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The Building Resiliency and Vocational Excellence (BRAVE) Program: A Violence-Prevention and Role Model Program for Young, African American Males

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Abstract: There are sharp disparities between non-Hispanic Whites and African Americans in mortality and years of potential life lost for numerous health-related conditions, including HIV/AIDS. The Building Resiliency and Vocational Excellence (BRAVE) Program is an intervention using Resiliency Networking designed for use with African American young men to help offset these disparities. Resiliency Networking incorporates coaching, career planning, and re-definition of gender roles to help young men develop a sense of purpose and future and to manage their lifestyles effectively. In addition to fostering a strong link with an older mentor, the program fosters healthy peer-to-peer relationships. The paper reports on preliminary use of the intervention and recommends future applications.

Key words: African American, youth, men, mentoring, Resiliency Networking.

Numerous health problems related to alcohol, tobacco and other drug (ATOD) consumption (such as acute heart palpitations, stroke, lung cancer, hepatitis, and liver cirrhosis) affect African Americans more detrimentally and severely than non-Hispanic Whites.[1–2] In 2002, the HIV/AIDS death rate per 100,000 population for African American males was 33.3 compared with 4.3 for White males in 2002.[3–4] These disparities in HIV/AIDS translate into a shorter life expectancy and diminished years of productive work life for African Americans: in 2002, there were 720.6 years of potential life lost (YPLs) due to HIV among African Americans and 84.7 YPLs for Whites.[3–4]

A good argument can be made that the sharp rise of HIV/AIDS among African Americans is related to the sharply disproportionate rate of incarceration for African Americans in comparison with non-Hispanic Whites.[5] Young African American males who get caught up in the criminal justice system often have little exposure to positive male role models who can lead them to a healthy and productive way of life, making interventions that provide them with surrogate sources of positive influence important.[6–8] Role models can mitigate the forces that lead to behaviors that place people at high risk for criminal behavior, ill health, and premature death.[6–9]

Learning lifestyle management techniques beginning in childhood is important for the reduction of risk factors that contribute to disparities in morbidity and mortality.[10–12] This paper describes a vocationally oriented, research-driven program

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called the Building Resiliency and Vocational Excellence (BRAVE) Program. The author designed the program to address some of the key ATOD prevention needs of a seriously affected group of African American males in the 16–20 year old age group. The paper goes on to discuss the barriers that the author encountered in implementing the program and to briefly sketch how the program helped to generate a new model for future interventions. In addition to the late adolescents among whom the BRAVE Program was first implemented, the program may be useful in working with African American males previously involved in the criminal justice system due to drug possession or other drug-related crimes. Let us start with a description of the BRAVE Program.

The BRAVE Program

The BRAVE Program is a substance abuse and violence prevention program designed for 16–20 year old African American youths who were at risk for involvement with ATODs and violence. Prevention research has aimed at addressing violence and ATOD use by seeking to understand their causes and to alleviate them, particularly among minority youth.[13–16] Much research indicates that having a positive personal relationship with a caring adult acts as a protective factor against drug use.[17–19] Researchers in the early 1990s found that families can intervene in the lives of older youths by demonstrating flexibility and providing support, behaviors that can also serve as protective factors.[20] Other researchers have identified risk factors for involvement in ATODs, including poor early academic performance[21–25] and antisocial behavior.[26] The BRAVE Program employs a cognitive behavioral approach to teach relevant skills.[26–28] Other paradigms and research findings from an extensive body of research in psychology,[29–36] especially research into the effectiveness of peers as agents of change, the relationship between ATOD use and vocational achievements,[37–38] violence prevention,[39] social development,[40] as well as other facets of cognitive behavioral psychology[41–55] also informed the design of the program.

Resiliency networking is a strength-based approach modeled after characteristics of the resilient child. The promotion of resiliency parallels a developmental process in that young people learn these skills early in life, perfect implementation of these behaviors as they grow, and carry resiliency characteristics forward into and throughout adulthood.[11–13,56] Thus, resiliency has its etiology in childhood, although the biological basis for its expression is not well understood. Nevertheless, resiliency research has revealed that some children have succeeded despite high odds working against them.

Researchers have begun to identify characteristics common among resilient youth, including positive social competence, good problem solving skills and, overall, an ability to cope with challenging life events in ways that produce positive health outcomes when negative outcomes would otherwise occur.[47, 55–58] Other behavioral strengths of resilient children identified by Bernard[56] include:

- autonomy, independent thinking, and resistance to negative social influence;
- sense of purpose and future;
- openness to beneficial, new experiences while demonstrating responsible judgment; and

- facility at convincing others of the soundness of the resilient youth's viewpoints and ideas.

The intervention model whose initial implementation as the BRAVE Program is described here is based on the cultivation of underlying skills that exemplify characteristics of the resilient child and Social Learning Theory.[51–52, 55–58]

The BRAVE Program used a standardized ATOD prevention curriculum, two violence prevention curricula, goal setting, vocational mentoring, vocational peer-to-peer support and manhood development training as prevention strategies. The link between the conceptual elements of the BRAVE Program and resiliency characteristics reported in behavioral research centered on the behaviors targeted in the program. The authors reasoned that if resilient youth are able to overcome negative environmental circumstances where chances dictate that they should fail, then modeling target behaviors after the characteristics of resilient youth might be successful. For BRAVE Program participants, developing a sense of purpose and future may be particularly relevant. Many are young men and boys who come from economically disadvantaged neighborhoods.

By employing evidence-based curricula, the program organizers worked to increase social competence, improve decision-making, strengthen problem-solving, and bolster assertiveness. The content of the curricula paralleled characteristics of the resilient child (autonomy, problem solving, social competence[56–57]) presented earlier in this discussion. Students also learned to cope with negative peer influence and gained greater knowledge about responsible male roles, commitment to community, economic independence, and resistance to involvement with ATODs and violence.

While teaching students to set meaningful career goals, the program organizers also encouraged the students to participate in the skilled trades, entrepreneurial ventures, or professional schools, as appropriate to their expressed career aspirations. The overarching goal of the program was to facilitate compliance with ATOD- and violence-free lifestyles. The premise of the BRAVE Program was that young adult African American men (i) who attach themselves to positive, successful community role models; (ii) who cultivate appropriate adaptive skills for community settings; (iii) who internalize social norms that equate manhood with personal responsibility; and (iv) who develop potentially rewarding vocational careers will be less likely to become involved with ATODs and to engage in violence.

Mentors are people who guide, coach, nurture, teach, and model for the advancement of their protégés.[7] Mentoring is a robust youth development process frequently cited in the behavioral science literature for fostering youth development and has been proven instrumental in the prevention of the initiation of alcohol use for African American youth.[8] Tierney and colleagues posit that an effective mentoring program requires one hour of mentor-to-protégé interaction every week throughout a school year. Having a positive role model in a youth's life is associated with less likelihood of participating in "weapon carrying, illicit drug use, daily smoking, and high risk sexual activity [p. 57]."[8] Elements of mentoring are central to Resiliency Networking.

As a school-based career development program, BRAVE included goal setting and monitoring in the classroom setting along with training using the Life Skills ATOD

Prevention curriculum.[26, 59] The five best-practice characteristics for mentoring programs that researchers have identified are[60–61]

- mentors should be recruited through organizations and not on a one-at-a-time basis;
- mentoring programs should concentrate on youth who need this kind of support and guidance;
- mentors need clear goals in order to be effective;
- mentors need continuing support from program staff; and
- mentoring needs a context such as the workplace or the school site in order to be meaningful to youth.

Only the second and third characteristics were incorporated in BRAVE since no organization was available for mentor recruitment and since staffing shortages precluded in-depth contacts with mentors from occurring more than once during each of two semesters.

The BRAVE Program was first implemented in Clarkston, Georgia during the 1998–1999 school year. Sixty young men attending an alternative school first took part in the program, which was conducted at the school in the evening. Participants were students who had current, past, or pending rule violations (e.g., school infractions or legal charges); came from economically disadvantaged or female-headed households; or were in danger of facing academic probation or becoming dropouts. Fifty-nine out of the 60 participants at the alternative school in the pilot year were African American males in the 16–20 year old age group. Many of the young men who participated in the pilot year of the program had had contacts with the criminal justice system and lived in environments where drug use, drug trafficking, and violence were commonplace.

During the day, some of the students worked in minimum wage positions while others spent a significant part of their time at local hang-outs such as neighborhood dance clubs, a popular mall reachable by public transportation, and public housing projects. These environments placed many of the students at risk for involvement with ATOD-related, violent, and disruptive behavior due to the exposure they provided to peers and young adults with criminal records. Almost all of the young men had academic deficiencies or had experienced academic failure. In fact, several were mildly retarded or carried conduct disorder diagnoses.

All program participants younger than 18 years of age required written informed consent from a guardian to participate in the program, which received Institutional Review Board approval. During the pilot year, the intervention took place as part of the evening school program (3:00 p.m.—9:00 p.m.).

The BRAVE Program staff worked with students in the classroom setting, as a result of which the staff gained valuable exposure to the students, enabling them to develop a maximally comprehensive approach to their work.

Training exercises closely followed the sequence and content outlined in each of the substance abuse and violence prevention curricula selected for the program, covering ATOD life skills, self-image and self-improvement, decision making, smoking myths

and realities, alcohol myths and realities, marijuana myths and realities, advertising, coping with anxiety, communication skills, social skills, and assertiveness. Violence prevention sessions were similar in format only. Rather than provide lectures, the curricula used in the program required that the BRAVE Program trainers facilitate role-play, discussion, demonstration, contingent praise, and homework assignments. Violence prevention training used a similar intervention approach for skill building and behavioral practice. Students were actively involved in the learning process.

Lessons Learned

In the pilot year, BRAVE Program staff heard many remarks from participants suggesting they were at risk for or already engaging in violence or criminal activity. For example, in the first semester of the pilot project and over the Christmas holiday, one of the students reported that he had been hospitalized for a cocaine overdose that almost killed him. Several of the students reported that they had been shot during their involvement with residents at a near-by public housing project. Other students barely escaped being struck by stray bullets during their visits to the local public housing project. Drug trafficking was the context for the gunshot incidents. Some of the young men reported that they were on probation or had been in the past.

Of equal concern was the fact that some of the *de facto* leaders among the participants made it very clear that they had little regard for females. They commonly referred to females as "b_ _ _ _ _ es" and "h_ _ s". Such references to females were a salient element of their subculture. Researchers have reported lack of respect and sexist attitudes towards women as evident among some subcultures of African American males,[62–63] and the youth in the BRAVE Program displayed such attitudes. Some young men offered the opinion that females had to "earn respect." As a result, the authors modified the intervention to include respect for women as part of the manhood development curriculum for the program. Manhood development programs have become increasingly visible with the advent of curriculum-based programs such as Wise Guys from the National Fatherhood Initiative,[64] which Aronson and colleagues describe as "attempting to help these men redefine what it means to be a man and a father in their communities, moving them from harmful to helpful roles [p. 732]".[12]

Further, the young men frequently glorified the fights that they had had over the weekend by bragging about details of each brawl. They reveled in each other's stories to such a degree that they competed for each other's attention through the recounting of these events. The louder and more graphic the description of the fight, the more impressive the story appeared to be to their peers.

Not enough young men in the 16–20 year old age group in the pilot year were available after attrition to assess the effectiveness of the BRAVE Program formally. The sample size did not provide enough statistical power to test adequately the prevention effects for the BRAVE Program service delivery model. Efforts to recruit participants from other alternative schools and two high schools proved futile. Another daunting challenge involved recruitment of sufficient numbers of mentors to work with the young men on a one-to-one basis; just as importantly, some of the young men did not want to have mentors.

New Direction: Younger Participants

As a result of these hurdles, the author changed the target age group to middle school and made arrangements to offer the program at a middle school on the west side of Atlanta within five miles of the downtown business district. The youth at the site were from low- to middle-income families and the new site provided ready access for the program to over 70 students per year. Participants in this phase of the BRAVE Program were 199 middle school students over the first years (1999–2003).

Although we cannot provide the details of a formal statistical analysis here, we can report that it appeared to program staff that the BRAVE Program resulted in a considerably lower rate of drinking to drunkenness over a given 30-day period for intervention versus comparison group participants. Many of the middle school students shared the same risk factors as the older males from the pilot study: many were at risk of academic failure or dropping out and lived in low-income and/or female-headed households.

BRAVE Mentors

Exposure to community role models who "made it," in the persons of successful skilled tradesmen and professionals who volunteered in the BRAVE Program, appeared to make a strong impression on participating middle school students.

Adult mentors who participated in the program were 21 years of age or older. Mentor recruitment occurred through announcements via a university e-mail system, word of mouth, and targeted public service announcements on an African American university radio station. Mentors completed a criminal background check and a two-hour training session that oriented them to the key components of the program. The principal investigator described the educational sessions scheduled to take place during health education classes, the Life Skills Curriculum,[26, 28] Violence Prevention Curriculum,[65] and violence prevention training videotapes.[66–67] The mentor orientation also included descriptions of the goal setting lessons and emphasized career planning and manhood development training. Mentors learned that the classroom sessions in manhood development provided the youth with an atmosphere where they could examine topics such as exercising male responsibility, treatment of women, and myriad issues that underscore the importance of becoming a mature, whole, successful African American man, a man who embodies class, dignity, and style.

The primary reason for this multifaceted classroom training was to strengthen the skills that the youth acquired by encouraging him to relate these skills to his personal experiences and ultimately to the demands of the world of work. The mentors who volunteered included an architect, a management information system director, a computer operator, and a lawyer. As the relationship developed, it was not unusual for the mentor to expose the student to his own work site as an educational experience. The architect, for example, brought his mentee to his offices to learn about drafting projects for buildings and about running the business. The BRAVE Program staff also scheduled recreational events such as a kick-off event, bowling, and skating in order to encourage sharing between the mentors and youth. In

addition, the mentors and mentees participated in community activities, including movies, museum tours, and sports events. The times and locations for these events were arranged by the youth, his parents, and his mentor. These activities provided opportunities for mentor-to-mentee bonding and for the youth to discuss with his mentor careers that he might wish to pursue and other topics.

Training Sessions

The middle school program just introduced served eighth graders (13–15 years old) and operated during the school day (8:45 a.m.—2:50 p.m.) in the course of regularly scheduled health education class periods. Certified teachers supervised the classroom sessions with training support from the trainer for the BRAVE Program. The BRAVE Program organizers scheduled the sessions 2–3 times per week for 50–90 to ninety minute health education sessions over a 9-week period.

The trainer for the BRAVE Program was a graduate student with training in counseling psychology followed by another graduate student with training in African American studies. Since formal training in the use of the curricula and other materials was not available, the principal investigator used weekly lesson planning sessions as periods for the trainers to review and practice using the training material. In order to encourage adherence to lesson plan content and to maintain the fidelity of the training, the trainers were required to prepare a service delivery schedule to document the delivery of lesson plan objectives.

In addition to studying the curricula discussed above, students developed career plans that incorporated short- and long-term goals leading to skilled trades (e.g., plumbing, carpentry, and electrical trades), entrepreneurship, or the professions. Pairs of students used a buddy system to monitor each other's progress towards attainment of their individual goals, monitoring that took place under the supervision of the BRAVE Program trainer. The goal of these sessions was to encourage the youth to acquire skills characteristic of the resilient child, especially to develop a sense of purpose and future through career planning. Periodic on-the-job visits with the mentors at the mentor's work site further aided generalization of classroom skills while better connecting the lessons to the student's life experiences and aspirations.

Targets for attitudinal and behavioral change included less favorable attitudes towards ATODs and violence. The youths were to learn assertive ways to resist involvement with ATODs and avoid violent resolution of interpersonal conflicts. For example, the sessions included learning to avoid becoming a victim of violence by avoiding unsafe places. Equally important was the acquisition of abilities to form healthy relationships with peers. As part of the manhood development component, participants learned to establish strong relationships with peers and the older generation, including mentors, and to give back to younger people. The training addressed the whole person by focusing on responsibility, maturity, and autonomy as they relate to being a successful adult.

By redefining the role of the African American man, the youths learned that eventually giving back to at least two younger males behind them is an integral part of becoming a successful adult in a process of ongoing dialogue named Resiliency Networking.

Measures of program effectiveness consisted of student self-reports, using items from the Monitoring the Future national survey.[68] Self-report measures assessed the frequency of ATOD use and the frequency of violence perpetration and victimization. Process measures consisted of attendance records at classroom sessions.

Systems-Level Intervention

Working with youth who are prone to criminal involvement may require attention to risk factors that are pivotal in this subpopulation, specifically, the risks posed by disadvantageous economic and social circumstances. Presenting evidence-based ATOD prevention curricula (such as Life Skills,[26, 28] Violence Prevention,[65] and the Dealing with Anger curricula[66]) and training African American men and adolescents in community institutions constitutes a powerful systems-level intervention. The BRAVE Program and Resiliency Networking are designed to empower African American males at various ages. Men and boys who participate in these programs become more competent advisers for youth, bolster peer-to-peer filial bonds, and generally strengthen the health promotional infrastructure in community settings. The long-term aim of Resiliency Networking is to weave a protective layer of resiliency characteristics throughout the community and around African American youth in particular. Testing the effectiveness of these programs through randomization at the neighborhood level would be an appropriate unit of analysis for future investigation.[69]

Notes

1. National Institute on Drug Abuse (NIDA). Drug use among racial/ethnic minorities. (NIH Publication No. 03-3888) Rockville, MD: NIDA, 2003.
2. Goldstein LB, Adams R, Becker K, et al. Primary prevention of ischemic stroke: A statement for healthcare professionals from the Stroke Council of the American Heart Association. Stroke 2001 Jan;32(1):280–99.
3. Center for Disease Control and Prevention. Health disparities experienced by black or African Americans—United States. MMWR 2005 Jan;54(1):1–3.
4. National Center for Health Statistics. Health, United States, 2004 with chartbook on trends in the health of Americans. (DHHS Publication No. 2004–1232) Washington, DC: U.S. Government Printing Office.
5. Lane SD, Rubinstein RA, Keefe RH, et al. Structural violence and racial disparity in HIV transmission. J. of Health Care for the Poor and Underserved 2004 Aug;15(3):319–35.
6. Harper CC, McLanahan SS. Father absence and youth incarceration. J Res Adolesc 2004 Sep;4(3):369–97.
7. Young CY, Wright JV. Mentoring: the components for success. Journal of Instructional Psychology. 2001 Sep;28(3):202–6.
8. Tierney JP, Grossman JB, Resch NL. Making a difference: an impact study of Big Brothers/Big Sisters. Philadelphia, PA: Public/Private Ventures, 1995.
9. Grossman JP, Tierney JP. Does mentoring work? An impact study of the Big Brothers/Big Sisters Program. Eval Rev 1998 Jun 22;(3):403–26.
10. Rew L, Horner SD. A Youth Resilience Framework for reducing health-risk behaviors in adolescents. J Pediatr Nurs 2003 Dec;18(6):379–88.

11. Knoke JD, Shanks TG, Vaughn JW, et al. Lung cancer mortality is related to age in addition to duration and intensity of cigarette smoking: an analysis of CPS-I data. Cancer Epidemiol Biomarkers Prev 2004 Jun;13(6):949–57
12. Aronson RE, Whitehead TL, Baber WL. Challenges to masculine transformation among urban low-income African American males. Am J Public Health 2003 May;93(5):732–41.
13. Baer JS, Marlatt GA, Kivlahan DR, et al. An experimental test of three methods of alcohol risk reduction with young adults. J Consult Clin Psychol 1992 Dec;60(6):974–9.
14. Minty B. Public care of distorted family relationships: The antecedents of violent crime. Howard Journal of Criminal Justice 1988 Aug;27(3):172–87.
15. Rutter M. Psychosocial resilience and protective mechanisms. In: Rolf JE, Masten AS, Chicchetti D, et al., eds. Risk and protective factors in the development of psychopathology. New York: Cambridge University Press, 1990; 181–214.
16. Werner EE. Resilient offspring of alcoholics: a longitudinal study from birth to age 18. J Stud Alcohol 1986 Jan;47(1):34–40.
17. Franz CE, McCllelland DC, Weinberger J. Childhood antecedents of conventional social accomplishment in midlife adults: a 36-year prospective study. J Pers Soc Psychol 1991 Apr;60(4):586–95.
18. Lytton H. Child and parent effects in boys' conduct disorder: a reinterpretation. Dev Psychol 1990 Sep;26(5):683–97.
19. McCord J. Family relationships, juvenile delinquency, and adult criminality. Criminology 1991;29(3):397–417.
20. Santisteban DA, Szapocznik J, Rio AT. Family therapy for Hispanic substance abusing youth: An empirical approach to substance abuse prevention. In: Mayers RS, Kail BL, Watts TD, eds. Hispanic substance abuse. Springfield, IL: Charles C. Thomas, 1993; 157–73.
21. Hawkins JD, Jensen JM, Catalano RF, et al. Delinquency and drug abuse: implications for social services. Soc Serv Rev 1988;62(2):258–84.
22. Hawkins JD, Lishner DM, Catalano RF, et al. Childhood predictors of adolescent substance abuse: toward an empirically grounded theory. Journal of Children in Contemporary Society 1985;18(1–2):11–48. Reprinted in Griswold-Ezekoye S, Kumpfer KL, Bukoski WJ, eds. Childhood and chemical abuse: prevention and intervention. New York: Hayworth, 1986.
23. Hawkins JD, Lishner DM, and Catalano RF. Childhood predictors and the prevention of adolescent substance abuse. NIDA Res Monogr 1985;56:75–126.
24. Hawkins JD, Lishner DM, Jenson JM, et al. Delinquents and drugs: what the evidence suggests about prevention and treatment programming. In: Brown BS, Mills AR, eds. Youth at high risk for substance abuse. (DHHS Pub. No. ADM87-1537) Rockville, MD: NIDA, 1987.
25. Zarek D, Hawkins JD, Rogers PD. Risk factors for adolescent substance abuse: implications for pediatric practice. Pediatr Clin North Am 1987 Apr;34(2):481–93.
26. Botvin GJ, Schinke S, and Orlandi MA, eds. Drug abuse prevention with multiethnic youth. Thousand Oaks, CA: Sage Publications, 1995.
27. Oetting ER, Beauvais F. Peer cluster theory, socialization characteristics, and adolescent drug use: a path analysis. J Counsel Psychol 1987 Apr;34(2):205–13.
28. Botvin GJ, Baker E, Dusenbury L, et al. Preventing adolescent drug abuse through a multimodal cognitive–behavioral approach: results of a 3-year study. J Consult Clin Psychol 1990 Aug;58(4):437–46.

29. Botvin GJ, Schinke SP, Epstein JA, et al. Effectiveness of culturally focused and generic skills training approaches to alcohol and drug abuse prevention among minority youths. Psychol Addict Behav 1994 Jun;8(2):116–27.
30. Botvin GJ, Epstein JA, Baker E, et al. School-based drug abuse prevention with inner-city minority youth. Journal of Child & Adolescent Substance Abuse 1997;6(1):5–20.
31. Hansen WB, Graham JW. Preventing alcohol, marijuana, and cigarette use among adolescents: peer pressure resistance training versus establishing conservative norms. Prev Med 1991 May;20(3):414–30.
32. Winters RA, Malione A. High school students as mental health workers: the Everett experience. Sch Couns 1975 Sep;23(1):43–4.
33. Corn KL, Moore DD. Reach for the S.T.A.R.S.--Students Teaching and Reaching Students: a two-faceted peer facilitating program at Greenfield-Central High School. Sch Couns 1992 Sep;40(1):68–72.
34. Wassef A, Mason G, Collins ML, et al. In search of effective programs to address students' emotional distress and behavioral problems part III: student assessment of school-based support groups. Adolescence 1996 Spring;31(121):1–16.
35. Massey RF, Neidigh LW. Evaluating and improving the functioning of a peer-based alcohol abuse prevention organization. J Alcohol Drug Educ 1990 Winter;35(2):24–35.
36. Brown BB, Clasen DR, Eicher, SA. Perceptions of peer pressure, peer conformity dispositions, and self-reported behavior among adolescents. Dev Psychol 1986 Jul;22(4):521–30.
37. Friedman AS, Granick S, Bransfield S, et al. The consequences of drug use/abuse for vocational career: a longitudinal study of a male urban African-American sample. Am J Drug Alcohol Abuse 1996 Feb;22(1):57–73.
38. Spicer RS, Miller TR. Impact of a workplace peer-focused substance abuse prevention and early intervention program. Alcoholism Clin Exp Res 2005 Apr;29(4):609–11.
39. Goldstein AP, Glick B. Aggression Replacement Training: a comprehensive intervention for aggressive youth. Champaign, IL: Research Press, 1987.
40. Hawkins JD, Weiss JG. The social development model: an integrated approach to delinquency prevention. J Prim Prev 1985 Winter;6(2):73–97.
41. Botvin GJ, Renick NL, and Baker E. The effects of scheduling format and booster sessions on a broad-spectrum psychosocial smoking prevention. J Behav Med 1983 Dec;6(4):359–79.
42. Botvin GJ, Baker E, Botvin EM, et al. Prevention of alcohol misuse through the development of personal and social competence: a pilot study. J Stud Alcohol 1984 Nov;45(6):550–2.
43. Botvin GJ, Baker E, Renick NL, et al. A cognitive-behavioral approach to substance abuse prevention. Addict Behav 1984;9(2):137–47.
44. Pentz MA. Prevention of adolescent substance abuse through social skills development. NIDA Res Monogr 1983;47:195–232.
45. Peyrot M, Yen S, Baldassano CA. Short-term substance abuse prevention in jail: a cognitive behavioral approach. J Drug Educ 1994;24(1):33–47.
46. Chaney EF, O'Leary MR, Marlatt GA. Skill training with alcoholics. J Consult Clin Psychol 1978 Oct;46(5):1092–1104.
47. Glantz MD, Johnson JL. Resilience and development: positive life adaptations. New York: Kluwer Academic/Plenum Publishers, 1999.
48. Haggerty KP, Wells EA, Jenson JM, et al. Delinquents and drug use: a model program for community reintegration. Adolescence 1989 Summer;24(94): 439–56.

49. Goldstein AP. Structured learning therapy: toward a psychotherapy for the poor. New York: Academic Press, 1973.
50. Goldstein, AP. Psychological skill training: the structured learning technique. NY: Pergamon Press, 1981.
51. Bandura A. Principles of behavior modification. New York: Holt, Rinehart, and Winston, 1969.
52. Bandura A. Aggression: a social learning analysis. Englewood Cliffs, NJ: Prentice-Hall, 1973.
53. Feindler EL, Marriott SA, Iwata, M. Group anger control training for junior high school delinquents. Cognit Ther Res 1984 Jun;8(3):299–311.
54. Novaco RW. Anger control: the development and evaluation of an experimental treatment. Lexington, MA: Lexington Books, 1975.
55. North Central Regional Education Laboratory (NCREL). Resilience research: how can it help city schools? Naperville, IL: NCREL, 1994.
56. Bernard B. Mentoring programs for urban youth: handle with care. Portland, OR: Northwest Regional Educational Laboratory, 1992.
57. Bernard B. Applications of resilience. In: Glantz MD, Johnson JL, eds. Resilience and development: positive life adaptations. New York: Kluwer Academic/Plenum Publishers, 1999.
58. Neiger B. Resilient reintegration: Use of structural equations modeling. Doctoral dissertation, University of Utah, Salt Lake City, 1991.
59. Botvin GJ, Eng A, Wilkins CL. Preventing the onset of cigarette smoking through life skills training. Prev Med 1980 Jan;9(1):135–43.
60. Freedman M. The kindness of strangers: reflections on the mentoring movement. Philadelphia, PA: Public/Private Ventures, 1992.
61. Rhodes JE. Youth mentoring in perspective. The Center: Today's 4-H connects youth to the world 2001 Summer:26–31. Available at http://www.fourh.umn.edu/resources/center/PDF/C2K1-A5.pdf
62. Parker WM, Berieda M, Sloan D. Exploring male-female relations among Black college students: a survey. Journal of Non-White Concerns in Personnel & Guidance. 1984 Jan;12(2):40–47.
63. Osei-Mensah A. Black male-female relationships: some observations. Journal of Black Studies 1989 March;19(3):320–42.
64. Gottsegen E, Philliber WW. Impact of a sexual responsibility program on young males. Adolescence 2001 Fall;36(143):427–33.
65. Prothrow-Stith D. Violence prevention curriculum for adolescents. Newton, MA: Education Development Center, Inc., 1987.
66. Hammond WR, Gipson V. Dealing with anger: givin it, takin it, workin it out: a violence prevention program for African American youth. (Video) Champaign, IL: Research Press, 1991.
67. Hammond WR, Yung BR. Preventing violence in at-risk African-American youth. J Health Care Poor Underserved 1991 Winter;2(3):359–73.
68. Johnston LD, O'Malley PM, Bachman JG. National survey results on drug use from the Monitoring the future Study, 1975–1995, Volume I: Secondary school students. (NIH Pub. No. 96-4139) Rockville, MD: NIDA, 1996.
69. Murray DM, Varnell SP, Blitstein JL. Design and analysis of group-randomized trials: a review of recent methodological developments. Am J Public Health 2004 Mar;94(3):423–32.