Our very grateful thanks to the authors for their contributions, and we wish you all an enjoyable read.

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TRAUMA, CONNECTION AND RECOVERY

Anthea Millar

What is at the heart of being human? Over 100 years ago Alfred Adler answered this question when he emphasised our social embeddedness and need for connection and belonging (Ansbacher & Ansbacher, 1956). The spontaneous movement in all of us is towards connection, health and aliveness. No matter how withdrawn and isolated we have become, or how serious a trauma we may have experienced, on the deepest level, just as a plant spontaneously moves towards sunlight, we attempt to move towards connection and healing.

Although this article explores the impact of trauma, it is fundamentally about restoring connection and it has a positive optimistic focus. Whilst not ignoring a person's past, there will be a special emphasis on how therapeutic input can support the person to re-connect positively and constructively with others, with themselves and their body, honouring and connecting with their strengths, capacities, resources and resilience – all crucial factors for recovery.

Adler emphasised that all human problems are basically social problems, the individual and society being inextricably linked (Ferguson, 2010). So much research in neuroscience of the last two decades offers clear evidence of Adler's concept of the social embeddedness of the person, and of the brain as a social organ. This is well exemplified in the discovery of mirror neurons or systems (Rizzolati et al., 1996; Gallese et al., 2002; Iacoboni, 2008).

Individual Psychology takes the optimistic view that the potential for community feeling *(Gemeinschaftsgefühl)* is within us all and forms the foundation for mental health, which is reliant on our experiencing a sense of belonging as social equals and of being able to find ways of contributing usefully to the wider social community.

All children need to feel connected to themselves and to their caregivers; they need to sense others are tuning into their needs and to feel safe in their dependence *and* independence.

Here are the building blocks to Adler's Life Tasks in later life: to find a satisfying occupation, to have a feeling of belonging amongst friends and contribute to the community, and to fulfil the task of intimacy, and also very crucially to have a positive connection with self and the cosmos.

This essential interdependent functioning for mental well-being is well captured by Daniel Siegel (2013) in his model of interpersonal neurobiology and creation of the neologism *"Mwe"* developed by combining *"Me"* and *"We"*. He is proposing that for health, we need to be both an *"I"* and part of an *"Us"*, echoing Adler's understanding of mental health nearly 100 years earlier.

Research on the developing brain in infancy and *in utero* has also revealed a significant correlation between children's perceptions of a positive sense of belonging and their increased capacity to handle stress in later life (Schore, 2003, 1994; Kern et al., 1996). Bonnano and Mancini (2008) noted that resilience is a fundamental feature of normal coping skills and that key factors enabling reduction of post-traumatic stress, in both children and adults, involved the individual's subjective experience of

belonging and the support from relationships and community resources.

What is Psychological Trauma?

Trauma can be defined as an event that overwhelms the Central Nervous System and changes the way we remember and react to things that remind us of it. The many dimensions of the impact of traumatic events are well captured by Herman (1992) when she writes that they "... overwhelm the ordinary systems of care that give people a sense of connection, control and meaning" (p. 33).

Similarly, Adlerian O'Connell and Hooker (1996) identify those diagnosed with Post-Traumatic Stress Disorder (PTSD) as having "been faced with experiences that have shattered their sense of personal identity, worth and belonging" (p. 180).

These definitions resonate with the experiences expressed by clients Steve (single shock trauma) and Alicia (developmental trauma) as follows [*]:

***Steve**, a bank cashier who successfully recovered from an armed robbery, described his early post-trauma experience as follows: "At first it felt as if my world had shattered in a thousand pieces. Nothing seemed to make sense any more and, despite family being around, I felt totally isolated."*

***Alicia**: following severe physical emotional and sexual abuse up to age 12 when she was then put into a foster home, created her own private logic as follows: "I exist to be used"; "I don't have*

[*] All client material in this article has been modified to ensure anonymity.

rights only duties"; "I'm not allowed to say no to anything"; "Others have all the power".

Connection is life itself. Steve and Alicia offer us vivid examples of responses to the experience of facing serious threats to this life force, and to their physical and psychological integrity. In Adlerian terms, the impact of severe trauma can be understood as the ultimate experience of inferiority, from which we attempt to maintain our well-being by "an oversized safeguarding component" (Adler, as cited in Ansbacher & Ansbacher, 1956, p. 263).

In my work as a psychotherapist, Adler's approach has guided me to appreciate more fully how my clients' presenting physiological and psychological symptoms of Post-Traumatic Stress are largely about safeguarding against that worst fear: feelings of extreme inferiority and loss of belonging.

Drawing on the criteria of the *American Psychiatric Association's* (APA) *Diagnostic and Statistical Manual Edition 5 (DSM-5)* (APA, 2013), the diagnosis of Post-Traumatic Stress Disorder is given when the person experiences long-term and persistent hyper-arousal and re-experiencing, alongside hyper-avoidance and possible dissociation following identifiable traumatic event(s).

This symptom-based diagnosis has been challenged by many, including the *British Psychological Society* (Greenberg, 2013) and by renowned traumatologist Bessel van der Kolk (2014); who notes how DSM 5 overlooks the social influences of those experiencing major on-going traumas and the disturbances on the relationship to the self, to the environment and to one's body.

Van der Kolk (2014) also points to further key omissions in DSM 5's criteria in terms of its focus largely on single shock traumas, not properly differentiating single traumatic events from on-going adverse early developmental experiences. He proposes a further diagnostic category: Developmental Trauma Disorder (DTD). In the cases of early-prolonged traumas such as emotional, physical and sexual abuse, DTD also identifies patterns of deeply entrenched dysregulation of physiology, emotional expression, attention and behaviour, and very crucially impairment of the positive sense of connection to oneself and others.

Children who have experienced prolonged adverse events in childhood or adolescence and who act out their distress may be diagnosed with such labels as "oppositional defiant disorder", "attachment disorder" and "conduct disorder". In later adulthood, the personality disorder labels may be applied freely, "Borderline Personality Disorder" (BPD) being one such common diagnosis. In an important early study undertaken by Herman, Perry and van der Kolk (1989), it was revealed that 81% of people diagnosed with BDP in one hospital reported severe histories of child abuse and neglect.

In addition to the dangers of applying fixed character traits on a person, diagnostic labelling gained from symptom assessment ignores the purpose of the behaviour. The Adlerian approach offers a frame of understanding, so we can appreciate how much disturbing behaviour is actually about a person's attempt to safeguard him- or herself against a sense of disconnection and fragmentation, both rage and withdrawal being aspects of a whole range of desperate purposive attempts to compensate for an on-going perception of loss of belonging.

***Mark,** age 15, was adopted at 9, after being taken away from his violent alcoholic parents. His adoptive mother died from cancer when he was 11, and his grieving adoptive father could not manage his seriously aggressive behaviour, resulting in him then moving between a number of temporary residential and foster homes. He used glue and alcohol, and was hospitalised for a number of suicide attempts. Those around Mark described him as aggressive, isolated and vindictive. Following formal psychological assessment, he was given the diagnoses of "intermittent explosive disorder", "reactive attachment disorder", "attention deficit disorder" and "substance use disorder".*

But what do these diagnostic labels actually tell us about Mark himself? How do they help us appreciate Mark's unique attempts to belong? We can only work usefully with those who have experienced extreme and prolonged traumas when we move away from a reductive labelling or medicalising and see the whole person, appreciating the purposeful safeguarding nature of the behaviour. From this understanding, we can support our clients to find ways of feeling connected to the world as an equal, worthwhile human being, identifying their unique qualities and strengths.

Holism: Mind and Body Connection

The need for safety and connection is fundamental and deeply based on our body's functioning, as identified in Adler's holistic approach:

> "The individual is 'indivisible' and needs to be understood holistically, every biological, psychological and social aspect of the person being dynamically and systematically connected. From the first days of life,

> uninterruptedly till the end, this partnership of growth and development continues ... body and mind co-operate as indivisible parts of one whole" (Adler, 1980, p. 27).

A further important aspect of this holistic approach can be seen in Adler's use of the term "Organ Jargon". In a seminal paper entitled *"Physical Manifestations of Psychic Disturbances"*, Adler (1934/1964) put forward the view that individuals express themselves through their organ systems (endocrine, cardiovascular, musculoskeletal and nervous systems), with every organ capable of expressing emotions and physical symptoms. The following case study offers an illustration:

***Tod,** age 62, was referred to me by his doctor for medically unexplained severe back and joint pain. As an ex-soldier, he had experienced major trauma during his war experiences, and now his wife of 40 years had recently died. He stated to me firmly that he did not want to work on any of the past traumas, but just to have help with the pain. And this was where I began, pacing the work gently, initially via the channel of the organ jargon of physical pain, honouring his safeguarding systems and building on his re-connections with his life now, with his children, his grandchildren and previous interests.*

The Polyvagal Theory

As Adler identified, connecting mind and body is crucial, and in trauma therapy, we need always to keep the body's physiology in mind. The ground breaking work of Stephen Porges (2011), with his "Polyvagal Theory of Emotion", offers an invaluable new frame for understanding the psycho-physiology of responses to traumatic events, further clarifying our need for social connection, and the major challenges that arise when this is not met.

Polyvagal refers to the many branches of the long vagus nerve which has evolved over millions of years: the more recently evolved "new" myelinated vagus optimises oxygen via heart and lung activity, and links to other nerves to engage our sense of hearing and enhance our neck, jaw face and throat muscles; and the old unmyelinated vagus immobilises us.

The "Polyvagal Theory" offers a more sophisticated understanding of the biology around safety and danger, taking it beyond the effects of fight and flight, and putting social relationships right at the centre of an understanding of trauma, which resonates with Adler's core theory of the crucial need for social connection for mental well-being.

Porges clarifies that the Autonomic Nervous System regulates three fundamental physiological states. When we perceive threat, if we are able, we go to the most recently evolved level:

1. *Social Engagement*: at this level we check what is happening; we are able to call for support and help, and to find comfort from those around us. If this fails (for example if no one comes to our aid), we will perceive the situation at a higher status of danger and we go to the second more primitive level;

2. *"Fight or Flight"*: we mobilise, either to fight off our attacker or to run away to somewhere safe.

A very young child cannot usually protect him- or herself by fighting or fleeing. So finding safe connection and social engagement is crucial for a future sense of well-being and security.

If mobilisation fails and we cannot get away, e.g., if we are held down or feel trapped, we may try to preserve ourselves by our most primitive survival system;

3. *Immobilisation*: we shut down and expending as little energy as possible. This may result in a *freeze* state, or develop on to a *faint or collapse*. This survival system of "playing dead", being "scared to death" creates immobility, shutdown and dissociation. The challenge here is that this very survival response suppresses our social connection system.

This immobilisation response evolved as a means of a brief survival mode for acute situations. However, highly traumatised and chronically neglected or abused individuals with developmental trauma experiences are commonly dominated by the immobilisation/shutdown system. They are also commonly plagued by dissociative symptoms, such as a sense of unreality and depersonalisation, and various somatic and health complaints, such as gastro-intestinal problems, migraines, persistent pain and chronic fatigue.

The Social Engagement System

Porges' work on identifying the physiological basis of the Social Engagement System resonates well with Adler's view that we all have the potential for *Gemeinschaftsgefühl*, or Community Feeling. When our safeguarding defences are turned off, we experience a state of safety and can "let our guard down". This, in turn, allows us to integrate new learning into our worldview, engage with the others and be vulnerable with one another. When we feel stable, we can be open to new thinking, rather than relying on long-established patterns of private logic.

Generally, when we feel threatened or upset, we first look to others, wanting to connect with their faces and voices, and to be able to find a way of communicating our feelings to secure safety. When we are able to activate the social engagement system, the more recently evolved myelinated vagus sends signals to the heart and lungs, slowing down our heart rate and breathing, optimising our sense of hearing and enabling activation of the muscles of the face, throat, middle ear and voice box (larynx). We are then able to make positive eye contact and listen, using the social engagement system to calm ourselves down. When this is functioning, we can smile, nod and frown, and, most crucially, we can hear appropriately, turning off our focus on detecting low-frequency sounds which are instinctually perceived as predators.

Many people who have experienced major trauma describe experiencing hypersensitivities to sounds, most notably low frequencies, and feeling vibrations that no one else seems to feel, often avoiding going into crowded places. This is an indication that the social engagement system is still shut off and the nervous system continually primed to detect potential predators. Whilst effective for detecting these, this compromises future social connection, leaving an individual with the underlying defensive strategies: either to fight or flee, or to disappear and shut down.

Trauma and Disconnection

Adler identified that a sense of belonging is our deepest need. Yet, where there has been serious developmental trauma, connection with others may also be our deepest fear. It is natural for all of us to pull away from the source of pain, as when we inadvertently touch a hot stove. So, it is understandable that

if people are left to recover on their own, they may try and create distance between themselves and the traumatic event. However, this very safeguarding process creates problems. By people separating themselves from their internal experience and emotional pain, there can also be profound alienation and disconnection from themselves, their thoughts and feelings, and from others. Here is where a vicious cycle can get set up, as being deprived of emotional contact and connection with self and others is deeply threatening to our psychological and physiological well-being.

What all people have to wrestle with in the aftermath of traumatic events is how to reconstruct a life and a worldview when what used to be there has been shattered. One of the critical assumptions often lost is around control.

***Nizar,** age 14, had fled a major war zone, where his parents and siblings had all been killed, and before coming to the UK, lived for 4 years in refugee camps, where he had experienced neglect and physical abuse. His perceptions of himself, others and the world were as follows: "I am vulnerable, people are hostile, the world is dangerous, therefore I must keep control by isolating myself from others and being totally self-sufficient."*

Dissociation

Stephen Porges' work identified that when we perceive a life threat, we disconnect or physiologically dissociate to avoid predictable pain. We shut down and go into an energy conservation "death preparation" state. Playing dead is an old vagus reptilian response, where we can escape out of our own body and emotions. The natural opioids secreted by the nervous system aim to limit the pain of death and induce a dreamy

quality. This dissociation can create both a pleasant spacy feeling and, equally, a terrifying loss of contact with reality.

From an Adlerian perspective (Sperry et al., 2015), dissociation can be seen as a protecting mechanism to help individuals deal with extreme feelings of inferiority and a means to avoid further pain, enabling the person to continue to function. However, this may result in rigidity, challenges in meeting the Life tasks and a sense of feeling exiled from self and others. In more extreme situations, a person may create different parts of him- or herself, or "alters", as a means of disconnecting from reality when feeling unsafe or threatened. Sperry et al. (2015) describe this as a means of both seeking distance and standing still, both strategies having the aim of somehow preventing the trauma happening again (p. 212). Here the ultimate aim in therapy is to integrate all the alters into one personality.

***James**, a seemingly charming and polite man came to see me, initially presenting with work-related issues where he had been accused of aggressive behaviour that he then completely denied. Within 2 sessions, the alter "Matt" came into the room, a violent disparaging and persecutory presence, then the alters "Stevie", a frightened frozen little boy, followed by "Emily", a highly critical elderly woman. It transpired that as a youngster, James had experienced severe sexual and emotional abuse at a residential centre that he attended following major difficulties at home. He had also later become a juvenile perpetrator of abuse. Our work focussed on integrating and reconnecting these aspects of his personality, supporting him to face the aggressive, critical aspects of his Life Style, all the while acknowledging his resources and honouring his bisexuality, for which he had felt shame.*

Connection and Recovery

Following the multiple physiological and psychological challenges faced by those who have experienced major developmental trauma, the journey towards recovery may seem gruelling. The antidote is both seemingly simple and challenging. The core aim of therapy is to improve the person's quality of life. If direct work on trauma memories helps this goal, then this will be useful; otherwise there is no need to excavate the details of the trauma. It is very important that helpers and therapists hold back from their own curiosity about the past events, but tune into the client's needs only.

Healing takes place when we can support clients to move on from being stuck in a hamster wheel of past fears, and enable them to focus on the present and towards the future. This involves connecting with self, the body and emotions, and learning to experience connection with others as an enriching reciprocal response rather than as a source of threat.

Stabilisation and Safety

Creating a safe trusting therapeutic relationship is a major contributing factor to successful therapy and was certainly identified by Adler (as cited in Ansbacher & Ansbacher, 1956) when he described the needs of "hated children", focussing on a compassionate therapeutic approach as follows:

> "Their treatment and cure ... would be to take on the double function of the mother ...: 1) to join with the child and to give him[her] the experience of a trustworthy fellow, and 2) to increase and spread the social interest and thus to strengthen independence and courage" (p. 119).

In order to support the client to reduce such common safeguarding behaviour as hyper-vigilance and dissociation, alternative safe anchors must first be in place. Enabling the client to feel grounded and safe in their immediate environments through their learning self-regulation of their own body and emotions is crucial. Until there is safety in the client's life circumstances, their support structures and resources identified, their symptoms more in control and the therapeutic relationship well established, working on the specifics of the trauma is unhelpful, and as stated above, not always necessary.

***Tania** 19, with a history of childhood sexual and emotional abuse, came to see me at a young person's "Drop-In" counselling centre. She was living on the street and recently, when very drunk, had been raped by 2 men. In the first session, she started immediately to relate the traumatic events. However, it was clear she was talking in a highly dissociated state and it was important to stop this flow, which was further aggravating the distress. Rather than working on the trauma, I focussed on some immediate "first aid" strategies such as grounding processes to enable body regulation; then, explored practical issues such as where she was planning to sleep that night, what money she had for food, who were her friends, and offering information about other available support agencies. I, then, introduced some basic strategies for handling her sensory symptoms and noted her resourcefulness in handling her life in the immediate moment. Only much later, when our relationship was well established and she was stable, did we begin to process the rape and other earlier traumas.*

Re-connection using Dual Awareness

When alarm systems continue to be on the alert, it is difficult, if not impossible, to process and integrate trauma memories into conscious mental frameworks as these memories become "stuck" in the brain's non-verbal sub-cortical regions (the amygdala, thalamus, hippocampus, hypothalamus and brainstem). This may lead to patterns of dissociation and hyper-arousal, reducing the normal capacity of dual awareness (Rothschild, 2000).

Dual awareness is our capacity to integrate both internal and external sensory stimuli, or a means of integrating the "experiencing self" with the "observing self" (van der Kolk & Fisler, 1995). For example, if we hear a sudden and unexpectedly loud noise, we may startle and experience a rush of adrenaline. However, if we are able to integrate this internal experience with external awareness, we can notice that it was simply some building materials being thrown into a skip. We can then know that all is safe and regulate our body to a stable state again.

So, in therapy, we need to enable clients to create a combination of the "experiencing self" and the "observing self". This creates a metaphorical "bridge" and connection between the amygdala and the cortex, enabling reduction of the fight-flight responses. Grounding and anchoring exercises, and work on building an imaged "safe place", are important foundations, alongside supporting the client to identify and name what is being experienced bodily and emotionally, the experiencing self's reality, whilst *connecting* this with the observing self's reality. This helps clients learn step-by-step to stay grounded in the face of intense sensations associated with the body's fear responses.

__Madesh__ came to see me 6 months after a car accident. At night, he regularly experienced frightening physiological and emotional flashbacks of the event. It was important not to use the flashback itself as a means of resolving the trauma, but to help Madesh re-stabilise and identify that the flashback was not actually happening in the moment and was a past memory. We worked together, preparing a ritual, using Rothschild's (2000) dual awareness protocol, making links between his anticipated "experiencing" and the "observing" self. He spoke this out loud before he went to sleep as a means of consciously preparing for the expected nightmare: "I'm going to wake up feeling terrified, I will be sweating, my heart will be beating fast, and my fists will be clenched because I'm remembering 'the accident' (here it is important not to focus on any details, using a label only). 'At the same time', I will look around where I am now on January 8th 2016, in my bedroom, and will see my cat and the picture on the wall and so will know that 'the accident' is not happening anymore." Madesh regained a sense of being in control and the flashbacks abated.

Connecting to Positive Resources

Whereas much psychotherapy has been oriented towards identifying pathology and focussing on problems, Adlerian therapy is an approach promoting growth that emphasises working with strengths as well as with symptoms. It orients towards resources, both internal and external, in order to support the development of an increased capacity for self-regulation. When clients view themselves and the world only through the lens of trauma, there is a distorted perspective of split-off anger, pain, disorientation and shock. A focus on resources is an antidote that shifts clients' attention to a broader, less distorted picture of themselves and their lives, and

re-builds on the potential for social Interest. There are always genuine resources from which to draw even in the most chaotic of lives. Many with traumatic histories go on to have successful, meaningful lives as adults, and so often they recall in their lives one or more significant people, or sometimes a special pet, who taught them that, despite their traumatic home life, there was still a place of positive connection and kindness.

Asking clients who or what helped, or is helping them get through the difficulties is one of the first key questions to ask with those who have experienced developmental trauma. With single shock trauma, such as a one-off attack or a car accident, asking about the first moment when the client felt safe after the event can be helpful in identifying a safe place.

With developmental trauma, however, when the experience of lack of safety has been chronic, the process of building resources and a sense of safety is more complex. Here it is important to look for any life experience in which such clients felt at least a sense of resourcefulness and relative safety, for example, cuddling their pet, working in the garden, cycling.

When remembering or imagining positive resources of any kind, past or present, it is important to direct the client's experience to the present moment: "As you tell me about patting your dog, what are you noticing right now?" As therapy progresses, through gradual integration of positive experiences and resources, clients develop new perceptions of other humans as possible sources of support rather than as sources of threat.

Non-Verbal therapy

Many leading trauma therapists note that talk therapy on its own is not enough to resolve traumatic suffering (Heller, 2012; Levine, 2010; Rothschild, 2000; van der Kolk, 2014) and stress that it is important to use both *top-down* and *bottom-up* approaches in trauma therapy. Top-down approaches emphasise cognitions and emotions as the primary focus. Bottom-up approaches, in contrast, focus on the body and the felt sense. Using both bottom-up *and* top-down orientations greatly expands therapeutic options and resonates well with an Adlerian holistic approach.

Porges (2011) described how experiencing traumatic events could turn off the social engagement system. Traumatised individuals often have gaze aversion and flat facial affect. Most therapeutic strategies attempt to engage with direct face-to-face eye contact, but these normal social engagement behaviours of the therapist may trigger fear and reactive defensive strategies.

Non-verbal therapies offer invaluable alternative pathways to healing that can re-engage the social connection whilst not needing initial face-to-face interaction. Once the social engagement system is enabled again, positive facial expressions and eye contact will naturally emerge, the client moving to a calmer physiological state, shifting from a numb disconnection to connection and unity. Such therapies include those using Movement, Art, Pets, Horses, Music, Horticulture, Yoga ... to name but a few.

***Raheela** had experienced severe domestic violence within her relationship for 15 years before her partner was finally prosecuted for serious assault. Withdrawn and selectively mute,*

she attended a therapy centre for women, but made no connection with others. She was given the responsibility of tending to the centre's vegetable patch and gradually, working alongside the horticultural therapist, she began to communicate verbally with others at the centre, became grounded in her body and built a sense of pride in her achievements.

***Paul,** an army veteran, retired from the services after serious injury, had regular anger outbursts that had culminated in a divorce and minimal connection with his children. Being given responsibility for the care of a rescue dog, Mufty, was transformative in helping Paul reduce his anger outbursts and, later, re-connecting with his children. Mufty's unconditional positive responses to Paul and her dependency on him for food, exercise and grooming helped shift Paul's focus away from himself and ultimately to others.*

Post Traumatic Growth – New Ways of Connecting

Finding meaning after terrible tragedies and traumas, and regaining a new found place in the world is a certain ingredient for healing. Adler's focus on therapy was always on what his patients were doing in the immediate present to help their situation, and I have been privileged to witness some remarkably courageous movement in this regard. Many clients have gone on to support others who are struggling with similar experiences; others have permitted themselves to embrace whole new openings such as going on to further education and learning new skills that they believed were not within their grasp. And all have found new meanings in relationships.

Nira Kfir (1989) in her work on *Crisis Intervention* describes this well:

> "Indeed, people beyond fear, in the nothing to lose state that often follows a crisis, can see a new dimension. Once the paradigm breaks, people are free to choose new directions ... Real change is often started from the depths of the pit of despair. As long as we interveners remember that, our counsellees have genuine hope" (p. 44).

Calhoun and Tedeschi's (2006) more recently coined term *"Post-Traumatic Growth"* further confirms the idea that major change can occur from the experience of terrible fear and pain. It is an opportunity not just to "get back to normal", but a means of finding a new "normal" to a place where we have never been before, an enhanced place. It is an opportunity for a new found sense of ourselves in which we can feel a greater flexibility and crucially reclaim connection with others and the world.

***Natalie**, who experienced major early traumas wrote at the end of her therapy saying: "It's now my focus in life to help others. I have learned to be compassionate to both myself and others; and without diluting the suffering undergone, my experiences have actually contributed to my life in the sense that I am a better person today."*

Traumatic events are unfortunately part of human experience. However, as human beings, we also have remarkable adaptability and resourcefulness in our striving to overcome adversity, in our potential for re-connection with *Gemeinschaftsgefühl,* finding expression in even the darkest of places.

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