CURE VIOLENCE – AN EVIDENCE BASED METHOD TO REDUCE SHOOTINGS AND KILLINGS

Gary Slutkin, MD, *Founder and Executive Director, Cure Violence*
Professor, Epidemiology and International Health, University of Illinois at Chicago (UIC)
Charles Ransford, MPP, *Senior Researcher, Cure Violence and UIC*
Brent Decker MPH, MSW, *Director, International Programs, Cure Violence and UIC*
Karen Volker, *Director DC Office, Cure Violence and UIC*

As Hasan Tuluy, the World Bank's Vice President for Latin America, recently pointed out, in the last decade over 70 million people have been brought out of poverty in Latin America and 50 million people have entered the middle class. These gains are wonderful news for the region, yet these numbers are only part of the picture. Despite massive economic growth, the violence that permeates people's lives has not improved. People continue to live in fear and suffer massive losses in family and community life due to violence. While this endemic problem has not received due attention, neglect of the issue does not need to continue. In fact, it is possible to reverse the spread of violence. The Cure Violence method, which already has three statistical evaluations demonstrating its effectiveness, is now being used in the Latin American region, with more and more cities and countries in Latin America beginning to adopt the method. This paper outlines, first, how the method works, and second, how countries and cities can adapt it to make life safer and more prosperous for everyone.

New Understanding of Violence – as a Contagion

For decade,s high rates of violence have plagued many communities around the world, despite an abundance of approaches that attempt to reduce them. While local successes have been achieved, no single approach or combination of approaches has managed to systematically reduce the amount of violence in communities throughout the world. In fact, many observers have espoused the belief that violence is just part of the human condition, something that will never truly be eradicated.

Centuries ago, many people also believed that epidemic diseases were just part of the human condition, something that would always be with us. This all changed beginning in the 1870s when scientists began to understand how these epidemic diseases operated and were transmitted. Today, as a result of this scientific understanding, we have developed specific methods of treating epidemics to reduce the transmission of diseases and reverse their spread. The lesson: a scientific understanding of the problem led to a scientific solution and epidemics are now largely rapidly moving into the past.

A scientific understanding of violence also has the potential to put violence into the past, and science already understands much about how people come to behave violently. As it turns out, violence operates just like a contagious or epidemic disease. Epidemic diseases have three main characteristics – *clustering*, *spread*, and *transmission* – and violence shares all of these characteristics.

It has been well established that, in the same way that cholera clusters around water sources, violence **clusters** in "hot spots" where local conditions create a much higher rate of violent events (see Figure 1). Violence also **spreads** like an epidemic disease, both temporally and geographically. Temporally, violence can be seen to spread nonlinearly with rapid increases

as “crime waves” break out (see Figure 2). Geographically, violence has been shown to move from one area of origination to surrounding areas, much like an epidemic disease spreads.

Finally, violence has a mechanism of **transmission** such that exposure to violence can increase an individual’s risk of perpetrating violence. This risk of transmission has been proven in numerous studies (for a partial list, see Slutkin 2012). For example, it is well established that victims of child abuse or neglect are at a much higher risk for becoming perpetrators of child abuse later in life (Kaufman & Zigler 1987). It has also been shown that those exposed to community violence are at increased risk of perpetrating community violence (DuRant et al. 1994; Spano 2010) and those exposed to intimate partner violence (IPV) are at increased risk of perpetrating such violence on their own partners (Stith et al., 2000). It has been further shown that there is transmission across different types of violence, such that exposure to any type of violence – child abuse, community, IPV, war, etc. – may increase one’s risk of perpetrating any kind of violence (some examples - Kaufman & Zigler 1987; Dubois et al. 2009; Widom 1989). The conclusion: all types of violence are related and contagious, a position that has been supported by the Institute of Medicine (Slutkin 2012).

The scientific understanding of exactly how violence transmits is an evolving field that still has much need for advancement. What scientists do know at this point is that all behaviors are contagious, in that we pick up our behaviors largely through unconsciously modeling the behavior of those we are exposed to; this unconscious modeling is particularly true with aggressive behavior (Bandura 1961).

Specifically applied to violent behavior, exposure to violence can lead to the unconscious adoption of behaviors, social scripts that lead to violence, and information pertaining to the norms of the community (DuRant et al. 1994, Kelly 2010), and multiple exposures has been shown to further increase risk (Finkelhor et al. 2011, Foster & Brooks-Gunn 2009). These violent behaviors are then reinforced by social norms that encourage people in the affected community to react violently to certain social cues. For example, in areas with chronic violence, the norms or “code of the street” creates social pressure to respond violently to very minor disagreements, perceived acts or words of disrespect, small financial issues, or misunderstandings (Anderson 1999, Wilkinson 2003).

Violence is a disease – this is more than just a clever metaphor. Violence shares the same characteristics of an epidemic disease, and furthermore the process of exposure to violence is entirely consistent with the process for how an epidemic disease functions. Exposure increases risk of contracting the disease, though – whether it is a microorganism or a behavior such as violence – not all who are exposed contract the disease. Whether or not the disease “takes” is determined by a number of factors such as the dose of exposure (intensity of violence), number of exposures, age at exposure, prior immunity (in the case of violence, a factor such as positive parenting), and many others. Exposure affects an organ of the body – brain for violence exposure, small intestine for cholera, stomach for gastroenteritis. Modulating factors may influence the susceptibility of those exposed – such as the presence of peers for violence.

How to Treat Violence Like a Disease - The Cure Violence Model

Understanding that violence operates like an epidemic disease is very good news because we have well-developed and tested methods for treating epidemic diseases – even those for which no antibiotics or immunizations exist. World Health Organization-endorsed methods includes three main components: 1) Interrupt transmission of the disease; 2) Prevent future

spread of the disease; and 3) Change social norms or conditions (in this case to use highly specific social pressure to shift behaviors) that increase transmission. For each disease and in each environment, the specific way in which these components are implemented differs, but the basic components remain the same.

The Cure Violence Model adapts this epidemic model to address the epidemic of violence. The model prevents violence through the three-prong approach described below:

1. Detection and interruption

The Cure Violence model deploys a new type of worker called a Violence Interrupter who is specially qualified and trained to locate potentially lethal, ongoing conflicts and respond with a variety of conflict mediation techniques both to prevent imminent violence and to change the norms around the perceived need to use violence. Violence Interrupters are culturally appropriate workers who live in the affected community, are known to high-risk people, and have possibly even been gang members or spent time in prison, but have made a change in their lives and turned away from crime. Interrupters receive specific training on methods for detecting potential shooting events, mediating conflicts, and keeping safe in these dangerous situations.

Interrupters use a variety of methods to detect conflicts including "intercepting whispers," going to hospitals after shootings occur to prevent retaliation, paying attention to anniversaries and other important dates, being present at key locations, and being a resource to those in the community with information who are not comfortable contacting the police. Mediations occur through many techniques such as meeting one-on-one with aggrieved individuals, hosting small group peace-keeping sessions to foster diplomacy between groups, bringing in a respected third-party to dissuade further violence, creating cognitive dissonance by demonstrating contradictory thinking, changing the understanding of the situation to one which does not require violence, allowing parties to air their grievances, dispelling any misunderstandings, conveying the true costs of using violence, and buying time to let emotions cool.

Interrupting an ongoing conflict before it becomes lethal cuts off a chain of events that are commonly known as retaliations. Importantly, it also prevents the exposure of others in the community to the potentially violent act, thus inhibiting transmission of the behavior and perpetuation of the norm.

2. Identify and change the thinking of highest potential transmitters

Cure Violence employs a strong outreach component to change the norms and behavior of high-risk clients, an approach that has been shown to be effective in other settings (Spergel 2007). Outreach workers act as mentors to a caseload of participants, seeing each client multiple times per week, conveying a message of rejecting the use of violence, and assisting them to obtain needed services such as job training and drug abuse counseling. The outreach worker develops a risk reduction plan for each high-risk participant that is intended to move him away from accepting the use of violence. Outreach workers are also available to their clients during critical moments – when a client needs someone to help him avoid a relapse into criminal and violent behavior.

What particularly sets the Cure Violence Model apart from other approaches is the level of risk of the participants. The model calls for working only with those at high-risk for involvement in violence. To determine risk level, outreach workers employ a list of risk factors specific to the community – usually including whether an individual is between 16 and 25 years

of age, a recent victim of a shooting, recently released from prison, and a carrier of a weapon. In order to have access and credibility among this population, Cure Violence employs culturally appropriate workers, similar to the workers used in other public health models. Having status as someone from the community who has lived the life of the served population is essential to the ability of outreach workers to access and treat the highest risk. Many well-designed programs fail to affect violence because of their inability to reach or gain the respect of those who are actually committing or likely to commit violence (Ransford et al. 2013).

3. Change group norms

In order to have lasting change, the norms in the community that accept and encourage violence must change. At the heart of Cure Violence's effort at community norm change is the idea that the norms can be changed if multiple messengers of the same new norms are consistently and abundantly heard. Cure Violence uses a public education campaign, community events, community responses to every shooting, and community mobilization to change group and community norms related to the use of firearms. These efforts involve all willing participants, particularly seeking to include community residents, local businesses, clergy, social service agencies, and police.

Currently in affected communities, people are encouraged to respond violently to petty grievances, acts of disrespect, and small financial issues. But if new norms reject the use of violence, or if existing norms opposing violence are better communicated to everyone in a community, they erect a barrier to violent behavior that is difficult to overcome. When new norms rejecting violence become established in a community, they can eventually create a group, sometimes referred to as herd, immunity to violence.

Three additional elements are essential for proper implementation. First, with all of these components, *data and monitoring* are used to measure and provide constant feedback to the system. Second, *extensive training* of workers is necessary to ensure that they can properly carry out their duties. This process includes an initial training before workers are sent out on the streets, follow up trainings every few months, and regular meetings in which techniques for effective work are reviewed. Third, the program implements a *partnership with local hospitals* so that workers are notified immediately of gunshot wound victims admitted to emergency rooms. These notifications enable workers to respond quickly, often at the hospital, to prevent retaliations.

Cure Violence - Proven Effective in Reducing Violence

The Cure Violence model was first implemented in the West Garfield Park community in Chicago, which was at the time considered one of the most dangerous communities in the United States. After the first year of implementation, West Garfield Park had a 67% reduction in shootings. Cure Violence then expanded to five new communities over three years, each resulting in a large statistically significant reductions in shootings with an average 42% drop in shootings in the first year across all six communities (Ransford et al. 2010).

From 2005 to 2006, the Cure Violence model was implemented in eight new communities in Chicago resulting in an average of 27% statistically significant reduction in shootings in first year (Ransford et al. 2010). This reduction was achieved at a time when shootings were increasing throughout the city of Chicago as a whole.

Independent Evaluations

In 2009, a formal evaluation of the Cure Violence model in Chicago was released. The evaluation work was funded by the National Institute of Justice and performed by a team from four universities led by Wesley Skogan of Northwestern University. It lasted more than three years. The evaluation examined seven different implementations of the model using three types of statistical analysis and covering eight years of implementation with a ten-year baseline.

The evaluators found that all seven communities had large reductions in shootings of 41% to 73%. The six full-implementations of the model resulted in statistically significant reductions in shootings by either time series or hot spot analysis[1]. Two communities had significant results across all four measures, one across three measures, and one across two measures. Overall, the evaluators concluded, "the impact of the CeaseFire Program is significant and moderate-to-large in size."

Importantly, the evaluators also found that the programs were successful in implementing the most important elements of the model. First, the program staff interrupted ongoing conflicts. In five communities there was a 100% reduction in retaliations in the settings of a murder. Second, the program reached the highest risk, with 84% of participants reported as high risk. And third, these high risk participants were given meaningful help, with participants reporting their outreach worker as the second most important adult in their lives behind only parents and with 87% receiving needed assistance.

A second multi-year independent evaluation was conducted on an adaptation of the model implemented in four of the most violent communities in Baltimore. A CDC-funded evaluation of these implementations was conducted by a team at Johns Hopkins University led by Daniel Webster, Director of the Center for Gun Policy and Research. The evaluation found that implementation of the program in all four sites was associated with statistically significant reductions in either shootings of up to 44%, or homicides of up to 56%, or both. The study also found that attitudes toward the acceptability of the use of violence were lower in a program site than controls. There was also evidence that the program effects extended beyond the program sites to communities that bordered the Safe Streets program sites; in some instances it found similar program effects as were found in the intervention areas (Webster 2012).

A third evaluation was conducted of an adaptation of the Cure Violence model implemented in the Crown Heights community in Brooklyn, New York. The study was conducted by researchers at the Center for Court Innovation and funded by the Bureau of Justice Assistance. The study found that the program was associated with gun crime rates 20% lower than would have been expected, given the trend in the comparison areas. The study also found high fidelity to the model with 86% of clients categorized as high risk and over 100 conflicts mediated (Picard-Fritsche & Cernaglia 2013).

Overall, there is strong evidence showing an association between faithful implementation of the model and large reductions in shootings and killings. In all, formal evaluations of 11 different full implementations of the Cure Violence model have found that all 11 of these sites

[1] The only community that did not have a statistically significant finding, Englewood, was a program that had only partial funding. The evaluation reports that the Englewood site had "only about 60 percent of the budget allocated to most CeaseFire areas." Despite this shortcoming, the Englewood site still had what the evaluation called "remarkable" results – including a 41% drop in persons shot, a change from 73% of the beat having a shooting density in the "most violent categories" to 0%, and a 100% reduction in retaliation homicides. However, the results were not statistically significant due to similar results in the comparison zones, although the results were "noticeably greater in the CeaseFire program area."

had a statistically significant reduction in either shootings or killings or both associated with implementation of the program.

Advantages of the Cure Violence Model for Making a City Safer

Perhaps the greatest advantage to the Cure Violence model is that it is *evidence-based*, with *three strong independent evaluations* covering 11 full implementations of the model. But many details regarding these results make the Cure Violence approach unique. First, the reports show that the program is capable of being successfully replicated in new environments, with the studies covering *11 unique implementations of the model*. The program has also been successfully adapted to environments outside the United States – in Latin America, Africa, Europe, and the Middle East with evaluations pending (more detail on these below).

Second, the Cure Violence Model is a *community level program, achieving community level results*. Many programs may successfully target and treat individuals but they do not address the underlying norms of the community, resulting in a persistence of the violence problem. Cure Violence targets these community norms in order to create a community level effect that can be sustained. The results from the survey in Baltimore suggest that the program is successful in changing these norms.

Finally, this approach represents a new method of treating violence. Violence is clearly a complex problem and the solution is generally agreed to be one requiring a multifaceted approach. Up to now the approach has been considered to be mostly about law enforcement and criminal justice, with other preventive approaches being either unproven or just proven for the change of one person at a time, or just for younger persons. Adding a new approach to complement the existing efforts that works on the problem *now* and gets results now – and that provides a crucial new element to making a city safer.

The Cure Violence Model is currently being implemented in 22 cities across eight countries. The value of the model has been recognized and substantiated by the United States Conference of Mayors, National League of Cities, National Governors Association, Department of Justice, the Institute of Medicine, and others. The program is supported with funding by many top funders including the United States Department of Justice, USAID, United States State Department, Inter-American Development Bank, Robert Wood Johnson Foundation, MacArthur Foundation, McCormick Foundation, and others. The Cure Violence organization was named 9th best NGO in world by Global Journal - 1st among all organizations devoted to reducing violence. The Economist named the model "The approach that will come to prominence." Several of the workers for the program in Chicago were featured in the award-winning documentary "The Interrupters."

The strong evidence, strong endorsements, and scientific model design around a scientific understanding of violence all make the Cure Violence model a crucial element of the effort to put violence in the past.

The Cure Violence Adaptation Process

Unlike many approaches to violence prevention that are based on factors specific to a city or country, the Cure Violence model *works on the exact process of how violent behaviors are formed and maintained.* This type of approach allows for the model to be adapted to different contexts through a three-step process. Initially, a local partner (for example, a Mayor's office, health ministry, non-governmental organization, foundation, etc.) with an infrastructure in place to manage a Cure Violence program is identified. Staff and representatives from the local partner

visit and tour one of Cure Violence's selected demonstration sites (in Chicago or elsewhere as appropriate at the time) and talk with all levels of staff in order to learn the key strategies and elements of the model. These locations provide ideal examples to learn the model because they are managed by the Cure Violence central office, have proven results over many years, and are fully implementing all components of the model.

Rather than a traditional presentation format, the *partner is immersed in community-based activities firsthand in a Cure Violence neighborhood to see the model in action*. They accompany violence interrupters and outreach workers on walks through the neighborhood, attend a shooting response, observe group level work with the highest risk, and participate in distribution of public education materials. Cure Violence materials are also provided for review by the visiting parties.

In the second phase of the adaptation process, *Cure Violence staff travels to the partner organization's city for an intensive two to three week assessment visit.* The objectives of the assessment visit are to: 1) understand the local characteristics of the violence problem by identifying the areas where violence is most acute, understanding the dynamics of violent incidents taking place, and determining criteria for targeting the highest; 2) identify community partners in the areas where violence is most acute to implement the model and assist the partners with the recruitment of the workers; 3) determine the profile of the individuals who could fill the roles of the violence interrupter and outreach worker and develop a recruitment plan and timeline; 4) begin the process of adapting of public education messaging for the local context; and, 5) develop the implementation plan for the model in the local context, sometimes including a set of strategic phases to ensure access to the highest risk and the safety of workers.

Ideally, discussions on the adaptation can be done in conjunction with *hands-on exploration* of the community to allow for a more efficient and effective implementation. Materials are reviewed at each step with the intent of concretizing the model's shift within the different cultural context from a theoretical basis to an actionable plan. For example, during adaptation to Iraq, adjustments had to be made to the background and character of the street level workers. The key components of the model were adapted to match the local situational context in Iraq, shifting to focus on religious leaders, community stakeholders and tribal representatives instead of the street gangs of the United States.

Networking maps are constructed to identify inroads to connect appropriately with the indigenous political and social structure. Having a visual reference by actually exploring the target communities enhances this process. Based on the networking maps, job descriptions for *street level workers* are adapted to reflect the best possible approach to connect with groups and organizations on the ground. Similar revisions may be required for the *community mobilization* components of the intervention. In the U.S. this component involves demonstrations, marches, and rallies, however given the political and social climate in some regions this may not be a realistic option. *Community trainings* can be developed to engage all facets of society in peacekeeping efforts with these sensitivities in mind. Public education materials should be developed to be highly culturally-specific with efforts made to incorporate messaging that anticipates potential violence.

Finally, general guidelines, revised training materials and job descriptions are presented to the entire partner staff for further discussion and debate. Cure Violence staff works intimately with translators to ensure presentations are conducted in the language(s) appropriate to the country in order to facilitate a free-flowing conversation. These discussions develop the specific details of what the program will actually look like on-the-ground.

After the assessment visits are complete, the partner organization, community partners, and workers are provided with 80+ hours of *initial training* to implement the model. Some of the major topics of the trainings include detection of violent events, conflict mediation, engaging high risk individuals, risk assessment and risk reduction planning, communication techniques, changing behaviors and norms, weekly target area strategic planning and implementation, and community mapping. After the initial set of trainings is complete, Cure Violence staff participates in weekly or monthly monitoring phone calls and returns to provide booster trainings once a quarter (where possible) to ensure the model is being implemented correctly.

Cure Violence in Latin America today and tomorrow

Over the past few years, since the first evaluation studies became more and more known, there has been an enormous interest in adapting and implementing the Cure Violence model in Latin America and the Caribbean. Cure Violence has participated in a number of site visits, conferences, and important learning exchanges across the region and has implemented an adapted version of the model in Loiza, Puerto Rico and San Pedro Sula, Honduras, and is currently in the planning stages of implementation in Barranquilla, Colombia; Recife, Brazil; and Port of Spain, Trinidad and Tobago. Requests from several other countries in the region are ongoing.

In Loiza, the Cure Violence model has been implemented through the local partner *Taller de Salud* since January of 2012. In the first year of implementation, Loiza has seen a 56 % reduction in homicides and has maintained this reduction for an additional eight months with approximately nine staff assigned to the target area. The staff has mediated over 280 high risk conflicts that likely would have led to a shooting or killing, held numerous events aimed at changing the community norms around violence, and implemented a public education campaign focused on behaviors associated with violence.

The work of adapting the model to an environment with extreme levels of violence in San Pedro Sula began in the fall of 2012. Through a number of assessment visits funded by USAID and Creative Associates, the community partners and workers were recruited and trained by March of 2013 and implementation began in April of 2013. During the first months of implementation the staff has been able to interrupt and mediate over 25 high risk conflicts that likely would have led to a shooting or killing, have worked with local partners to implement a strategic late night soccer league for the highest risk youth, and have had a number of other strategic community activities as outlined by the model.

Barranquilla, Port of Spain, and Recife have begun the assessment process to determine the issues that need to be considered in adapting and implementing the model. In all cases the potential target areas, community groups to implement the model, profile of the workers to serve as interrupters and outreach workers, and initial implementation plans have been developed with support from the Inter-American Bank and the Bernard Van Leer Foundation. The first half of 2014 should see the full implementation of the Cure Violence model in all three of these cities.

As Cure Violence continues to develop partnerships and work in the region, the focus will be on reducing the levels of shootings and killings in the areas where the model is implemented and on facilitating independent evaluations to understand how the Cure Violence model can be further applied to those situations in Latin America and the Caribbean which now have high levels of violence.

Conclusion

Violence does not need to be the endemic problem as many people currently see it. Just as we have largely overcome the other epidemic diseases of our past by scientifically understanding and treating them, we also can overcome violence, and cities and communities can be made much safer through scientific understanding and treatment. Thus far, the scientific understanding of violence has shown us that violence acts like an epidemic disease, and in fact should be considered an epidemic disease. Of particular importance is the realization that *violent behavior is a contagious process* and that treating it as a contagious process completely changes the outcome. Exposure to violence increases the risk that the behavior will be unconsciously adopted, and the behavior becomes further locked in by norms that encourage further spread.

The Cure Violence method treats violence like one would treat an epidemic disease, and has been proven effective with three independent multi-year evaluations conducted by leading violence researchers. These evaluations covered 11 different full implementation sites, showing not only that the approach is effective, but also that it can be effectively adapted to different contexts. A system of interruption, behavior change to limit spread, and norm change – using specific public health methods and practices brought into a package or system adapted for each country – has now been repeatedly shown to reliably reduce the violence and make communities safer.

Cure Violence is a powerful way to make a community safer. And, the model has been shown to be adaptable to many different contexts. Results from the approach happen very quickly, within the first few months, and the program provides a strong compliment to existing approaches. Also, crucially, Cure Violence works to achieve not just individual level change, but community level change to affect the norms that otherwise keep violence persistent. Cure Violence breaks down these norms to allow violence to disappear, therefore offering a practical way for our citizens to have a safer future.

References

Anderson, E. 1999. Code of the Street: Decency, Violence, and the Moral Life of the Inner City. New York: Norton.

Bandura, A., Ross, D., & Ross, S. 1961. Transmission of Aggression Through Imitation of Aggressive Models. Journal of Abnormal and Social Psychology. 63, 575-582.

Dubow, E. F., Huesmann, R., Boxer, P. (2009). A Social-Cognitive-Ecological Framework for Understanding the Impact of Exposure to Persistent Ethnic-Political Violence on Children's Psychosocial Adjustment. *Clinical Child and Family Psychological Review.* 12: 113-126.

DuRant, R.H., Pendergrast, R.A., & Cadenhead, C. (1994). Exposure to violence and victimization and fighting behavior by urban black adolescents. *Journal of Adolescent Health*. 15: 311-318.

Finkelhor, D., Ormrod, R., & Turner, H. (2007a). Polyvictimization and trauma in a national longitudinal cohort. Development and Psychopathology, 19, 149–166.

Foster, H., and Brooks-Gunn, J. (2009). Toward a Stress Process Model of Children's Exposure to Physical Family and Community Violence. Clinical Child and Family Psychology Review.

12:71–94.

Kaufman, J. Zigler, E. (1987). Do Abused Children Become Abusive Parents? *American Journal of Orthopsychiatry.* 57: 186-192.

Kelly, S. (2010). Exposure to Gang Violence in the Community: An Integrated Review of the Literature. *Journal of Child and Adolescent Psychiatric Nursing.* 23: 61-73.

Picard-Fritsche, S., & Cerniglia, L. (2013) Testing a Public Health Approach to Gun Violence. New York: Center for Court Innovation.

Ransford, C. L., Slutkin, G., Kane, C. (2013). The Evidence on the Cure Violence Model for Violence Prevention. Manuscript in preparation.

Ransford, C. L., Kane, C., Metzger, T., Quintana, E., and Slutkin, G. (2010). An Examination of the Role of CeaseFire, the Chicago Police, Project Safe Neighborhoods, and Displacement in the Reduction in Homicide in Chicago in 2004. In *Youth Gangs and Community Intervention.* Ed. Chaskin, R. J. Columbia University Press: New York.

Skogan, W., Harnett, S. M., Bump, N., & DuBois, J. (2009). *Evaluation of CeaseFire-Chicago.* Chicago: Northwestern University Institute for Policy Research.

Slutkin, G. (2012). Violence is a contagious disease. In Contagion of violence: Workshop summary, Part II. Institute of Medicine and National Research Council (Washington, DC: The National Academies Press).

Spano, R. Rivera, C. Bollard, J. M. (2010). Are Chronic Exposure to Violence and Chronic Violent Behavior Closely Related Developmental Processes During Adolescence? *Criminal Justice and Behavior*, 37: 1160-1179.

Spergel, I.A. (2007) *Reducing Youth Gang Violence: The Little Village Gang Project in Chicago*, Lanham, MD: AltaMira.

Stith, S. M., Rosen, K. H., Middleton, K. A., Busch, A. L., Lundeberg, K. Carlton, R. P. (2000). The Intergenerational Transmission of Spouse Abuse: A Meta-Analysis. Journal of Marriage and Family. 62: 640-654.

Webster, D. W., Whitehill, J. M., Vernick, J. S., & Parker, E. M. (2012). *Evaluation of Baltiore's Safe Streets Program: Effects on Attitudes, Participants' Experiences, and Gun Violence.* Baltimore, MD: Johns Hopkins Center for the Prevention of Youth Violence.

Widom, C. S. (1989). The Cycle of Violence. *Science*. 244: 160-166.

Wilkinson, D. (2003). Guns, Violence, and Identity Among African American and Latino Youth. New York: LFB