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What Social Workers Need to Know About Client Violence

Lucy D. Rey

ABSTRACT: *Client violence perpetrated against social workers has increased during the past decade as violence in society and the media has increased, social service resources decreased, and clients have become increasingly powerless. A survey of 175 licensed social workers and 98 agency directors in a western state showed that 25% of social workers had been assaulted by a client, nearly 50% had witnessed violence in an agency, and more than 75% were fearful of workplace violence. The author summarizes the skills that social workers and agency directors need to prevent and cope with client violence. These skills range from self-awareness and client assessment to debriefing and support of the traumatized worker.*

IN THE PAST DECADE violence perpetrated against social workers and other helping professionals has increased (Hiratsuka, 1988; Schultz, 1987). Some social workers and agency heads regard client violence as part of "the territory" and burnout and worker turnover as the inevitable price paid in an increasingly violent society (Schultz, 1987).

Social workers at all levels can be educated to cope successfully with client violence. Administrators can create safe workplaces, develop protective policies, and provide worker inservice training to guard against violence. Workers in the field can develop skills to help them identify potentially violent clients, learn techniques to deescalate violent situations, and develop protocols for requesting assistance. A key component of this effort is the development of high professional self-esteem and refusal to accept violence as a condition of life for our clients or ourselves.

Causes of Client Violence

Kaplan and Wheeler (1983) argued that violence is caused by disequilibrium in power.

> Robbed of power over his or her own life, an individual is at risk not only of feeling anger but of acting on it destructively to reclaim that power. Violence is a final way of restoring balance (p. 339).

In searching for causes of client violence against helping professionals, we find evidence of powerlessness with regard to clients' self-control and interpersonal relations as well as with regard to clients' ability to deal with macro issues at the societal and institutional levels. Violent behaviors are modeled daily in the news and entertainment media. Exposure to such violence predisposes persons to accepting interpersonal violence in their own lives (Hiratsuka, 1988). At the societal level, unemployment creates economic insecurity.

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New immigrants displace older workers in jobs and housing and intergroup violence erupts. Exacerbating matters, easy access to guns provides a ready tool with which to act upon one's frustrations (Hiratsuka, 1988).

Today, many social work clients have violence-related presenting problems, including domestic violence, child abuse, elder abuse, gang violence, and violence in schools (Kaplan & Wheeler, 1983). Many of these clients are mentally or emotionally impaired (Breakwell & Rowett, 1988), reflecting the deinstitutionalization trends of the past decade. Social work agency budgets have been cut while case loads have risen, inhibiting the effectiveness of social workers. The worker who can deliver less help but must still uphold bureaucratic regulations may be seen less as a helper than as an agent of social control (Kaplan & Wheeler, 1983; Tully, Kropf, & Price, 1993). Budget cuts have also resulted in fewer resources for managing aggression and constructing safe workplaces (Hiratsuka, 1988; Nuehring & Houston, 1992). Moreover, many agencies are adopting home visitation services. However, few agencies have developed safety plans for home visits (Nuehring & Houston, 1992; Wasik, Bryant, & Lyons, 1990).

Extent of the Problem

Research on the prevalence of patient/client violence has suffered from a lack of standardized operational definitions and uniform reporting procedures (Breakwell & Rowett, 1988). Also, research in this area has a low reporting rate because of the assumptions that professionals should be able to protect themselves and that failure to do so represents lack of competence (Lanza, 1985).

As early as 1978, psychiatric hospitals in the United States responded to patient violence by training professional staff in behavior management and by adopting policies whereby a criminal complaint was filed against patients who assaulted staff (Scott & Whitehead, 1981). Hospital emergency rooms recognized the volatility of some patients and their emotionally distressed families and friends, introducing protocols for prevention and restraint of violence (Fahrney, 1983).

In 1988, the American Psychiatric Association established a task force on clinician safety that evaluated the nature and extent of client violence. The task force found that 40% of psychiatrists had been assaulted at one time during their careers. Family practitioners were assaulted at a slightly higher rate than psychiatrists. In high-volume emergency rooms, 72% of physicians had experienced at least one threat of violence with a weapon over a five-year period (Dubin, 1993). Among medical professionals, nurses appear to have the highest rate of victimization by patients, with 80% indicating at least one occasion of assault during their careers (Lanza, 1985).

Clinical psychologists' experience with assault is similar to that of medical practitioners. Tryon (1986) surveyed a random sample of 500 clinical psychologists in the United States and found that 81% had experienced at least one incident of verbal abuse, harassment, or physical attack, with two-thirds of incidents occurring in the course of agency work and one-third in private practice. In Britain, a survey of clinical psychologists revealed that 52% had been assaulted by a client one or more times; 18% had been assaulted in the preceding year. Also, 67% had experienced violence against personal property and 72% verbal abuse (Hillen, 1991).

Social workers report client violence in virtually all of the settings in which they work. In a survey of British social service districts covering the years 1978–1982, the operational definition of violence was restricted to "actual physical assault resulting in some injury or pain" (Breakwell & Rowett, 1988, p. 235). Male workers were assaulted more often than were females, especially in residential settings. High assault rates occurred in urban areas, especially London, where 25% of social workers had been assaulted on at least one occasion.

Although a national study of client violence in the United States has not been published, several statewide studies indicate the extent of the problem. In a random sample of 150 social workers in West Virginia, two-thirds reported at least one incident of physical violence; corrections, residential, health, and mental health programs were most hazardous (Schultz, 1987). Many cases of verbal

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threats and property damage that caused worker stress and contributed to potential burnout were reported. Tully et al. (1993) found that among social work field instructors for the University of Georgia, 62% had been verbally abused and 24% physically attacked by at least one client. At practicum sites, 26% of students had been verbally abused and 13% physically attacked.

A new, unpublished study of a national sample of National Association of Social Workers members links social worker victimization by clients with a climate of fear in the workplace, which contributes to worker burnout. Victimized workers are likely to be younger and less experienced than their colleagues (Cameron, 1994).

State Study of Client Violence

The author found that incidences of client violence against social workers in a western state were almost identical to Tully and colleagues' (1993) results for Georgia. Twenty-three percent of licensed social workers had been physically attacked by one or more clients. The study attempted not only to determine the extent of client violence against social workers but to determine agency directors' knowledge of and attitudes toward client violence. Surveys were sent to a purposive sample of 150 directors of agencies; 98 directors responded. From a current list of 1,500 licensed social workers (which did not include the directors), 300 randomly selected workers were sent surveys; 175 workers responded. No attempt was made to match agency heads with their employees because doing so would have been a violation of confidentiality. Of the social worker sample, 72% were female, 17% minorities of color, and 63% educated at the master's level or higher. Of the agency directors, 59% were female, 8% minority, and 55% educated at the master's level or higher.

The agencies ranged in size from 1 to 3,000 employees and represented 20 areas of social work. More than 80% of both directors and social workers indicated that they believed that safety issues in social work have been an increasing concern throughout the past 10 years. Table 1 presents social workers' reports of personal experience with violence, awareness and fear of violence, symptoms of high work-related stress, and education and training about violence.

TABLE 1. Licensed social workers' experiences with client violence.

	%
Client violence experienced during social work career	
Verbally abused	88.8
Threatened by a client	59.6
Had property stolen	47.3
Harassed via telephone	45.3
Had objects thrown	24.2
Physically assaulted by a client	23.0
Had property damaged	19.3
Threatened with a weapon	17.5
Awareness and fear of violence during career	
Fearful of client violence	82.0
Fearful of client family or friends	58.6
Fearful of neighborhood	54.5
Aware of violent incidents in agency	63.0
Witnessed violence in agency	47.3
Symptoms of high stress during the past year	
Extreme fatigue	65.6
Sleep problems	56.0
Poor attention span	47.2
Anxiety, extreme nervousness	39.2
Somatic complaints	35.2
Emotional outbursts	26.4
Academic course work on violence	
Child abuse	80.5
Domestic violence	71.0
Sexual abuse	69.8
Post-traumatic stress disorder	55.6
Elder abuse	46.7
Sexual assault	46.2
Clinical predictors of violent behavior	40.8
Gang violence	36.7
Effects of working with traumatized clients	35.5
Violence prevention	32.0
Training experiences at agencies	
Verbal deescalation of violence	63.9
Orientation to an organization's safety policy	52.3
Client characteristics that threaten violence	48.7
Physical restraint of a violent person	44.4
Use of safety equipment (e.g., panic button)	21.8
Safety procedures for home visits	21.8

Note: $N = 175$

Twenty-three percent of social workers had been physically assaulted by a client during their careers, and 63% were aware of vio-

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lent incidents that had occurred in the agency. Awareness and fear of violence may contribute to high stress and potential burnout; 65.6% of social workers had experienced at least one symptom of high work-related stress. With regard to educational preparation, only 41% had studied the clinical predictors of violent behavior and 32% violence prevention. Slightly more than half had been oriented to their agency's safety policy, but only 22% had been trained in safety measures for home visitation. Of social workers who had experienced a violent incident on the job, 76% reported the incident. More than half of those workers felt that the agency's response was satisfactory. However, it is possible that workers who were most traumatized on the job left the agency or the profession.

Table 2 compares social workers' and directors' responses regarding safety policy and procedures. Social workers were more aware of safety measures than were their directors. This discrepancy may indicate that staff take an informal approach to safety and that safety policies are not developed at the top and handed down to staff. Only 15% of agency directors

TABLE 2. Directors' and social workers' awareness of agency safety measures.

	Directors (n = 98)	Social workers (n = 175)
Agency manual of policies and procedures for personal safety (%)	39	51
Office safety: Ability to check on worker while with a client (%)	35	47
Home Visits		
Procedures for checking (%)	6	35
Procedures for backup (%)	17	28
Safety manual (%)	2	0
Training of supervisors to deal with employee stress and trauma (%)	33	
Median years of employment in social services	15	10
Median years in the current organization	7	5
Median years in agency management	12	

indicated that they were aware of employee victimization during the past year, and only 10% indicated their awareness of cases of high stress among employees.

Training for Violence Prevention And Protection against Harm

In light of gaps in worker preparation and director awareness as revealed by this research, it is appropriate to consider what social workers need to know about workplace violence and safety. A comprehensive program should include (1) theory of causes of client violence; (2) extent of the problem; (3) how to assess the likelihood that a client will become violent; (4) becoming aware of one's own reactions and self-control; (5) techniques for verbal deescalation of violence; (6) physical control; (7) designing safe office space, including waiting area, reception desk, and security; (8) safety procedures for working with unknown or suspicious clients; (9) safety procedures for home visits; (10) debriefing and support of traumatized workers in order to prevent post-traumatic stress disorder; and (11) agency policy for preventing, managing, and follow-up with workplace violence.

Assessing the Likelihood of Client Violence

Major predictors of violence include past history of interpersonal violence, fire setting, cruelty to animals, use of weapons, involvement with gangs, alcohol and drug use and addiction, head trauma, and diagnosis of psychosis or antisocial personality disorder. Social workers should request and review referral materials before seeing a new client (Griffin, 1993). Presenting problems known to trigger violence include domestic violence, divorce and child custody, denial of benefits, and involuntary hospitalization.

Worker's Awareness of Own Reactions and Self-Control

Responsibility for assessment rests primarily with the worker in face-to-face interaction with a client (Johnson, 1988). When interviewing a client, the worker should be alert to

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cues of agitated depression and verbal warnings, for example, "I'm going to blow my top."

Preparation for a social work career in general and for work with volatile clients in particular should include training in self-awareness of feelings, including fear. Kaplan and Wheeler (1983) recommend anxiety management training, which helps social workers learn to use their physical symptoms of anxiety as stimuli for relaxation. These skills are useful for all workers and may be helpful for some clients. As part of self-awareness training, the beginning worker might consider, for example, whether his or her clothes impede movement (Wasik et al., 1990) and whether hair style, jewelry, and ties provide a potential hold for an agitated client.

Verbal Deescalation

Verbal deescalation is based on empathy and respect for the client as well as on personal assertiveness grounded in self-respect. The practitioner expresses empathy for clients' feelings of pain and rage, while setting clear limits on clients' acting out these feelings. Social workers should adopt nonconfrontative postures that do not imply vulnerability, for example, standing when the client stands and never touching an agitated client without asking for and receiving permission (Griffin, 1993).

Physical Control of a Client

Physical-control techniques include blocking a blow followed by containment of the violent client's arms and/or legs without hurting the client, then walking or carrying the client to a safe place. These techniques need to be practiced regularly to assure continued proficiency (Mitchell & Bray, 1990).

Physical-control techniques are not the same as self-defense techniques. Reliance on self-defense may tempt a worker to become overconfident about physical safety and does not focus on the client's well-being and rapid return to self-control.

Safe Office Space

Office safety begins in the waiting room. At a minimum, comfortable chairs should be arranged to provide a measure of privacy; reading materials, water, and a rest room should be available for use; and a place for children to play safely should be within view. Soothing colors for walls and furnishings are helpful, and the swimming motions of fish in a tank can calm clients in the waiting room. A sign should clearly state that weapons are not permitted either in the waiting area or offices. Efforts should be made to shorten the waiting time and to tell clients approximately how long it will be until they are seen. Reception personnel should be protected by glass. A low-key and cordial security guard can contribute to the positive atmosphere of the reception area. Local police should be prepared to offer back-up help upon request (Star, 1984).

Intake Procedures

Offices where clients are interviewed should be devoid of heavy objects that might be used as weapons of opportunity (Griffin, 1993). An unobtrusive "panic" button should be available to alert security or the receptionist that assistance is needed. Star (1984) stated that every agency or private practice should have a special interviewing room that has two doors for exit as well as a window or door panel through which colleagues can observe. Large cushions are useful as shields. The receptionist should have a code word for notifying a worker that the special room should be used. Similarly, codes for summoning assistance should be developed and communicated to all staff. Some agencies are changing their procedures from interviewing in private offices to interviewing in general-purpose rooms.

Home Visits

Home visits create special risks for social workers and thus require special guidelines and procedures (Breakwell & Rowett, 1988; Nuehring & Houston, 1992; Wasik et al., 1990). Griffin (1993) developed a risk scale to be used by workers anticipating a home visit. Workers should be accompanied by a police officer if firearms, ongoing violence, substance abuse, mental illness, removal, or dangerous neighborhood locations are involved. The worker should bring a co-worker on the visit if the client has a history of violent behavior, if dangerous animals are at the location, or if the visit must be made after normal working hours.

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The worker should always inform his or her supervisor about destination, route, time of departure, and time of expected return. Cellular telephones are helpful. The worker should be fully aware of the neighborhood. In a dangerous neighborhood, the client may meet and escort the worker through the neighborhood and into the home. It is also acceptable to meet the client at a safe place nearby or to conduct the interview in a library or restaurant. The worker should be alert to all persons and activities in the home. The worker may conduct the interview in the front room near the door, on a front porch, or in an apartment foyer.

Debriefing and Support of Traumatized Workers

Workers who have been attacked, whether injured or simply frightened, need a full range of empathy and support from fellow workers, immediate supervisor, and agency director. Mitchell and Bray (1990) developed critical-incident-stress debriefing (CISD) for emergency service workers but it is equally applicable to social workers who have experienced workplace violence. With CISD, a worker is given an opportunity within 24 hours to discuss the traumatic event. The trained debriefer avoids any blame of the victim but takes advantage of the opportunity to explore alternative responses, thus restoring the worker's sense of control over his or her environment.

After debriefing, ongoing support for up to one year needs to be available. Braithwaite (1990) noted that traumatic effects of violence may not emerge until two to three days after the incident. Friedman, Framer, and Shearer (1988) showed that traumatized workers who were treated within six weeks of the incident tended not to develop PTSD and returned quickly to work and to healthy functioning. Post-traumatic stress increases over time and becomes more difficult to treat. A model program for treatment of staff assaulted by patients at a large psychiatric hospital involves a worker committee, which provides weekly stress-management seminars, debriefing, follow-up contacts with the traumatized worker, and a support group for staff who have been assaulted (Flannery, Fulton, Tausch, & DeLotti, 1991). Griffin (1993) pointed out that victims' families and co-workers are also traumatized and thus need services, too.

Agency Policy for Prevention, Management, and Follow-up

Administration must demonstrate support for workers who face threats from clients. A manual of procedures and policy should be given to new workers and students. Clear procedures for reporting incidents and keeping records should be provided. Inservice training, safety needs in the office and the field, and follow-up after worker victimization are best handled by a safety committee made up of employees from various levels and programs in the agency (Flannery et al., 1991). Directors may wish to consider whether developing procedures for prosecuting clients who assault workers may serve as a deterrent to violence and as an assurance of safety to workers (Scott & Whitehead, 1981).

Developing a Workshop on Client Violence

Large agencies may find it convenient to schedule workshops on client violence and social worker safety tailored to their unique clientele, circumstances, history, and needs. Topics should correspond to the needs of the worker group. Twelve hours is adequate time for leader input, thorough discussion of material, and practice of techniques (Griffin, 1993). It may be appropriate to group workers in related areas of social work, such as child and family services, as well as other workers who deal with similar clients and use the same facilities. The workshop leader should be comfortable with the material and experienced in work with victims of violence. Participants must be encouraged to discuss their experiences, feelings, and needs throughout the workshop.

Schools of social work bear responsibility for the general training of students and field instructors, whereas agencies are expected to provide specific training (Agency Risk Reduction Guidelines, 1992; Cameron, 1994; Tully et al., 1993). Social work students should be exposed to realistic situations with which they will need to cope without developing paralyzing fear of client violence or early burnout.

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Material on client violence toward practitioners can be related to violence experienced by clients, for example, child abuse. The University of California at Berkeley requires affiliated field agencies to develop policies and procedures for social worker safety and to orient students to these procedures. The university consults with agencies on the development of safety policies specific to their needs (Agency Risk Reduction Guidelines, 1992). The University of Michigan has developed a full-day safety training program and manual for students (Cameron, 1994).

Phillips and Leadbetter (1990) devised an interesting course on client violence and social worker safety. Specific discussion of client violence is initiated in the context of assertiveness training and reflection on personal experiences with violence. Actors, both live and on video, perform client violence situations possible in social work settings. Excerpts of videos of popular dramas can also be used to illustrate causes of violence and emotions surrounding violence.

Conclusion

Client violence against human service professionals is a growing problem reflective of a violent and uncertain world. Violence prevention must be approached simultaneously on many levels, from design of safe office space to the development of procedures for home visits to worker training. Agency provision of critical-incident-stress debriefing and follow-up is important. Violence education efforts must reject the notion that risk "comes with the territory" in the social work profession.

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