Injury and Anomie: Effects of Violence on an Inner-City Community

ABSTRACT

Objectives. Widespread violence affects individuals but also alters group life. This study was designed to examine the effects of violence on an inner-city community.

Methods. A qualitative study was undertaken that included field observations and semistructured interviews. The study took place in Washington Heights, a New York City neighborhood with a high rate of violence, largely secondary to the drug trade.

Results. The 100 people interviewed differed widely in their definitions of violence and in their likelihood of having experienced violent acts in the course of daily life. High, medium, and low violence microenvironments were identified; risk of exposure to violence, but not individual definitions of violence, differed by location. Violence in all parts of the neighborhood inhibited social interactions, but the intensity of this effect differed by microenvironment.

Conclusions. In Washington Heights, violence has injured individuals and fractured social relationships, leading to the state of social disarray referred to as "anomie." The public health response to the violence epidemic should address anomie through community organizing efforts. (*Am J Public Health.* 1998;88:924–927)

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Introduction

The United States witnessed an upsurge in violence between 1985 and 1990 signaled by an increase in the number of firearm-related homicides (notably among young African-American and Hispanic men[1]) and closely linked to struggles to control territory for dealing illicit drugs.[2] At the same time, public awareness of the deleterious effects of other forms of violent trauma, such as domestic violence and sexual assault, led to increased attention to those problems.[3] By 1991, the US Public Health Service had recognized that an "epidemic of violence," unique in being composed of several subepidemics, was undermining the health of the country.[4,5]

In some locales in the United States, these subepidemics coincided; one such locale is Washington Heights, a New York City neighborhood that became known as "Cocaine Central" during the heyday of the crack epidemic. In 1991, Washington Heights, with 119 murder cases, ranked first in the borough of Manhattan in terms of number of homicides and ranked high in terms of other violent crimes as well.[6] Not only were the subepidemics coinciding in the community, but they also intersected in the lived experience of community residents. One example was provided by Gloria, a woman who attempted suicide in the wake of childhood abuse, domestic violence, and homelessness.[7]

In line with a growing body of research that seeks to examine the effects of events on the specific locations in which they unfurl,[8–10] the project described here was designed to examine the effect of the violence epidemic on community life. Because the goal of this study was to describe a complex and poorly understood phenomenon, qualitative research methods were used.

Methods

Site of the Study

Washington Heights is a densely populated urban area composed of a variety of subcommunities arranged on a north–south gradient, with high poverty levels, much of the violence, and the drug trade concentrated at the southern end. As of the 1990 census, 198 192 people lived in Washington Heights; 18.7% of these individuals were White, 11.4% were African American, and 67% were Hispanic, largely of Dominican origin. The population was largely young (median age: 31.9 years), minimally educated (46% of adults had less than a high school education), and poor (21.3% received some kind of public assistance). Of the 100 286 foreign-born residents, 47.1% had arrived in the US between 1980 and 1990.

Subjects

Snowball sampling was used to recruit participants. Sampling was initiated within each interviewer's social network as well as within the specific geographic subarea of Washington Heights to which the interviewer was assigned. One hundred adults (56 women and 44 men) who lived and/or worked in Washington Heights were interviewed for this study. Respondents included teachers, police officers, security guards, secretaries, health care professionals,

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housewives, students, small business owners, the unemployed, and the homeless. Some lived in the area (27%), others worked there (28%), and some both lived and worked there (45%). Of every 10 respondents, 6 (59%) were born in the United States. The foreign-born respondents were from 11 different countries, including the Dominican Republic, Peru, and Germany. Respondents ranged in age from 21 to 90 years. All signed informed consent; study procedures were approved by the committee for the protection of human subjects at the New York State Psychiatric Institute.

Data Collection

Data were collected between June 1995 and January 1996 by 24 graduate students at the Columbia School of Public Health trained for 20 hours in study methods. Audiotaped interviews, which varied in length from 20 minutes to 2 hours, followed a semistructured format and included such questions as What does the word "violence" mean to you? and What are the most common forms of violence seen in your community? A 2-page summary of each interview was created by the interviewer. Several interviewers were fluent in Spanish and conducted interviews in that language. Interviewers varied in the number of interviews completed (range: 1 to 19).

Analysis

Demographic information, interview summaries, and field notes were the major data sources for this report. The interview summary was examined for 3 purposes: (1) to determine individual definitions, experiences, and ideas for interventions; (2) to search for common themes among the summaries; and (3) to identify areas of marked disagreement among study participants. Field notes were examined for observations of the different sections of the community, such as integrity of the urban infrastructure, signs of street violence or antiviolence campaigns, and the interviewer's sense of personal safety.

Results

What Is Violence?

Definitions of violence varied from individual to individual. Individual experience appeared to be an important factor shaping these distinctly personal statements. According to a man who had been raised in a violent home and who had been abusive to his own wife and children, "Maybe because I am very violent, I see violence everywhere."

Although varied in content, the definitions had in common a complex understanding of violence. For example, one definition was as follows:

> Confrontation with the police where the people have problems understanding each other. Shooting on the streets is violent, but when you grow up with it, you get used to it, and don't think of it as violence. Domestic violence is violence as well, but it's hard to think of shooting and domestic violence as the same thing. Drug violence comes when the dealers try to cheat each other and domestic violence is a result of personal problems but I don't know about that.

The definitions offered, by including racism, police brutality, poverty, and other forms of structural violence, often went far beyond the problems acknowledged by public health writings on violence. One individual defined violence as

> economic violence . . . the violence of people put at the mercy of a system that's run for profit instead of people's needs. I think of people working full-time jobs at minimum wage that still is not enough for them to buy food or pay for an apartment. The sort of violence that's trumped up by politicians to get votes is sort of a smoke screen for keeping people's attention off of what is really the problem at hand.

Violence to One's Person

Personal experiences of violence were prevalent in the sample. Overall, two thirds of those interviewed reported one or more episodes of violence, including 29 individuals who had learned about a violent attack on a loved one, 25 who had witnessed violence (e.g., murder), 11 who had been physically assaulted (including domestic violence), 10 who had been mugged, and 2 who had been sexually assaulted. Violence against the self was also described: one teacher reported that 5 of her students had committed suicide. Respondents reported a wide range of physical and psychological effects of violence, including mental illness (e.g., posttraumatic stress disorder), behavioral problems (e.g., drug addiction), and physical problems (e.g., insomnia).

Violence in One's Territory

The territory of interviewees centered in an apartment or work site and radiated out over a few square blocks within which there were shops, services, and social contacts. The personal microenvironment was unique for each individual; however, people describing microenvironments within a given geographic subarea were likely to agree in their perceptions of violence. Based on these shared perceptions, we were able to rate sections of the neighborhood as "low," "medium," and "high" violence areas.

People living in the low violence areas felt safe within their home territory. They thought of violence as happening "elsewhere." A 90-year-old retired railroad worker who had lived in the northern part of Washington Heights for many years commented that violence was "way east, like further east, down below, near the hospital, not here."

In the medium violence areas, violence was not a part of daily life, but residents expressed concern that signs of decay were evident. The residents believed that the drug trade was trying to move into the area. The battle over territory was largely waged between police and drug dealers, but occasional efforts by residents were also noted.

High violence areas were characterized by the seeing, hearing, and experiencing of many different forms of violence, including police harassment or indifference, drug-related violence, crowd violence, and family violence (see Figure 1). Gunshots were often heard in the streets. In the high violence segments of the community, the reign of terror of the drug lords and their young henchmen altered movement in the streets and interactions between neighbors. One woman pointed out that "I cannot stop on the corner because I saw you and want to say hello, and feel comfortable. I can't stand in front of my building like I used to . . . because they throw things from the roof."

Whatever section of Washington Heights people inhabited, all those interviewed agreed that the escalation in violence was a change in the character of the community from years gone by. A young man, commenting on the deterioration in the quality of life, said, "I don't feel safe, maybe because I'm older and more conscious, or maybe because the violence has gotten worse . . . and just, drugs has gotten worse in the neighborhood."

Social Processes Linked to Violence

Respondents were depressed by the deteriorating neighborhood, public spaces occupied by drug dealers, stores cluttered by day but shuttered with metal gates at night, and graffiti covering walls and street signs. Drugs were universally held to blame for the deterioration of the neighborhood. The wars between drug dealers became increasingly dangerous in the 1980s, when guns began to be an integral part of the

battle for territory and power. Explaining the acceleration of firearm violence, one young man said, "When you have a weapon on you, you feel more powerful and you want to use it." Interviewees likened the ease of buying a gun in the neighborhood to the ease of buying candy, beer, or a soft drink.

Articulations of blame—often muttered in a low voice in the course of an interview—also revealed complex intergroup prejudices. Most commonly, people of other ethnic groups blamed "Dominicans" for the closely linked problems of violence and the drug trade; Dominicans, in turn, were defensive about the fact that the "whole community was blamed for the actions of a few." There seemed to be general agreement that the drug trade took advantage of the vulnerabilities of unskilled immigrants who were in need of work, on the one hand, and freed of traditional social controls, on the other. One respondent commented, "The social circles that these so-called violent people had in their country, they don't have here in New York. . . . There is no societal punishment for them from the people who really mean something to them . . . here everything goes."

Managing the Violent Context

A continuum of responses to violence emerged in this study. On one pole, that of "retreatism," were those who sought to isolate themselves from violence. They tended to focus on home security with the intention of creating a safe personal retreat. The apartment was the center of this safe zone, and it was protected by locks and barriers on the windows. One mother described pushing a file cabinet in front of her bedroom window to protect her family from random gunfire. When moving outside the apartment, family members often coordinated their movements with telephone calls to alert each other to unexpected trouble. Families tended to keep children confined to the safety of the apartment as long as they could, fearing the "street" influences that might injure them outside the home.

At the opposite pole to those choosing to retreat were a number of people who adopted antiviolence activism. Typical of these community activists was an older woman, a former Peace Corps volunteer, who was deeply involved with neighborhood beautification. She carried a can of graffiti remover with her and erased tags as soon as they appeared. She hired young people to work in a neighborhood garden she had created, on the theory that they would be less likely to destroy something they had helped to create.

FIGURE 1—Street scene in Washington Heights, summer 1995 (photograph by Lesley L. Green).

Some of the officers of the 2 local police precincts were also involved in antiviolence activism. They organized a variety of youth activities, including athletic programs and area beautification efforts. Despite these efforts, residents of high violence areas were ambivalent about the police. While they saw the police as the key actors in stopping the drug trade, they feared police corruption and brutality.

Discussion

Communities, like families, teams, or other social groups, are held together by the mutual actions and shared responsibilities of their members, activities that require an investment of time and energy to maintain the effective functioning of the group. Tradition, shared interests, and common culture work together to engender these actions.[11] However, if these cohesive forces are damaged, the community may fall apart, a social condition that French sociologist Emile Durkheim referred to as "anomie."[12] Anomie represents a serious departure from a state of health for the community as a whole; the decline in community functioning, in turn, poses a threat to the health of community members.[13,14]

The data presented here show that violence undermined social functioning in Washington Heights. In the wake of the violence epidemic, people were less free to move about, more fearful of being on the streets, and more concerned about the intentions of their neighbors. Retreatism (i.e., increased isolation from the larger group) was the dominant solution to the problems of community violence. The wish to avoid others reflected the fears of parents, who wanted to protect their children, and the fears of those who had been victims of violence, who wanted to insulate themselves from further harm. The cumulative effect of the violence epidemic was the growth of anomie, as evidenced by the presence of intergroup prejudice and neighborhood stratification and the absence of common, unifying sites or symbols.

The practice of public health is predicated, in large measure, on the need to protect the integrity of the "body public" (in this instance, the effective functioning of a local community). While the control of violence had elicited intensified police efforts[15] and more effective care for victims of violence,[16–19] the dissolution of the community itself had not, at the time of this study, received appropriate attention. Overcoming anomie is not a simple task, and it can be particularly difficult in the face of intergroup differences. At the turn of the century, social reformers, aware of the lack of social cohesion among immigrant groups from different countries, developed a settlement house movement to create common ground and common activities.[20] In the 1980s, community leaders in Detroit initiated a program designed to control a form of violence that was a particular problem in that city: high rates of arson over the Halloween weekend.[21] The program led to the

annual mobilization of 35000 people and to the elimination of excess fires. Both approaches—settlement houses and mobilization—are needed to rebuild community life in Washington Heights.

Examining the violence epidemic from within the community is useful, but area residents, as we have noted, often commented on violence as a reflection of social problems that originated far outside the boundaries of the community. Interviewees pointed out that the cumulative effects of poverty, racism, and other forms of social injustice are not only potential causes of violence but forms of violence in and of themselves. Furthermore, all of these are problems that originate outside of the local community. Arthur Kleinman has called such forms of structural violence the "violences of everyday life" (written communication, October 1996). Re-creating a healthy environment may require action within the community, as well as attention to the structural problems in the broader society that have contributed to a distressed local context. □

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