Police Brutality and the Institutional Patterning of Stressors

See also DeVylder et al., p. 1704.

In the current issue of *AJPH*, DeVylder et al. (p. 1704) examine police violence as a distinct form of violence and the implications of this distinction for mental health. As they show in Table 1 in their article, several studies connect police violence to poor mental health. Police brutality—acts of violence as well as conduct that dehumanizes without conscious intent—affects mental health so profoundly that it is associated with antenatal depression among Black women.[1] Black people are five times more likely to worry about police brutality than are Whites.[2] Indeed, the stress from trying to avoid the police is a mechanism through which previous incarceration increases the odds of depressive symptoms among Black men.[3]

What makes police violence distinctively detrimental for mental health? DeVylder et al. argue that the answer lies in three categories of factors: those that increase exposure to police violence, those that exacerbate its impact on mental health, and those that make it hard for victims to cope. Their conceptualization of the mechanisms through which police violence affects mental health is consistent with the stress process model: a prominent sociological framework for understanding variability in mental health outcomes. According to the stress process, group differences in mental health originate from group differences in exposure to stressors and in access to resources that enable people to cope or that buffer the impact of stressors on mental health.[4] In the case of police violence, several factors concurrently increase exposure, exacerbate impact, and impede coping. In my view, DeVylder et al. make a strong theoretical contribution to the conceptualization of police brutality as an institutionally patterned stressor sustained by White supremacy. I explore the implications of this conceptualization.

Stressors are experiences and conditions that produce stress. Exposure to stressors is grounded in social conditions: those with the most marginalized statuses are disproportionately at risk over the life course.[4] Police brutality is a stressor because its victims are predominantly persons marginalized by oppressive structures. For research, this means that as we document structural causes of ill health, we must assess exposure to stressors that are salient among populations marginalized by structural inequality, such as police brutality. We must also specify the role of racism when we measure police brutality as a stressor. Brown argues, "The respondent's attribution is the only factor that distinguishes 'loss of a job' from 'loss of a job because my White supervisor is prejudiced.'"[5(p55)] This applies to attributions of racism in our measures of police brutality. When we ignore these attributions, we are left with assessing exposure to a stressful event that by itself does not tell a complete story. Eradicating police brutality requires us to examine the roles of racism and White supremacy, not only conceptually but also in our measures, data collection, and analyses.

Police brutality is a stressor that is sustained by a powerful institution. DeVylder et al. state:

> In interactions with civilians, police officers are in positions of relatively greater power because of both the symbolic and state-sanctioned status of their profession, and their immediate legal availability of means (e.g., guns, batons, tasers) to wield force, threat of force, and coercion, at their discretion. (p. 1705)

Stressors that are associated with societal institutions and hierarchical arrangements are particularly damaging for mental health.[4] Stressors that affect mental health can also proliferate through institutional racism.[6] Therefore, as an institution, law enforcement provides an infrastructure through which the state can exercise control over populations already marginalized by racist systems and inflict the kinds of stressors that DeVylder et al. describe as acute violence.

Law enforcement is not the only institution that inflicts violence on populations marginalized by structural inequalities, however. Our educational systems do the same through the school to prison pipeline and other practices that oppress Black and Indigenous students and other students of color. Our medical institutions inflict racialized violence owing to racial inequities in quality of care. As we test the model proposed by DeVylder et al., we need to emphasize that police violence does not exist in a vacuum. The structural nature of racism enables racism to occur simultaneously in different institutions.

As a stressor, racism proliferates.[6] As a racialized stressor, police brutality and its consequences also proliferate. For example, police brutality might harm mental health indirectly by making it less likely for people exposed to police brutality to seek medical care because of

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crossover institutional mistrust.[7] Therefore, police brutality can harm mental health directly through trauma and indirectly by preventing access to care. Because the impact of police brutality is exacerbated by its institutionalization and connection to structural racism, public health scholars and practitioners should examine and advocate policies that will prevent institutionalized harm. One example of this is defunding the police: reallocating resources to services necessary for addressing conditions such as addiction that are disproportionately criminalized in Black and Indigenous communities and other communities of color.

Even though DeVylder et al. conceptualize instances of police violence as acute, they infer that it is ongoing given that "police violence is normative, rather than an acute or singular event" (p. 1707). The pervasive presence of police and the lack of internal accountability also render police brutality a chronic stressor. Chronic stressors are enduring and open-ended. They are a constant source of worry that requires emotional labor to manage over time. Predominantly Black and poor neighborhoods that are often hyperpoliced are stressed by persistent police surveillance.[3] Police officers are everywhere—not only responding to crime but also patrolling in neighborhoods, schools, and hospitals. People have no control over how to limit their exposure to police brutality. In addition, because of the "code of silence," victims have no idea whether and how police brutality and its effects will be resolved.

The chronic nature of police brutality matters for its effects on mental health. As DeVylder et al. hypothesize, the lack of recourse and the pervasiveness of police presence may be detrimental to mental health over time because they might impede coping. In addition to testing this hypothesis, we need to collect data on how victims of police brutality cope and what resources are needed to buffer the impact of police brutality on mental health. At the level of policy, interventions that could increase police accountability are necessary.

The conceptual model that DeVylder et al. put forth is necessary. We must engage in two things simultaneously: research and action. Research will test the mechanisms that link police violence to poor mental health in distinctive ways. It will give us the evidence needed to design and implement specific interventions to meet the needs of populations that are disproportionately exposed to police brutality. But even without the evidence that DeVylder et al. call for, we know police brutality is a public health issue that increases morbidity and mortality, especially among Black people, Indigenous people, and people of color, and that systemically disempowers these communities. The profession and practice of public health implore us to commit to actions that put the well-being of communities marginalized by structural inequalities at the forefront. White supremacy in law enforcement underlies the institutional patterning of police brutality. Public health is not exempt from the grip of White supremacy. We must learn to recognize White supremacy and commit to dismantling it in our institutions, teaching, scholarship, and practice. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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