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# Refugee Trauma: Culturally Responsive Counseling Interventions

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This article presents the Multiphase Model of Psychotherapy, Counseling, Social Justice, and Human Rights as a culturally responsive intervention model for working with refugee trauma. The model specifically addresses unique challenges in working with refugees with trauma, taking into account premigration displacement and postmigration adjustment and adaptation brought about by the increased number of global refugees with high rates of posttraumatic stress and psychopathology due to war and conflict.

*Keywords*: refugees, trauma, migrants, cross-cultural mental health, multicultural counseling

In 2013, war and persecution created the highest number of global refugees, 51.2 million people, since World War II (United Nations High Commissioner for Refugees [UNHCR], 2014). This is 6 million more than the 45.2 million displaced people in 2012 (UNHCR, 2014). Thus, the number of refugees worldwide now equals the entire population of Spain, South Africa, or South Korea, or more than double the inhabitants of Australia (Smith-Spark, 2014). The increasing number of refugees is due to ongoing conflicts, such as those in Syria, the Central African Republic, and South Sudan (UNHCR, 2014). Compared with immigrants who chose to migrate to another country for a better life, refugees have no choice and are forced to migrate because of massive destruction and devastation in their communities and countries (Bemak & Chung, 2015). Often, their departure is sudden with little or no time for planning or preparation and fraught with uncertainty about their destination, travel route, and means of travel, forcing refugees to face threats to their safety and psychological and physical danger (Bemak & Chung, 2015).

In 2013, there were 1.1 million refugees seeking asylum in developed countries, with a large number being unaccompanied minors (i.e., children separated from their parents; UNHCR, 2014). Syria had the largest number of asylum applications with 64,300, followed by the Democratic Republic of the Congo (60,400) and Myanmar (57,400; UNHCR, 2014). Most refugees continue to come from developing countries and consist mainly of women, children, and people with disabilities (Bemak & Chung, 2015). In 2013–2014, a total of 70,000 refugees were authorized to resettle in the United States (U.S. Department of State, 2014); these individuals predominantly came from Iraq, Africa, and Cuba. Given the unique experiences of refugees, it is critical that counselors are culturally competent in working with this population. Therefore, the aim of this article is to present the Multiphase Model (MPM) of Psychotherapy, Counseling, Social Justice, and Human Rights, a culturally responsive model of intervention specifically designed to address the unique circumstances and mental health needs of refugees, including trauma. To provide a foundation for using the MPM, we first present an overview of the refugee experience and challenges encountered during displacement and premigration, as well as those encountered during postdisplacement and postmigration. We then examine how these events affect refugee trauma and provide a description of the MPM.

## Overview of Refugee Experiences and Trauma

### Displacement and Premigration Trauma

Given that refugees fear persecution and are forced to involuntarily flee their homes to escape intolerable conditions, displacement and premigration trauma are critical considerations when working with refugees. Premigration events may be a precursor to psychological trauma and more pronounced mental health problems and play an important part in refugees' postmigration adjustment and adaptation (Kirmayer et al., 2011; Nickerson, Bryant, Steel, Silove, & Brooks, 2010;

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Robjant, Hassan, & Katona, 2009). To work effectively with refugees with trauma, counselors must acknowledge and understand the impact of displacement and traumatic premigration events on postdisplacement and postmigration adjustment and adaptation (Bemak & Chung, 2014, 2015).

Displacement and premigration situations of war and conflict may involve witnessing or being subjected to torture, killings, atrocities, incarceration, starvation/deprivation (e.g., food, shelter), rape, sexual assault, and physical beatings. Many refugees experience multiple traumatic events. Nevertheless, escaping to refugee camps does not guarantee a safe haven because camps are frequently overcrowded, physically unsafe, and unsanitary; they also tend to provide poor nutrition and medical care. Furthermore, violence may create dangerous conditions in the camp, compounding already existing trauma and psychological problems. Studies have found that refugees, compared with the general U.S. population, have higher rates of psychopathology, including depression, dissociation, anxiety, posttraumatic stress disorder (PTSD), and psychosis (American Psychological Association, 2010; Arnetz, Rofa, Arnetz, Ventimiglia, & Jamil, 2013; Fazel, Wheeler, & Danesh, 2005).

In addition, specific groups of refugees are at higher risk for developing more serious mental health problems and trauma. These groups include (a) older refugees, who may be more settled in their ways and may find adjusting to a new environment more challenging; (b) unaccompanied minors; (c) single men younger than 21 years who lack familial and social support; (d) women who are widowed because their husbands were killed during war; and (e) women and girls who were victims of rape and sexual assault during displacement and premigration (Chung, 2001; Chung & Bemak, 2002b).

### Postdisplacement and Postmigration Psychosocial Adjustment and Adaptation Challenges

To provide effective treatment, counselors must understand the impact of displacement and premigration trauma on postdisplacement and postmigration adjustment, adaptation, and trauma. Forced migration followed by adjustment to a new environment and culture may engender trauma. Although refugees receive services such as medical assistance, employment and training programs, and food assistance, the U.S. Refugee Resettlement Program prioritizes economic self-sufficiency. In addition, the United States and Canada are the only two resettlement countries that require refugees to repay airfare and transportation costs (Alexander, 2010), which may add significant pressure to an already stressful situation. In fact, research has shown a correlation between displacement trauma and financial burden (Wagner et al., 2013).

Studies have also indicated a significant relationship between displacement and premigration trauma and postdisplacement and postmigration daily stressors whereby trauma may affect individuals' successful adjustment and mental health (e.g., Kirmayer et al., 2011; Miller & Rasmussen, 2010). Lindencrona, Ekblad, and Hauff (2008) described four resettlement stressors: (a) social and economic strain, (b) loss of status corresponding with racism and discrimination, (c) threats and violence, and (d) alienation. Although economic strain and alienation were found to be significant predictors of mental illness, the four stressors were predictive of PTSD symptoms, with premigration and displacement torture being the strongest predictors. Therefore, the first few postmigration years constitute a critical period when refugees are challenged to learn new coping skills and behavioral and communication patterns while attempting to meet basic needs such as housing and employment (Bemak, Chung, & Pedersen, 2003). For example, some refugees may survive displacement and premigration by becoming numb and unresponsive to minimize feelings associated with traumatic memories of psychological, physical, and sexual violence (Spahic-Mihajlovic, Crayton, & Neafsey, 2005). However, this survival strategy may be incongruous and maladaptive in the resettlement country, where refugees need to learn new, culturally appropriate coping strategies (Bemak & Chung, 2014).

Refugees may experience secondary trauma or cumulative trauma during postmigration and postdisplacement (Akinsulure-Smith, 2009; Finklestein & Solomon, 2009). For example, many Vietnamese refugees on the Gulf Coast were retraumatized by the destruction caused by Hurricane Katrina, which brought back memories of the Vietnam War (Bemak & Chung, 2011). Similarly, some U.S.-based refugees were retraumatized after the events of 9/11. Also contributing to secondary trauma is survivor's guilt (Bemak & Chung, 2014), which is characterized by relocated refugees' remorse and guilt about having family and friends in their home countries who are still in danger. News of escalating conflict in their home countries may increase survivor's guilt as refugees compare the perilous circumstances facing relatives and friends with their own safety.

Efficacious acculturation closely relates to a refugee's acceptance or rejection of the resettlement country's rules and worldviews and may correlate with trauma. Integration into the new culture may correlate with successful adaptation (Berry, 2002) and hence diminish trauma. Factors such as establishing social networks, learning the host country's language, and maintaining one's cultural identity (e.g., through culturally based food and music) all contribute to positive adjustment (Yoon, Langrehr, & Ong, 2011) and may lower incidences of trauma. Furthermore, refugees may experience culture shock during resettlement that contributes to existing trauma and feelings of helplessness and disorientation (Oberg, 1960; Ward, Bochner, & Furnham, 2001). Often, these feelings are magnified for refugees from sociocentric cultures who are adjusting to new reference groups that may emphasize individualism (Bemak & Greenberg, 1994;

Bhugra, 2004). These types of experiences play an important role in integrating one's culture of origin with the relocation culture. In summary, successful integration is often dependent on refugees' openness to adaptation, development of new social support systems, identification with new reference groups, acceptance of new norms and values, and ability to resolve psychological trauma.

### Language, Employment, and Education

Lack of proficiency in the host country's language, underemployment or unemployment, and educational background may hinder refugees' postdisplacement and postmigration adjustment and contribute to already existing or newly developed trauma (Renner & Senft, 2013). Learning a new language may be challenging and exacerbates frustrations in adjusting; contributes to culture shock, trauma, and feelings of helplessness; and raises questions about self-worth and decreased social status (Bemak & Chung, 2015; Renner & Senft, 2013; Willott & Stevenson, 2013). In addition, the pressure of becoming economically self-sufficient and repaying airfare and transportation costs may heighten trauma. Refugees are also confronted with challenges finding work that matches their training and education (Renner & Senft, 2013; Willott & Stevenson, 2013), because educational qualifications and certifications from their country of origin are often not transferable to their resettlement country. Thus, refugees may experience underemployment and downward vocational and socioeconomic mobility (Davila, 2008), as well as difficulties in employability (Bemak & Chung, 2014; Willott & Stevenson, 2013; Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008). Vocational difficulties and regulatory barriers to occupational mobility may add to existing trauma and stress (Renner & Senft, 2013; Willott & Stevenson, 2013). For example, refugee wives may be forced to work if their husbands are unemployed or underemployed. This new relationship dynamic may contribute to conflict regarding gender roles and the importance of traditional cultural values, which may result in domestic violence previously absent in their home country (Bemak & Chung, 2014, 2015).

### Changes in Family Dynamics

Family dynamics may change after postdisplacement and postmigration (Bemak & Chung, 2015). Children acculturate faster than adults and are sometimes used by parents and service providers as translators of culture and language. Consequently, parents must often rely on their children for resource access and communication (Deng & Marlowe, 2013). As a result of acculturation, children may also question their parents about traditional customs and values regarding dating, marriage, parties, curfews, and extracurricular activities (Deng & Marlowe, 2013; Renzaho, McCabe, & Sainsbury, 2011). Furthermore, traditional ways of parenting, childrearing, discipline, and punishment may contradict legal practices in the resettlement country, creating additional frustration and stress (Bemak & Chung, 2015; Deng & Marlowe, 2013). Thus, refugee children may lose confidence in their parents as they witness a transformation from autonomous and culturally competent caretakers to depressed, overwhelmed, and dependent individuals who are trying to learn a new language and customs (Bemak & Chung, 2015; Deng & Marlowe, 2013). In addition, the authority of the adults may be undermined by familial conflict over traditional values and practices, resulting in strained relationships and changes in family dynamics, all of which may compound already existing trauma (Bemak & Chung, 2015; Deng & Marlowe, 2013).

### The Relationship Between Racism and Xenophobia and Refugee Trauma

Successful postdisplacement and postmigration adjustment may be hindered by experiences of discrimination, racism, and xenophobia, which may contribute to hostility, exclusion, rejection, and subsequent refugee trauma (Aydin, Krueger, Frey, Kastenmüller, & Fischer, 2014; Kira et al., 2010). The literature clearly establishes a link between racism, xenophobia, and mental health problems (Aydin et al., 2014; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Priest, Perry, Ferdinand, Paradies, & Kelaher, 2014). Refugees who are racially and ethnically different from the majority culture find themselves at higher risk of experiencing racism and discrimination compared with those who are physically similar to the majority culture (Berry & Sabatier, 2010). Racism and discrimination toward refugees related to housing, health care, employment, professional advancement, home mortgages, and educational access may manifest overtly or covertly (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). Furthermore, the economic stability in the resettlement country combined with job and resource competition influences attitudes toward refugees. Media coverage regarding undocumented migrants together with the economic stress and changing demographics of communities may precipitate the blaming of refugees for unemployment or underemployment and the lack of resources and opportunities. Therefore, economic difficulty may foster xenophobia and fear (Bemak & Chung, 2014) and exacerbate preexisting trauma or precipitate newly developing trauma.

### Political Countertransference

Counselors need to be aware of *political countertransference*, which Chung, Bemak, and Kudo Grabosky (2011) defined as a negative reaction toward migrant and refugee populations. Like all citizens, counselors are exposed to overt and covert political messages by public and social media (e.g., television, newspapers, movies, Twitter, blogs), which may influence their worldviews. In addition, the current and at times heated debates about immigration and the updated terrorist alerts fuel a culture of fear about terrorists and foreigners and add to refugees' psychological trauma. The conscious and

subliminal impact on counselors by these public and social media messages may affect and inhibit their work with refugee clients and create political countertransference (Chung et al., 2008, 2011). For example, the negative media portrayal of people from Muslim backgrounds, such as their association with terrorism, may cause a counselor whose family member died in a 9/11 plane crash to feel anger and resentment toward Muslim refugee clients and lack empathy for their trauma. Consequently, counselors must be aware of their reactions to politically charged issues related to migration and refugees.

## Impact of Culture on Refugee Mental Health and Trauma

Counselors should understand how culture affects refugees' manifestation and conceptualization of mental health and trauma, help-seeking behavior, and treatment expectations (Chung & Kagawa-Singer, 1995). For example, African refugees who believe that deceased ancestors provide wisdom and guidance may present with symptoms of head pain or insomnia, which they believe are caused by upset ancestral spirits (Bemak & Chung, 2015). Accordingly, counselors should seek the help of individuals who respect and honor their clients' cultural belief system, such as traditional healers, in order to communicate with ancestors to establish the cause of the problem and heal their trauma. Although similar complaints and traumatic reactions are found across cultures, symptoms differ and may be attributed to different causations (e.g., Chung & Kagawa-Singer, 1995), making it important for counselors to understand and accept the complexity and influence of culture on refugee mental health and trauma.

Hence, counselors must acknowledge and be aware of cross-cultural errors in under- or overdiagnosing symptomatology and use culturally responsive therapeutic interventions and strategies to deal with trauma that correspond to refugees' cultural worldviews and beliefs (Bemak & Chung, 2014). For example, because Cambodian refugees often somaticize their PTSD symptoms (Hinton, Kredlow, Pich, Bui, & Hofmann, 2013), using solely Western assessments will not accurately capture and interpret this set of somatic symptoms (Rousseau, Measham, & Nadeau, 2013). Therefore, counselors must be aware that Western individualistic cultural models may conflict with refugees' belief systems that are rooted in collectivistic cultures; may interfere with trauma work; and may inhibit working from a framework that focuses on interpersonal relationships, social networks, interdependence, and a holistic approach to healing.

Culture also affects help-seeking behavior (Chung & Lin, 1994). Because of the severity of refugee trauma, there is a great need for culturally responsive mainstream mental health services despite refugees' preference to seek help that is consistent with their traditional cultural beliefs and practices, such as the use of herbs, shamans, and witch doctors. However, refugees' utilization of mainstream services is often a last resort and pursued only after exhausting all other cultural treatment modalities (Chung & Bemak, 2012). Thus, when refugees do access mainstream mental health services, they may present with severe symptoms and trauma and already be using traditional healing interventions (Chung & Lin, 1994). Refugees also hesitate to seek help from mainstream services because of providers' cultural insensitivity, which has been well documented and results in high dropout rates and premature client termination (e.g., S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991); language difficulties, which are often compounded by mental health services' lack of translators or ineffective translators (Bemak et al., 2003; Kim et al., 2011); and accessibility and cost (Wagner et al., 2013; Wu, Kviz, & Miller, 2009).

## Using the MPM to Treat Refugees With Trauma

To be effective when working with refugees with trauma, counselors must understand change, loss, displacement, trauma, and transition within the refugee's historical, sociopolitical, cultural, and psychological context. The MPM incorporates these issues using constructs of other trauma-based models, such as Briere and Scott's (2015) humanistic trauma approach; the New Haven Trauma Competency Group's (2014) competencies for trauma assessment and interventions; McLean and Foa's (2013) exposure therapy; Herman's (1997) triphasic model; the U.S. Department of Veterans Affairs and U.S. Department of Defense (2010) clinical practice guidelines; Beck, Coffey, Foy, Keane, and Blanchard's (2009) group cognitive behavior therapy; and Meichenbaum's (1996) stress inoculation approach. In addition, the MPM incorporates the framework of the Multicultural Counseling Competencies (Arredondo et al., 1996; D. W. Sue, Arredondo, & McDavis, 1992), which provides a structure to comprehend the complexity of the refugee experience, including past (displacement and premigration) stressors, present (postdisplacement and postmigration) stressors, trauma, psychological adjustment, adaptation challenges in acculturation, and cultural conceptualizations of mental illness and healing. Fundamental in using the MPM is personal awareness and understanding of the relationship between trauma and political countertransference, refugee cultural identity, and the interaction between pre- and postmigration (Bemak & Chung, 2015; Chung et al., 2011). In addition, cross-cultural empathy, or working with people who are different from one's own ethnocultural group (Rasoal, Jungert, Hau, Stiwne, & Andersson, 2009), is a critical skill when working with refugee trauma and requires incorporating the sociopolitical and ecological context of refugee clients (Chung & Bemak, 2002a; Draguns, 2007). Being unaware of these issues frequently leads to misdiagnoses, premature termination by refugee clients, and even harmful treatment

and fosters *psychological colonialism* (Bemak & Chung, 2011). (See Bemak & Chung, 2015, for a comprehensive description regarding the development of the MPM.)

The MPM provides a psychosocial model that comprises affective, cognitive, and behavioral interventions; incorporates resilience and prevention; and is rooted in cultural foundations and community and social processes. Within the MPM, there are five phases: (a) mental health education; (b) individual, group, and/or family psychotherapy; (c) cultural empowerment; (d) indigenous healing; and (e) social justice and human rights. The counselor determines when and how to use each of the five phases; therefore, phases may be used concurrently or sequentially. The MPM requires a reconceptualization of the counselor's role as a helper without requiring additional resources or funding.

### Phase I: Mental Health Education

Often, refugee clients have little or no knowledge about the counseling process. Therefore, Phase I of the MPM is focused on educating refugee clients about counseling practices and interventions. Therapeutic practices that counselors take for granted, such as intake procedures, interpersonal dynamics in the counseling process, self-disclosure, confidentiality, the interpreter's role, or time boundaries, may be peculiar notions for refugees. Accordingly, in Phase I, counselors should explain to the individual, family, or group about the MPM and respective roles and expectations in the client–counselor encounter. Because refugee displacement, premigration, and trauma may foster mistrust and uncertainty (Majumder, O'Reilly, Karim, & Vostanis, 2015; Ní Raghallaigh, 2014), it is critical in Phase I that counselors establish a working alliance that builds trust and safety (Bemak & Chung, 2015; Kruse, Joksimovic, Cavka, Wöller, & Schmitz, 2009) while using cross-cultural empathy that incorporates acceptance, intellectual understanding, and skills (Chung & Bemak, 2002a). Although Phase I is always explained in the first counseling session, it may be reintroduced at later points in counseling as needed.

### Phase II: Individual, Group, and/or Family Psychotherapy

Phase II is based on culturally responsive individual, group, and family counseling interventions that incorporate cultural norms and practices into the healing process. Because refugees are typically unfamiliar with Western psychodynamic practices and consider counselors to be professional experts, counselors may sometimes need to be more directive and active during counseling (Bemak & Chung, 2014). In addition, for many refugees, Western psychotherapy's emphasis on autonomy and independence is in direct contrast to the reliance and strength they gain from their families and communities (Bemak & Chung, 2015; Hong & Domokos-Cheng Ham, 2001).

*Cross-cultural therapeutic skills*. To be culturally responsive, counselors should use specific intervention strategies while addressing refugee trauma (Bemak & Chung, 2015). Heightened active listening is one such strategy (Lindy, 2012). Although active listening is basic to counseling, working with refugee clients with trauma requires an intensified level of active listening to hear and understand painful traumatic experiences within a cultural framework. Other cross-cultural therapeutic skills for trauma work include (a) interpreting actions, feelings, and experiences from a cultural perspective; (b) culturally understanding the quality and nature of verbal interactions between client and counselor; (c) considering the verbal and nonverbal context of communication across cultures; (d) knowing about the interrelationship of somatic and physical symptoms with refugee psychological distress and trauma; and (e) having an ability to integrate culturally responsive healing methodologies, such as metaphor, imagery, myth, ritual, narrative therapy, dreamwork, gestalt, role playing, psychodrama, and storytelling (Bemak & Chung, 2015; Schottelkorb, Doumas, & Garcia, 2012). In addition, cognitive behavior interventions are helpful when working with refugee trauma (Duarte-Velez, Bernal, & Bonilla, 2010; Schottelkorb et al., 2012), as is existential counseling (Parthasarthi, Durgamba, & Murthy, 2004). For example, the ability to assimilate displacement and premigration trauma and cultural losses into current experiences was found to be helpful in assisting African refugees in Egypt to cope with daily stressors (Henry, 2012).

*Sociopolitical context*. When working with refugees with trauma, counselors must consider the impact of the refugees' sociopolitical background on their current psychological functioning. In many instances, refugees flee their countries because they are subjected to aggressive intrusions by governments and authority figures, creating fear and distrust that contribute to their trauma (Bemak & Chung, 2015). During displacement and premigration, daily survival requires being hypervigilant about the motives of those seeking personal information. Therefore, personal questions asked by counselors may trigger traumatic memories and be perceived as threatening. Given that counseling requires self-disclosure and interpersonal intimacy, counselors must be sensitive to the refugee client's history when asking personal questions and probing. Counselors can cultivate trust by keeping in mind the impact of the client's experiences on the therapeutic relationship. To illustrate the importance of understanding refugee clients' sociopolitical context, we provide the following example:

> A Sudanese woman presented with blunted affect and a high level of mistrust and was unable to express her personal feelings or thoughts. During counseling, she revealed that, in her home country, she had watched several men beat and murder her younger brother while she was hiding. She felt powerless to

act and knew that she would be killed if she tried to defend her brother. In listening to the woman's story, the counselor was able to understand her trauma through the lens of her sociopolitical background and contextualize her mistrust.

*Collectivistic culturally responsive therapeutic interventions*. Collectivism is based on the principle of placing greater emphasis on the group (e.g., family, community) than on individual interests and needs. Individuals from collectivistic cultures tend to value cooperation, interdependence, social connectivity, collective group identity, and cooperative group decision making (Hofstede, 2001; Triandis, 2001). The MPM aims to foster adjustment, interdependence, and healing from trauma and psychological distress with an emphasis on collectivistic cultures. This focus on collectivistic cultures is based on a report by the UNHCR (2014) identifying the top 10 countries of origin for refugees: Afghanistan, Syria, Somalia, Sudan, the Democratic Republic of the Congo, Iraq, Colombia, Vietnam, and Eritrea. The collectivistic cultural backgrounds of refugees from these countries are consistent with the cultural backgrounds of most contemporary refugees. Given the preponderance of refugees coming from collectivistic cultures, the MPM highlights group, family, and community interventions as culturally responsive for refugees. Therapeutic factors in group work that are applicable to working with refugee trauma include corrective emotional experiences, altruism, universality (Yalom, 2005), and love (Bemak & Epp, 1996). The merits of social support and group counseling with refugees have been acknowledged (e.g., Bemak & Chung, 2014; Stansfield, 2006), and the sharing of stories and social engagement have been found to be highly effective interventions for addressing refugee stressors and trauma (Ehntholt, Smith, & Yule, 2005; Goodkind, Githinji, & Isakson, 2011). Thus, group counseling is highlighted in Phase II and extends to psychoeducational group sessions in Phase I and cultural empowerment groups in Phase III. Phase II groups enable refugees to heal by sharing their stories, exploring coping strategies, and having an opportunity to assist other refugees experiencing similar difficulties (Akinsulure-Smith, 2009; Bemak & Chung, 2015).

Strong family ties and the demands on entire refugee families to adapt are conducive to making family counseling another important Phase II intervention for refugee trauma. In using this therapeutic intervention, counselors emphasize the social support network through family work that examines changing family dynamics and roles related to displacement, migration, interpersonal dynamics, communication, and relationships. Accordingly, counselors must be knowledgeable about the traditional family relationships and values in the refugees' cultures of origin. Studies have shown that multigroup and multifamily treatments are effective (Lacroix & Sabbah, 2011) when there is an emphasis on reconstructing family, social, and community supports and networks within the context of cultural traditions that aid with trauma work and build on strength and resiliency rather than vulnerabilities. Given the unique challenges in working with refugee families and trauma, counselors must work collaboratively with other mental health and social service providers to develop a wraparound, integrative approach with refugee clients and their families (Rousseau et al., 2013).

### Phase III: Cultural Empowerment

First defined by Solomon in 1976, *cultural empowerment* refers to clients' ability to connect with their own power to advocate for themselves and overcome cultural barriers. Phase III of the MPM helps refugees gain environmental mastery that supports healing trauma. For example, many counselors often find themselves working with refugee clients who are more concerned with mastering skills to adapt to their new community than with addressing their psychological problems. Thus, it is important, as a component of psychotherapy, that counselors first resolve their clients' practical problems and frustration regarding access to services and resources, such as those related to education, language training, social services, housing, medical care, employment, and transportation (Bemak & Chung, 2014). This approach requires counselors to be familiar with the challenges of acculturation and incorporate case management–type assistance into counseling that fosters client empowerment.

It is important to note, however, that counselors using the MPM are not expected to assume the role of the client's case manager; rather, the goal is for counselors to become a *cultural systems information guide*, who helps the refugee client locate relevant information that supports his or her adjustment and alleviates trauma. Examples of interventions include reviewing school and work holidays with the client, determining the best public transportation routes and schedules to travel to work, role playing a meeting with a social services official, and practicing how to do a job interview. The counselor may need to periodically revert to Phase III during extended counseling sessions with a long-term goal of helping refugee clients develop and master skills to succeed in the new culture, thus diminishing trauma and psychological distress. An important dimension of cultural empowerment in the MPM relates to helping refugees handle experiences of discrimination and racism in the resettlement country (Dietz, 2010), because some refugees come from racially homogeneous societies and have little or no experience with racial, ethnic, or cultural diversity or familiarity as an ethnocultural minority. In addition, economic and political trends and subsequent changes in federal and state laws and policies may lead to increased hostility toward refugees, resulting in scapegoating and discrimination. Therefore, counselors must maintain up-to-date information about policy changes and understand the effects of individual and institutional racism and discrimination on refugee trauma, while helping refugees explore strategies to handle these experiences.

### Phase IV: Indigenous Healing

Phase IV of the MPM outlines how to integrate Western and indigenous healing methodologies. According to the World Health Organization (2003), combining Western and indigenous healing practices produces better therapeutic outcomes. Nevertheless, indigenous practices that may be successful in refugees' cultures of origin are often disregarded by Western mental health professionals. The MPM emphasizes the importance of incorporating home country–based healing practices into Western-based counseling. Still, counselors must be mindful that not all indigenous healers are legitimate, nor are all indigenous healing practices effective or relevant. Accordingly, counselors should assess the credibility and capability of indigenous healers before incorporating them in treatment partnerships. To illustrate cooperative treatment, we provide the following example:

> A counselor was working with a Sudanese widow who was having problems within her community as a result of her jealousy and resentment toward other Sudanese women whose husbands were still alive. Knowing that the woman was a devout Muslim and that a cornerstone of her religious belief system was generosity, fairness, and honesty toward other Muslims, the counselor referred her to the local imam. The imam instructed the woman to repeat special prayers while continuing weekly sessions with the counselor. In counseling, the woman described the impact of the prayers and the importance of meeting with the imam. For the client, the balance of traditional Islamic practice and counseling was extremely helpful and led to a more open and trusting relationship with the counselor.

### Phase V: Social Justice and Human Rights

Counselors should keep in mind that refugees may also have experienced human rights violations in their countries of origin, including torture, imprisonment, beatings, and rape. Thus, Phase V of the MLM addresses social injustices and potential human rights violations encountered by refugees. Similar to the other MPM phases, Phase V is not a discrete phase, but is imbued throughout the various other MPM phases. Embedded in this phase is a social advocacy role for counselors that underscores basic human rights affecting psychological well-being and trauma. Counselors in Phase V are proactive in addressing human rights violations and social injustices, including unequal access to resources, services, or opportunities; health, housing, and employment discrimination; and prejudicial treatment in the legal and educational systems. The premise of Phase V is that counselors must also address the ecological social justice and human rights factors that affect refugee clients' trauma and mental health, with the aim of improving the conditions of their daily lives (Chung & Bemak, 2012). For example, a counselor heard from an Ethiopian refugee high school student that other students repeatedly threw food at her during lunch and called her names. Using the MPM, the counselor not only discussed the student's reaction to the discrimination and coping strategies to handle the situation, but also contacted school administration to proactively change the situation for all students in similar situations. Examples of counselor social justice work in Phase V include (a) educating clients about their rights; (b) assisting clients, their families, and their communities to speak out and stand up for equal treatment and learn how to access resources and opportunities; (c) changing policy and legislation by writing to legislators and speaking at public hearings; and (d) educating colleagues and other helping professionals about refugees' experiences and the sociopolitical, historical, and cultural influences on their lives. The social justice and human rights work is integral to the MPM and important in the healing of refugee trauma.

## Conclusion

Providing counseling to address refugee trauma is complex and requires understanding the psychological, cultural, sociopolitical, historical, ecological, and economic dynamics that contribute to the refugee experience. The premigration displacement experience of refugees creates significant disruption, chaos, psychological distress, and trauma. Postmigration resettlement also presents momentous challenges and may exacerbate premigration trauma. To effectively address refugee trauma and psychological distress, we have proposed the MPM of Psychotherapy, Counseling, Social Justice, and Human Rights, a five-phase intervention approach that integrates culturally responsive Western psychotherapy with indigenous healing methods, cultural empowerment, psychosocial interventions, and social justice/human rights. Effectively implementing the model requires that mental health professionals have a clear understanding of refugee premigration trauma, issues in postmigration adaptation, the influence of dominant cultural and political values on refugees, and familiarity with human rights issues as they pertain to refugees. Future research is recommended that investigates the short- and long-term outcomes of the MPM and its specific application to refugee populations.

## References

Akinsulure-Smith, A. (2009). Brief psychoeducational group treatment with re-traumatized refugees and asylum seekers. *The Journal for Specialists in Group Work, 34,* 137–150. doi:10.1080/01933920902798007

Alexander, C. (2010, November). *Who pays the airfare to transport refugees to the U.S., and how does it work?* Retrieved from http://immigrantconnect.medill.northwestern.edu/blog/2010/11/30/who-pays-the-airfare-to-transport-refugees-to-the-u-s-and-how-does-it-work/

American Psychological Association. (2010). *Resilience and recovery after war: Refugee children and families in the United States.* Washington, DC: Author.

Arnetz, J., Rofa, Y., Arnetz, B., Ventimiglia, M., & Jamil, H. (2013). Resilience as a protective factor against the development of psychopathology among refugees. *The Journal of Nervous and Mental Disease, 201,* 167–172. doi:10.1097/NMD.0b013e3182848afe

Arredondo, P., Toporek, R. L., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42–78. doi:10.1002/j.2161-1912.1996.tb00288.x

Aydin, N., Krueger, J. I., Frey, D., Kastenmüller, A., & Fischer, P. (2014). Social exclusion and xenophobia: Intolerant attitudes toward ethnic and religious minorities. *Group Processes & Intergroup Relations, 17,* 371–387. doi:10.1177/1368430213510569

Beck, J. G., Coffey, S. F., Foy, D. W., Keane, T. M., & Blanchard, E. B. (2009). Group cognitive behavior therapy for chronic posttraumatic stress disorder: An initial randomized pilot study. *Behavior Therapy, 40,* 82–92. doi:10.1016/j.beth.2008.01.003

Bemak, F., & Chung, R. C.-Y. (2011). Post-disaster social justice group work and groups supervision. *Journal for Specialists in Group Work, 36,* 3–21. doi:10:1080/01933922.2010.537737

Bemak, F., & Chung, R. C.-Y. (2014). Immigrants and refugees. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology: Vol. 1. Theory and research* (pp. 503–517). Washington, DC: American Psychological Association.

Bemak, F., & Chung, R. C.-Y. (2015). Counseling refugees and migrants. In P. B. Pedersen, W. J. Lonner, J. G. Draguns, J. E. Trimble, & M. R. Scharron-del Rio (Eds.), *Counseling across cultures* (7th ed., pp. 323–346). Thousand Oaks, CA: Sage.

Bemak, F., Chung, R. C.-Y., & Pedersen, P. B. (2003). *Counseling refugees: A psychological approach to innovative multicultural interventions.* Westport, CT: Greenwood Press.

Bemak, F., & Epp, L. (1996). The 12th curative factor: Love as an agent of healing in group psychotherapy. *Journal of Specialists in Group Work, 21,* 118–127. doi:10.1080/01933929608412240

Bemak, F., & Greenberg, B. (1994). A study of Southeast Asian refugee adolescents: Implications for counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 22,* 115–124. doi:10.1002/j.2161-1912.1994.tb00250.x

Berry, J. W. (2002). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement and applied research* (pp. 17–38). Washington, DC: American Psychological Association.

Berry, J. W., & Sabatier, C. (2010). Acculturation, discrimination and adaptation among second generation immigrant youth in Montreal and Paris. *International Review of Psychiatry, 20,* 317–329. doi:10.1080/09540260802090363

Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica, 109,* 243–258. doi:10.1046/j.0001-690X.2003.00246.x

Briere, J. N., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Thousand Oaks, CA: Sage.

Chung, R. C.-Y. (2001). Psychosocial adjustment of Cambodian refugee women: Implications for mental health counseling. *Journal of Mental Health Counseling, 23,* 115–126.

Chung, R. C.-Y., & Bemak, F. (2002a). The relationship of culture and empathy in cross-cultural counseling. *Journal of Counseling & Development, 80,* 154–159. doi:10.1002/j.1556-6678.2002.tb00178.x

Chung, R. C.-Y., & Bemak, F. (2002b). Revisiting the California Southeast Asian mental health needs assessment data: An examination of refugee ethnic and gender differences. *Journal of Counseling & Development, 80,* 111–119. doi:10.1002/j.1556-6678.2002.tb00173.x

Chung, R. C.-Y., & Bemak, F. (2012). *Social justice counseling: The next steps beyond multiculturalism.* Thousand Oaks, CA: Sage.

Chung, R. C.-Y., Bemak, F., & Kudo Grabosky, T. (2011). Multicultural–social justice leadership strategies: Counseling and advocacy with immigrants. *Journal of Social Action in Counseling and Psychology, 3, 86–102.* Retrieved from http://jsacp.tumblr.com/

Chung, R. C.-Y., Bemak, F., Ortiz, D. P., & Sandoval-Perez, P. A. (2008). Promoting the mental health of migrants: A multicultural–social justice perspective. *Journal of Counseling & Development, 38,* 310–317. doi:10.1002/j.1556-6678.2008.tb00514.x

Chung, R. C.-Y., & Kagawa-Singer, M. (1995). An interpretation of symptom presentation and distress: A Southeast Asian refugee example. *The Journal of Nervous and Mental Disease, 183,* 639–648. doi:10.1097/00005053-199510000-00005

Chung, R. C.-Y., & Lin, K. M. (1994). Help-seeking behavior among Southeast Asian refugees. *Journal of Community Psychology, 22,* 109–120. doi:10.1002/1520-6629(199404)22:2<109::AID-JCOP2290220207>3.0.CO;2-V

Davila, L. T. (2008). Language and opportunity in the "land of opportunity": Latina immigrants' reflections on language learning and professional mobility. *Journal of Hispanic Higher Education, 7,* 356–370. doi:10.1177/1538192708321652

Deng, S. A., & Marlowe, J. M. (2013). Refugee resettlement and parenting in a different context. *Journal of Immigrant & Refugee Studies, 11,* 416–430. doi:10.1080/15562948.2013.793441

Dietz, J. (Ed.). (2010). Employment discrimination against immigrants. *Journal of Managerial Psychology, 25,* 104–122. doi:10.1108/02683941011019320

Draguns, J. G. (2007). Empathy across national, cultural, and social barriers. *Baltic Journal of Psychology, 8,* 5–20. Retrieved from http://www.lu.lv/apgads/izdevumi/elektroniskie-izdevumi/zurnali-un-periodiskie-izdevumi/baltic-journal-of-psychology/

Duarte-Velez, Y., Bernal, G., & Bonilla, K. (2010). Culturally adapted cognitive-behavior therapy: Integrating sexual, spiritual, and family identities in an evidence-based treatment of a depressed Latino adolescent. *Journal of Clinical Psychology, 66,* 895–906. doi:10.1002/jclp.20710

Ehntholt, K. A., Smith, P. A., & Yule, W. (2005). School-based cognitive-behavioural therapy group intervention for refugee children who have experienced war-related trauma. *Clinical Child Psychology & Psychiatry, 10,* 235–250. doi:10.1177/1359104505051214

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: A systematic review. *Lancet, 365,* 1309–1314. doi:10.1016/S0140-6736(05)61027-6

Finklestein, M., & Solomon, Z. (2009). Cumulative trauma, PTSD and disassociation among Ethiopian refugees in Israel. *Journal of Trauma & Disassociation, 10,* 38–56. doi:10.1080/15299730802485151

Goodkind, J., Githinji, A., & Isakson, B. (2011). Reducing heath disparities experienced by refugees resettled in urban areas: A community based transdisciplinary intervention model. In M. Kirst, N. Schaefer-McDaniel, S. Hwang, & P. O'Campo (Eds.), *Converging disciplines* (pp. 41–55). New York, NY: Springer-Verlag.

Henry, H. (2012). African refugees in Egypt: Trauma, loss and cultural adjustment. *Death Studies, 36,* 583–604. doi:10.1080/07481187.2011.553330

Herman, J. L. (1997). *Trauma and recovery.* New York, NY: Basic Books.

Hinton, D. E., Kredlow, M. A., Pich, V., Bui, E., & Hofmann, S. G. (2013). The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI). *Transcultural Psychiatry, 50,* 347–370. doi:10.1177/1363461513481187

Hofstede, G. (2001). *Culture's consequences: Comparing values, behaviors, institutions, and organizations across nations.* Thousand Oaks, CA: Sage.

Hong, G. K., & Domokos-Cheng Ham, M. (2001). *Psychotherapy and counseling with Asian American clients: A practical guide.* Thousand Oaks, CA: Sage.

Kim, G., Loi, C. X. A., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45,* 104–110. doi:10.1016/j.jsychires.2010.04.031

Kira, I. A., Lewandowski, L., Templin, T., Ramaswamy, V., Ozkan, B., & Mohanesh, J. (2010). The effects of perceived discrimination and backlash on Iraqi refugees' mental and physical health. *Journal of Muslim Mental Health, 5,* 59–81. doi:10.1080/1556490100362210

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183,* E959–E967. doi:10.1503/cmaj.090292

Kruse, J., Joksimovic, L., Cavka, M., Wöller, W., & Schmitz, N. (2009). Effects of trauma-focused psychotherapy upon war refugees. *Journal of Traumatic Stress, 22,* 585–592. doi:10.1002/jts.20477

Lacroix, M., & Sabbah, C. (2011). Posttraumatic psychological distress and resettlement: The need for different practice in assisting refugee families. *Journal of Family Social Work, 14,* 43–53. doi:10.1080/10522158.2011.523879

Lindencrona, F., Ekblad, S., & Hauff, E. (2008). Mental health of recently resettled refugees from the Middle East in Sweden: The impact of pre-settlement trauma, resettlement stress and capacity to handle stress. *Social Psychiatry & Psychiatric Epidemiology, 43,* 121–131. doi:10.1007/s00127-007-0280-2

Lindy, J. D. (2012). Listening to what the trauma patient teaches us: A 35-year perspective. In R. A. McMackin, E. Newman, J. M. Fogler, & T. M. Keane (Eds.), *Trauma therapy in context: The science and craft of evidence-based practice* (pp. 15–27). Washington, DC: American Psychological Association.

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry, 61,* 129–136. doi:10.1177/0020764014537236

McLean, C., & Foa, E. (2013). Dissemination and implementation of prolonged exposure therapy for posttraumatic stress disorder. *Journal of Anxiety Disorders, 27,* 788–792. doi:10.1016/j.janxdis.2013.03.004

Meichenbaum, D. (1996). Stress inoculation training for coping with stressors. *The Clinical Psychologist, 49,* 4–7.

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine, 70,* 7–16. doi:10.1016/j.socscimed.2009.09.029

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development, 92,* 57–66. doi:10.1002/j.1556-6676.2014.00130.x

The New Haven Trauma Competency Group. (2014). A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings. *Psychological Trauma: Theory, Research, Practice, and Policy, 6,* 300–307. doi:10.1037/a0036747

Nickerson, A., Bryant, R., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatry Research, 44,* 229–235. doi:10.1016/j.jpsychires.2009.08.006

Ní Raghallaigh, M. (2014). The causes of mistrust amongst asylum seekers and refugees: Insights from research with unaccompanied asylum-seeking minors living in the Republic of Ireland. *Journal of Refugee Studies, 27,* 82–100. doi:10.1093/jrs/fet006

Oberg, K. (1960). Culture shock: Adjustment to new cultural environments. *Practical Anthropology, 7, 177–182.*

Parthasarthi, M. S., Durgamba, V. K., & Murthy, N. S. (2004). Counseling migrant families in Southern India. *International Journal for the Advancement of Counselling, 26,* 363–367. doi:10.1007/s10447-004-0171-0

Priest, N., Perry, R., Ferdinand, A., Paradies, Y., & Kelaher, M. (2014). Experiences of racism, racial/ethnic attitudes, motivated fairness and mental health outcomes among primary and secondary school students. *Journal of Youth & Adolescence, 43,* 1672–1687. doi:10.1007/s10964-014-0140-9

Rasoal, C., Jungert, T., Hau, S., Stiwne, E. E., & Andersson, G. (2009). Ethnocultural empathy among students in health care education. *Evaluation & the Health Professions, 32,* 300–313. doi:10.1177/0163278709338569

Renner, W., & Senft, B. (2013). Predictors of unemployment in refugees. *Social Behavior & Personality: An International Journal, 41,* 263–270. doi:10.2224/sbp.2013.41.2.263

Renzaho, A. M. N., McCabe, M., & Sainsbury, W. J. (2011). Parenting, role reversals and the preservation of cultural values among Arabic speaking migrant families in Melbourne, Australia. *International Journal of Intercultural Relations, 35,* 416–424. doi:10.1016/j.ijintrel.2010.09.001

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *British Journal of Psychiatry, 194,* 306–312. doi:10.1192/bjp.bp.108.053223

Rousseau, C., Measham, T., & Nadeau, L. (2013). Addressing trauma in collaborative mental health care for refugee children. *Clinical Child Psychology and Psychiatry, 18,* 121–136. doi:10.1177/1359104512444117

Schottelkorb, A., Doumas, D., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized controlled trial. *International Journal of Play Therapy, 21,* 57–73. doi:10.1037/a0027430

Smith-Spark, L. (2014, June 20). *World Refugee Day: 50 million forced from their homes worldwide, U.N. say*s. Retrieved from http://www.cnn.com/2014/06/20/world/world-refugees-unhcr/

Solomon, B. (1976). *Black empowerment.* New York, NY: Columbia University Press.

Spahic-Mihajlovic, A., Crayton, J. W., & Neafsey, E. J. (2005). Selective numbing and hyperarousal in male and female Bosnian refugees with PTSD. *Journal of Anxiety Disorders, 19,* 383–402. doi:10.1016/j.janxdis.2004.03.004

Stansfield, S. (2006). Social support and social cohesion. In M. Marmot & R. Wilkison (Eds.), *Social determinants of health* (pp. 148–171). Oxford, England: Oxford University Press.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64–88. doi:10.1002/j.2161-1912.1992.tb00563.x

Sue, S., Fujino, D., Hu, L., Takeuchi, D., & Zane, N. (1991). Community mental health services for ethnic minority groups: A test of cultural responsive hypothesis. *Journal of Consulting and Clinical Psychology, 59,* 533–540. doi:10.1037/0022-006X.59.4.533

Triandis, H. C. (2001). Individualism–collectivism and personality. *Journal of Personality, 69,* 907–924. doi:10.1111/1467-6494.696169.

United Nations High Commissioner for Refugees. (2014). *Global trends 2013.* Geneva, Switzerland: Author.

U.S. Department of State. (2014). *Proposed refugee admissions for fiscal year 2014: Report to the Congress.* Retrieved from http://www.state.gov/documents/organization/219137.pdf

U.S. Department of Veterans Affairs & U.S. Department of Defense. (2010). *VA/DoD clinical practice guideline for management of post-traumatic stress.* Washington, DC: Author.

Wagner, J., Burke, G., Kuoch, T., Scully, M., Armeli, S., & Rajan, T. (2013). Trauma, healthcare access, and health outcomes among Southeast Asian refugees in Connecticut. *Journal of Immigrant Minority Health, 15,* 1065–1072. doi:10.1007/s10903-012-9715-2

Ward, C., Bochner, S., & Furnham, A. (2001). *The psychology of culture shock.* London, England: Routledge.

Willott, J., & Stevenson, J. (2013). Attitudes to employment of professionally qualified refugees in the United Kingdom. *International Migration, 51,* 120–132. doi:10.1111/imig.12038

World Health Organization. (2003). *Traditional medicine* (Fact Sheet No. 134). Retrieved from http://www.who.int/mediacentre/factsheets/2003/fs134/en/

Wu, M. C., Kviz, F. J., & Miller, A. M. (2009). Identifying individual and contextual barriers to seeking mental health services among Korean American immigrant women. *Issues in Mental Health Nursing, 30,* 78–85. doi:10/1080/01612840802595204

Yakushko, O., Backhaus, A., Watson, M., Ngaruiya, K., & Gonzalez, J. (2008). Career development concerns of recent immigrants and refugees. *Journal of Career Development, 34*, 362–396. doi:10.1177/0894845308316292

Yalom, I. (with Leszcz, M.). (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.

Yoon, E., Langrehr, K., & Ong, L. Z. (2011). Content analysis of acculturation research in counseling and counseling psychology: A 22-year review. *Journal of Counseling Psychology, 58,* 83–96. doi:10.1037/a0021128