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EMBODIED RESILIENCE
IN UNACCOMPANIED LATIN AMERICAN CHILDREN
IN A UNITED STATES RECEPTION CENTER

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Thesis submitted to the faculty of Columbia College Chicago

in partial fulfillment of the requirements for

Master of Arts

in

Dance/Movement Therapy & Counseling

Department of Creative Arts Therapies

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Abstract

The purpose of this study was to explore ways in which a group of unaccompanied children (UC) from El Salvador, Guatemala, Honduras, and Brazil embodied resilience during their stay at a temporary reception center in the United States. The center was located in Illinois and received funding from the Office of Refugee Resettlement (ORR), under the U.S. Department of Health and Human Services. The 12-week clinical case study included a total of 19 male participants aged 12 to 17 years old attending dance/movement therapy sessions, which were scheduled weekly. Group progress notes and individual movement assessment coding sheets were completed and analyzed. A strengths-based lens was utilized to identify and understand resilience-related patterns and processes in participants. Conclusions include identification of participants' individual and collective embodied resilience and the role of dance/movement therapy in fostering collective embodied resilience through rhythmic group activity. The author identified bound flow and enclosing shaping qualities among participants' ways of coping with and adjusting to the immigration detention environment.

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Chapter I: Introduction

Unaccompanied children (UC) have been prominently featured in the media in the last few years (Gonzalez-Barrera & Krogstad, 2015; Lillis, 2016; Park, 2014; Tobia, 2014). This has been due to a surge during 2012 through 2014 in the number of UC trying to reach the United States via Mexico (United Nations High Commissioner for Refugees [UNHCR], 2014). More than 68,000 children were caught crossing the United States border between October 2013 and September 2014, which was double the number from the previous year (Park, 2014). The vast majority of UC were from El Salvador, Guatemala, and Honduras (Tobia, 2014). Many of them were boys between ages 15 and 17 (Park, 2014). The main reasons for migrating were poverty or violence in their home country, or family reunification in the U.S. (Park, 2014).

The United Nations High Commissioner for Refugees (2008) referred to unaccompanied children as “children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so” (p. 8). More specifically, the Homeland Security Act of 2002 (2002) stated that an unaccompanied child is a child who has no lawful immigration status in the United States, is under 18 years of age, and has no parent or legal guardian in the country present or available to provide care and physical custody.

The flow of UC through the U.S. immigration system is a complex process that can be confusing for people implementing the system and for UC. After being apprehended by federal authorities, UC are placed under the custody of the Office of Refugee Resettlement (ORR), and receive care through a network of local providers across the U.S. As of July 2011, approximately 50 ORR-funded facilities and programs were operating in 12 states (Byrne & Miller, 2012). In order to accommodate the large number of UC apprehended at the border, the U.S. Administration opened additional

shelters and holding facilities (Seghetti, Siskin, & Wasem, 2014). Unaccompanied children are held in these reception centers for an average of 61 days pending approval for sponsorship in the United States (Byrne & Miller, 2012). In cases where sponsorship or legal relief are not viable, UC are repatriated to their home country (Byrne & Miller, 2012).

There seems to be only one available study covering the mental health of UC in immigration detention (Australian Human Rights Commission [AHRC], 2014). The study identified UC as a particularly vulnerable group, with nearly half reporting depression and hopelessness all of the time (AHRC, 2014; Paxton et al., 2015). In the study, the Commission concluded that UC required higher levels of emotional and social support because they did not have a parent in the detention environment (AHRC, 2014).

Motivation for the Study

For over 10 years I worked at the United Nations Secretariat in New York translating documents related to, inter alia: children, migration, and refugees. Therefore, I was familiar with these issues at the program development and evaluation level. As an emerging dance/movement therapist, I am now interested in working at the community level, studying the well-being and protective factors of this population, and in particular their resilience.

Migration is a topic to which I can relate. I have lived outside my home country for the past 20 years. After graduating from college in Spain, I lived and worked in Taiwan and China for 8 years to further my professional development as a translator. For the past 12 years I have lived in the United States under different types of work and student visas. I would like to clarify that in no way I am trying to correlate my migration experience with that of the UC's. However, I can relate my migration

experience to the development of my own embodied resilience. During the time I lived in Taiwan, I balanced being a student and a teacher with the practice of tai chi and qigong. It helped me cope with the challenges of living with limited means in a foreign country. I learned to relax my body and mind through increased attention to breath, which in turn helped me become more aware of and regulate my inner states. My body-mind practice has evolved over the years and currently includes yoga and mindfulness. These self-care practices contribute to my embodied resilience in the face of life's challenges.

As part of the Master Program in Dance/Movement Therapy and Counseling at Columbia College Chicago, I did a 780-hour clinical internship at an ORR-funded reception center in Illinois for UC. The minors came mostly from Latin America and India. During my clinical sessions on coping skills at the center, I noticed Latin American participants pressing and sliding their hands against their legs while seated (increasing pressure), and moving their arms from their chest up and outwards (core-distal connectivity). Participants engaged in these types of movements when they were talking about how they coped with stressors at the center. Based on my personal experience with embodied resilience, as well as my clinical observation, I interpreted these movements that occurred during these types of narratives to be demonstrative of embodied resilience. I was interested in exploring the phenomenon of embodied resilience in greater depth through a case study.

Resilience and Embodiment

A concise definition of resilience that aligns with my understanding of the term can be found in the American Psychological Association's Psychology Help Center. In this web-based resource, resilience was described as "the process of adapting well in the face of adversity" (American Psychological Association [APA], 2016). My

understanding of embodiment aligns with what dance/movement therapist Lenore W. Hervey (2007) called the “lived experience of the body” (p. 95).

Embodied resilience. As an emerging dance/movement therapist, I am interested in embodied fields of study. What do I mean by embodied resilience? As understood in this study, resilience is inherently body-based, embodied. There is a body-based experience when we face a challenge, when we are under stress, when we cope and adapt. The body is paying attention, perceiving and sensing, is present, and is engaged in the challenging experience (Csordas, 1993). By combining the definitions of resilience and embodiment, embodied resilience can be understood as the adaptive process experienced by the body in the face of adversity.

Approach to Resilience

In this study, I followed the strengths model developed by Rapp and Goscha (2011), I observed participants’ movements using the Laban Movement Analysis framework (Moore & Yamamoto, 2012), and I focused on cohesiveness as a key group therapeutic factor (Yalom & Leszcz, 2005).

Strengths Model. Against a historical backdrop focused on deficits and the pathological in social work and other helping professions, the strengths model developed by Rapp and Goscha (2011) emphasizes “the person’s strengths, the relationship, and building hope” (p. 53). The model falls under the umbrella of positive psychology, a branch of psychology which focuses on nurturing rather than fixing, amplifying strengths rather than repairing weaknesses (Seligman & Csikszentmihalyi, 2000). The purpose of the model is “to assist another human being, not to treat a patient” (Rapp & Goscha, 2011, p. 51). Theory principles include acknowledging that the capacity for growth and recovery is already present within the people we serve and that the client is the director of the helping process; focusing on individual strengths

rather than deficits; and viewing the therapist-client relationship as essential and the community as a resource (Rapp & Goscha, 2011). The model works with a combination of individual and environmental strengths.

I was drawn to the strengths model because it puts people first. My personal approach to facilitating dance/movement therapy is clearly strengths-based, meeting clients where they are in their resilience. Due to their involuntary and usually protracted stay in a civil detention setting, participants often reported feeling powerless. While fully acknowledging and validating those emotions, I also focused on participants' strengths such as resilience in order to instill hope and to empower them. "We need to act as 'mirrors' reflecting the person's sense of worth, strengths, capacities, and aspirations" (Rapp & Goscha, 2011, p. 25). The goal was to foster awareness of participants' strengths, of what they already had, and of their internal locus of control. Also, as a dance/movement practitioner, I was drawn to a model that fosters creative ways to work with people that honor their skills, competencies, and talents (Rapp & Goscha, 2011).

Laban Movement Analysis. LMA is an observational and analytical framework grounded in Rudolph Laban's "elucidation of the core elements and organizational principles common to all movements" (Moore & Yamamoto, 2012, p. 148). Laban Movement Analysis is based on the following premises: movement is a process of change in spatial positioning, body activation, and energy usage; the change is patterned and orderly; human movement is intentional and satisfies a need; the basic elements of human motion may be articulated and studied; and movement must be approached at multiple levels if it is to be properly understood (Moore & Yamamoto, 2012). The framework was further developed by Irmgard Bartenieff and Warren Lamb (Moore,

2010). Its parsimonious nature was deemed appropriate for this study as a general system of movement description (Moore, 2010).

Group Cohesiveness. Yalom and Leszcz (2005) described cohesiveness as “the group therapy analogue to relationship in individual therapy” (p. 53). In *The Theory and Practice of Group Psychotherapy*, group cohesiveness was seen as a necessary factor for other group therapeutic factors to occur (Yalom & Leszcz, 2005). Taking on an active role, “members of a cohesive group feel warmth and comfort in the group and a sense of belongingness; they value the group and feel in turn that they are valued, accepted, and supported by other members” (Yalom & Leszcz, 2005, p. 55).

Cohesiveness is also part of my own preferences and biases, and one of my goals as group facilitator.

Clinical Questions

The main question for this clinical case study was: How is resilience embodied by unaccompanied children from Brazil, El Salvador, Guatemala, and Honduras at a reception center in the United States? A secondary question was: How can dance/movement therapy support embodied resilience in unaccompanied children from Latin America in reception centers in the United States? The first question focused on resilience as an internal protective factor, while the second question focused on resilience as an external protective factor.

Chapter II: Literature Review

Unaccompanied Children

From 2012 through 2014, there was a surge in the number of unaccompanied children (UC) from Central America trying to reach the United States via Mexico (UNHCR, 2014). Figures for 2015 pointed to a decrease in the number of children apprehended by U.S. authorities at the U.S.-Mexico border (Gonzalez-Barrera & Krogstad, 2015). This was due to increased deportations of UC from Central America by the Mexican Government (Gonzalez-Barrera & Krogstad, 2015). Another possible reason for the decrease in apprehensions was public information campaigns in Central America launched by the U.S. Government to discourage children from trying to cross into the U.S. (Gonzalez-Barrera & Krogstad, 2015). In 2016, child migration seemed to be near 2014 levels again (Lillis, 2016). The increase was attributed to the ongoing violence in Central America and to human smugglers adapting to the 2015 crackdown (Lillis, 2016).

Reasons to migrate. UNHCR (2014) conducted a study of the reasons why children from El Salvador, Guatemala, Honduras, and Mexico left their home countries. More than 400 unaccompanied or separated children from those four countries were interviewed for the study. The term “separated children” refers specifically to children “separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives” (UNHCR, 2008, p. 8). The study found that 48 percent of the children “shared experiences of how they had been personally affected by the augmented violence in the region by organized armed criminal actors, including drug cartels and gangs or by State actors” (UNHCR, 2014, p. 6). The study also found that 21 percent of the children “had survived abuse and violence in their homes by their caretakers” (UNHCR, 2014, p. 6). Family reunification or better

opportunity in the United States was mentioned by 81% of children, and deprivation and social exclusion was mentioned by 16% of children (UNHCR, 2014).

Meanwhile, a report on UC by the Congressional Research Service stated that there was no clear answer to the root causes of the increase in UC attempting to illegally enter the United States (Seghetti et al., 2014). A confluence of different pull and push factors seemed to contribute to the upsurge, including “recent U.S. policies toward unaccompanied children, faltering economies and rising crime and gang activity in Central American countries, the desire for family reunification, and changing operations of smuggling networks” (Chishti & Hipsman, 2014, Why is this happening?, para. 3). One of the main reasons cited for the 2012-2014 surge in the media was that “because so many minors caught in the past few years were reunited with their families [in the U.S.] and not immediately deported, many Central Americans were left with the perception that the United States was allowing children to stay” (Park, 2014, “What caused the sudden increase”, para. 1). In fact, children were not deported immediately because under an anti-trafficking statute adopted in 2008, minors from Central America must be given a court hearing (Park, 2014). Once released to a sponsor in the United States, given the huge backlog of cases, UC may have to wait up to three years for a hearing before they are deported or allowed to stay (Greenblatt, 2014).

Most of the UC arriving at the U.S.-Mexico border in the last few years were from Honduras (28 percent), Mexico (25 percent), Guatemala (24 percent), and El Salvador (21 percent) (Chishti & Hipsman, 2014). This breakdown represented a significant shift: prior to 2012, more than 75 percent of UC came from Mexico (Chishti & Hipsman, 2014). Under special rules for children who come from the contiguous countries of Mexico and Canada (Byrne & Miller, 2012), the vast majority of unaccompanied Mexican children apprehended at the southern border elect to go back

to Mexico through a voluntary return process without additional penalties (Byrne & Miller, 2012). Over the course of this study, UC from Brazil started arriving at the reception center. The reasons for migration to the U.S. reported by Brazilian UC during the initial assessment were similar to those of UC from Central America, and included educational and economic advancement and family reunification in the U.S.

International protection and United States policy. The Convention on the Rights of the Child is the fundamental international framework for the rights and protection of children (UNHCR, 2014). The Convention highlights “the special protection needs of children deprived of their family environment and of children who are refugees or are seeking asylum, and it states that all the provisions of the Convention apply without discrimination to all children under the jurisdiction of a State” (UNHCR, 2014, p. 3). Many UC arrive “in the context of ‘mixed migration’ movements, which include both individuals in need of international protection and migrants without international protection needs” (UNHCR, 2014, p. 3). The UNHCR study (2014) tried to ascertain the international protection needs of these children. The study found that “58% of the 404 children interviewed were forcibly displaced because they suffered or faced harms that indicated a potential or actual need for international protection” (UNHCR, 2014, p. 6). The study identified two overarching patterns of harm related to potential international protection needs: violence by organized armed criminal actors and violence in the home (UNHCR, 2014). The study concluded that “given the high rate of children who expressed actual or potential needs for protection, all unaccompanied and separated children from these four countries must be screened for international protection needs” (UNHCR, 2014, p. 6).

United States policy for the treatment and administrative processing of UC is mainly governed by the Flores Settlement Agreement of 1997, the Homeland Security

Act of 2002, and the Trafficking Victims Protection Reauthorization Act of 2008 (Seghetti et al., 2014). The Flores Settlement Agreement “established a nationwide policy for the detention, treatment, and release of UC and recognized the particular vulnerability of UC while detained without a parent or legal guardian present” (Seghetti et al., 2014, p. 3). The Homeland Security Act of 2002 “divided responsibilities for the processing and treatment of UC between the newly created Department of Homeland Security (DHS) and the Department of Health and Human Services’ (HHS) Office of Refugee Resettlement (ORR)” (Seghetti et al., 2014, p. 3). The Department of Homeland Security handles the apprehension, transfer, and repatriation responsibilities, while HHS is responsible for coordinating and implementing the care and placement of UC in appropriate custody (Seghetti et al., 2014). The Trafficking Victims Protection Reauthorization Act (TVPRA) of 2008 directed DHS and other federal agencies “to develop policies and procedures to ensure that UC in the United States are safely repatriated to their country of nationality or of last habitual residence” (Seghetti et al., 2014, p. 4).

The surge of UC has strained U.S. government resources and created a complex crisis with humanitarian implications (Kandel, 2016). Experts have warned that “significant migration flows will continue until policymakers in the countries of origin and the international community address the poor socioeconomic and security conditions driving Central Americans to leave their homes” (Meyer, Margesson, Ribando Seelke, & Taft-Morales, 2016, p. 2). For more information on the political and financial aspects of how the U.S. is addressing the surge of UC, see Kandel (2016) and Meyer et al. (2016).

Immigration detention. Once apprehended and charged with violating U.S. immigration laws, UC enter the highly complex immigration detention and removal

system. In *The Flow of Unaccompanied Children Through the Immigration System*, Vera's Center on Immigration and Justice found that

- up to 15 percent of unaccompanied children enter the system as a result of being apprehended “internally” in the United States (as opposed to at a port of entry);
- most children referred by [the Department of Health and Human Services] to [the Office of Refugee Resettlement (ORR)] (80 percent) are placed in a shelter setting—the least restrictive type of placement available within the ORR system;
- most children (75 percent) remain in ORR custody for one week to four months, with an average stay of 61 days;
- at least 65 percent of children admitted to ORR custody are ultimately placed with a sponsor living in the United States;
- approximately 40 percent of children admitted into ORR custody are identified as eligible for a form of legal relief from removal (such as asylum, special immigrant juvenile status, or visas for victims of crime or trafficking). (Byrne & Miller, 2012, p. 4)

Apart from family reunification (65%), other types of discharge from ORR custody included return to home country (17%), either through voluntary departure or a removal order; and attaining adult status (10%) (Byrne & Miller, 2012).

Mental Health of Unaccompanied Children

There are few studies on the mental health status, including risk and protective factors, of UC. A study of unaccompanied asylum-seeking children and adolescents (UASC) from the Balkans and Horn of Africa resettled in the United Kingdom found that “UASC had experienced high levels of losses and war trauma, and posttraumatic stress symptoms” (Hodes, Jagdev, Chandra, & Cunniff, 2008, p. 1). Geltman et al. (2005) conducted a survey on the functional and behavioral health of unaccompanied

Sudanese refugee minors resettled in the United States. The authors concluded that unaccompanied Sudanese minors had done well in general, functioning well in school and in activities, but manifesting behavioral and emotional problems in their home lives and emotional states (Geltman et al., 2005).

There seems to be only one available study on the emotional and mental well-being of UC in immigration detention (AHRC, 2014). The study conducted by the Australian Human Rights Commission (2014) included 83 UC held in detention centers in Australia and Nauru in 2014. The unaccompanied children were 15 to 17 years old, most of them from Afghanistan, Myanmar, Somalia, and Iran (AHRC, 2014). In March 2014, the average length of detention for UC was 217 days (AHRC, 2014). In the study, the Commission concluded that

unaccompanied children require higher levels of emotional and social support because they do not have a parent in the detention environment. Detention is not a place where these children can develop the resiliencies that they will need for adult life.

There are causal links between detention, mental health deterioration and self-harm in unaccompanied children. (AHRC, 2014, p. 34)

The study identified UC as a particularly vulnerable group (Paxton et al., 2015). In the AHRC study (2014), 58% of the UC described detention as “crazy-making” and “depressing” (p. 152); 48% of UC stated feeling depressed all of the time, and 45% stated feeling hopeless all of the time.

Protective factors. The literature seems to be focused more on risk factors than on protective factors, including resilience, for UC. Focusing only on psychopathological symptoms does not take fully into account the complex profiles of UC. Lustig et al. (2003) stated that conceptualizing refugee children’s stress responses from a

psychopathological perspective pathologizes the individual, potentially ignoring coping and resilience. Also, using a diagnostic system developed and validated on Euro-American populations may lead to misdiagnosing, overpathologizing, or failing to identify mental health problems in people of other cultures (Dana, 2001).

In a white paper on child and adolescent refugee mental health, Lustig et al. (2003) cited social support and parental well-being as protective factors in the context of refugee camps. Using a risk and resilience framework and a case study of a Sudanese refugee, Carlson, Cacciatore, and Klimek (2012) identified sources of resilience among unaccompanied refugee minors resettled in the United States. These sources included “positive outlook, use of healthy coping mechanisms and religiosity, and connectedness to prosocial organizations” (Carlson et al., 2012, p. 1). Same ethnic group contact was found to reduce posttraumatic stress and depressive symptoms in unaccompanied refugee minors from Sudan settled in the United States (Geltman et al., 2005). Hodes et al. (2008) concluded that UC “might have less psychological distress if offered high-support living arrangements and general support as they approach the age of 18 years” (p. 1).

Further studies are needed to investigate the range of risk and protective factors, including resilience, among UC (Carlson et al., 2012; Hodes et al., 2008; Lustig et al., 2003). There were also concerns about the relevance of international research findings to UC in the United States, in terms of UC’s country of origin and treatment upon arrival by the host country (Carlson et al., 2012). With the prolonged and indefinite detention of asylum-seeking children, the immigration detention environment in Australia described in the AHRC’s report (2014) seemed much harsher than the immigration detention environment in the United States described by Byrne & Miller (2012).

Embodied Resilience

Resilience. There are many interpretations of resilience depending on the field of study. Even just in the field of psychology, there are diverging definitions of the term. Resilience can be seen as a process and as a product. As a process, the American Psychological Association's Psychology Help Center described resilience as "the process of adapting well in the face of adversity" (APA, 2016, What is resilience?, para. 1). As a quantifiable product, resilience was defined as a good outcome in the face of adversity (Center on the Developing Child, 2015). Resilience was also seen as a combination of internal and ecological protective factors that enable people to adapt in the face of serious hardship (Center on the Developing Child, 2015). In their literature review of child and youth resilience, Khanlou and Wray (2014) argued for a hybrid approach. Khanlou and Wray (2014) described resilience as a process developing over time and depending on the interactions of the systems involved; as a continuum influenced by the support available and challenges faced over time; as well as a global concept with specific dimensions, such as academic resilience and social resilience.

Embodiment. As with the resilience construct, embodiment is understood differently in different fields. My understanding of embodiment aligns with what dance/movement therapist Lenore W. Hervey (2007) called the "lived experience of the body" (p. 95). Along those lines, Csordas (1993) talked about embodiment as "attending 'with' and attending 'to' the body" (p. 138). Csordas (1993) also provided a more contextualized definition of embodiment as "culturally *elaborated* attention *to* and *with* the body in . . . an *intersubjective* milieu" (p. 139).

There are emerging studies on embodied constructs and experiences, such as embodied empathy (Harris, 2007b), embodied ethical decision making (Hervey, 2007), and embodied trauma (Caizzi, 2012). Harris (2007b) explored embodied/kinaesthetic

empathy to promote trauma healing and community reconciliation in Sierra Leone. Kinaesthetic empathy helped foster authenticity and disclosure in participants; evocation of emotions through role-play and bodily movement allowed participants to feel empathy for victims and for themselves (Harris, 2007b).

Embodied Resilience. Available dance/movement therapy (DMT) studies on resilience and refugee populations focus on interventions aimed at fostering resilience. Gray (2001) concluded that dance/movement therapy, following the experience of torture, can be beneficial in rebuilding an individual's sense of wholeness and self, and in improving interaction skills and relationship capacity. Based on his work with unaccompanied refugee minors from the Southern Sudan resettled in Pennsylvania and former child soldiers in Sierra Leone, Harris (2007a) stated that DMT approaches, whether introduced in refuge or post-conflict, were shown to embody revitalizing psychosocial support in the aftermath of massive violence. Wengrower (2015) reported on possible contributions of dance/movement therapy to resilience-facilitating interventions. Viewing the body as a resource, interventions encouraged body awareness, conscious breathing, Effort modulation, relaxation techniques, and dance (Wengrower, 2015).

In her master's thesis, Jayme Kelton (2014) explored how DMT could inform the experience of resilience in a group of female African-American and Latina adolescents in the U.S. The qualitative case study provided insight on how the researcher and participants conceptualized resilience differently, based on their respective culture and value systems. However, the study was not able to establish an explicit connection between movement and resilience.

Conclusion

In 2016, the number of UC from Central America trying to reach the United States via Mexico seemed to be near 2014 surge levels again (Lillis, 2016). The main reasons to migrate reported by UC from El Salvador, Guatemala, and Honduras included violence in society, abuse in the home, deprivation and social exclusion, and family reunification or better opportunity (UNHCR, 2014). A confluence of different pull and push factors seemed to contribute to the upsurge, including recent U.S. policies toward UC, faltering economies and rising crime and gang activity in Central American countries, and changing operations of smuggling networks (Chishti & Hipsman, 2014). Given the high rate of children who expressed actual or potential needs for protection, UNHCR (2014) concluded that “all unaccompanied and separated children from these four countries must be screened for international protection needs” (p. 6).

Once apprehended and charged with violating U.S. immigration laws, UC enter the highly complex immigration detention and removal system. Most children (75 percent) remained in ORR custody for one week to four months; at least 65 percent of children admitted to ORR custody were ultimately placed with a sponsor living in the United States; and approximately 40 percent of children admitted into ORR custody were identified as eligible for a form of legal relief from removal (Byrne & Miller, 2012).

Few studies specifically addressed mental health in UC. A study by the Australian Human Rights Commission (2014) identified UC in immigration detention as a particularly vulnerable group, with nearly half reporting depression and hopelessness all of the time. Sources of resilience among unaccompanied refugee minors resettled in the United States included “positive outlook, use of healthy coping mechanisms and religiosity, and connectedness to prosocial organizations” (Carlson et

al., 2012, p. 1). Further studies are needed to investigate risk and protective factors, including resilience, among UC (Carlson et al., 2012; Hodes et al., 2008). There were also concerns about the relevance of international research findings to UC in the U.S., especially in terms of treatment upon arrival (Carlson et al., 2012).

Depending on the paradigm used, resilience is seen as a process and as a product, as well as a combination of internal and ecological protective factors that enable people to adapt in the face of serious hardship (APA, 2016; Center on the Developing Child, 2015). Embodiment is understood as the “lived experience of the body” (Hervey, 2007, p. 95), attending with and to the body (Csordas, 1993). Some studies have focused on embodied phenomena such as embodied empathy (Harris, 2007b). Available DMT studies on resilience and refugee populations focused on interventions aimed at fostering resilience (Gray, 2001; Harris, 2007a). There seemed to be scant research on embodied resilience as an internal protective factor.

Chapter III: Case Presentation and Analysis

A case study employs a “qualitative approach in which the investigator explores a real-life, contemporary bounded system (a case) . . . over time, through detailed, in-depth data collection involving multiple sources of information . . . and reports a case description and case themes” (Creswell, 2013, p. 97). This is a clinical case study. This kind of case study is guided by clinical questions and clinical theory and demonstrates how theory is applied to practice (Creswell, 2013).

Case

The case was made up of a total of 19 UC from Brazil (N=8), El Salvador (N=1), Guatemala (N=9), and Honduras (N=1). The 19 UC attended weekly dance/movement therapy sessions for 12 weeks. The number of participants in each session varied. Participants were sometimes unavailable because they were meeting with their assigned counselor for individual sessions, with family reunification specialists, or with the doctor. Also, as participants were released, new participants were included in the group for an average group size of six to seven participants.

During initial assessments of UC, their assigned clinical counselor would assess their biopsychosocial functioning and needs. Clinical counselors would also ask participants about any potential traumatic events experienced in home country and during migration. One participant reported experiencing difficulty learning in school; another participant who had experienced physical abuse by his father, had engaged in self injurious behavior; another participant had taken medication for anxiety for several years after his parents separated in a household with domestic violence; some admitted having suicidal ideation in the past. Some participants may have not disclosed information for fear of delaying their release from the center. Safety concerns were reassessed on a monthly basis. None of the participants were in safety plans for risk of

harm to self or others during the study. In line with the AHRC report (2014) on the mental health status of UC in immigration detention, participants showed depression symptoms and hopelessness during sessions.

Participants' ages ranged from 12 to 17 years old. Participants presented with different levels of psychological maturity, personality type (introverted/extroverted), and physiology. Participants' length of stay at the center ranged from a month to four months. Participants who were released during the course of the study were reunited with a parent or with a family friend in the United States.

Participants in the study had a diverse combination of family history in home country and migration experiences. In their home countries, some participants had been raised by one or both parents, and others by a relative or a caregiver. Some had suffered physical and emotional abuse in the home. Some participants were still in school before they migrated, others worked in agriculture or in small businesses. One participant had fathered a child in his home country. A participant from Guatemala had two years to repay a \$4,000 debt incurred by his family in which the family house was provided as collateral. Guatemala's gross national income per capita, expressed in purchasing power parity (PPP) dollars, was 7,510 PPP dollars in 2015 (World Bank, n.d.). During their migration journey, a participant had travelled with his sisters, who had already been released from the center. Another participant had made the journey with his father, who was incarcerated at a separate adult facility for illegal entry into the U.S. Another participant almost drowned crossing Rio Bravo and was kidnapped by unknown men for several days in Mexico before he tried to cross the border again. While most participants had been apprehended at the U.S.-Mexico border, two participants had been apprehended internally after being in the United States for about a year. One of them

had been working 12-hour shifts in a restaurant. Another participant was considering returning to his home country since he did not have a viable sponsor in the U.S.

Participants usually stated that they did not expect to be apprehended at the border. Also, by the time participants arrived at the center, some of them had already been in temporary camps and had not seen their primary caregivers for several months. This successive transfer through different facilities seemed to have had an impact on their morale. During their stay at the center, participants' main concerns were progress in their reunification cases, aging out (i.e., turning 18 years old and being transferred to an adult facility), and the lack of freedom in their daily life in detention. In particular, participants regularly complained about having to line up 20 times throughout the day, including roll calls to ensure all participants were present, to transition to the different scheduled activities at the center.

Setting

The dance/movement therapy sessions were conducted at a reception center for unaccompanied children in Illinois. The center fell under the shelter care category of the Office of Refugee Resettlement. Most children in shelter care do not have special needs or a history of contact with the juvenile or criminal justice system (Byrne & Miller, 2012). The site was licensed to host a maximum of 250 UC, ages ranging from 0 to 17 years old. Minors at the center came mostly from Central America and India. The floor where I conducted the study could accommodate around 40 participants. The census was low while I conducted the study on that floor, oscillating between 11 and 16 participants.

The center provided housing, medical care, counseling, case management, education, family reunification, and recreation services. The center employed a strengths-based approach, fostering participants' coping skills; a trauma-informed lens,

asking participants about their experience of trauma when assessing them for services; and culturally-sensitive approaches and activities carried out by Spanish-speaking staff. Most of the clinical staff and case managers were Latino, and spoke English and Spanish. Some staff spoke Portuguese. During weekly clinical group meetings, clinical counselors took turns presenting individual cases and collectively brainstormed ways of supporting participants' emotional wellbeing.

Information Documentation

Information was documented through group progress notes and movement assessment coding sheets (MACS) for each participant. Unidentified group progress notes were written after each session (see Appendix A). Progress notes included a description, assessment, and plan for each session. Using a strengths-based lens, participants' verbal and nonverbal engagement during session was described, as well as different body-mind activities. The electronic progress notes were stored on the center's computer network.

Movement Assessment Coding Sheets (MACS) utilized Laban Movement Analysis (LMA) structure and terminology (see Appendix B). The coding sheets followed LMA's four categories: Body, Effort, Shape and Space. The Body category looked at what body parts were active or held, and at connections in the body according to principles of efficient movement functioning (Hackney, 2002). The Effort category looked at how the body moved in terms of effort exerted to aim and orient movement (space), to pace the movement (time), to apply pressure (weight), and to control movement (flow) (Moore, 2010). These four motion factors under Effort can be approached by the mover from an inner fighting or indulging attitude (Moore, 2010). Shape looked at body shapes, including shaping qualities describing the direction in which the body is changing shape (Moore, 2010). Space looked at where participants

moved inside a sphere of space immediately adjacent to their body, referred to as kinesphere (Moore, 2010). The MACS were completed after every session to document the observation of participants' movement qualities. The unidentified coding sheets were stored in a secure filing cabinet at the center's clinical office.

Information Analysis and Interpretation

Information analysis and interpretation started in parallel with the 12 weekly sessions, in the form of extended progress notes, which are the basis for the session-by-session description in this chapter. I followed the strengths model developed by Rapp and Goscha (2011), which provides a framework that “uncovers strengths and the power within people” and “allows for new and creative ways to work with people that honor their skills, competencies, and talents” (Rapp & Goscha, 2011, p. 56). The theory focuses on fostering individual strengths such as competencies and confidence, and environmental strengths such as access to resources and social relations. The weekly session descriptions include how key concepts of the theory were implemented during sessions.

Validation Strategies

Validation strategies included member checking, comparison of documented information, and consultation with thesis advisor. During each session, I shared what I noticed with participants, such as strong or light movements when they danced or enclosing postures while they sat on the couch. I also looked for consistency in identified movement qualities across different data sources, as well as within the same data sources. Monthly consultation with my thesis advisor provided an external check of the process in the clinical case study.

Ethical Considerations

Participants were minors, away from their parents or caregivers, in a foreign country, and under temporary detention. Those four vulnerability factors posed a major power differential in the clinical intern/participant relationship. Participants had to follow a strict schedule of sleep and wake times, meal times and activities. Clinical groups sessions were part of the scheduled activities and participants were required to attend them as part of their individualized service plan. To minimize the level of coercion imposed on participants to attend the DMT sessions, I always gave participants the option to decide their level of engagement during sessions. If the session took place in the milieu, participants could choose not to take part in activities. If the session was in a lounge room, participants had the option to go back to the milieu instead. Also, as a safety measure, a licensed clinician or case manager was present during most of my sessions, and the door was kept open when I was the only staff member in the room with participants. I did close the door while doing vocalizations with participants so as not to disturb staff working in nearby offices. The clinical team welcomed the DMT activities I introduced during sessions to help participants cope with their distress.

As an intern seeking deeper understanding of resilience, the main ethical dilemma I faced was remaining a clinician while knowing that I was interested in exploring embodied resilience, yet protecting participants' wellbeing. During sessions, I focused on attending to participants' clinical needs. The resilience lens came out gradually and more explicitly while writing longer progress notes, which form the basis for the session-by-session description in this chapter.

I approached all participants with empathy and respect. While fostering participants' strengths, skills and hope, I avoided the "cheerleader approach" (i.e., focusing only on the positive when participants were feeling distressed) (Rapp &

Goscha, 2011, p. 77). I fully acknowledged and validated participants' feelings of isolation and emotional distress, as well as the daily challenges in connection with the detention environment. I do not think that I was viewed by participants as an authority representing the institution or U.S. immigration. I was on the floor where I conducted the study only one day a week, and participants knew I was there as part of my internship as a master-level student.

To ensure the confidentiality of the data, I have not collected or included any information that might lead to the identification of the participants. Participants are identified in this study by alphabet letters. This study was approved by the center's Director of Clinical Services and did not involve a traditional research approach. Rather, the clinical work and documentation was reviewed to explore the phenomenon of embodied resilience through a strengths-based lens.

Socioeconomic and Cultural Considerations

During group sessions, I was mindful of socioeconomic and cultural differences and similarities between my Spanish background and that of the Central American and Brazilian participants, as well as between Central American and Brazilian participants. I come from a developed, European country, where I received government scholarships to attend school as a child from a low-income household. Participants came from developing, Latin American countries, where they usually lacked safety and opportunities. There was also a significant difference in our respective arrivals to the United States. In 2004, I flew into the U.S. with a work visa, while participants were arrested after crossing the U.S.-Mexico border on foot or on a raft through an unauthorized point of entry.

Despite these socioeconomic differences, as a male Spanish-speaker I was able to establish a quick rapport with most participants. There seemed to be enough common

ground in the group's and my own cultural identities to support this quick development of rapport. For example, I shared a primary language with Central American participants, since we all spoke Spanish. Spanish spoken in Spain and Spanish in Latin America differ somewhat. However, I was able to communicate smoothly in Spanish with Central American participants. Brazilian participants spoke Brazilian Portuguese. Spanish and Portuguese are closely-related languages. Therefore, speakers of either language can often understand each other easily. Since Brazilian participants understood basic Spanish, I spoke in Spanish most of the time. I sometimes spoke in English to clarify a point with Brazilian participants, who also spoke some English.

I grew up speaking Spanish and Catalan, and many Guatemalan participants also spoke indigenous languages, including K'iche' and Mam. During one session, I took advantage of this multilingual environment to explore the expression of key concepts such as "heart" in the different languages spoken by participants and their embodied expression.

Central American and Brazilian participants come from different socioeconomic and cultural backgrounds. In general, Brazilians had attended school more years and had more access to services. A Brazilian participant reported working for his father's business, owning a car, and having disposable income. In general, Brazilian participants seemed more assertive, with stronger use of weight in their movements. Participants from Guatemala and Honduras usually came from small villages, had attended school until third grade and worked in agriculture. The one participant from El Salvador came from an urban area. In general, Central American participants seemed more reserved initially, often moving in near reach in relation to their kinesphere. I validated Central American and Brazilian cultures providing opportunities to listen to songs in their

mother tongue and to move in their respective dance forms. Participants' different cultural dance forms are documented in the session-by-session descriptions.

Dance/Movement Therapy Sessions

I led a total of 12 weekly dance/movement therapy sessions. An average of six to seven Central American and Brazilian participants attended the hour-long sessions at a time. As participants were being released from the center, new participants were included in the group. Since there was usually at least a new participant each week, I started each session providing a brief, teenager-friendly explanation of dance/movement therapy. I described DMT as a discipline that allowed us to acknowledge and explore the interconnectedness of emotions and their expression in the body. It seemed to make sense to them as evidenced by their nodding. I viewed participants as owners of the process, regularly asking them what they needed from the session and from the group, and inviting them to suggest or take part in activities. In the strengths-based approach, “the presence of an invitation keeps power in the hands of the client and reinforces the principle of the client being the director of the helping process” (Rapp & Goscha, 2011, p. 74).

There was no explicit treatment plan at the site. There was an individualized service plan for each participant, which included weekly individual and group clinical sessions. The overarching goals of both types of sessions were to provide general mental health support. I led DMT sessions as part of group clinical sessions. The specific goals of the weekly DMT sessions were to help participants express and release emotions or tension through creative self-expression, including dance from their culture of origin; to foster group cohesiveness through collective movement as a protective factor; and to foster hope and well-being through mindfulness. The AHRC report (2014)

and Rapp and Goscha (2011) found mindfulness to be an effective tool for promoting hope and well-being among UC.

I implemented DMT from a culturally-informed approach, taking into account participants' culture of origin. I invited participants to move in their preferred dance style. Central American participants danced *bachata* and Brazilian participants danced *capoeira*. In view of participants' emotional distress due to the detention environment, sessions also included psychoeducation on emotional regulation. I explained how body and mind were interconnected and how one could influence the other. I explained that DMT and mindfulness could help them acknowledge and modulate their emotional and physical states. Many participants reported issues with sleep, so I also included psychoeducation on sleep hygiene.

Week 1. On week 1, I introduced myself to the group as a DMT clinical intern and told participants that I would be running weekly sessions for about three months at the site. To start the session, I focused on signature movements to get a general sense of participants' preferences in relation to fundamental patterns of total body connectivity (Hackney, 2002), Effort qualities, body shapes and use of space. Each participant (3 Brazilian, 5 Central American) shared a movement that represented their individual personalities or mood. Participants showcased a diverse range of movement qualities. Examples include: stretching out one arm forward and upward, moving into their far reach kinesphere; making a 360° stationary turn, bending their knees and leaning their torso forward; twisting their torso left and right, with their arms hanging loose and swinging along; bending both knees and twisting their torso to the side, bringing one hand underneath their chin; standing sideways and pushing their pelvis outward; hopping while turning around several times. The participants brought in an element of

humor and play in their signature movements and laughed several times while they moved.

During that first session, I also invited participants to dance to Latin, Brazilian and English-language songs in order to foster their creative self-expression, and to help them release held tension in their bodies. “Dance therapy essentially makes use of people’s natural kinesthetic response to musical rhythm,” which can contribute to the “basic fulfillment of emotional release and relating to others” (Sandel, Chaiklin, & Lohn, 1993, p. 208). Participants listened to and sang along with songs in their mother tongue, and shared *bachata* and *capoeira* steps. From a Space category, *bachata* steps use near reach and central approach to kinesphere. *Capoeira* steps use low, middle and high levels; near, mid, and far reach, and peripheral approach to kinesphere. Both styles seemed to bring joy to the respective participants. Some participants also did basic breakdance steps, which could speak to the cross-border appeal of street culture among teenagers. While they danced in a loose circle in the room, participants’ affect became brighter and their mood became euthymic. Participants laughed together during the movement activity. A moment of collective embodied resilience took place, with participants coping with the restrictions of a detention environment through rhythmic group activity. “As feelings are expressed in a shared rhythm, each member draws from the common pool of energy and experiences a heightened sense of strength and security” (Sandel et al., 1993, pp. 80-81).

To cool down and to promote wellbeing in participants, I invited them to sit in a circle and to do several breathing exercises with guided visualization. I invited participants to breathe in, allowing positive energy in, and to breathe out, letting go of any emotional burdens. Participant F from Guatemala started making animal sounds and other participants followed. Participants making the sounds talked about being around

farm animals in their rural environment. The vocalizations seemed to be an expression of cultural identity as well as one of using humor as a coping skill.

My intention for that first session was to invite participants to express themselves and their emotions through movement. Reflecting on that first session, participants were open to create a signature movement to express their individuality, and moved collectively in their culture-of-origin dance, as well as in breakdance and freestyle.

Week 2. On week 2, the same eight participants attended the session (3 Brazilian, 5 Central American). My academic supervisor was also present as part of a site visit for clinical supervision. During verbal check-in, participants stated a wide range of emotions, ranging from feeling anxious and sad to good and happy. I observed some incongruences, with participants saying they were “doing okay,” while their body language said otherwise, with enclosed shapes and bound flow, and limited expression in their faces.

During check-in, participant D stretched his arms up victoriously, while participant C tapped his chest with his right hand, mentioning sadness and pain in his heart. Participant E stated, “feeling okay,” with his arms crossed over his chest. Participant H said he was anxious, having received bad news about his case, with his arms also crossed over his chest. Participant A stretched his arms and torso upwards as he mentioned that he had received bad news as well. Other participants also had their arms crossed over their chest or hanging on both sides. Some participants swung their arms forward and backwards.

Based on the wide range of emotions and movement qualities in participants, I asked participants what they wanted to do during the session. “Opportunities to move each client closer to being the director of the helping situation should be found, created,

and exploited” to keep “the practitioner centered on what is important and meaningful to the person” (Rapp & Goscha, 2011, p. 59). Participants stated that they wanted to dance. I invited participants to do a warm-up while dancing to a mid-tempo Latin song. Then, I invited participants to dance in freestyle while listening to Brazilian, Latin and English-language songs. Brazilian participants showed basic *capoeira* steps such as the *ginga*, stepping to the side with one leg and taking a step back with the other with a slight rotation of the torso towards the front leg. More advanced steps followed, such as the leg fan and handstands. Most participants followed the capoeira steps.

During this session, I started noticing a formation pattern of gathering and scattering. This pattern would become part of the weekly sessions. Participants gradually scattered around the room. I started mirroring participant C, who was popping and locking with his upper body. Then, I invited the other participants to gather together in a circle to pass an “electric current” from one arm, across the torso, to the other arm and then passing it on to the next participant. It was a moment of “we-ness” (Yalom & Leszcz, 2005, p. 55), with participants visibly engaged in the activity, paying attention to the group as a whole, and displaying brighter affect. The original idea was that participants would pass the current around one at a time; in the end, several participants were passing the electric current around simultaneously.

We also danced like robots, mirroring each other back and forth. I started to feel that they were open to more intentional directions from me. Participants seemed open to movement activities, as when I taught them the steps from the “Watch Me” song (Hawk & Mingo, 2014), and an improvised choreography to other Top 40 songs. At that point, I realized I could bring more structured movement to sessions. Participants went back to doing handstands, testing their own physical limits. To cool down and end the session, I

invited participants to sit in a circle to breathe with their eyes closed and in silence for a minute.

Reflecting back on the session, I did a lot of dyadic mirroring when participants were scattered. Mirroring was especially useful to connect with participants who seemed more introverted. In one particular case, I reflected back a robotic movement phrase, which seemed to pleasantly surprise a participant, as evidenced by his raised eyebrows. It helped me connect with him at a nonverbal level (Sandel et al., 1993; Tortora, 2006).

Week 3. On week 3, the same eight participants attended the session (3 Brazilian, 5 Central American). Most participants seemed very active in the beginning of the session. Participant A did some soccer movements, passing an invisible ball sideways. He also did the crow and other yoga poses. Participant E did a handstand; he also moved around with his torso leaning forward, one arm across his chest, and the other arm stretched in front of him with his head down. He smiled while he moved. Participant H was very talkative with high upper torso mobility in different directions. Other participants noticed it and started mirroring him; participant G seemed upset, with a lowered chin, and engaged in side-talk in Portuguese with another participant. Participant B, who was more reserved in previous sessions, showed more initiation by offering movement ideas, and displayed more active shoulders and increased use of space. Participant F danced with *bachata*-like short steps, with his forearms up, elbows bent close to his torso, and shoulders slightly up. Participant C was more withdrawn that week, sitting by himself on one corner of the room. Participant D was bouncing around, breakdancing a little, with quick use of time and free flow. Some participants were doing cartwheels and handstands.

Participants were scattered around the room in two clusters, one Brazilian and one Central American. Taking advantage of participants' high energy level and common athletic strengths (Rapp & Goscha, 2011), I brought in an Effort modulation activity in order to help participants channel that energy (Moore, 2010). From their scattered clusters, I invited participants to run around the room as if riding a motorcycle on a race track. Participants ran faster and faster with each turn, sometimes adding engine and skidding sounds. On the final round, after they could not run any faster, participants slowed down, catching their breaths and letting out audible laughter. The activity seemed to bring them out of their psychological/emotional rut and brought some laughter and relaxed affect, creating a moment of group cohesiveness (Yalom & Leszcz, 2005).

Besides the race track activity, the group felt loose during most of the session, with little initiation from participants. When I tried mirroring back their movements, it felt forced and, for the most part, they did not connect to it. I was faced with the challenge of meeting them where they were and developing an activity around it. In that moment, I started to become aware of my own resilience. It was my first big insight during this study. These sessions were testing my own resilience and strengths, my own tolerance of feeling challenged, and my own preference and bias towards group cohesiveness. Participants talked more than usual among themselves in small clusters. Several times, I stood in the middle of the room and asked participants to focus on the group activity. I felt lost, stuck. It also seemed like an appropriate metaphor for participants' situation at the center.

To end the session, I led a mindfulness activity to foster participants' wellbeing. After that, I shared with participants my understanding that it was not easy being in a detention facility, and that I believed that each one of them was unique and had

something to bring to the world, instilling hope in them (Rapp & Goscha, 2011; Yalom & Leszcz, 2005). The day after, a thought came to my mind: maybe participants were holding up their emotions with bound flow, as their way of coping and adjusting to the center, as their embodied resilience.

Overall, the third session felt scattered. I noticed more side-talking among participants and more redirecting from me. However, after three weeks of building rapport with the same group of participants, I was starting to notice that some participants, who had been more reserved in previous sessions, were starting to show more initiation by offering movement ideas for the group. Also, there seemed to be a correlation between participants' movement behavior and the lack of progress in reunifying with family. Participants whose cases were stalled seemed to be more withdrawn from the group.

Week 4. On week 4, 10 participants attended the session. There were three more participants that week (1 Brazilian, 2 Central American), who usually attended a different clinical group. One Central American participant had been released. Some participants seemed energetic at the start of the session: two Brazilian participants were dancing around the room in quick-time, *samba*-like steps even before I played any music. It was a participant's last session. He would be released soon and be reunited with a family member in the U.S. He was smiling and moving with freer flow than in previous weeks. So was another participant, after receiving good news about his case. He would be leaving soon as well.

There was a general sense of disorganization and chaos in the room. Participants were scattered in loose culture-of-origin clusters and side-talking, while I played music from their home countries at their request. Taking into account that participants were at the center against their will, I offered participants several options (Rapp & Goscha,

2011). Options included to dance, either a country-of-origin dance or in freestyle, to learn a choreography, and to practice relaxation and mindfulness. Participants immediately expressed interest in learning new dance steps. I suggested a Top 40 song. It turned out that participants had already performed a choreography to that song for the Christmas show and they seemed happy to perform it again. The steps were simple and repetitive. They especially remembered a part where they all lined up, with the odd numbers taking a step to the right and the even numbers taking a step to the left. Participants seemed to enjoy and gain something out of structured rhythmic group activities such as a choreographed piece.

Towards the end of the session, I transitioned to a mindfulness activity focusing on breath and a guided visualization, inviting participants to imagine oxygen or light entering their body with every breath. Mindfulness seemed to help participants channel their anxiety (AHRC, 2014). Most participants seemed to be able to bring their focus inward. In some cases, it seemed as if they were praying, with their eyes tightly closed, their hands clasped together, and their lips moving silently. Religion seemed to be a source of resilience for many participants (Carlson et al., 2012). During this activity, most participants preferred to lie down on the floor. Some participants were lying on the floor with bound flow, others with freer flow. I noticed that participants who had received bad news that week about their cases seemed unable to relax, keeping their eyes half open and pressing their fingers together.

After the mindfulness exercise, I invited participants to engage in verbal processing. Each of them talked briefly about their cases. I tried to encourage awareness of universality by saying that they were all in a similar situation, facing similar challenges and a common goal, to be reunited with a family member or family friend (Yalom & Leszcz, 2005). I also acknowledged that it was not culturally normative for

Latino men to show emotional vulnerability in public (Davis & Liang, 2015). The presence of a male case manager in the room could also be a deterrent for opening up. As a running theme from the previous week, participants seemed to cope by holding their emotions inside with enclosing shaping qualities, as reflected in several participants' MACS. It seemed like an appropriate metaphor for the fact that they were held, enclosed, at the center.

As a closing ritual, I introduced the dimensional scale (Laban, 1966), inviting participants to move along the vertical, horizontal, and sagittal dimensions. The activity was well received as evidenced by participants' full commitment to it. In the retreating/advancing section of the scale, I invited participants to create an energy ball in their hands and send it across the room to someone else, as in the Dragon Ball cartoon series (Dragon Ball, n.d.). Participants' affect brightened during this activity. It seemed to help them release some held tension.

Week 5. On week 5, I ran a smaller group in a smaller room, with couches and a big colorful rug. Six participants attended the session (3 Brazilian, 3 Central American). A counselor was also present. The three Brazilian participants were sitting with their legs stretched out or spread out. The three Central American participants were sitting in enclosing positions, in a body twist or with their arms crossed.

During verbal check-in, participants shared a wide range of emotions. It made me wonder how to attune to all participants in such different emotional states. Most participants stated feeling tired in general. However, Brazilian participants wanted to move, Central American participants wanted to sit down and relax. Throughout the 12 sessions, I kept reminding participants that they had the freedom to decide their level of engagement in group, and participants engaged in different activities at their own pace and energy level.

After a short grounding sequence, I led a body part warm-up, sitting first. My invitation to them to start moving while remaining seated was well received by participants, meeting them where they were (Sandel et al., 1993). Then, I invited participants to stand up and continue with the warm-up. The warmup included core-distal movements (enclosing and spreading), and cross-lateral movements (bringing the elbow to the opposite knee). I also invited them to place their head below their heart, changing the relationship in space between body parts (Hackney, 2002). Stretching the arms up and lifting the knees up one at a time seemed to have an uplifting effect, as evidenced by brighter affect and freer flow in their upper and lower limbs. Through resourcing the body, I engaged in an exploration of space and of the possibilities in relationship with the self, with others and with the surrounding space (Hackney, 2002).

To close the session, as in the previous week, I invited participants to move through the dimensional scale. When descending along the vertical dimension and rolling into a ball, participant E mentioned self-protection. When enclosing in the horizontal dimension, I mentioned loving oneself or hugging a loved one. Then, for retreating and advancing, based on participant H's Dragon-Ball-inspired movement in a previous session, I invited participants to amass a ball of energy in their hands and to pass it to another participant. Then, I asked participants to modulate through the defense scale at a faster or slower pace, inviting them to carry out the same tasks, but offering them individual choice about how to do it. Participants' affect shifted and their faces became more active, smiling and laughing with each other. I was starting to see that the dimensional scale could be used as a symbol of embodying resilience and resourcing the self. Participants gathered their own strengths while retreating, and benefitted from them collectively while advancing.

As a side note, early that morning I had attended a training about resistant youth. In the day-long training, I learned about engaging teenagers by talking about topics they were interested in or passionate about, like sports. Also, by the time the weekly evening group started, I was feeling tired and, maybe for that reason, I was not as focused on clinical goals and activities. Towards the end of the session, as part of verbal processing, instead of asking participants directly how they felt, I went with whatever topic came up, such as physical endurance in their daily soccer practice. After all, most participants mentioned practicing sports as one of their main coping skills at the center. This session turned out to be useful for building rapport with them and them seeing me as a resource. I talked about endurance, breathing, and pacing oneself in soccer matches and long-distance running. That day, I gained new insights about being more engaging with participants and being a resource for them, as opposed to expecting things from them.

Also, that day I had been transferring music to an mp3 player, looking for songs on YouTube, preparing a choreography. The mp3 player did not work in the end. I used it as a lesson about improvising, resourcing the self as resilience, when facing challenges. Funnily enough, participants seemed less upset than me about the fact that there would be no music. After the session, I noticed that resilience, either in participants or in myself, was coming up regularly, effortlessly, as I was writing about sessions in greater detail.

Week 6. On week 6 (6 participants, 2 Brazilian, 4 Central American), I ran the session in a different lounge based on space availability at the time. It was a small room with couches. The space had little room to move and resulted in a mainly verbal group. It helped me to continue building verbal rapport with participants, “viewing the relationship as an experience in mutual learning” (Rapp & Goscha, 2011, p. 72).

That week, three participants had left, and three new participants attended the session. I was continually adjusting to the shifting nature of the group composition. I introduced myself as a graduate student from Spain, having worked and lived legally in the United States for over 11 years. Participants seemed interested in knowing more about my life and work in the U.S. and asked questions about legal status and work visas. I moved the conversation forward, paying attention to the body-mind. We shared words like “heart” in different languages, with participants placing their hands on their chest when saying the word in their mother tongue and talking about people they loved in their lives. Overall, after having attended the training on resistance the previous week, I noticed I was embodying a new, evolving clinical role. I felt more present during the session, as if I were meeting participants and listening to them for the first time.

Towards the end of the group, I led a guided visualization. Participant C and participant G presented two distinct embodied and emotional states. Participant C was a shy participant and usually stopped moving when I looked in his direction. Today it looked as if he were breakdancing with his eyes closed, as I invited participants to focus on tensing and relaxing different body parts during a progressive muscle relaxation. He seemed to be in a different place, with his eyes closed and a smile on his face. Meanwhile, participant G was visibly anxious, as evidenced by his quick time in his hands and feet, indirecting in space, constantly moving his head in different directions, and increasing pressure in his fingers, which were pressing against each other and tapping the couch. He mentioned having trouble sleeping. After the activity, he stated feeling more relaxed. He seemed to have released some held tension in his chest, and I noticed freer flow in his limbs. Both participants seemed to find a way to get something

out of the activity, be it escaping to a familiar place with their imagination, or focusing on breathing and the body as a resource to feel better.

Week 7. On week 7 (8 participants, 4 Brazilian, 4 Central American), we were back in the cozy lounge. After some technical issues, I was able to play music again. I played Spanish- and English-language songs. Two Brazilian participants were doing body drumming on their chests at the beginning of the session while seated. I mirrored them and invited other participants to join in. It was exciting to see participants create sounds, rhythm, and movement effortlessly while using their own body as a musical instrument. Participants created sounds tapping on their chests or on furniture for a while until the rhythm died down.

I then led a warm-up, first seated, then standing up. At their request, I taught them a piece of choreography I had prepared. The steps in the chorus included movements with increasing pressure and directing in space, stomping with their feet, punching downward with their arms, a quick turn and jump. Based on my body knowledge and body prejudice, the choreography conveyed strength and assertiveness. “Client-worker relationships should be empowering; they should provide strength to the person” (Rapp & Goscha, 2011, p. 74). The goal was to elevate participants’ energy level and mood, to bring joy and to empower them through group dance. Some participants seemed to like it and danced to the steps several times. Other participants did not connect to it and sat back on the couch. Participants danced in freestyle to other songs. A new Brazilian participant remained seated in a corner, witnessing the session. During the session I invited him to take part in the warm-up, dance, and guided visualization activities, but he declined.

The group ended with a guided visualization activity. After the activity, participants seemed more calm as evidenced by freer flow in their upper and lower

limbs. At the end of the session, participants remained in the lounge, chatting in small clusters, and writing down songs they would like to listen and dance to in group the following week.

Week 8. On week 8, I felt challenged by the larger number of participants (11 participants, 5 Brazilian, 6 Central American). We were back in the main room, a larger multifunctional space used in earlier sessions. Participants were scattered around the room and I walked around to get their attention. Given such a large group and the high energy level that I noticed in Brazilian participants, who were speaking loudly in Portuguese and moving in quick time, I invited participants to have a dance party. The group welcomed the idea. The session felt very chaotic and disorganized, with some staff coming in and out of the room, and with participants looking out of the window into the street on repeated occasions.

The Brazilian and Central American participants danced in two separate clusters. Only when I played current Top-40 English-language songs and showed them a piece of choreography, would most participants increase their focus on the activity. Most of the songs were upbeat, and the movements were a combination of fighting and indulging qualities, with increasing pressure and direct use of space, free flow, and alternating slow and quick time. Some participants asked to revisit the choreography I showed them in session 7. It was the first time I felt that there was a continuity through the weeks and spontaneous feedback from their side. I was providing more structure and more guided movements. I was offering them resilience from the outside, services provided by me and by the site, when their own resilience reserves were running low.

At times, due to their higher energy level in sessions, Brazilian participants seemed to take over the group, while Central American participants retreated toward the back of the room. It was a balancing act to be with both cultural clusters in the same

room at the same time. Brazilian participants were ready to start dancing even before the music started playing, moving with short, quick steps around the room. Central American participants were more stationary and seemed to be holding tension in their bodies, with bound flow, taking small steps, and making pin-like shapes narrowing their shoulders. Breakdance was the preferred dance style for many of the Central American participants, going over the same steps repeatedly. They would usually freeze if I approached them to either attune to them or to dance with them. They would keep moving when I moved away and let them move without any external interaction.

To end the group, participants asked to listen to slow-tempo songs in their mother tongue during a mindfulness exercise. I played a Latin song while participants cooled down, sitting or lying on the floor, and then I led a short guided visualization inviting participants to visualize a positive image while breathing in oxygen.

Participants seemed to be able to go into deeper relaxation while listening to songs from their home country.

Week 9. On week 9 (11 participants, 5 Brazilian, 6 Central American), most participants seemed to be in a lower energy mood than the previous week, sitting on chairs with passive use of weight, either leaning forward and resting their elbows on the table, or leaning against the back of the chair. I sensed participants' frustration about being held at the center, based on the way they held their breath for a while and then let out audible breaths. Also, group participants seemed tired from a long day of activities and chores: English language, math and science classes, soccer practice, meetings with different staff, cleaning. I was also challenged by the presence of two floor staff, which was distracting when they redirected participants. Also, staff came in and out of the room and some participants came in late. The session felt disorganized. Yet I went with the flow. I reflected back participants' body language with humor, slouching my back

and dragging my feet across the room, mirroring their tired bodies after a full day of scheduled activities. It brought out smiles in some of them.

Then, I led a 20-minute guided visualization, which most participants seemed to follow. In the beginning, their breath seemed shallow, not very audible or visible in their torsos. I led the visualization walking up and down the aisle between the two rows of tables where participants sat. During the semi-improvised guided visualization, I invited participants to locate areas in their bodies that felt sore or tense, to bring in light to those areas with every inhale, and to let go of any negative weight or emotions with every exhale. During the activity, some participants seemed unable to look down or to close their eyes; others fell asleep. At the end of the activity, most participants were leaning over the table, with their head resting on their forearms. I could not see their faces and it was hard to know whether they had been following the guided imagery. Participants gradually sat back up in their chairs. They were quiet.

After a while, I asked them about their sleep, a recurring theme with other groups at the center. Some participants shared that they had trouble falling asleep or that they would wake up in the middle of the night and then it would be difficult to fall back asleep. I showed them two mindfulness techniques to relax the body and quiet the mind before going to bed. One was to trace the shape of one hand with the index finger of the other hand; the other was a breathing sequence with the exhale lasting one or two seconds longer than the inhale (Altman, 2016). After trying them out, participants said in general that they did not feel any difference, or that it did not help them feel more relaxed. There seemed to be a “mismatch between what the person wants and what the provider has to offer” (Rapp & Goscha, 2011, p. 87). I felt disheartened by the apparent lack of effectiveness of the techniques that I had previously found useful for myself. Interestingly, participants kept bringing back the hand profiling exercise over the course

of the following weeks. Towards the end of the session, at participants' request, I played several slow-paced Brazilian and Latin songs, while participants listened to them from their chairs.

During the session, I kept reminding myself to be present, to stay grounded, visualizing my vagus nerve going from head, to chest, down the back and finally to my stomach and guts (Altman, 2016). This visualization helped me tap into my own resilience and helped me keep going during a challenging session. Being present also allowed me to acknowledge participants' frustration and despair, and to not become upset or angry at them. "Reluctance is normal for most people as they confront an uncertain and somewhat invasive interpersonal situation" (Rapp & Goscha, 2011, p. 83). Participants were in a detention environment, deprived of their freedom for an indefinite period of time, whereas I would be leaving in half an hour.

Week 10. On week 10 (6 participants, 3 Brazilian, 3 Central American), most participants seemed to be in a lethargic mood, as evidenced by their enclosed postures and passive use of weight. I also observed some underlying anxiety as evidenced by their fidgeting and restless legs. We met in the smaller lounge. During check-in, participants showed humor and creativity in their energy levels from 0 to 10, giving answers such as 0.1, minus 5, 2-3-4, etc.

At participants' request, I played several Latin, Brazilian and English-language songs. Participants seemed comforted while listening and singing along to songs in their mother tongue, sitting with freer flow in their body, as evidenced by reduced fidgeting and restlessness in their limbs. We also danced to the "Watch Me" song (Hawk & Mingo, 2014) mobilizing both the upper and lower body while remaining seated. Participants' affect became more relaxed and bright.

Then, based on my observation during check-in, I invited participants to stand up and to release any tension or strong emotions they were holding inside through vocalization (Mitchell, 2010). Participants vocalized or yelled out their strongest emotions: anger, frustration, despair, impatience. Towards the end of their breath, their yelling usually turned into laughter. This activity seemed to help participants move out of their stuck mode, as evidenced by more active connections between body parts and freer flow in their bodies.

Based on participants' recent comments about having difficulty sleeping at night, I provided psychoeducation on sleep hygiene and showed participants several mindfulness exercises to help them relax before going to bed (Altman, 2016). Participants moving with quick time said that they noticed how pressing their hands together for five seconds helped them relax, release tension, and feel better.

To close the session, in order to keep fostering resilience in participants, I invited them to come up with a positive statement about their inner strength or hope and to visualize it while listening to a relaxing song. Participants mentioned their faith, their family and loved ones, and their future life in the U.S. Overall, running smaller groups seemed to allow participants to open up more and share their feelings, and made the group more cohesive. Participants stated feeling better at the end of the session and that the weekly sessions were helping them cope during their stay at the center.

Week 11. (5 participants, 2 Brazilian, 3 Central American) Three group participants had been released during the previous week. Two new participants attended the group. Thus, the group included participants who had been at the center for at least a month whose cases were progressing slowly; participants who had been at the center for at least a month who had received good news that week and would probably leave soon; and newly arrived participants whose family reunification cases were being started.

Every week saw a combination of these three different types of participant profiles based on length of stay and progress in their cases.

Despite the new composition of the group, week 11 felt like a continuation of the progress experienced in the previous session. After listening to songs in their mother tongue, participants seemed open to sharing memories from their home country and their migration journey. They talked about feelings of loss and isolation, and also about being aware of their strengths and coping skills, and learning to find a balance between them.

The session included a mindfulness exercise to help participants release anxiety, and a movement activity to shake out strong emotions. Participants seemed more energized as evidenced by their brighter affect and increased mobility in torso and limbs. Participant R moved with freer flow than in the previous week. He had been living illegally in the United States for over a year before he was apprehended by immigration officials. He had arrived recently at the center. He spoke English fluently and maintained a religious practice that seemed to give him strength. Participant R lay on the rug while listening to music and during the mindfulness activity. He seemed to be able to release held tension in his chest, which increased his breath connectivity. Two other participants also lay on the rug and seemed to be able to release held tension in their chest and limbs. Participant E, usually very engaged during sessions, seemed sullen and sad that week, as his case was not moving forward and he would be aging out soon, a prospect that produced increased anxiety in the participant. When participants turn 18 years old, they are transferred to an adult detention facility with fewer services. Participant E remained in bound flow, enclosed posture, and sad affect during the session.

To finish the session, I led a yoga sequence based on grounding positions to foster participants' inner strength, hope and resilience.

Week 12. (7 participants, 3 Brazilian, 4 Central American) On week 12, the group felt disconnected and disorganized again. In contrast to the previous week when, despite a reshuffle of participants, the group seemed to stay cohesive, challenges to group cohesion on week 12 included having two new participants in the group and two other participants leaving soon. I redirected some participants several times to bring their focus inward while practicing relaxation, so that they would stop making fun of other participants.

Participant E was excited about his immediate release from the center. His body was moving in quick time, directing in space, with increasing pressure and in freer flow than in previous weeks. Over the course of the session, he modulated his energy down and became more calm while listening to music and resting on the couch. Participant E was the only participant who attended all 12 group sessions in this study. He had been eager to dance to Brazilian and Latin songs during the first half of the weekly DMT sessions. It seemed to help him externalize pent-up energy accumulated from being at the center, and to be joyful and reconnect to his culture of origin. Towards the second half of the weekly DMT sessions, as his case seemed to encounter some setbacks and progressed more slowly than expected, he seemed to become more reserved, with increased bound flow in his torso and limbs. He stated his preference for listening to slow-tempo Brazilian music while lying down with enclosing shapes, as a form of healthy escapism from the center and connecting back to memories from home country and hope for the future.

Participant I carried two small stuffed animals on his shoulders on his way to group and put them on his chest when he lay on the floor. The two new participants

were quiet and did not talk much. During the last session, I played Brazilian and Latin music at participants' request, which elicited memories from their home country.

Participants seemed to be able to relax, as evidenced by freer flow in their upper and lower limbs, while sitting on the couches or lying on the floor.

I told participants that the following week would be my last session as a clinical intern at the site. Participants seemed surprised and saddened by the news, stating that they enjoyed the DMT groups and that it helped them relax and feel better. Participants also stated being happy for me and for my future career as a dance/movement therapist. By week 12, only participant E had attended all sessions and would be leaving soon. The other participants had arrived recently at the center and had only attended one or two sessions. In retrospect, I would have announced the end of the DMT sessions further in advance to address any feelings of separation and loss, especially with participant E.

Movement Assessment Coding Sheets

I completed 61 MACS for a total of 19 participants. Participants' movement qualities were different when sitting, standing or moving. It was therefore challenging to accurately reflect on paper the different movement qualities participants displayed during the hour-long sessions. "Movement is indeed a complex, multifaceted phenomenon whose description and analysis challenge the observer" (Moore & Yamamoto, 2012, p. 149). When completing the MACS, the intention was to reflect each participant's salient movement qualities, the ones that were still present in my mind after each session. MACS were not completed for the first two sessions due to time constraints.

Overall salient movement qualities. Salient movement qualities in participants over the 12-week period are shown in Table 1 under the Body, Effort, Shape, and Space categories.

Table 1

Participants' Salient Movement Qualities

Body	Effort	Shape	Space
Lowered chin	Prevalence of indulging qualities over fighting qualities	Prevalence of pin shapes	Near reach in <i>bachata</i> steps
Shallow breath	Directing in space while talking or listening; indirecting in space when moving	Sinking and enclosing when sitting	Peripheral approach in <i>capoeria</i> steps
Lack of scapular connectivity	Accelerating and decelerating		
Active hands, fingers	Passive weight when sitting		
Active legs, feet	Increasing pressure with fingers on surfaces Bound flow when sitting Alternating free and bound flow when moving		

Evolution of movement qualities during the study. The coding sheets tracked the evolution of participants' movement qualities over the course of the 12 weeks. The completed MACS seem to align with the session-by-session descriptions and evolution of group sessions. That is, during roughly the first six weeks, in which dance was more

prevalent, group participants as a whole showed both fighting and indulging qualities under the Effort category and near reach of and peripheral approach to kinesphere under the Space category. During the last six weeks, in which participants were more introspective and preferred to sit or lie down and listen to music, participants showed a preference for indulging qualities and near reach of kinesphere.

For connectivities and active/held parts under the Body category, the options were a circle if the movement quality was present, or a cross if the quality was missing. On a coding sheet on week 4, I jotted down an insight: a circle signifying a strengths-based approach, and a cross signifying a deficit-based approach. It made me realize that when I designed the MACS a year earlier, I was not fully aware of the strengths-based lens. Looking back at the completed coding sheets, circles seemed to be more prevalent than crosses during the first half of the study. Ironically, however, and to my surprise, during the second half of the study, crosses seemed to be more prevalent. This insight can help me be more aware in the future of what participants already have versus what they supposedly are missing (i.e., using a strengths-based approach versus a deficit-based approach) (Rapp & Goscha, 2011). Also, halfway through the study, besides the circle and cross, I added a third symbol: a wavy line crossing through the word to signify that the identified quality was partially present.

Chapter IV: Conclusions and Implications

In 2016, the number of UC from Central America apprehended at the U.S.-Mexico border seemed to be near 2014 surge levels again (Lillis, 2016).

Unaccompanied children's reasons to migrate were poverty and violence in their home country, and family reunification in the U.S. (Park, 2014). Once apprehended by immigration authorities, the minors received care through a network of providers across the United States while they awaited family reunification, legal relief, or deportation (Byrne & Miller, 2012).

A study of UC under immigration detention in Australia identified UC as a particularly vulnerable group, with high rates of self-reported depression and feelings of hopelessness (AHRC, 2014). Carlson et al. (2012) identified "positive outlook, use of healthy coping mechanisms and religiosity, and connectedness to prosocial organizations" as sources of resilience among unaccompanied refugee minors resettled in the United States (Carlson et al., 2012, p. 1). However, attention should be paid to the transferability of other research findings to UC under immigration detention in the United States, based on differences in country and culture of origin of UC, their migration experience, and treatment upon arrival by the host country. In view of the ongoing arrival of UC at the U.S.-Mexico border, as well as the current refugee crisis in Syria and other parts of the world, further studies are needed to investigate the range of mental health issues and risk and protective factors, including resilience, among UC (Carlson et al., 2012; Hodes et al., 2008).

This clinical case study explored ways in which a group of UC from El Salvador, Guatemala, Honduras, and Brazil embodied resilience during their stay at a temporary reception center in the United States. The 12-week clinical case study included a total of 19 male participants aged 12 to 17 years old attending

dance/movement therapy sessions, which were scheduled weekly. A strengths-based lens, including the strengths model developed by Rapp and Goscha (2011), was utilized to identify and understand resilience-related patterns and processes.

Embodied Resilience

Embodied resilience is understood in this study as the adaptive process experienced by the body in the face of adversity (APA, 2016; Hervey, 2007). The original purpose of this study was to explore specific gestures and movements related to resilience in UC during their stay at a reception center. However, during week 3 of the study I started noticing something more subtle. Toward the end of the session, during verbal process, participants seemed to be holding up their own body with bound flow. Using a model that “uncovers strengths and the power within people” (Rapp & Goscha, 2011, p. 56), I interpreted this bound flow as participants’ way of coping and adjusting to the immigration detention environment, as their embodied resilience. The Effort factor of flow refers to the degree of control in the body and in movement; bound flow refers to the attitude of keeping the action contained, involving “the participation of antagonistic muscles which help in the steady control of an action” (Moore & Yamamoto, 2012, p. 147). Accordingly, while they sat or lay on the floor, I observed participants holding muscle tension throughout their bodies. Metaphorically, they seemed to be holding their emotions inside within a constraining environment.

Over the course of the weeks, participants also seemed to frequently embody enclosing shaping qualities, as reflected in several participants’ MACS. Shaping qualities refer to the way in which the body is extending or flexing in relation to the environment; enclosing shaping qualities refer to flexion in the horizontal dimension (Lamb & Watson, 1979). I observed participants standing, sitting or lying with their arms close to or across their torso. It seemed like an appropriate metaphor of their

embodied resilience response to the fact that they were held, enclosed at the center. Both bound flow and enclosing shaping qualities can be interpreted as having a protective function under challenging circumstances (Moore & Yamamoto, 2012).

Dance/Movement Therapy and Embodied Resilience

Resilience includes a combination of internal and ecological protective factors (Center on the Developing Child, 2015; Rapp & Goscha, 2011). On one hand, embodied resilience seemed to be an internal protective factor that helped participants adjust during their stay at the reception center. On the other hand, the session-by-session description helped illuminate the ecological role that DMT played in fostering embodied resilience in UC. Dance/movement therapy sessions, which included rhythmic group activity, Effort modulation, the defense scale, creative self-expression, and mindfulness, helped participants reconnect with their embodied resources in order to foster their own strengths and resilience (Center on the Developing Child, 2015; Wengrower, 2015). Activities helped participants express their individuality and collaborate with other participants, fostering resilience from the outside, when their own resilience reserves were running low. This was seen in DMT activities such as the signature movement (week 1), passing around an imaginary electric charge (week 2), running around the room as if riding a motorcycle (week 3), inviting participants to imagine oxygen or light entering their body with every breath (weeks 4 and 11), exploration of space and the possibilities in relationship with the self, with others and with the surrounding space (week 5), embodying key words in their mother tongue (week 6), creating sounds, rhythm, and movement while using their own body as a musical instrument (week 7), revisiting a choreographed dance (week 8), and vocalizations to release any tension or strong emotions (week 10).

Collective embodied resilience. Collective embodied resilience emerged as a subtheme from week 1, with participants coping with the restrictions of the detention environment through rhythmic group activity in the form of *capoeira*, *bachata*, and freestyle dance. Moving together to a shared rhythm, participants seemed to experience a heightened sense of strength (Sandel et al., 1993), as evidenced by participants' increased breath connectivity and body-part coordination. Brazilian and Central American participants usually danced in separate clusters when dancing to their culture-of-origin dance form, and danced together in a loose circle when dancing in freestyle to top 40 songs.

Another DMT activity that fostered collective embodied resilience was the dimensional scale. Participants gathered their own strengths while retreating, and used them collectively while advancing: retreating for resourcing the self and self-protection, advancing to engage in the “groupness” (Yalom & Leszcz, 2005, p. 55).

Trauma-Informed Care

Both the literature on UC leaving Central America (UNHCR, 2014) and UC's profiles at the reception center provide evidence of the many instances of traumatic events experienced by this population in their home country and during migration, from physical and emotional abuse by a parent to almost drowning while crossing the border. Being in a reception center without the knowledge of the coming release date could also be considered a form of traumatic experience as a minor.

In this trauma-informed facility, participants were asked about their experience of trauma when assessing them for services, recognizing and respecting when participants were not ready to talk in order to avoid potential retraumatization. Participants met regularly as well as on as-needed basis with their assigned clinical counselors for individual sessions. Due to the temporary nature of UC's stay at the

reception center, trauma was not directly addressed during DMT group sessions. It would not have been ethically responsible to start work on past traumatic experiences with participants who might not be at the center the following week. “Detention is not a place where unaccompanied children are able to recover from past trauma” (AHRC, 2014, p. 169). Participants with reported history of trauma were provided access to counseling services after their release.

Challenges and Compensations

The information collected in the 61 MACS for 19 participants covered Body, Effort, Shape, and Space categories for gestures, postures, and movements while participants were seated, standing, moving, or dancing. The variation in the range of movement being observed is so wide that it could be interpreted in several ways, depending on the theoretical approach used. It was also challenging to observe all participants during a given session. When completing the MACS, I focused on each participant’s salient movement qualities, the ones that were still present in my mind after each session. Group progress notes also helped compare and contrast information included in MACS.

During the analysis and interpretation stages of the study, I was faced with my own movement biases. Over the weeks, I started noticing bound flow in participants in the form of muscle tension throughout their bodies. However, could something I used to see as a negative quality such as bound flow be considered a strength or a protective factor? Having a preference for free flow in my own movement practice, I used to view bound flow as limiting, restraining. Interacting with participants and witnessing their embodied adaptation to the reception center helped me see the role of bound flow as a protective factor under specific circumstances.

I was not the participants' main counselor. Therefore, I did not conduct the initial clinical assessment with them and was not privy to all the information. Also, I was on the participants' floor only one day a week, which limited my rapport with them. However, I did consult with participants' main counselors before each session, which was helpful in getting a general sense of the floor during the week and in learning about any updates in participants' wellbeing.

Suggestions for Future Study

Conducting this study has made me more aware of the importance of taking into account the cultural dimensions of resilience, in particular, exploring gender attributes of resilience expression. I would also suggest exploring embodied resilience in UC from a trauma-informed approach, and under what circumstances trauma can be approached at a temporary detention facility. I would also suggest studying embodied resilience in UC during resettlement in host countries.

Conclusion

The purpose of this clinical case study was to explore ways in which a group of UC from El Salvador, Guatemala, Honduras, and Brazil embodied resilience during their stay at a temporary reception center in the United States. The clinical work and documentation was reviewed to explore the phenomenon of embodied resilience through a strengths-based lens. This study fills a void in DMT literature by focusing on embodied resilience as an internal protective factor. The study contributes to the DMT field by describing DMT-informed activities with migrant children in a civil detention setting. On one hand, embodied resilience seemed to be an internal protective factor that helped participants adjust during their stay at the reception center. On the other hand, DMT played an ecological role in fostering embodied resilience in UC under immigration detention. Conclusions include identification of bound flow and enclosing

shaping qualities as participants' embodied resilience to cope with and adjust to the immigration detention environment. Also, dance/movement therapy helped foster collective embodied resilience in UC through rhythmic group activity.

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Appendix A

Group Progress Note Template

Date	Location	Clinical Group	Start Time	End Time	Session length
GROUP SUMMARY					
<p>Description:</p> <p>Assessment:</p> <p>Plan:</p>					

Appendix B

Blank Movement Assessment Coding Sheet

CODING SHEET

Prepared by Marcos Oro Caldero

Date: _____
Client Name: _____

Session #: _____
Location: _____

BODY

1. Alignment (notes, tic marks)

Head/Neck:
Spinal:
Heel/Sitzbone:

3. Connectivities (circle or cross out)

Breath Core-distal
Head-tail Upper-lower
Body half Cross-lateral

2. Active/Held parts (circle or cross out)

Face Neck
Torso Scapula Arms/Hands
Pelvis Legs/Feet

4. Phrasing (name body parts used)

	Initiation	Exertion	Follow-thru	Recup.
Simult.				
Success.				
Sequent.				

EFFORT

1. Elements (tic marks)

Space	Direct	Indirect
Time	Accelerating	Decelerating
Weight	Increasing	Decreasing
Flow	Free	Bound

4. Action Drives (tic marks)

Float	Punch
Glide	Slash
Dab	Wring
Flick	Press

2. States (tic marks)

Awake (S/T)	Dream (W/F)
Rhythm (T/W)	Remote (S/F)
Mobile (T/F)	Stable (S/W)

3. Transformation Drives (tic marks)

Passion Drive (spaceless) _____
Vision Drive (weightless) _____
Spell Drive (timeless) _____

5. Phrasing types (circle, tic marks)

Even _____
Increasing Intensity: Impactive _____
Decreasing Intensity: Impulsive _____
Incr. > Decr. Intensity: Swing _____
Decr. > Incr. Intensity _____
Accented _____
Vibratory _____
Resilient: Elastic/Buoyant/Weighty _____

SHAPE

1. Body Shapes (tic marks)

Pin (straight/narrow)

Wall (straight/spread)

Ball (rounded)

Screw (upper twisted against lower)

Pyramid (wider base, narrower upper)

2. Modes of shape change

(circle, name body part, tic marks)

Mode present	Body part used
Shape flow	Growing Shrinking
Spoking	
Arcing	
Carving	

3. Shaping Qualities (tic marks)

Rising	Sinking
Spreading	Enclosing
Advancing	Retreating

SPACE

Kinesphere (tic marks)

Levels	Low	Middle	High
Reach	Near	Mid	Far
Approach	Central	Peripheral	Transverse

Dimensions (1d): Vertical Horizontal Sagittal

Planes (2d): Vertical Horizontal Sagittal

Diagonals (3d):

