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Living under surveillance: Gender, psychological distress, and stop-question-and-frisk policing in New York City

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ABSTRACT

A growing body of research highlights the collateral consequences of mass incarceration, including stop-and-frisk policing tactics. Living in a neighborhood with aggressive policing may affect one's mental health, especially for men who are the primary targets of police stops. We examine whether there is an association between psychological distress and neighborhood-level aggressive policing (i.e., frisking and use of force by police) and whether that association varies by gender. The 2009–2011 New York City (NYC) Stop, Question, and Frisk Database is aggregated to the neighborhood-level ($N = 34$) and merged with individual data from the 2012 NYC Community Health Survey ($N = 8066$) via the United Hospital Fund neighborhood of respondents' residence. Weighted multilevel generalized linear models are used to assess main and gendered associations of neighborhood exposures to aggressive police stops on psychological distress (Kessler-6 items). While the neighborhood stop rate exhibits inconsistent associations with psychological distress, neighborhood-level frisk and use of force proportions are linked to higher levels of non-specific psychological distress among men, but not women. Specifically, men exhibit more non-specific psychological distress and more severe feelings of nervousness, effort, and worthlessness in aggressively surveilled neighborhoods than do women. Male residents are affected by the escalation of stop-and-frisk policing in a neighborhood. Living in a context of aggressive policing is an important risk factor for men's mental health.

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Media (Balko, 2015; Goodman, 2015; Leovy, 2015; Lewis, 2015; The Associated Press, 2015) and scholarly (Cooper et al., 2004; Lee et al., 2014; Massoglia, 2008; Massoglia and Pridemore, 2015; Sewell and Jefferson, 2016) attention to the over-policing of neighborhoods has grown. For residents of such neighborhoods, police stops may be a chronic stressor occurring repeatedly over days, weeks, months, and years (Brunson and Miller, 2006; Brunson and Weitzer, 2008; Cooper et al., 2004; Engel and Calnon, 2004; Lerman and Weaver, 2014). The health associations of such a stressor are only beginning to be examined. This study uses a multilevel research design to examine the mental health of individuals living in highly surveilled neighborhoods, particularly neighborhoods that are surveilled with aggressive policing tactics of frisking and use of force. Special attention is paid to gender differences in the strength of the association of living in neighborhoods where pedestrian stops are more likely to incur frisking and use of force because men are the primary targets of stop-and-frisk practices. Specifically, individual-level health data from the New York City Community Health Survey (NYC-CHS) is matched to geocoded administrative data from the New York City Stop, Question, and Frisk Database (NYC-SQF), and a cross-level interaction between male gender and living in an (aggressively) surveilled neighborhood is evaluated.

The policing of pedestrians is gendered. For instance, an analysis of administrative data from the NYC-SQF indicates that men comprise about 88 percent of pedestrian stop suspects in NYC (Ridgeway, 2007). As such, men's mental health may be especially affected by *direct* contact with the police. Indeed, a recent study of young men in NYC found higher levels of trauma and anxiety symptoms among those men who reported frequent contact with the police, especially if such contact was conceived as “intrusive” or

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"unfair" (Geller et al., 2014). Men living in highly policed neighborhoods, especially men of color, indicate high levels of worry and anticipation caused by the possibly of being stopped by the police at any time, as well as anger, frustration, and resentment caused by the perception that police unfairly target them (Anderson, 1990, 1998, 2003; Dottolo and Stewart, 2008; Goffman, 2009; Jones, 2014; Young, 2006).

Yet, a burgeoning body of research suggests that *indirect* contact with the criminal justice system is also associated with negative health consequences (Hatzenbuehler et al., 2014; Lee et al., 2014; Sewell and Jefferson, 2016; Wildeman et al., 2012). For instance, living in a neighborhood with high incarceration rates is linked to higher risks of depression and anxiety (Hatzenbuehler et al., 2014) and asthma (Frank et al., 2013) for men and women. On one hand, living in neighborhoods where pedestrian stops are more likely to incur frisking and use of force may represent a unique stressor for men, who are more likely to be stopped and, therefore, anticipate being stopped. On the other hand, both men and women living in such neighborhoods may experience policing similarly, suggesting that neighborhood policing invokes the same types of stress and coping processes across the gender continuum.

Research suggests a palpable relationship between aggressive policing and the risks of psychiatric illness for men (Geller et al., 2014). Living in highly policed areas may be harmful to one's mental health, via the negative effects of hypervigilance and perceived unfairness (Brunson and Miller, 2006; Brunson and Weitzer, 2008; Cooper et al., 2004; Geller et al., 2014; Kessler et al., 1999; McEwen, 2004; Shedd, 2012; Unnever and Gabbidon, 2011; Williams and Mohammed, 2009; Williams et al., 2003; Williams et al., 1997). When police stops within a neighborhood frequently escalate to frisking and use of force, residents are more likely to perceive stops as discriminatory or unfair (Brunson and Miller, 2006; Brunson and Weitzer, 2008; Cooper et al., 2004; Unnever and Gabbidon, 2011). Perceived unfairness not only is linked to poor mental health (Kessler et al., 1999; McEwen, 2004; Williams et al., 1997, 2003) but also creates a "climate of fear" in which residents live with knowledge that they could be criminalized at any moment and in turn feel more vigilant (Shedd, 2012). Moreover, hypervigilance, through the psychological expenses of chronically activating coping mechanisms (Cohen et al., 1986; Meyer, 1995), can produce changes in the hippocampus, prefrontal cortex, and amygdala that precipitate depression and/or anxiety (Kessler et al., 1999; Lerman and Weaver, 2014; McEwen, 2004; Williams et al., 1997, 2003). The climate of fear produced by aggressive policing practices may be especially impactful for male residents who are more likely to feel it is unfair that the police target them on a day-to-day basis. Perceptions of injustice in policing, in turn, may be directly linked to pedestrian stops turning aggressive, such that ill effects are associated with frisking and use of force, but not the rate of pedestrian stops in the neighborhood.

To our knowledge, this is the first study to examine the mental health consequences of stop-and-frisk policing at the community-level. We examine (1) the association between psychological distress and the escalation of neighborhood police stops, holding constant key individual- and neighborhood-level correlates of health and (2) gender variation in the association between mental health and community-level escalated police encounters. We propose two hypotheses that are examined using data on pedestrian stops in NYC:

1. Living in (aggressively) surveilled neighborhoods is associated with a greater risk of reporting psychological distress among neighborhood residents.
2. The association between living in such (aggressively) surveilled neighborhoods and psychological distress is stronger for men than for women.

1. Methods

1.1. Data

This multilevel study merges individual-level data from one data source with neighborhood-level data from multiple data sources.

1.1.1. Individual level

The analysis is based on a sample of adults ($N = 8797$) participating in the 2012 NYC-CHS collected by the NYC Department of Health and Mental Hygiene (New York City Department of Health and Mental Hygiene, 2012). NYC-CHS is an annual random-digit-dial health survey of non-institutionalized adult (18+) New Yorkers. This survey evaluates the health of New York residents citywide, by neighborhood, and across demographic subpopulations. The survey gathers a broad range of health measures and is based on the national Behavioral Risk Factor Surveillance System coordinated by the U.S. Centers for Disease Control and Prevention. Each year, the NYC-CHS interviews approximately 10,000 people. All data, collected by telephone or cellphone, are self-reported, publicly-available, and include community identifiers for individuals surveyed. Respondents live in 1 of 34 United Hospital Fund (UHF) neighborhoods (NYC Department of Health and Mental Hygiene, 2006); only 303 respondents (0.3%) were missing neighborhood identifiers.

1.1.2. Neighborhood level

Administrative data from the 2009–2011 NYC-SQF provide pedestrian stop-level data (New York City Police Department, 2009–2011), which are aggregated to UHF neighborhoods by geocoding stop locations for 1,816,871 of the 1,818,465 pedestrian stops (99.9%) occurring during the study period. These data are used to create neighborhood-level densities of post-stop outcomes by counting the number of stops occurring in each UHF neighborhood and the outcome of the stop. Data from the 2010 decennial census and the New York City Police Department (NYPD) provide additional neighborhood-level variables. The publicly available data are exempt from IRB review by the authors' institutions.

1.2. Measures

1.2.1. Outcome measures

Our outcomes of interest are the six items comprising the Kessler-6 Psychological Distress Scale (K6) (Kessler et al., 2003), as well as a dichotomous measure of psychological distress based on this scale (Table 1). All NYC-CHS respondents are asked the following questions: "During the past 30 days, how often did you feel: (1) So sad that nothing could cheer you up?; (2) Nervous?; (3) Restless or fidgety?; (4) Hopeless?; (5) That everything was an effort?; and (6) Worthless? The response categories for the items are: (1) All of the time; (2) Most of the time; (3) Some of the time; (4) A little of the time; (5) None of the time. Responses are reverse coded, such that higher values indicate more frequent and severe psychological distress. Individuals who responded "don't know", "not sure", or refused to provide a response are classified as missing data. As is convention (Kessler et al., 2003), summary scale scores (Range: 6–30) were converted to a dichotomous measure of non-specific psychological distress (NSPD) (1: K6 = 12+; 0: K6 $\leq$ 12). We treat NSPD as a binary response outcome, while we

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