Child Abuse & Neglect 111 (2021) 104862

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Principle-driven program design versus manualized programming in humanitarian settings

F. Giordano [a,*], M. Ungar [b]

[a] Department of Psychology – Resilience Research Unit, Università Cattolica del Sacro Cuore, Largo Gemelli 1, 20121, Milan, Italy
[b] Canada Research Chair in Child, Family and Community Resilience, Resilience Research Centre, Dalhousie University, PO Box 15000, Halifax, NS, B3H4R2, Canada

ARTICLE INFO

Keywords
Resilience
Psychosocial support
Intervention
Cultural adaptation
Principle-driven

1. Introduction

> "*Monkey saw Fish swimming. He did not know that fish liked water. He sympathized with fish and took it out of the water thinking it would drown. In the process, fish died. Monkey cried and said he was only helping*" (Training Handbook for Teachers, AVSI Foundation Uganda).

Providers of psychosocial support (PSS) for children in humanitarian settings have been accused of doing harm when interventions are offered that ignore the culturally and contextually-specific needs of populations under stress (see, for example, Bellido, Bernal, & Bonilla, 1995; Bernal, Trimble, Burlew, & Leong, 2003). Though programming may be offered with the best of intentions, there is potential for unintended negative impacts when interventions are imported into settings different from those where they were developed. One reason this occurs may be manualization. Though manualization may increase fidelity, programs for children may lose their relevance and decrease their efficacy when standardized (Hatzichristou, Lampropoulou, & Lykitsakou, 2006).

Despite efforts to decolonize knowledge and privilege marginalized perspectives on mental health, much of PSS in humanitarian settings continues to be done by outside experts who import evidence-based practices into contexts under severe stress. Wessells (2009) coined the term "parachuting" to indicate the arrival of Western doctorate-level psychologists trained in North American and European universities who lack knowledge about the culture, socio-historic context, or current situation of the young people they are trying to help. In particular, an emphasis on individualized solutions to complex social and environmental problems, incongruity between proposed solutions and local cultural norms, the excessive focus on deficits such as mental health issues and victimhood rather than collective resilience, power abuses such as the imposition of outsider approaches to intervention and evaluation, and the provision of inadequate training and supervision for staff have all been shown to contribute to the unintended harm of child populations requiring humanitarian assistance (Bonanno, 2004; Boothby, Crawford, & Halperin, 2006; Masten & Obradović, 2007; Masten, 2001; Wessells,

* Corresponding author.
E-mail addresses: francesca.giordano@unicatt.it (F. Giordano), michael.ungar@dal.ca (M. Ungar).

https://doi.org/10.1016/j.chiabu.2020.104862
Received 19 September 2019; Received in revised form 21 October 2020; Accepted 24 November 2020

2006). Therefore, when designing treatment, prevention, and mental health services in humanitarian settings, cultural and social processes must be considered (Bernal & Sharron-Del-Rio, 2001; Gladstone et al., 2010; Raman et al., 2017). Despite this need, developing evidence-based, culturally sensitive interventions remains a challenge as there are very few orienting frameworks for PSS program developers who would like to tailor treatment or preventive interventions to work with specific child populations from different cultures (Bernal. & Sáez-Santiago, 2006; Ungar, 2018).

In this paper, we review different ways of designing and delivering psychosocial support (PSS) programs for children in humanitarian settings, describing a range of approaches that increase sensitivity to the cultural and contextual differences of program participants. In particular, we identify and address the barriers to the implementation of manualized programming in emergency settings and propose principle-driven design as a more culturally sensitive alternative.

To illustrate the application of a principle-driven approach to practice, we present a case study of the Tutor of Resilience (TOR) program (Giordano & Ferrari, 2018; Giordano, Ragnoli, Brajda, et al., 2019). TOR is a transnational model that provides social workers, educators, psychologists and other helping professionals with resilience-focused practical tools and general guidelines for developing and planning psychosocial interventions with children who have been victims of violence and other traumatic experiences. TOR is built on the premise that resilience is a process that helps individuduals navigate and negotiate for resources across social and physical ecologies through interpersonal relationships that increase access to psychosocial supports (Giordano, Caravita, & Jefferies, 2020; Hobfoll & De Jong, 2014; Ungar, 2011). TOR-trained facilitators work with service providers to protect vulnerable children against risk and promote positive development by flexibly delivering content that builds children's well-being.

2. Current approaches to designing culturally-adapted PSS programs

Lyon and Koerner (2016) have shown that one of the main difficulties when implementing psychosocial treatment is the disconnection between the design context and the space where implementation takes place (between the "monkey" and the "fish"). This can lead to programs that are not well aligned with the needs of beneficiaries and are not necessarily applicable to the constraints of the contexts in which they are delivered (Addis, Wade, & Hatgis, 1999).

For example, Belfer (2006), criticizes international NGO's for their conscious provision of modes of care not adapted to the needs of children in specific cultural contexts or that do not fit the specifics of the clinical status of the children. Indeed, although the incidence of significant child psychopathology is relatively low, there too often appears to be a propensity among disease-focused NGOs to emphasize the diagnosis of PTSD (Weiss, Saraceno, Saxena, & van Ommeren, 2003). The validity of this diagnosis has been challenged particularly when applied across cultures (Summerfield, 2001; Weiss et al., 2003). The result has been the inappropriate use of psychopharmacological interventions and other therapies for PTSD, such as, de-briefing, ventilation or eye movement desensitization reprocessing (EMDR) (Belfer, 2006; Seidler & Wagner, 2006).

2.1. Adapting manualized programs

In general, the development of evidence-based PSS treatments has tended to emphasize the needs and perspectives of those developing the intervention who are typically PhD researchers or professors working in academic settings, international donors and the NGOs which administer the interventions (Lyon & Koerner, 2016; Wessells, 2009, 2017). Beneficiaries, in particular children, may be consulted but many programs simply adapt models to local contexts rather than build programs from the ground up in humanitarian settings (Hyde, 2013; Weisz, Jensen-Doss, & Hawley, 2006).

There are, fortunately, exceptions. Betancourt and Williams (2008) highlighted the importance of considering local priorities for the mental health issues facing children and youth in order to desing interventions that may be considered relevant and prioritized by affected communities. A program delivered in Chechnya with internally displaced youth - the International Rescue Committee's (IRC) North Caucasus Emergency Education Programme (Betancourt, 2002, 2004, 2005)– provided young beneficiaries with a place to connect to others, gain social support and offered hope for a better future.

However, evidence-based treatments (EBTs) in humanitarian settings often show poor outcomes as a consequence of their low acceptability, feasibility, and appropriateness (Chambers, Glasgow, & Stange, 2013; Proctor et al., 2011). Furthermore, the complexity of the humanitarian context makes it exceedingly difficult to train workers to deliver standardized EBTs. Ongoing consultation or coaching can also be difficult to deliver, as they can be too expensive or inaccessible for many practitioners living in remote areas, compromising program fidelity and contributing to a "train and hope" approach which is unlikely to result in meaningful behavior changes by beneficiaries (Lyon & Koerner, 2016). Therefore, incorporating the needs of program participants into the development process is a fundamental step in designing appropriate PSS programs. Successful implementation occurs as a function of both the quality of the intervention itself and the characteristics of the destination context (Rogers, 2003).

Much of the literature on designing programs for children that are contextually sensitive details how to adapt material to be culturally relevant rather than contextually responsive (MCKleroy et al., 2006; Parra-Cardona et al., 2012). For example, parenting programs in low-income countries where communities have experienced mass trauma tend to accommodate cultural differences in parenting norms but have focused far less on whether families are continuing to experience community violence, social marginalization or extreme poverty which prevent parents from implementing parenting strategies, even when these strategies are culturally relevant (Gewirtz et al., 2008). Recently, however, a growing body of literature has emerged on the issue of multiculturalism and cultural competence in PSS programming that builds upon studies of nuanced understandings of the mental health needs of cultural and ethnic minority populations (Arendondo, McDavis, & Sue, 1992; Torino & Sue, 2005; Ungar, 2018) and the quality of their environments. These works have shown that collective efforts are needed to adapt and tailor PSS interventions to diverse beneficiaries in

different countries and across the life span. Indeed, there is a general consensus on the importance of applying modifications to program protocols, adapting treatment goals and methods, and making more effort to meet the specific needs of target populations to ensure the validity of interventions that change both children and adults' access to supportive social and physical ecologies (Bellido et al., 1995; Ungar, 2018).

These challenges are not new. It has been more than four decades since Wolf (1978) identified three aspects of social validity that should be taken into consideration when designing culturally appropriate PSS programs. First, programs should examine the social significance of the program goals. In particular, experts who are cultural insiders should assess whether the identified goals are significant for the target community. Second, treatment procedures should be acceptable to the community which is the target of intervention. It is critical to determine whether the treatment which is being offered is perceived as fair, justified, and reasonable with regard to its level of intrusiveness (Kazdin, 2000). Third, the effects of treatment should be assessed in terms of both the process used to implement the program and the relevance of the selected outcomes to the beneficiaries. For example, a program that is adapted to a specific cultural space may require surface-level changes (e.g., translated measures, bilingual therapists) and/or much deeper structural changes (e.g., adding a treatment component that explores local cultural values).

2.2. Building bottom-up cultural adaptations of PSS programs

Cultural adaptations of programming can be done through a "top-down" theory driven approach or through a "bottom-up" approach that involves collaborating with service users as early as possible in the program design sequence (Aguirre, Orrell, Spector, & Woods, 2013). Community-based developmental approaches emphasize sharing decision-making with local partners. Examples of locally driven processes, however, tend to be slow and complex because they require ongoing attention to power dynamics (i.e., between program developers and both children and their caregivers) though the investment tends to be rewarded with greater ongoing investment by stakeholders in the delivery and sustainability of interventions, even when delivered by professionals who are cultural outsiders (Wessels & Monteiro, 2004, 2006).

For example, de Jong and colleagues (De Jong, Ghane, & Slobodin, 2018; Thomas et al., 2016) employed a four-phase period of adaptation that included a "bottom-up" approach to design a mental health intervention for asylum seekers: (1) a qualitative phase based on a needs assessment which identified intervention objectives; (2) a global expert panel to define and prioritize intervention modalities for low-resource settings; (3) a systematic review of the literature and distillation of practice elements from EBTs; and (4) stakeholder meetings to explore the sociocultural feasibility and acceptability of the intervention which was developed. Other program developers, like El-Sarraj, Punamäki, and Qouta (2001) recommend a detailed pre-intervention assessment aimed at detecting the peculiarities of each sociocultural context of the risk factors confronting program participants. Approaches like this can ensure programs build on local resources, i.e., established protocols for collaboration between traditional healthcare services and traditional healers and religious leaders.

3. A new model for designing culturaly appropriate PSS interventions for children: the ladder of program adaptation

Though we can identify several examples of ways to adapt programs to different humanitarian settings, no comprehensive model exists that can account for the adaptation of manualized programs, the development of local programming that becomes manualized, or principle-driven program design that remains endlessly flexible as it is used in different cultural spaces. To develop such a model, we were inspired by Hart's (1992) "Ladder of Children's Participation," an illustration of a ladder with eight rungs (levels), each describing a different experience of young's people's participation in the design and delivery of programs meant to benefit them. In Hart's model, the lowest rung characterizes children's participation in program planning as "manipulation" disguised as participation. Children are asked to participate in program design but given little information upon which to base their decisions. The second rung of the ladder is "decoration" which refers to adults using children to bolster their cause with few benefits for the children involved. "Tokenism", the third rung, describes circumstances in which children are apparently given a voice, but actually have little or no opportunity to affirm

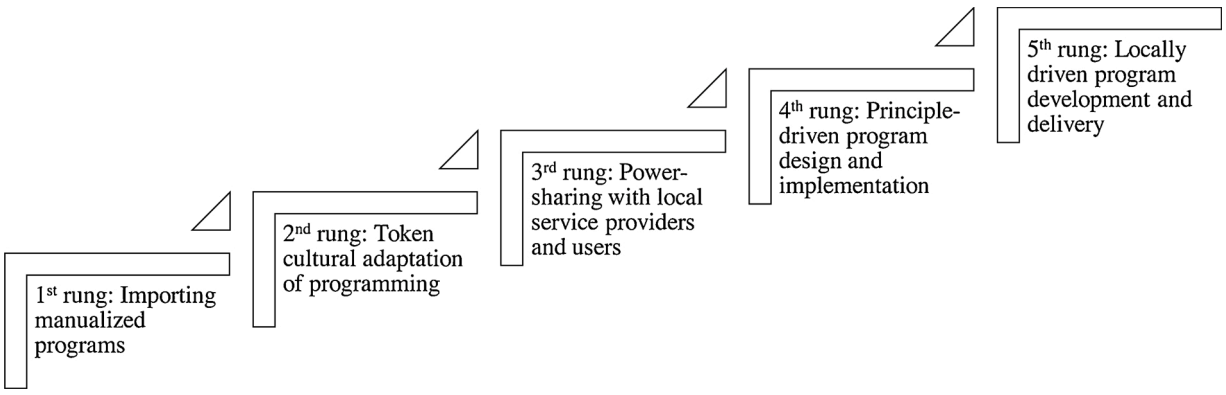

Fig. 1. The ladder of Program Adaptation.

their own opinions and little or no choice about the subjects to be discussed or the style or timing of communication. All three rungs are portrayed negatively by Hart.

The upper part of the Ladder of Participation illustrates different degrees of appropriate participation by children in interventions. The fourth rung is "assigned but informed", referring to occasions when children understand the intentions of a project, are aware of who made the decisions concerning their involvement and why. In this instance, they play a meaningful role in the initiative and are invited to volunteer for the project after it is explained to them clearly. The fifth rung, "consulted and informed" describes the experience of young people who work as consultants for adults, with the authority to have their voices heard built into the structure of the consultations. The sixth rung, "adult initiated, shared decisions with children" refers to projects that are initiated by adults, but leave the decision-making with children. "Child initiated and directed", the seventh rung of the ladder, occurs when children conceive of and carry out projects with only minor support from adults (these tend to be smaller initiatives). Finally, on the eighth rung are program design processes that are "child initiated, shared decisions with adults". These programs are, according to Hart, rare as they require adults who are attuned to the particular interests of young people and who are willing to engage with children as equal partners.

Building on Hart's work, we propose a five rung "Ladder of Program Adaptation" (see Fig. 1) to differentiate approaches to the development and implementation of PSS programs for children in humanitarian settings (see Table 1 for details of the model).

On the first rung, "importing manualized programs", are simple adaptations of EBTs (or treatments that lack an evidence base but are nonetheless exported to humanitarian settings). Typically, these programs are designed in high-income countries in North America and Europe, then implemented in low- and middle-income countries. Expert trainers provide PSS training using manualized materials and protocols, frequently with the support of a local translator. Program fidelity is expected and routinely assessed. When implementation becomes haphazard or deemed to be culturally inappropriate by trainees, the program is said to lack fidelity and program outcomes (effectiveness) is generally found to be poor when evaluated by criteria set by cultural outsiders (Castro, Barrera, & Martinez, 2004; Elliott & Mihalic, 2004; Whaley & Davis, 2007).

Programs like these are characterized by conventional approaches to training with learning as a product and the training as a transfer of knowledge. Trainers are experts while learners are passive recipients of content. An example of this rung would be the emergency educational programmes provided by international NGOs in the aftermath of natural disasters (Belfer, 2006), which are employed as standard packages regardless of the culture and values of the receiving community. Content is directly transferred to local service providers. Therefore, the training contents are selected by the NGOs according to what they think is useful or appropriate without appreciating the expertise of locals, their culture or their most pressing needs. These programs tend to show low sustainability. Indeed, when the lessons are abstract or not culturally attuned the likelihood of recruited providers to continue the provision of care in the area of mental health is minimal (Belfar, 2006). Freire (1989) refers to programming like this as the "banking concept of education" where education is conceived of as an act of depositing knowledge. Participants are required to patiently receive, memorize and store

Table 1
The five rungs of the Ladder of Program Adaptation.

The Ladder Rungs	Description	Roles of individuals/Groups involved in the process	Materials	Evaluation Tools
1st rung: Importing manualized programs	Programs designed in Western Countries exported to Humanitarian settings	The training consists in a unidirectional flow of expertise from the trainer, who is the 'expert', to the learner, who is conceived as a passive recipients of content	Use of manualized materials translated/with the support of a local translator	Program fidelity and program outcomes are assessed with manualized protocols
2nd rung: Token cultural adaptation of programming	Programs that adapt some elements of a manualized program in order to provide it with local content	The training consists in a unidirectional flow of expertise from the trainer, who is the 'expert', to the learner, who is conceived as a passive recipients of content	The core concepts of the program remain imported, with minimal cultural adaptations (e.g. local case vignettes).	Only few adaptations are reported in the assessment tools.
3rd rung: Power-sharing with local service providers and users	Programs where local stakeholders have the opportunity to shape the intervention.	Local stakeholders are engaged with the trainers in the adaptation of the program and redesign it to reflect local concepts	The program manual is rewritten with several local content	Evaluation tools are adapted to ensure they are culturally and contextually relevant
4th rung: Principle-driven program design and implementation	Evidence-informed programs which consists in the dissemination of key principles that guide program development and delivery.	Facilitators create and sustain a structured learning environment, helping generate new learning starting form the shared principles. Learners are encouraged to voice their own ideas, explore ways to solve their problems, and investigate their own reality.	Manuals and other material is only for single setting use.	The Evaluation tools are adapted, and/or chosen by the local community
5th rung: Locally driven program development and delivery	Initiatives where the community and (often local) facilitators work to address a problem they identify, and develop their own program without reference to an external set of principles or manualized interventions.	Trainers use a process of trial and error, receiving feedback from local program participants, to design and adjust a program to meet local needs in culturally relevant ways	Local experts and facilitators develop their own materials without reference to an external set of principles or manualized interventions	The Evaluation tools are chosen by the local community

the deposits. Fortunately, many program developers are now questioning the wisdom of the rapid and wholesale transport of EBTs to an increasingly diverse number of populations in different settings (Bernal & Sharron-Del-Rio, 2001; Hall, 2001a, 2001b; Shirk, 2004).

The second rung of the Ladder of Program Adaptation, "token cultural adaptation of programming", includes programs that adapt some elements of a manualized program in order to provide it with local content. There is acknowledgement that programs will need local case vignettes and new methods to engage people in ways that are culturally relevant, though the core concepts of the program remain imported. A review of studies of psychosocial or mental health treatment and intervention programs with children in low- and middle-income countries who have experienced protracted periods of violence and complex emergencies showed that while a majority of the publications reported cultural adaptations of programming, adaptations were generally minimal and briefly described or just simply recommended (Jordans, Tol, Komproe, & De Jong, 2009). The review focused on three different aspects of cultural adaptation that programs employ: changing how outcomes are assessed to be more culturally relevant; changing some elements of the treatment protocol; and the steps used to develop programming. Despite the focus of the review being on diverse marginalized populations globally, only two-thirds (66.7 %) of the articles mention cultural adaptation as a recommendation or as a pre-requisite for implementation. Furthermore, even when treatment-related adaptations were recommended, they were mainly focused on the minor inclusion of local approaches to the healing process such as religious practices and rituals or collaborations with existing resources like traditional healers (Boyden, 1994; Wessels & Monteiro, 2004, 2006). Few of the papers included in the review (7.8 %) called for adaptations of assessment tools to ensure that the screening of mental health and psychosocial problems included locally developed and cross-culturally valid instruments. Slightly less than a fifth of the studies (18.2 %) emphasized the need to adapt the process of program development, including: limiting international helpers as experts; applying a participatory approach to program design (as opposed to the imposition of a program designed elsewhere); integrating people's local perceptions of possible solutions to complex problems; adapting language related to distress, health and healing; adapting notions of child development; and working with local professionals/partnerships to make content more collectivist rather than individualistic (where appropriate). Finally, very few (3%) of the studies reviewed by Jordans et al. (2009) combined adaptations in assessment, treatment and program development. Given such patterns, the second rung of the Ladder of Cultural Adaptation is where one finds many recent efforts to bring EBTs to populations under stress.

The third rung of the Ladder, "power-sharing with local service providers and users", shifts the focus of intervention to ensuring that local stakeholders have the opportunity to shape the intervention. Those responsible for program development, delivery and assessment engage local stakeholders early in the adaptation of the program being importing into a community. A lengthy period of engagement is used to guarantee that local perspectives are included regarding a program's intended objectives, principles and outcomes during program implementation. A small group of local professionals typically receive training in an approach to treatment imported from elsewhere, but then are active in the redesign of interventions to reflect local concepts. The program manual is rewritten with plenty of local content. Evaluation tools are also adapted to ensure they are culturally and contextually relevant.

The fourth rung of the Ladder of Program Adaptation, "principle-driven program design and implementation", is similar to the third but is distinguished by the removal of the manual and a shift in focus to a generic set of principles that characterize the development of programs in many different settings. At this level, programs are evidence-informed rather than evidence-based. The existing literature is used to discern a set of core principles that guide program development and delivery. This literature includes manuals when they exist either for multiple sites or single use settings. In particular, the facilitator, based on the existing literature including academic literature, previous project reports and program manuals, and on factors/strategies that turned out to be contextually relevant throughout the training, shares with local experts during the training a list of potential principles relevant to a specific context. It is important for facilitators to discuss with participants whether these adapted principles are appropriate for their target beneficiaries. Professional facilitators (either from within the community or community outsiders invited into the community by local stakeholders) work with local trainers and trainees to develop interventions that are useful responses to local challenges. At the end of the program a set of guiding principles might be shared with other teams of program developers in other settings to inspire a similar intervention based on the same set of principles which are now shown to influence positive psychosocial outcomes. In this way, evidence for the effectiveness of these principles is gathered without producing a single manualized program. The main principle-driven programs development steps are illustrated in Table 2.

An example of a fourth rung, principle-driven intervention is the Assisted Resilience Approach Therapy (ARAT) implemented with children victims of violence in Lithuanian (Giordano, Cipolla, Ragnoli, & Brajda, 2019; Giordano, Ragnoli, & Brajda, 2019). ARAT is a

Table 2
The principle-driven program's development steps.

1. Needs analysis	Facilitators work with local service providers to do a needs analysis to identify the psychosocial needs and barriers to service experienced by the intended beneficiaries of programming, and the most relevant protective factors and processes that could support beneficiaries in dealing with local challenges.
2. Co-design guiding principles	Facilitators work with local trainees and trainers to develop principles using the needs assessment and the literature to identify a set of principles previously employed by other communities that have successfully coped with similar crises.
3. Action plan design	Facilitators work with local trainers and trainees to start preparing/setting the Intervention Action Plan including program curriculum content that is tailored to the community's needs based on the needs analysis results and evidence- informed principles. The action plan is then finalized by local trainees.
4. Ensuring fidelity	Once the intervention action plan is finalized by participants, they share it with facilitators who supervise/confirme that action plans reflect the program's guiding principles.
5. Monitoring program outcomes	A monitoring system is set up to track the impact of the program on beneficiaries.

resilience-focused therapeutic model which is a local adaptation of a principle-driven approach to addressing children's needs in contexts of violence and humanitarian crises (see the description of the ToR program below). ARAT strengthens children's resources to help them overcome traumatic experiences of violence related to war or child abuse. Developed through a collaboration between the Resilience Research Unit at the Catholic University of Milan and the Lithuanian non-governmental organization Paramos Vaikams Centras, ARAT includes three parts: training, application, and monitoring. Training for psychotherapists is done over eight days. The program is offered to children through a series of 22 sessions. The number of sessions was somewhat arbitrary but sufficiently long to expect results when children were assessed before and after intervention. Local psychotherapists from different disciplinary backgrounds are trained in the theory of resilience and techniques to apply that body of theory to practice, including a strengths-based perspective of patients, how to deal with both risk and protective factors that influence children's resilience after exposure to violence, strategies and tools for understanding and managing children's emotions that occur after traumatic events, and ways to shape a child's therapeutic setting. Though the content may sound prescriptive, the ARAT program does not provide specific therapeutic practices but instead emphasizes a set of core principles that therapists can integrate into their practice in many different ways. Fidelity is assessed by the number and frequency with which therapists exhibit these principles in their practice with children, though each sequence of 22 treatment sessions will include different activities suited to the needs of each child population and the particular strengths of the therapist offering the intervention.

Specifically, the facilitators (a combination of cultural insiders and outsiders) who provided the eight days of training for the psychotherapists had five goals, each reflecting principles associated with building resilience with children who have experienced violence:

1 Widening the psychotherapist's point of view on the child, in order to change his or her focus from impairments and psychological wounds to the child's strengths and capacity to heal.
2 Helping psychotherapists discover locally relevant ways of assisting children to discover their internal resources and talents and reinforce them (Cesana, Giordano, Boerchi, Rivolta, & Castelli, 2018). In particular, coping abilities (Spaccarelli & Kim, 1995), problem-solving skills and emotional self-regulation (Masten, Best, & Garmezy, 1990) were all emphasized.
3 Reinforcing children's interpersonal relations, starting with a positive therapeutic engagement with the therapist to facilitate trust building and build an internal sense of security.
4 Enhancing children's emotional recognition and trauma processing, in order to mitigate negative consequences of stress (Cameron, Carroll, & Hamilton, 2018; Giordano et al., 2012; Giordano et al., 2015; Giordano, Cipolla et al., 2019).
5 Reinforcing the strengths of family systems through the establishment of a trusting relationship with parents/caregivers, avoiding fears of prejudices or negative intentions, especially for intra-familiar violence cases, creating/reinforcing family support networks (Afifi & MacMillan, 2011; Sagy & Dotan, 2001), and encouraging positive parenting practices (Howell, Graham-Bermann, Czyz, & Lilly, 2010; Spaccarelli & Kim, 1995).

With these goals in mind, the program monitors outcomes. Past efforts to implement the program have shown a significant improvement in resilience and a significant decrease of trauma-related symptoms throughout the ARAT intervention. Furthermore, the increase in resilience during treatment predicted lower levels of anger and dissociation at the end of the treatment (Giordano & Ferrari, 2018; Giordano, Ragnoli et al., 2019).

The fifth and final rung on the Ladder of Program Adaptation, "locally driven program development and delivery", includes initiatives where the community and a facilitator (usually a professional from inside the community) work to address a problem they identify and develop their own matierals and program without reference to an external set of principles or manualized interventions. In this case, trainers may use a process of trial and error, receiving feedback from local program participants, to design and then re-design a program to meet local needs in culturally relevant ways. To illustrate, Resilience-Focused Case Management is a program developed for the Libyian staff of the Italian NGO, Cooperazione e Sviluppo (CESVI). Participants were case workers in charge of case management for migrant women who were victims of GBV and their children hosted in Community Development Centers (CDC) and children detained in jails or living in camps for internally displaced persons.

Rather than importing a case management model, CESVI staff asked an external facilitator to help them develop a contextually specific approach to working with highly traumatized beneficiaries of service in a work setting where there was a very high turnover of case workers. Initial review of current practices by the local service coordinators found that case management was often delivered through a set of standardized protocols that included a great deal of paperwork for which new staff were never sufficiently trained to complete. Rather than helping staff provide services to more and more people as demand steadily increased, the standardized protocols (imported into the setting from other service settings) had become a way that case managers limited the size of their caseloads as it placed too many demands on their time.

A new approach was developed through stakeholder input that emphasized the building of worker-client relationships. Training was provided to workers by local case managers who emphasized a shift in perspective from client vulnerability to strengths, adapting the procedures of case management to make them more resilience promoting (e.g., more time for relationship building and less paperwork), and finding setting-specific ways for workers to do case management better with their clients. In practice this meant that case managers working with women who had histories of GBV developed a set of resilience-focused case management guidelines that emphasized: empowerment (empowering survivors and strenghtening their own resources); positivity (helping survivors see the positive things they had done in their lives and inspiring them with stories of other successful women); support (facilitating workshops for women to share their stories of pain and resilience, and teaching life skills appropriate to each context); awareness (informing survivors about their rights); and follow-up (planning for the future). Other case managers (such as those working with children in

detention centers) developed their own set of guidelines, though each group was committed to building the resilience of their clients. Training is now sustainable as local case managers take the lead to train new employees when they start working.

4. Case example

Programs that populate the first three rungs of the Ladder of Program Adaptation, traditional manualized programs in humanitarian and other stressed environments, have been characterized by four limitations: (1) they focus almost excessively on deficits such as mental health problems (Maton, Schellenbach, Leadbeater, & Solarz, 2004); (2) they import their own treatment and evaluation protocols which may have little resonance with local stakeholders (Rogler, 1999); (3) they rely on evidance-based intervention packages which are often too complex to be delivered by mental health professionals or lay helpers in stressed environments; and (4) they lack sufficient flexibility in their design to adapt to the nuances of a specific setting or culture. To address these shortcomings, a team of researchers and professional therapists developed a principle-driven alternative to manualized treatment: the TOR program. TOR is a validated effort to develop a methodology for interventions on the fourth rung of the Ladder. Though an adaptation of TOR (ARAT) was described earlier, a fuller discussion of how principle-driven programs are developed and implemented is included here.

The TOR model adopts a strenghts-based approach focused on exploring and building the positive potential of individuals and systems (Boustead & Thomlinson, 2005). The excessive focus on deficits such as mental health problems creates a biased picture that limits program alternatives, supports stereotypes of people as helpless victims, and reflects the biases of researchers rather than the complex realities of traumatized populations typically found in humanitarian and other stressed envrionments (Giordano, Ragnoli, Brajda, & Boerchi, 2018; Wessells, 2009).

To address these concerns, TOR facilitators are typically invited by local service providers to help them solve a particularly intransigent problem: dealing with major migratory flows of war-affected populations (in Lebanon with Syrian refugees); providing PSS in emergency setting (in camps for displaced persons following the 2009 Italian earthquake); and in communities highly affected by natural disasters (in Croix des Bouquets in Haiti, and in Paredeones and Bucalemu in Chile, following the 2010 earthquakes and tsunami). TOR trainers then convene a group of local service providers for a needs analysis, where they facilitate the definition of the main psychosocial needs and problematics detected among beneficiaries and also of the relevant protective resources that could support beneficiaries in dealing with those issues. The employ of creative methodologies (photovoice, role playing, etc) increases the successful engagement of local stakeholders during this first fundamental phase of program development. TOR training is then tailored to reflect the information that is collected and delivered thorugh an initial four days of training and a further 2 days follow-up training during which trainees develop curriculum content based on a structure of principles that are evidence-informed from other communities that have successfully coped with similar crises. Concurrent with the development of the program content, a three-step assessment is developed (baseline, post-intervention, and follow-up) to track the impact of the model on beneficiaries' wellbeing.

During the first four-day workshop, the following topics are dicussed:

1 *Psychosocial approach to support and resilience*. Starting with a discussion that deconstructs the victimizing, individualizing and medicalization of children exposed to complex stressors, the workshop focuses on the meaning of empowerment, resilience and young people's natural potential for recovery. Participants are encouraged to shift their perspective from a deficit-focus approach to care to a strengths-based reframing of what beneficiaries need.
2 *Psychological trauma in children and its interaction with multilevel developmental processes.* The component of the workshop provides a comprehensive summary of what is known regarding the developmental impact of trauma and the underlying mechanisms through which trauma impairs children's cognitive, emotional and social development. While the science is presented as objective, its application to each specific context is the focus of discussions.
3 *Identification, prevention and appropriate responses to children who have experienced adversity*. The workshop enhances participants' capacities to intervene with children and families at risk through the application of resilience-focused methods, tools and strategies, starting from the principles of resilience building "I have, I can, I am" (Grotberg, 1993).
4 *Monitoring the implementation of the TOR program.* A monitoring plan is developed and refined with participants.

Each module shares some of the relevant science on related topics but no specific activities are suggested as interventions. Instead workshop participants are encouraged to reflect on the principles of effective practice and how these can be adapted to the needs of the people with whom they work with the goal of designing new activities that reflect the principles they are learning during their training. In practice, the participatory nature of the training is best done as a less formal ongoing educational process in which learners and facilitators co-create possible content for use with the target population.

During the two-day follow-up workshop, the focus is on the following themes:

1 *Program refinement.* Investigating strengths, weaknesses, advantages and disadvantages of the TOR program which have been identified by participants during the first period of program implementation.
2 *Ongoing evalutation and scaling up.* Designing a new action plan of the TOR program to be executed as the program is scaled up, reflecting the results of the first phase evaluation.

Done this way, contexutally sensitive principle-driven PSS program design has the potential to produces much simpler interventions than the complicated manualized intervention protocols brought to communities under stress. A local manual is still produced to guide training and ensure the principles of resilience are conveyed to participants. The content, however, is highly

localized, emphasizing the program developers' perspective.

5. Conclusion

Culture and context play a fundamentally important role in psychosocial interventions, especially in humanitarian settings or other stressed environments where populations as a whole are disadvantaged (Rogler, 1999). Principle-driven approaches to program design and implementation, like TOR, are typical of appraoches to program that are better able to adapt interventions to different settings (those on rungs four and five of the Ladder of Program Adaptation). In this sense, they help to create programs that are more likely to be accepted by the populations they are intended for (Aarons et al., 2014; Lyon & Koerner, 2016). Explicit codesign processes— in which trainers specify major core components and an overarching structure, but collaborate with participants to define more specific aspects of the intervention in real time— have been proposed as a method for the development of contextually appropriate practices in fields such as education (Penuel, Roschelle, & Shechtman, 2007) and mental health (Chorpita, Bernstein, & Daleiden, 2011). We characterize these interventions as being on rung three of our Ladder of Program Adaptation. We argue here that these practices may not be contextually sensitive enough for implementation in environments that are more stressed such as humanitarian settings requiring PSS. In these more extreme settings, interventions higher on the Ladder are showing promise, though further research and evaluation is still needed to refine methods, ensure engagement of participants make programs sustainable.

Acknowledgments

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

Aarons, G. A., Chaffin, M. J., Fettes, D. L., Gunderson, L., Hurlburt, M. S., Palinkas, L. A., et al. (2014). Collaboration, negotiation, and coalescence for interagency-collaborative teams to scale-up evidence-based practice. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 915–928. https://doi.org/10.1080/15374416.2013.876642

Addis, M. E., Wade, W. A., & Hatgis, C. (1999). Barriers to dissemination of evidence-based practices: Addressing practitioners' concerns about manual-based psychotherapies. *Clinical Psychology. Science and Practice, 6*(4), 430–431. https://doi.org/10.1093/clipsy.6.4.430

Afifi, T., & MacMillan, M. (2011). Resilience following child maltreatment: A review of protective factors. *The Canadian Journal of Psychiatry, 56*, 266–272. https://doi.org/10.1177/070674371105600505

Aguirre, E., Orrell, M., Spector, A., & Woods, R. T. (2013). Cognitive stimulation for dementia: A systematic review of the evidence of effectiveness from randomised controlled trials. *Ageing Research Reviews, 12*(1), 253–262. https://doi.org/10.1016/j.arr.2012.07.001

Arendondo, P., McDavis, R. J., & Sue, D. W. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 20*(2), 64–88. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Belfer, M. L. (2006). Caring for children and adolescents in the aftermath of natural disasters. *International Review of Psychiatry, 18*(6), 523–528. https://doi.org/10.1080/09540260601048877

Bellido, C., Bernal, G., & Bonilla, J. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology, 23*(1), 67–82. https://doi.org/10.1007/BF01447045

Bernal, G., & Sharron-Del-Rio, M. G. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7*(4), 328–342. https://doi.org/10.1037/1099-9809.7.4.328

Bernal, G., Trimble, J. E., Burlew, A. K., & Leong, F. T. L. (2003). *Handbook of racial and ethnic minority psychology*. Thousand Oaks, CA: Sage.

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psycology, 34*(2), 121–132. https://doi.org/10.1002/jcop.20096

Betancourt, T. S. (2005). Stressors, supports and the social ecology of displacement: Exploring the psychosocial dimensions of an emergency education program for Chechen adolescents displaced in Ingushetia, Russia. *Culture, Medicine & Psychiatry, 29*, 309–340. https://doi.org/10.1007/s11013-005-9170-9

Betancourt, T. S. (2002). The IRC's emergency education and recreation program for Chechen displaced youth in Ingushetia. *Forced Migration Review, 15*, 28–30.

Betancourt, T. S. (2004). *Connectedness, social support and mental health in adolescents displaced by the war in Chechnya. The Rosemarie Rogers working paper series.* Cambridge, MA: MIT-Mellon Program on NGOs and Forced Migration.

Betancourt, T. S., & Williams, T. (2008). Building an evidence base on mental health interventions for children affected by armed conflict. *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 6*(1), 39–56. https://doi.org/10.1097/WTF.0b013e3282f761ff

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*(1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

Boothby, N., Crawford, J., & Halperin, J. (2006). Mozambican child soldier life outcome study: Lessons learned in rehabilitation and reintegration efforts. *Global Public Health, 1*(1), 87–107. https://doi.org/10.1080/17441690500324347

Boustead, R., & Thomlinson, R. P. (2005). Tipping the balance toward strengths? A review of investing in children, youth, families, and communities: strengths-based research and policy. In K. I. Maton, C. J. Schellenbach, B. J. Leadbeater, & A. L. Solarz (Eds.), *PsycCRITIQUES* (p. 15), 50 (52).

Boyden, J. (1994). Children's experience of conflict related emergencies: Some implications for relief policy and practice. *Disasters, 18*(3), 254–267. https://doi.org/10.1111/j.1467-7717.1994.tb00311.x

Cameron, L. D., Carroll, P., & Hamilton, W. K. (2018). Evaluation of an intervention promoting emotion regulation skills for adults with persisting distress due to adverse childhood experiences. *Child Abuse & Neglect, 79*, 423–433. https://doi.org/10.1016/j.chiabu.2018.03.002

Castro, F. G., Barrera, M., & Martinez, C. R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science, 5*, 41–45. https://doi.org/10.1023/B:PREV.0000013980.12412.cd

Cesana, M. L., Giordano, F., Boerchi, D., Rivolta, M., & Castelli, C. (2018). Drawing to reconstruct: Pilot study on acknowledging prisoners' internal and external resources in a penitentiary institution. *World Futures. The Journal of New Paradigm Research, 74*(6), 392–411. https://doi.org/10.1080/02604027.2018.1445913

Chambers, D., Glasgow, R., & Stange, K. (2013). The dynamic sustainability framework: Addressing the paradox of sustainment amid ongoing change. *Implementation Science, 8*(1), 117. https://doi.org/10.1186/1748-5908-8-117

Chorpita, B. F., Bernstein, A., & Daleiden, E. L. (2011). Empirically guided coordination of multiple evidence-based treatments: An illustration of relevance mapping in children's mental health services. *Journal of Consulting and Clinical Psychology, 79*(4), 470–480. https://doi.org/10.1037/a0023982

De Jong, J. T., Ghane, S., & Slobodin, O. (2018). Developing a culturally sensitive mental health intervention for asylum seekers in the Netherlands: A pilot study. *Intervention, 16*(2), 86–94. https://doi.org/10.4103/INTV.INTV_2_18

Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5*(1), 47–53. https://doi.org/10.1023/B:PREV.0000013981.28071.52

El-Sarraj, E., Punamäki, R., & Qouta, S. (2001). Resiliency factors predicting psychological adjustment after political violence among Palestinian children. *International Journal of Behavioral Development, 25*(3), 256–267. https://doi.org/10.1080/01650250042000294
Freire, P. (1989). *Pedagogy of the oppressed*. New York: Continuum.
Gewirtz, A., Forgatch, M., & Wieling, E. (2008). Parenting practices as potential mechanisms for child adjustment following mass trauma. *Journal of Marital and Family Therapy, 34*(2), 177–192.
Giordano, F., & Ferrari, C. (2018). Processi di resilienza in minori vittime di violenza: un progetto di intervento con adolescenti in Lituania. *Maltrattamento e abuso all'infanzia, 2*, 105–116. https://doi.org/10.3280/MAL2018-002007
Giordano, F., Caravita, S. C. S., & Jefferies, P. (2020). Social-ecological resilience moderates the effectiveness of avoidant coping in children exposed to adversity: An exploratory study in lithuania. *Frontiers in Psychology, 11*, Article 536353. https://doi.org/10.3389/fpsyg.2020.536353
Giordano, F., Orenti, A., Lanzoni, M., Marano, G., Biganzoli, E., Castelli, C., et al. (2015). Trauma and temporal discontinuity in children victims of natural disasters. The Test de trois dessins: Avant, pendant et avenir. [Trauma e discontinuità temporale nei minori vittime di disastri naturali. Il Test de trois dessins: Avant, pendant et avenir]. *Maltrattamento e Abuso all'Infanzia, 17*(2), 87–116. https://doi.org/10.3280/MAL2015-002005
Giordano, F., Ragnoli, F., Brajda, B. F., & Boerchi, D. (2018). Resilience and trauma-related outcomes in children victims of violence attending the Assisted Resilience Approach Therapy (ARAT). *Children and Youth Services Review, 96*, 286–293. https://doi.org/10.1016/j.childyouth.2018.11.050
Giordano, F., Castelli, C., Crocq, L., & Baubet, T. (2012). Non-sense and chaos in the drawings of children victims of the earthquake in Abruzzo [Le non-sens et le chaos dans les dessins des enfants victimes du tremblement de terre aux Abruzzes]. *Annales Médico-psychologiques, 170*(5), 342–348. https://doi.org/10.1016/j.amp.2012.05.011
Giordano, F., Cipolla, A., Ragnoli, F., & Brajda, B. F. (2019). Transit migration and trauma: The detrimental effect of interpersonal trauma on Syrian children in transit in Italy. *Psychological Injury and Law, 12*(1), 76–87. https://doi.org/10.1007/s12207-019-09345-x
Giordano, F., Ragnoli, F., & Brajda, B. F. (2019). Data on resilience and trauma-related symptoms in Lithuanian children victims of violence. *Data in Brief, 23*, 10379. https://doi.org/10.1016/j.dib.2019.103791
Gladstone, M., Lancaster, G., Umar, E., Nyirenda, M., Kayira, E., van den Broek, N., et al. (2010). Perspectives of normal child development in rural Malawi - a qualitative analysis to create a more culturally appropriate developmental assessment tool. *Child: Care, Health and Development, 36*(3), 346–353. https://doi.org/10.1111/j.1365-2214.2009.01008.x
Grotberg, E. (1993). *Promoting resilience in children: A new approach*. University of Alabama at Birmingham: Civitan International Research Center.
Hall, G. C. N. (2001a). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*(3), 502–510. https://doi.org/10.1037/0022-006X.69.3.502
Hall, G. C. N. (2001b). Psychotherapy with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*(3), 502–510. https://doi.org/10.1037/0022-006X.69.3.502
Hart, R. A. (1992). Children's participation: From tokenism to citizenship. *Papers Inness 92/6. Innocenti Essays n.4*. Available at: http://www.unicef-irc.org/publications/pdf/childrens_participation.pdf.
Hatzichristou, C., Lampropoulou, A., & Lykitsakou, K. (2006). Addressing cultural factors in development of system/community interventions. *Journal of Applied School Psychology, 22*(2), 103–126. https://doi.org/10.1300/J370v22n02_06. Multicultural Issues and School Psychology Practice.
Hobfoll, S. E., & De Jong, J. T. (2014). The course and limitations of natural recovery from trauma: The centrality of threats to attachment and safety and their reinstatement. In L. A. Zoellner, & N. C. Feeny (Eds.), *Facilitating resilience and recovery following traumatic events* (pp. 69–89). New York, NY: Guilford Press.
Howell, K. H., Graham-Bermann, S. A., Czyz, E., & Lilly, M. (2010). Assessing resilience in preschool children exposed to intimate partner violence. *Violence and Victims, 25*(2), 150–164. https://doi.org/10.1891/0886-6708.25.2.150
Hyde, P. S. (2013). *Report to Congress on the nation's substance abuse and mental health workforce issues*. Washington, DC: U.S. Department for Health and Human Services, Substance Abuse and Mental Health Services.
Jordans, M. J. D., Tol, W. A., Komproe, I. H., & De Jong, J. T. V. M. (2009). Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war. *Child and Adolescent Mental Health, 14*(1). https://doi.org/10.1111/j.1475-3588.2008.00515.x, 2 14.
Kazdin, A. E. (2000). Perceived barriers to treatment participation and treatment acceptability among antisocial children and their families. *Journal of Child and Family Studies, 9*, 157–174. https://doi.org/10.1023/A:1009414904228
Lyon, A. R., & Koerner, K. (2016). User-centered design for psychosocial intervention development and implementation. *Clinical Psychology: Science and Practice, 23*, 180–200. https://doi.org/10.1111/cpsp.12154
Masten, A. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*(3), 227–238. https://doi.org/10.1037/0003-066X.56.3.227
Masten, A., & Obradović, J. (2007). Disaster preparation and recovery: Lessons from research on resilience in human development. *Ecology and Society, 13*(1). art. 9. Retrieved from www.ecologyandsociety.org/vol13/iss1/art9/.
Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2*(4), 425–444. https://doi.org/10.1017/S0954579400005812
Maton, K. I., Schellenbach, C. J., Leadbeater, B. J., & Solarz, A. L. (2004). *Investing in children, youth, families, and communities: Strengths-based research and policy*. Washington: American Psychological Association.
MCKleroy, V. S., Galbraith, J. S., Cummings, B., Jones, P., Harshbarger, C., Collins, C., et al. (2006). Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Education and Prevention, 18*(4A), 59–73. https://doi.org/10.1521/aeap.2006.18.supp.59
Parra-Cardona, J. R., Domenech Rodriguez, M., Forgatch, M. S., Sullivan, C., Bybee, D., Tams, L., et al. (2012). Culturally adapting an evidence-based parenting intervention for Latino immigrants: The need to integrate fidelity and cultural relevance. *Family Process, 51*, 56–72. https://doi.org/10.1111/j.1545-5300.2012.01386.x
Penuel, W. R., Roschelle, J., & Shechtman, N. (2007). Designing formative assessment software with teachers: An analysis of the co-design process. *Research and Practice in Technology Enhanced Learning, 2*(1), 51–74. https://doi.org/10.1142/S1793206807000300
Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., et al. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Administration and Policy in Mental Health and Mental Health Services. *Research, 38*, 65–76. https://doi.org/10.1007/s10488-010-0319-7
Raman, S., Ruston, S., Irwin, S., Tran, P., Hotton, P., & Thorne, S. (2017). Taking culture seriously: Can we improve the developmental health and well-being of Australian Aboriginal children in out-of-home care? *Child: Care, Health and Development, 43*(6), 899–905. https://doi.org/10.1111/cch.12488
Rogers, E. M. (2003). *Diffusions of innovations* (5th ed.). New York, NY: Free Press.
Rogler, L. H. (1999). Methodological sources of cultural insensitivity in mental health research. *American Psychologist, 54*(6), 424–433. https://doi.org/10.1037/0004-066X.54.6.424
Sagy, S., & Dotan, N. (2001). Coping resources of maltreated children in the family: A salutogenic approach. *Child Abuse & Neglect, 25*(11), 1463–1480. https://doi.org/10.1016/S0145-2134(01)00285-X
Seidler, G. H., & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioural therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine, 36*, 1515–1522. https://doi.org/10.1017/S0033291706007963
Shirk, S. R. (2004). Dissemination of youth ESTs: Ready for prime time? *Clinical Psychology: Science and Practice, 11*(3), 308–312. https://doi.org/10.1093/clipsy.bph086
Spaccarelli, S., & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect, 19*(9), 1171–1182. https://doi.org/10.1016/0145-2134%2895%2900077-L
Thomas, F. C., Tol, W. A., Vallipuram, A., Sivayokan, S., Jordans, M. J. D., Reis, R., et al. (2016). Emic perspectives on the impact of armed conflict on children's mental health and psychosocial well-being: Applying a social ecological framework of resilience in Northern Sri Lanka. *Peace and Conflict, 22*(3), 246–253. https://doi.org/10.1037/pac0000172

Torino, G. C., & Sue, D. W. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In C. R. T (Ed.), *Handbook of racial-cultural psychology and counseling, volume 2: Training and practice*. Hoboken, NJ: Wiley.

Ungar, M. (2011). The social ecology of resilience: Addressing contextual and cultural ambiguity of a nascent construct. *American Journal of Orthopsychiatry, 81*(1), 1–17. https://doi.org/10.1111/j.1939-0025.2010.01067.x

Ungar, M. (2018). *What works: A manual to design programs that build resilience*. Halifax, NS: Resilience Research Centre. http://www.resilienceresearch.org.

Weiss, M. G., Saraceno, B., Saxena, S., & van Ommeren, S. (2003). Mental health in the aftermath of disasters: Consensus and controversy. *Journal of Nervous Mental Disease, 191*, 611–615. https://doi.org/10.1097/01.nmd.0000087188.96516.a3

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. *American Psychologist, 61*, 671. https://doi.org/10.1037/0003-066X.61.7.671

Wessells, M. G. (2006). *Child soldiers: From violence to protection*. Cambridge, MA: Harvard University Press.

Wessells, M. G. (2009). Do no harm: Toward contextually appropriate psychosocial support in international emergencies. *American Psychologist, 64*(8), 842–854. https://doi.org/10.1037/0003-066X.64.8.842

Wessells, M. G. (2017). Children and armed conflict: Interventions for supporting war-affected children. And overview. *Peace and Conflict: Journal of Peace Psychology, 23*(1), 4–13. https://doi.org/10.1037/pac0000227

Wessells, M. G., & Monteiro, C. (2006). Psychosocial assistance for youth: Towards reconstruction for peace in Angola. *Journal of Social Issues, 62*(1), 121–139. https://doi.org/10.1111/j.1540-4560.2006.00442.x

Wessels, M., & Monteiro, C. (2004). Internally displaced angolans: A child-focused, Community-based intervention. In K. E. Miller, & L. M. Rasco (Eds.), *The mental health of refugees: Ecological approaches to healing and adaptation* (pp. 67–94). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist, 62*(6), 563–574. https://doi.org/10.1037/0003-066X.62.6.563

Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis, 11*(2), 203–214. https://doi.org/10.1901/jaba.1978.11-203