected from the world for a time.

Initiation. In Vicky's experience, her guiding mentor appeared sometime after she crossed the initial threshold. After a particularly disturbing encounter during a therapeutic group experience on a challenge rope course, Vicky was confronted with dissociated parts of herself that she could no longer deny. In response to a group exercise, she reacted with extreme fear and curled into the fetal position on the ground while screaming in a manner typical of a young child. The group counselor, remarkably skilled in treating childhood trauma and dissociative coping, spoke encouraging words to help soothe her emotional escalation. This new mentor powerfully reframed her coping behaviors as heroic survival skills and walked with her on her journey of heroic recovery work that included emerging memories of organized criminal abuse perpetrated by a network of adults preying on vulnerable children.

The next years did, indeed, hold many trials, tests, and ordeals for Vicky. With her therapist, she began to unravel the source of her terror. Nightmares, flashbacks, depression, severe dissociation, intrusive sensations, numbing, and a constant state of fight or flight relentlessly assaulted her. In turn, her urge to cope with alcohol, cutting, self-harm, and anorexia were overpowering. The split between her highly competent self and the one emerging in the counseling room was so profound that only a very few of her closest friends knew she was struggling at all.

Looking back on her life, Vicky could see that as a very young child, she had dissociated highly traumatized parts of herself in order to survive. By the time she was an adolescent, dissociating was such common practice that it had developed into an unconscious, automated behavior, like breathing. However, organizing and understanding her method of coping did not come into full focus until extensive assessments confirmed her experiences as features of

Dissociative Identity Disorder³. Presented with the reality of her dissociative coping, Vicky described this moment of realization by saying, “I felt the entire paradigm of life shift. For the first time, things began to make (terrifying) sense. I knew I would never again be who I was and that something entirely new was going to have to be constructed. Life, as I had known it, was over.” It was the beginning of her transformation.

Vicky describes her early work with her mentor therapist as “dumping hundreds of pieces of a puzzle on the table,” but the puzzle’s completed picture from which to make sense of the fragmented pieces was agonizingly absent as she grappled with the work of reassembly. Early on, she began to spontaneously use collage and art journaling as therapeutic tools to overcome an inability to speak during sessions. The graphic and horrific content of the art formed a bridge between herself and her mentor to communicate experiences that went beyond words. Over time, the painstaking process began to fit the fragmented pieces into a narrative and a picture emerged. Through her creativity, she found a voice with which to speak what had previously been unspeakable.

Return. The journey back to health and an entirely different sense of self was not easy or short. Over time, Vicky stopped seeing her life in disjointed pieces such as “before my dad’s suicide, and after my dad’s suicide”; now, her journey was knitted together into one coherent story. She no longer felt a sense that something dark was always chasing her; now, she was able to look forward instead of always looking back over her shoulder. She no longer lived in terror that something would happen to her children, loved ones or herself; now, she felt a sense of relative safety and a confidence that she could take care of herself and her loved ones. She grieved deeply for all that had been lost because of the things she experienced as a small child.

Vicky’s courage to face the terror and pain of her memories ultimately transformed her. As she processed her experiences and made connections between what she had experienced and how she had subsequently lived in the world, the less she needed to cope through destructive behaviors such as self-harm, anorexia, and dissociation. She was gradually able to relinquish the coping behaviors that had saved her life by protecting her from horrific memories. With a new perspective on her former ways of coping, she could see how these familiar safeguards were ultimately causing her harm and further isolating her in pain. Vicky learned to regulate her emotions, reengage in relationships, and pursue more hopeful, creative outlets.

Through her own therapeutic process, Vicky created hundreds of pieces of art, which offered her a process that provided a powerful and healthy way of dealing with trauma material. Over time, she began to share some of her art in appropriate settings with other survivors of childhood trauma who found them very meaningful and began to use the same tools in their own recovery. As Vicky continued to transform, space and freedom opened up for creating art that was increasingly infused with hope and inspiration. Vicky emerged a different person with a deep capacity to engage in relationships and life.

³ Dissociative Identity Disorder, previously known as Multiple Personality Disorder, is a diagnosis characterized by both fragmented experience of identity (two or more states) and significant gaps in memory that lead to distress and/or impairment of functioning.

Return with the elixir. During her years of recovery, Vicky had unknowingly developed powerful recovery tools for survivors of severe trauma. What began as a desperate attempt to communicate the wordless stories inside her, emerged as a process that offered help to others. As opportunities continued to grow to share her work, a deep calling grew in her to reach back into the community of trauma survivors and share what she had learned.

Vicky has worked hand in hand with trauma therapists to use expressive art therapies with trauma survivors. Today, Vicky provides direct care to trauma survivors by guiding them into new ways to process their experiences through art in many diverse settings, such as individual sessions, workshops, faith-based recovery programs, and childhood trauma recovery groups. She is sought after to share her knowledge and artwork at mental health conferences through presentations and workshops. Speaking from the foundation that emerged from her post-traumatic growth, Vicky shares her honest expression of her recovery journey in hopes that others will find the courage to find a voice for the wounded places of their hearts as they embark on their own heroic journey.

Conclusion

In closing, we return to the traditional conceptualization of trauma as a deficit-oriented and disordered condition. Words have inherent power. Constructivist therapeutic models of therapy, such as narrative therapy, highlight the significance of language, words, and how the labels we use have a significant impact on identity (Dybicz, 2012). Diagnostic labels may perpetuate a problem-saturated perspective and “reduce the complexity of the individual by assigning an all-embracing, single description to the essence of the person” (Corey, 2017, p. 382). Conversely, using heroic terminology may, in fact, highlight an individual’s strengths and empower an alternative identity: “What clients may need ... is someone to nurture their courage and competency so they can discover that they are heroes of their own stories” (Digati, 2015 p. 5). Undoubtedly, the manner in which we conceptualize symptoms and frame experiences carries profound implications on the trauma survivor’s future path.

Some trauma survivors are the living narrative of such heroic tales, and we, as a society, have the power to reframe difficult aspects of that narrative. We are offered the choice to perpetuate the pain of these survivors by solely pathologizing their “disordered” behavior, or we can choose to see survivors as those who have embarked on a hero’s journey through their response to the call to adventure, as they battle through the impacts of trauma towards a victorious transformation. Recognizing survivors in this way empowers them to continue to fight bravely for the ability to change their own story (Williams, 2017). Let us honor not only the incredible deeds committed voluntarily and selflessly by individuals to help others but also the courageous heroism of persevering through recovery, experiencing personal growth, and inspiring other survivors in the aftermath of trauma.

REFERENCES

- Allison, S. T. (2016). The initiation of heroism science. *Heroism Science*, 1(1), 1-9. Retrieved from <https://heroismscience.wordpress.com/journal/heroism-science-volume-1-2016/the-initiation-of-heroism-science/>
- Allison, S. T., & Goethals, G. R. (2015). Hero worship: The elevation of the human spirit. *Journal for the Theory of Social Behavior*, 46(2), 187-210. doi:10.1111/jtsb.12094
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.
- Beggan, J. K. (2016). Monomyth, transformation and inspiration: The hero's journey in the extreme fitness exercise infomercial. *Heroism Science*, 1(1), 1-12. Retrieved from <https://heroismscience.wordpress.com/journal/heroism-science-volume-1-2016/monomyth-transformation-and-inspiration-the-heros-journey-in-the-extreme-fitness-exercise-infomercial/>
- Bray, P. (2017). The hero-journey, *Hamlet*, and positive psychological transformation. *Journal of Humanistic Psychology*, 1-31. doi:10.1177/0022167816689357
- Briere, J. N., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Los Angeles, CA: Sage.
- Brown, T. B., & Kimball, T. (2013). Cutting to live. A phenomenology of self-harm. *Journal of Marital and Family Therapy*, 39(2), 195-208. doi:10.1111/j.1752-0606.2011.00270.x
- Campbell, J. (1949). *The hero with a thousand faces*. Princeton, NJ: Princeton University Press.
- Center for Disease Control and Prevention. (2015). *Behavioral Risk Factor Surveillance System Survey ACA Module Data, 2010*. Atlanta, GA. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/ace_brfss.html
- Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Boston, MA: Cengage Learning.
- D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van de Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, 82(2), 187-200. doi:10.1111/j.1939-0025.2012.011154.x
- Digati, B. J. C. (2015). *Dialectical behavioral therapy for heroes: A comparative study of the hero's journey and DBT*. Phd thesis. Retrieved from <https://search-proquest-com.ezproxy.regent.edu/docview/1669977685?pq-origsite=summon>
- Downes, C., Harrison, E., Curran, D., & Kavanagh, M. (2012). The trauma still goes on...: The multigenerational legacy of Northern Ireland's conflict. *Clinical Child Psychology and Psychiatry*, 18(4), 583-603. doi:10.1177/1359104512462548

- Dybicz, P. (2012). The hero(ine) on a journey: A postmodern conceptual framework for social work practice. *Journal of Social Work Education, 48*, 267-283. doi:10.5175/JSWE.2012.201000057
- Favazza, A. (1996). The coming of age of self-mutilation. *Journal of Nervous and Mental Disease, 186*, 259-268.
- Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics, 167*(7), 614-621. doi:10.1001/jamapediatrics.2013.42
- Fisher, J. (2017). *Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation*. New York, NY: Routledge.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.
- Franco, Z., Blau, K. E., & Zimbardo, P. G. (2011). Heroism: A conceptual analysis and differentiation between heroic action and altruism. *Review of General Psychology, 15*(2), 99-113. doi:10.1037/a0022672
- Friedman, M. J. (2016). *PTSD history and overview*. Retrieved from National Center for PTSD, U.S. Department of Veterans Affairs website: <https://www.ptsd.va.gov/professional/ptsd-overview/ptsd-overview.asp>
- Gaskill, R. L., & Perry, B. D. (2012). Child abuse, traumatic experiences, and their impact on the developing brain. In P. Goodyear-Brown (Ed.), *Handbook of child sexual abuse: Identification, assessment, and treatment* (pp. 29-47). Hoboken, NJ: John Wiley & Sons, Inc.
- Guerreiro, D. F., Cruz, D., Frasilho, D., Santos, J. C., Figueira, M. L., & Sampaio, D. (2013). Association between deliberate self-harm and coping in adolescents: A critical review of the last 10 years' literature. *Archives of Suicide Research, 17*, 91-105. doi:10.1080/13811118.2013.776439
- Herman, J. (1997). *Trauma and recovery: The aftermath of violence - from domestic abuse to political terror*. New York, NY: Basic Books.
- Lawson, G. (2005). The hero's journey as a developmental metaphor in counseling. *Journal of Humanistic Counseling, Education and Development, 44*(2), 134 – 144.
- MacIntosh, H. B., Godbout, N., & Dubash, N. (2015). Borderline personality disorder: Disorder of trauma or personality, a review of the empirical literature. *Canadian Psychology, 56*(2), 227-241. doi:10.1037/cap0000028
- Ochberg, F. (2013). An injury, not a disorder. *Military Review, 93*, 96-99.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: W.W. Norton.

- Parnell, L. (2007). *A therapist's guide to EMDR*. New York, NY: W.W. Norton.
- Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry*, 4(1), 65-79.
- Rotolone, C., & Martin, G. (2012). Giving up self-injury: A comparison of everyday social and personal resources in past versus current self-injurers. *Archives of Suicide Research*, 16, 147-158. doi:10.1080/13811118.2012.66733
- Satel, S. (2011). PTSD's diagnostic trap. *Policy Review*. Hoover Institution of Stanford University. Retrieved from <http://www.hoover.org/research/ptsds-diagnostic-trap>
- Substance Abuse and Mental Health Services Administration. (2016). *Types of trauma and violence*. Retrieved from <https://www.samhsa.gov/trauma-violence/types>
- Substance Abuse and Mental Health Services Administration (2014). Appendix C - Historical Account of Trauma. In *Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801*. (pp. 267-269). Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Retrieved from <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- Teague, C. M. (2013). Developmental trauma disorder: A provisional diagnosis. *Journal of Aggression, Maltreatment & Trauma*, 22, 611-625. doi:10.1080/10926771.2013.804470
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15(1), 1-18. Retrieved from <http://www.jstor.org/stable/20447194>
- Thompson-Hollands, J., Jun, J., & Sloan, D. (2017). The association between peritraumatic dissociation and PTSD symptoms: The mediating role of negative beliefs about self. *Journal of Traumatic Stress*, 30, 190-194. doi:10.1002/jts.22179
- Van der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. New York, NY: Viking.
- Van der Kolk, B., & Najavits, L. M. (2013). Interview: What is PTSD really? Surprises, twists of history, and the politics of diagnosis and treatment. *Journal of Clinical Psychology: In Session*, 69(5), 516-522. doi:10.1002/jclp.21992
- Williams, C. (2017). The hero's journey: A mudmap for change. *Journal of Humanistic Psychology*, 57, 1-18. doi:10.1177/0022167817705499

Brenda Keck

Brenda Keck is a licensed Marriage and Family Therapist and a third-year student in Regent University's Ph.D. in Counselor Education program. For more than a decade, she has practiced as an MFT with a focus on trauma recovery and families that live and work cross-culturally. She has served families in over 10 countries by providing brief therapy, debriefings, and training on issues of cross-cultural living, compassion fatigue, and raising resilient families. Brenda has led workshops at national conferences, served as Global Adjunct Faculty at Le Tourneau University, and as a Teaching Assistant in Regent University's masters and doctoral programs.

Lisa Compton

Lisa Compton is a licensed Clinical Social Worker who holds a Ph.D. in Counselor Education and is a Certified Trauma Specialist. She has over 22 years of experience counseling individuals, couples, families, and groups. Her current positions include full-time faculty in the masters and doctorate counseling programs at Regent University and director of Richmond Alliance of Faith-based Therapists. Lisa is also a conference speaker at workshops related to trauma, parenting, marriage, and mental health. Her career is dedicated to helping the hurting through the integration of faith and social sciences.

Corie Schoeneberg

Corie Schoeneberg is a Licensed Professional Counselor, Registered Play Therapist-Supervisor, and Nationally Certified Counselor, and she is a doctorate student in Counselor Education and Supervision PhD program at Regent University. Corie specializes in early childhood mental health with an emphasis on trauma and attachment problems. Corie is an adjunct instructor in the clinical and school counseling program at the University of Central Missouri, and she is the author of several book chapters and journal articles as well as a Past President of the Missouri Association for Play Therapy. Corie provides consultation services and interdisciplinary trainings regarding childhood mental health.

Tucker Compton

Tucker Compton is a senior at Trinity Episcopal School in Richmond, Virginia and takes International Baccalaureate (IB) classes. He has studied the topic of post-traumatic stress disorder (PTSD) and served as a research assistant for Regent University's Psychology and Counseling department. Tucker's academic interests also include economics and finance. He plans to attend college next year and major in business.

Suggested citation for this article:

Keck, B., Compton, L., Schoeneberg, C., & Compton, T. (2017). Trauma recovery: A heroic journey. *Heroism Science*, 2(1), 1-17.