THE PREVALENCE OF VICTIMIZATION AND PERCEPTIONS OF JOB NEIGHBORHOOD SAFETY IN A SOCIAL SERVICE AGENCY AND THE NEED FOR SCREENING

Carl C. Bell, MD, Lynne Mock, PhD, and Gary Slutkin, MD
Chicago, Illinois

Because staff attitudes and affects are impediments or strengths in appropriately assessing and managing traumatized or violent patients, the authors discuss the need to explore staff's experience with trauma and violence. A survey of social service field and administrative office-based staff revealed that numerous staff had experienced traumatic events. Compared with staff based in a downtown administrative office, significantly more field-based staff were dissatisfied with their job's neighborhood and perceived their job's neighborhood as a dangerous place to work. Further, significantly more field staff perceived that their job's neighbors would be "unlikely" to intervene in observed antisocial behaviors. In our sample of primarily female, African-American, social service staff, the ratio of victimization was higher than rates in other studies. Screening social service staff for experiences of trauma and victimization and asking about their perceptions about their job's neighborhood will help leadership shape efforts to address these dynamics. By addressing staff's perceptions of their job's neighborhood, leadership can influence staff's willingness to participate in proactive community organizing and prevention activities designed to reduce violence and increase safety. Several recommendations to reduce violence in the workplace are presented. (J Natl Med Assoc. 2002;94:602–608.)

Key words: victimization ◆ safety ◆ screening ◆ violence ◆ supervision

Field-based social service staff are among the persons listed at high risk for on-the-job physical assault.[1,2] In a Minnesota study of assaulted

social workers, almost all were assaulted by a patient with whom they worked with on a daily basis.[2] Unfortunately, there is evidence that social service workers under-report nonfatal physical assault, harassment, threats, and intimidation on the job for fear of a negative job evaluation.[3,4] Direct costs of reported assaults include medical and nonmedical claims, and, on average, 14 lost work days per year. Indirect costs include loss of wages, rehabilitation costs, decreased quality of life, pain, and emotional suffering for the victim.[2]

The Community Mental Health Council, Inc. was asked to consult with a predominately African-American social service agency in Chicago regarding the issue of safety and perceived violence within their target service community. The Community Mental Health Council developed a training program designed to teach staff skills with which to manage violent patients,[5,6] to build their own resiliency,[7] and to cope with personal trauma and violence.[8] Additionally, the Community Mental Health Council gave consultations regarding paradigms with which to understand the various types of violence[9] and how to craft prevention and intervention strategies to address each different type of violence.[10] To facilitate these initiatives, the authors screened the employees for issues of trauma and victimization, and for their perceptions of their home and job's neighborhood regarding satisfaction, violence and safety, and social fabric.

METHODS

A survey research design was used to explore staff perceptions of safety and experiences with violence in the neighborhood surrounding their office. Because the study is exploratory and 14 mean comparisons were made in the data analyses, only differences at or greater than the $p < 0.01$ level will be reported as significant to compensate for multiple mean comparisons.

Subjects

A total of 75 subjects were surveyed. Two thirds ($n = 49$) of the staff worked in the field in a poor, underserved, African-American community providing social services, and one third ($n = 26$) worked in the downtown administrative offices.

Instrument

Using a survey developed by the Chicago Project for Violence Prevention, at the University of Illinois School of Public Health, and designed to measure perceptions of home neighborhood safety, the authors added corol-

lary questions about the participants' job's neighborhood safety and personal and vicarious victimization experiences (Table 1). After explaining that the survey was designed to assess staff's experience with violence and their perceptions of their job's neighborhood's levels of safety and social fabric, the surveys were administered to staff during the spring of 1999 in a way to insure individual confidentiality.

Analysis Plan

The results were analyzed using univariate and bivariate analysis to describe and compare the field verses office-based staff regarding their perceptions of their home and job's neighborhood safety and social fabric. Also, rates of past-year sexual and physical assault and lifetime experiences of being witness or victim of severe violence were calculated.

RESULTS

Sample Characteristics

Two thirds of the sample (66.0%) were African American, 31.3% were Euro-American, and 2.7% were other. Almost all (95%) were women. The median income for the sample was $30,681. Some staff had a high school diploma or the equivalent (13.2%), and there was nearly an equal number of staff who had some college (29.1%), Bachelor's degree (26.4%), or a Master's degree (29.1%). A smaller percentage had a PhD or advanced degree (2.2%).

Victimization

Three percent ($n = 2$) of the total staff reported being physically assaulted, and 7% ($n = 5$) reported being robbed in the past year. Further, 9% ($n = 7$) of the total staff reported being raped, 11% ($n = 8$) reported being shot at with 3% ($n = 2$) of those being hit, and 3% ($n = 2$) reported having been stabbed. Regarding witnessing violence, 25% ($n = 19$) of the staff reported seeing someone get shot, 25% ($n = 19$) reported seeing someone stabbed, and 11% ($n = 8$) reported seeing someone killed. Finally, 55% ($n = 41$) of the total staff

Table 1. Survey Items

Items		Response Set
1.	In general, in the past 12 months would you say your job's neighborhood has. . .	Gotten Worse; Stayed about the same; Become a better place to live
2.	On the whole, how do you feel about your job's neighborhood as a place to live/work? Are you. . .	Very dissatisfied; Somewhat dissatisfied; Somewhat satisfied; Very satisfied
3.	How do you think your job's neighborhood compares with most other job neighborhoods in the city of Chicago? Is it. . .	Better, the same, or worse
4.	How much violence is there in your job's neighborhood? Would you say. . .	None; A little; Some; A lot
5.	How often does worry about violence prevent you from doing the things you would like to in your job's neighborhood? Would you say. . .	Never; Rarely; Somewhat Often; Very often
6.	Twelve months ago, how often were there fights in your job's neighborhood in which a gun was used? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
7.	Now, how often are there fights in your home's/job's neighborhood in which a gun is used? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
8.	Twelve months ago, how often were there gang fights or gang-related violence in your home's/job's neighborhood? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
9.	And now? How often are there gang fights or gang-related violence in your home's/job's neighborhood? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
10.	Twelve months ago, how often were there shootings in your job's neighborhood? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
11.	And now? How often are there shootings in your job's neighborhood? Would you say. . .	Never; Less than once a month; 2–3 per month; Once a week; 2–3 per week; Almost every day
12.	If some children were spray painting graffiti on a local building, how likely is it that your job's neighbors would do something about it? Would you say it is. . .	Very Unlikely; Unlikely; Likely; Very Likely
13.	If there was a fight in front of your job and someone was being beaten or threatened, how likely is it that your job's neighbors would break it up? Would you say it is. . .	Very Unlikely; Unlikely; Likely; Very Likely
14.	If there were people selling drugs on a street corner or an alley in your home's/job's neighborhood, how likely is it that your home's/job's neighbors would call the police? (Would you say. . .	Very Unlikely; Unlikely; Likely; Very Likely

reported knowing someone who was murdered, and 48% ($n = 36$) reported knowing someone who was raped. Yet only 3% ($n = 2$) reported ever being counseled. The reported victimization rates between administrative and field staff were not significantly different, al-

Table 2. Comparisons Between Administrative and Field Staff: Likelihood of Confrontation with Neighbors in Their Job's Neighborhood

Item	t	df	p
To prevent spray painting graffiti	3.10	37	0.004
To break up a fight	3.06	62	0.003
Call police to report drug dealing	3.81	56	0.000

though field staff had some nonsignificant trends toward more victimization experience.

Confronting Neighborhood Disorganization and Crime

Field staff were more likely to perceive that their job's neighbors would be "unlikely" to do something about children spray painting graffiti on a local building ($p < 0.004$), to break up a fight or someone being threatened in front of their house ($p < 0.003$), or to call the police if people were selling drugs on a street corner or in an alley of the neighborhood ($p < 0.000$), compared with administrative staff who reported that their job's neighbors would be "likely" to do something in those same situations (Table 2).

Perceived Job Neighborhood Safety

Regarding personal safety, administrative staff felt their job's neighborhood had stayed the "same," whereas field staff felt their job's neighborhood had "gotten worse" ($p < 0.007$). Administrative staff also felt "somewhat satisfied" with their job's neighborhood, compared with field staff who felt "somewhat dissatisfied" with their job's neighborhood ($p < 0.000$). Ad-

ministrative staff felt their job's neighborhood was the "same," compared with field staff who felt their job's neighborhood was "worse" than other Chicago neighborhoods ($p < 0.000$) (Table 3).

Regarding their job's neighborhood safety, administrative staff noted "a little" violence in their job's neighborhood, whereas the field staff reported "some" violence in their job's neighborhood ($p < 0.000$). Further, field staff reported that violence in their job's neighborhood prevented them from doing things in the neighborhood "somewhat often," whereas administrative staff said such concerns "rarely" prevented their activity ($p < 0.000$) (Table 4).

Twelve months before the survey, administrative staff perceived the frequency of various violent incidents in their job's neighborhood was "less than once a month," compared with field staff who perceived the same violent incidents occurring "once a week" ($p < 0.000$). Similarly, during the survey, administrative staff also perceived the frequency of various violent incidents involving a gun in their job's neighborhood was "less than once a month," compared to field staff who perceived the same violent incidents occurring "once a week" ($p < 0.002$) (Table 5).

Table 3. Comparisons Between Administrative and Field Staff: Observations and Perceptions of Their Job's Neighborhoods

Item	t	df	p
Perception of job's neighborhood	-2.77	61	0.007
Satisfaction with job's neighborhood	-5.50	58	0.000
Compare job's neighborhood with others	-6.86	60	0.000

Table 4. Comparisons Between Administrative and Field Staff: Job's Neighborhood Safety

Item	t	df	p
Amount of violence in job's neighborhood	5.29	40	0.000
Concern about violence in job's neighborhood inhibits behavior	5.68	57	0.000

DISCUSSION

Because there is wide variability of victimization survey measures, ascertaining whether our sample had rates of victimization and covictimization comparable to other samples is difficult. However, it seems that our sample of predominately African-American, female, social service staff had higher rates of victimization than several other samples. We found that 9% reported they had been raped, and 10.3% reported being physically assaulted within the past year. These rates are much higher than the rates reported by Norris,[11] who found that 0.2% of their sample of women had experienced rape and 3.1% had experienced physical assault within the past year. In fact, our sample's past-year rates of exposure to actual rape and physical assault are comparable to several other studies of lifetime exposure rates. For example, Resnick and colleagues[12] found that the overall lifetime exposure to rape was 12.6% and physical assault was 10.3%. Kessler and colleagues[13] found that 9.2% and 6.9% of the women in their sample had a lifetime experience of rape and assault, respectively. Similarly, Breslau and colleagues[14] found that 9.4% and 16.4% of their sample of women reported a lifetime prevalence of rape and assault, respectively.

Further, over their lifetimes, 3% of our sample reported being shot and 3% reported being stabbed. These rates are also higher than the rates reported in the 1996 Detroit Area Survey of Trauma[14] that found women's lifetime exposure to being shot or stabbed was 1.8%. In addition, 25% of our sample reported witnessing someone being shot, 25% reported seeing someone being stabbed, and 11% reported witnessing someone being murdered over their lifetimes. In contrast, Kessler and colleagues[13] found the women in their sample had a lifetime experience of 14.5% for reporting having witnessed someone being badly injured or being killed.

Because personal victimization, witnessing violence, and knowing people who have been victimized influence staff perceptions about safety, social service staff need supervision regarding victimization issues and issues related to trauma. Such supervision may correct hindrances that interfere with or augment strengths useful in treating patients who have also been witnesses or victims to violence or in managing violent patients. First, to break through denial of risk,[6] the author's recommend that a major focus of this supervision should be a candid discussion about the rates

Table 5. Comparisons Between Administrative and Field Staff: Frequency of Violence: Frequency of Violence Incidents in Their Job's Neighborhood

Item	t	df	p
Fights involving a gun 12 months ago	3.98	51	0.000
Fights involving a gun now	3.57	21	0.002
Gang-related violence 12 months ago	4.25	51	0.000
Gang-related violence now	3.87	48	0.000
Shootings 12 months ago	5.37	48	0.000
Shootings now	4.48	49	0.000

of victimization in various populations. Second, supervisors should ask staff about their attitudes regarding aggression and violence. Specifically, they should ask staff about their general experiences with trauma and violence. We are not suggesting, for example, that supervisors ask staff if they have ever been raped. A more generic question about having ever been victimized and what the response was to the victimization would be in order, rather than getting specifics about the nature of the victimization.

Supervisors should follow such generic exploration of experiences with trauma and violence with an enquiry about how the staff feels such experiences shape their responses to violent and traumatized patients. The author's feel that by using supervision in this proactive manner issues of "compassion fatigue," "vicarious traumatization," and "covictimization" can be avoided.[15] Further, such supervisory discussions help staff clarify their attitudes about issues involved in responding to violent patients.

In this study, although administrative and field staff may have suffered similar victimization experiences, administrative staff perceive more safety in their job's neighborhood than field staff. Accordingly, administrative staff may have less understanding of the daily sense of dangers that field staff experience while doing their jobs. In addition, field staff may feel that they have less support from their job's neighborhood's neighbors in helping to create an environment that provides safety. These perceptions may attenuate staff's efforts in helping their job's neighborhoods reestablish or strengthen social fabric—a characteristic of neighborhoods shown to be a retardant against violence.[16,17] An alternative explanation may be that because only a few of the social service staff lived in the neighborhood where their agency delivered services, they may have had a negative bias regarding their jobs' neighborhood social fabric.

Hewitt and Levin[1] propose several types of strategies to reduce violence in the workplace: environmental controls, training, and policy.

The nature of field work makes the environmental control strategy challenging, contingent upon the agency's level of control and collaboration with community partners (e.g., apartment building managers, relatives, or neighbors) in different settings in the field. Dvoskin and colleagues[18] make clear recommendations about field work safety that include collecting information about the individual and the environment, assessing the location, general safety precautions, maintaining a daily log for staff daily itinerary, maintaining contact with the office, parking safely, how to approach buildings, how to enter the building, and how to conduct the interview. In addition, Berg and colleagues[6] provide best practice guidelines for managing potential, imminent, and emergent violence and recommend basic educational and training guidelines for clinicians. Finally, policies to decrease the risk of assault include field work in teams, cellular phones for emergencies, mandatory safety manuals and training, conflict resolution training, training updates, crisis and critical incidents reporting, prosecution of perpetrators, and postincident trauma counseling.[3,4]

CONCLUSIONS

This paper reveals the importance of screening for victimization in a predominately female, African-American social service staff, which are characteristics of many African-American social service agencies in Chicago. Being victimized does not automatically suggest that an individual will have difficulty dealing with future aggression or trauma,[8] however, staff with victimization histories may be more likely to have difficulties with these issues. Accordingly, the authors recommend that leadership consider surveying social service staff for concerns regarding trauma and victimization. Education, supervision, and training are necessary to give field staff a realistic view of the dangers of fieldwork. Learning strategies to deal with different levels of violence and threats from patients is also in order. A major focus of such education, supervision, and train-

ing is to transform the potential experience of "learned helplessness" into "learned helpfulness."[19] For staff with severe trauma histories, treatment may be necessary to improve their responses to threats and/or help them prevent physical assaults in the field.

REFERENCES

1. Sullivan C, Yuan C. Workplace assaults on minority health and mental health care workers in Los Angeles. Am J Public Health. 1995;85:1011-1014.

2. LaMar WJ, Gerberich SG, Hohman WH, Zaidman B. Work-related physical assault. J Occup Environ Med. 1998;40:317-324.

3. Gates DM. Workplace violence. Am Assoc Occup Health Nurs. 1995;3:537-543.

4. Hewitt JB, Levin PF. Violence in the workplace. Ann Rev Nurs Res. 1997;15:81-99.

5. Bell CC. Assessment and management of the violent patient. J Natl Med Assoc. 2000;92:247-253.

6. Berg A, Bell CC, Tupin J. Clinician safety—assessment and management of the violent patient. In: Bell CC, ed. Psychiatric Aspects on Violence: Understanding Causes and Issues in Prevention and Treatment. San Francisco: Jossey-Bass; 2000:9-29.

7. Bell CC, Suggs H. Using sports to strengthen resiliency in children—training "heart." Child Adolesc Psychiatr Clin North Am. 1998;7:859-865.

8. Mattis JS, Bell CC, Jagers RJ, Jenkins EJ. Towards a critical approach to stress-related disorders in African-Americans. J Natl Med Assoc. 1999;91:80-85.

9. Baker FM, Bell CC. African Americans: treatment concerns. Psychiatr Serv. 1999;50:362-368.

10. Bell CC. Community violence. Causes, prevention, and intervention. J Natl Med Assoc. 1997;89:657-662.

11. Norris FH. Epidemiology of trauma: frequency and impact of different potentially traumatic events on different demographic groups. J Consult Clin Psychol. 1992;60:409-418.

12. Resnick H, Kilpatrick DG, Dansky B, Sanders BE, Best CL. Prevalence of civilian trauma and posttraumatic disorder in a representative sample of women. J Consult Clin Psychol. 1993; 61:984-991.

13. Kessler R, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry. 1995;52:1048-1060.

14. Breslau N, Kessler R, Chilcoat HD, Shultz LR, Davis GC, Andreski P. Trauma and posttraumatic stress disorder in the community: the 1996 Detroit Area Survey of Trauma. Arch Gen Psychiatry. 1998;55:626-632.

15. Kluft RP, Bloom SL, Kinzie JD. Treating traumatized patients and victims of violence. In: Bell CC, ed. Psychiatric Aspects on Violence: Understanding Causes and Issues in Prevention and Treatment. San Francisco: Jossey-Bass; 2000:79-102.

16. Sampson RJ, Raudenbush SW, Earls F. Neighborhoods and violent crime: a multilevel study of collective efficacy. Science. 1997;277:918-924.

17. Bell CC, Flay B, Paikoff R. Strategies for health behavioral change. In: Chunn J, ed. The Health Behavioral Change Imperative. Theory, Education, and Practice in Diverse Populations. New York: Kluwer Academic/Plenum Publishers; 2002: In press.

18. Dvoskin JA, Massaro J, Nerney M, Harp H. Safety Training For Mental Health Workers in the Community. New York: Information Exchange, Inc.; 1995.

19. Apfel RJ, Simon B, eds. Minefields in their Hearts. New Haven: Yale University Press; 1996:9-11.

We Welcome Your Comments

Journal of the National Medical Association welcomes your Letters to the Editor about articles that appear in the *JNMA* or issues relevant to minority health care.

Address correspondence to Editor-in-Chief, *JNMA*, 1012 Tenth St, NW, Washington, DC 20001; fax (202) 371-1162; or ktaylor @nmanet.org.