

Help-Seeking in the Norwegian Police Service

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Abstract: Help-Seeking in the Norwegian Police Service: Anne Marie BERG, et al. Department of Behavioural Sciences in Medicine, University of Oslo, Norway—A traditional view is that police officers

possess negative attitudes toward seeking professional help. However, few empirical studies have investigated help-seeking behaviour in police services. This study aimed to investigate help-seeking behaviour, gender differences, and the relationship to self-reported physical and mental health problems in the Norwegian police service. Comparisons were made with a sample of the general Norwegian population. A comprehensive nationwide questionnaire survey of 3,272 Norwegian police officers at all hierarchical levels was conducted; measurements included help-seeking, Subjective Health Complaint questionnaire (SHC), the Hospital Anxiety and Depression Scale (HADS), Paykel's Suicidal Feelings in the General Population, alcohol and medication to cope, self reported health, and sick leave. Female police officers contacted nearly all health professionals more than their male counterparts. Help-seeking was largely unaffected by age. Less than 10% of those reporting anxiety or depressive symptoms or serious suicidal ideation had contacted a psychologist or psychiatrist. A chiropractor had been contacted by 14.5% of the sample during the past year, compared with 7% in the general Norwegian population. Anxiety symptoms were associated with seeking a chiropractor (OR 1.9, 95% CI 1.3–2.7). The strongest association with contacting a psychologist or psychiatrist was medication used to cope (OR 5.8, 95% CI 3.0–11.1). The first nationwide study on help-seeking behaviour showed that police officers sought help among specialists in private practice, physiotherapists and chiropractors relatively often. However, they contacted a psychologist or psychiatrist rarely, even when reporting serious suicidal ideation.

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Police officers may generally be reluctant to seek help. Several reasons may account for the supposed resistance, especially to mental health assistance. Police officers are trained to be problem solvers and to control their emotions, work situations and other people's problems while on the job. The “professional” attitude may apply in all life domains, so if police officers suffer personal problems, they do not seek help, but try to solve them alone. To admit his or her own problems can be a difficult shift of the mind for a police officer. They may have “to move from being a problem solver to be a problem haver”¹⁾. It has been claimed that the police organization itself has an inherent culture that does not want officers to admit that they have problems, which means that police officers have an occupation that produces risk factors for health and well being, but at the same time culturally discourages them from seeking help²⁾. Additionally, police officers often distance themselves from other service personnel, as non-police will not understand their problems and therefore not provide competent help, which may reinforce mistrust and negative attitudes about seeking help from outside the police force³⁾.

The empirical evidence for these assumptions is, however, scarce. In general, the help-seeking literature has claimed that whether people seek help is associated with the perception of need, sociodemographic factors and attitudes^{4–6)}. In addition, studies have shown that, for mental health problems and depression, people prefer to seek help from a friendship network or other lay support systems rather than from health care professionals^{7–9)}.

An US study showed that the attitudes of police officers toward mental health services were overall, indifferent or neutral, but not negative¹⁰⁾. The resistance by officers against seeking help was not mainly due to mistrust and negative attitudes to professionals, but rather concern about anonymity, cost and availability.

Other factors why police officers may not be seeking

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help may be relevant. There may be an influence of a masculine stereotype, which makes men more reluctant to seek help. The police force is still a male dominated occupation, and men are more reluctant to seek help from health professionals than women^{6,11}. It is assumed that the masculine stereotype does not allow help-seeking, even if help is needed and could be available¹². Men generally report a better subjective health and less somatic, emotional and depressive symptoms than women do. Lack of help-seeking may therefore be an adequate behaviour, which reflects a better level of health and quality of life in men, or it may represent health illiteracy, i.e. the inability to gain access to, understand, and use information in ways that promote and maintain good health^{12,13}. Additionally, some illnesses may present in different forms among men and women, such as depression¹⁴.

Lack of empirical evidence of help-seeking behaviour among police officers calls for studies on a nationwide basis, and this study attempted to gain knowledge about this in the Norwegian police service. The study is part of the first large, nationwide, cross-sectional survey on health and working conditions among Norwegian police officers^{15,16}, and it covers all occupational levels of the police force.

The aims of this study were to assess help-seeking behaviour in the Norwegian police service according to age and gender; relate help-seeking behaviour to subjective health complaints, anxiety and depressive symptoms, and serious suicidal ideation; and compare help-seeking behaviour of police officers with the general Norwegian population as regards contact with general practitioners, chiropractors, physiotherapists, and psychologists or psychiatrists.

Methods

Background

This study included officers, middle managers and managers. Hence, the term "police" is used to describe respondents in the general sample. Policing in Norway comprises three categories: investigation, uniformed policing, and administration. All personnel were members of the largest police industrial organization in Norway, The Norwegian Police Union, of which approximately 95% of the police force are voluntary members. The police service in Norway comprises two types of districts: urban districts and rural ("lensman") districts. Personnel in the two categories have the same education and training, but police in the rural districts work in smaller communities, often including large country areas with scattered houses. The number of police is typically small. Urban districts serve larger communities and cities. The term "inhabitants" is used to describe people who reside and/or work in the districts. The sample is described in detail elsewhere¹⁵.

Comparisons with respect to contact with a general practitioner, chiropractor, physiotherapist, and psychologist or psychiatrist were made as part of the Survey of Living Conditions by Statistics Norway¹⁷. The study initially comprised a representative sample of the general population in Norway, with 5,119 respondents from 16 to 79 yr of age. The response rate was 70.1%, and the methods were a questionnaire and interviews by personal visit and/or telephone.

Distribution of the questionnaire

In December 2000, a questionnaire was distributed by The Norwegian Police Union to all 6,398 educated police service members. The questionnaire included 396 questions on background information, physical and mental health, working conditions, job satisfaction, burnout, coping, personality and suicidal ideation. Replies were anonymous and the instrument was distributed once. Several written reminders were distributed through trade union representatives and the internal data system of the police service. The final response rate was 51%, which represents 3,272 people. The general retirement age in the Norwegian police service is 60 yr. Nine people older than 60 yr responded to the questionnaire, and they were excluded from the analyses. The sample is presented in Table 1.

The sample is not representative of the total police population, i.e. the sample is younger (38.9 vs. 40.2 yr; $t=8.3$, $p<0.001$), women and upper management are underrepresented, and non-management and rural police are overrepresented. However, the sample is representative of all members of the Police Union.

Because of problems in distributing the questionnaire, as described previously¹⁵, 680 letters were distributed to randomly selected police from the original sample in November 2001, asking whether they had received the questionnaire. The response rate was 70% ($n=475$). The results showed that 26% had never received the questionnaire. Based on this figure, the true response rate is higher than 51%.

Help-seeking

Help-seeking was measured by one question: "Have you, during the last 12 months, contacted any of the following health professionals?" The responses were "Yes" or "No" on 10 different alternatives. The alternatives are specified in the Tables 2 and 3. The responses were not mutually exclusive.

Anxiety and depression

The Hospital Anxiety and Depression Scale (HADS)¹⁸ includes 14 questions, divided into an anxiety subscale (HADS-A), and a depression subscale (HADS-D). Each subscale contains seven items, and is scored on a four-point scale. In this study, the two subscales were used as

Table 1. Description of the sample

		Frequency	Per cent	Per cent Total Police Population	Significance
Gender	Men	2,692	84.3	82.1	$\chi^2=4.6^*$
	Women	501	15.7	17.9	
Age (yr)	Total sample (102 did not answer)	3,170			
	20–29	509	16.1		
	30–39	1,175	37.1		
	40–49	1,047	33.0		
	50–59	430	13.6		
Marital status	Single	342	10.6		
	Married/common law	2,715	84.3		
	Separated/divorced	164	5.1		
Rank	Upper management	96	2.9	9.6	$\chi^2=144.3^{***}$
	Middle management	1,034	31.7	32.3	$\chi^2=ns$
	Non-management	2,128	65.3	58.1	$\chi^2=49.3^{***}$
Service	Rural police districts	870	26.6	23.0	$\chi^2=24.3^{***}$
	Urban police districts	2,399	73.4	77.0	
Main task	Investigation	1,379	43.4		
	Uniformed police	1,286	40.5		
	Administration	513	16.1		
Inhabitants	> 50,000	1,626	51.2		
	20,000–50,000	648	20.4		
	5,000–20,000	728	22.9		
	< 5,000	175	5.5		

* $p<0.05$, *** $p<0.001$.

dichotomized variables to distinguish respondents with symptoms of mental distress. Cut-off scores of 8 and 11 were used for both subscales¹⁹. In total, 11.2% (women 11.8%; men 10.8%; NS) scored above 8 on the HADS-A, and 8.2% (women 4.8%; men 8.7%; $p=0.003$) scored above 8 on the HADS-D. In total, 3.2% (women 4.0%; men 3.0%; NS) scored above 11 on the HADS-A, and 2.2% (women 0.8%; men 2.5%; $p=0.02$) scored above 11 on the HADS-D.

Subjective health complaints

The subjective experience of health was assessed by a 10-item version of the Subjective Health Complaint (SHC) questionnaire. This questionnaire consists of questions examining the occurrence, intensity, and duration of musculoskeletal pain, migraine/headache, and digestive problems for the past 30 d^{20, 21}. The items are scored on a four-point rating scale ranging from no complaints (0) to serious complaints (3). In this study, the SHC sum score was transformed to a dichotomous variable. Consistent with a previous study²², those who had a response of 2 or 3 on at least one of the 10 items were scored as “cases”. In total, 40.7% (women 46.2%, men 39.7%; $p=0.007$) reported somatic health problems and were defined as “cases”. No diagnosis was given.

Alcohol and medication to cope

Use of alcohol and medication were measured by two questions: (1) “When you feel worried, anxious, tense or nervous, do you sometimes drink alcohol to manage the situation better?” (2) “When you feel worried, anxious, tense or nervous, do you sometimes use medication to manage the situation better?” The responses were on a four-point scale: “Never”, “Seldom”, “Sometimes”, and “Often”. The responses were dichotomized into never (0) and any frequency (1) for analysis.

Suicidal behaviour

The prevalence of suicidal ideation and attempts was assessed by a modified questionnaire, originally introduced by Paykel *et al.*²³. Paykel’s Suicidal Feelings in the General Population questionnaire contains five questions, of which question 4 was used in our study: “Have you ever reached the point where you seriously considered taking your life, or perhaps made plans how you would go about doing it?”. This question contained six response possibilities: never, once, 2–3 times, 4–5 times, 6–9 times, and at least 10 times. The response to the question was dichotomized into never (0) and any frequency (1) for analysis.

Sick leave

Sick leave was measured by one question, "Have you been on sick leave because of stress at work during the last year?" Responses were "Yes" or "No". In total, 11.1% of the sample (women: 10.3%; men: 9.7%; NS) reported having been on sick leave because of stress at work during the last year.

Self reported health

Overall health was measured by one question: "In general, how do you rate your health?" Responses were measured on a five-point scale: "Very good", "Good", "Neither good nor bad", "Bad", and "Very bad". The responses were dichotomized, the two first categories (0) and the three latter categories (1), for analysis. In total, 91% of women and 88% of men (NS) reported very good or good health. The corresponding figures in the general Norwegian population were 77% and 83%, respectively.

Statistics

χ^2 tests were used to measure the differences between the study sample and the total police population according to gender, rank and service. Student's *t* test was used to test the differences between the sample and the total police population according to age. Frequencies were reported to describe the prevalence of contact with different helping professions related to background variables and health. Logistic regression analyses were used to test the significance of the differences found in these analyses, and to test the interaction effects between anxiety, depression, serious suicidal ideation and gender, according to contact with a psychologist or psychiatrist. The multivariate model was also adjusted for the variables marital status, rank, use of alcohol to cope, and self reported health. Only completed questionnaires were included in the multivariate analyses. SPSS version 11.5 was used for statistical analyses.

Ethics

The project was approved by the Norwegian Data Inspectorate and the Regional Committee for Research Ethics and the Norwegian Police Union. The study was anonymous. Participation in the project was voluntary, and there were no negative consequences whatsoever for those who refused to participate.

Results

General practitioners were the most often contacted health practitioner during the past 12 months, independent of gender, age, marital status, and rank (Table 2). In total, 81% of the women and 61% of the men ($p < 0.001$) had contacted a general practitioner. In the general population, the corresponding figures were 78% and 71%. In total, 25% of female police, and 17% of male police ($p < 0.001$) had contacted a specialist in private practice.

The corresponding figures in the general population were 20% and 14%. In total, 16% of female police and 14% of male police (NS) had contacted a chiropractor, compared with 7% for both genders in the general population. In total, 29% of the female police and 16% of male police ($p < 0.001$) had contacted a physiotherapist. The corresponding figures for the general population were 18% and 12%. In total, 4% of the women and 2% of the men ($p = 0.002$) had contacted a psychologist or psychiatrist. The corresponding figures for the sample of the general Norwegian population were 4% and 3%.

All age groups over 30 yr contacted occupational health practitioners significantly more often than the age group 20–29 yr ($p < 0.001$), while contact with other health professionals showed small differences between age groups. Of those who had subjective health complaints, 75.3% had contacted a general practitioner, while chiropractors and physiotherapists were contacted by 23.5% and 30.7% respectively. In total, 78% of people with anxiety and depressive symptoms with cut-off scores of 8 had contacted a general practitioner, and less than 10% of them had been in contact with a psychologist or psychiatrist. A corresponding increase in contact with these health professionals was shown at cut-off scores of 11. The same pattern was shown for police with serious suicidal ideation; 73.9% had been in contact with a general practitioner in the past year, and 6.7% had contacted a psychologist or psychiatrist.

Fifty-two police had both serious suicidal ideation and depressive symptoms defined as cases. In total, 39 of these reported physical health complaints defined as cases, four of these also had bad self-reported health. Of these 39 officers, four (10.3%) had visited a psychologist or psychiatrist.

In total, 416 police, 88 women and 323 men ($p < 0.001$) had visited four or more health professionals during the past 12 months. In total, 8.2% ($n = 34$) of those who visited four or more health professionals had serious suicidal ideation, compared with 6.1% ($n = 174$) of those who visited less than four professional groups (NS). In total, 13.5% ($n = 56$) of those who visited four or more professionals had depressive symptoms, compared with 7.4% ($n = 211$) of those who visited less than four ($p < 0.001$), and 19.8% ($n = 82$) had anxiety symptoms, compared with 9.9% ($n = 282$) of those who visited fewer than four health professionals ($p < 0.001$). In total, 68% ($n = 283$) of those who visited more than four professionals had physical health complaints, compared with 36.6% ($n = 1045$) of those who visited fewer than four ($p < 0.001$).

Being female was significantly more related to contact with nearly all health professionals by police in the multivariate analyses (Table 3), especially a psychologist or psychiatrist (OR 2.6, 95% CI 1.3–5.9), general practitioner (OR 2.5, 95% CI 1.9–3.3), and physiotherapist (OR 1.8 95% CI 1.3–2.3). However,

Table 3. Help-seeking behaviour by Norwegian police. Adjusted model†

	General practitioner	Specialist in private practice		Occupational health practitioner		Hospital physician without admission		Hospital physician with admission		Other physician		Chiropractor		Homeopathist		Physiotherapist		Psychologist /psychiatrist		
		OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
Gender																				
	Men	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
	Women	2.54*** (1.9–3.3)	1.54** (1.2–2.0)	.68** (0.5–0.9)	1.06 (0.8–1.4)	1.56* (1.1–2.3)	2.01** (1.2–3.1)	.91 (0.7–1.3)	1.38 (0.7–2.4)	1.79*** (1.3–2.3)	2.58* (1.3–5.9)									
Age	20–29	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
	30–39	1.06 (0.8–1.4)	.67* (0.5–0.9)	1.48** (1.1–1.9)	.91 (0.6–1.3)	.85 (0.5–1.4)	.36*** (0.2–0.6)	1.05 (0.7–1.5)	1.08 (0.5–2.3)	.89 (0.6–1.3)	.94 (0.3–2.5)									
	40–49	0.98 (0.7–1.3)	.68* (0.5–1.0)	1.75*** (1.3–2.4)	1.17 (0.8–1.7)	.94 (0.5–1.6)	.46* (0.3–0.9)	.96 (0.6–1.5)	1.19 (0.5–2.8)	.71 (0.5–1.0)	1.35 (0.4–4.2)									
	50–59	1.17 (0.2–5.1)	.76 (0.5–1.2)	2.54*** (0.5–12.4)	.77 (0.5–1.3)	1.20 (0.6–2.3)	.89 (0.4–2.0)	.81 (0.5–1.4)	1.52 (0.5–4.5)	1.11 (0.7–1.8)	1.43 (0.2–5.5)									
HADS-A > 8	1.21 (0.9–1.7)	.91 (0.6–1.3)	.93 (0.7–1.2)	.98 (0.7–1.4)	1.23 (0.7–2.0)	1.50 (0.8–2.7)	1.85*** (1.3–2.7)	1.40 (0.8–1.7)	1.40 (0.7–2.8)	1.17 (0.7–1.7)	.94 (0.3–2.9)									
HADS-D > 8	1.41 (0.9–2.1)	1.49 (1.0–2.3)	1.07 (0.8–1.5)	.92 (0.6–1.4)	1.12 (0.7–2.0)	1.29 (0.7–2.5)	1.78** (1.2–2.7)	.67 (0.4–1.1)	1.23 (0.6–2.7)	.77 (0.5–1.3)	1.67 (0.6–5.4)									
Subjective health complaints	1.85*** (1.5–2.2)	1.95*** (1.6–2.5)	1.36** (1.1–1.6)	1.57*** (1.3–2.0)	1.26 (0.9–1.8)	1.78** (1.2–2.7)	2.98*** (2.3–3.8)	2.98*** (2.3–3.8)	2.07** (1.2–3.5)	3.76*** (3.0–4.6)	1.09 (0.5–2.3)									
Use of medication to cope	Never	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
	Sometimes or more	2.18* (1.1–4.2)	1.11 (0.7–1.7)	1.21 (0.8–1.8)	1.51* (1.0–2.2)	1.48 (0.9–2.4)	1.18 (0.6–2.2)	.52 (0.3–1.0)	1.51 (0.8–2.8)	1.36 (0.9–2.1)	5.78*** (3.0–11.1)									
Serious suicidal ideation	1.08 (0.7–1.6)	.99 (0.7–1.5)	.84 (0.6–1.2)	.96 (0.6–1.5)	.96 (0.5–1.7)	.66 (0.3–1.4)	.66 (0.3–1.4)	.72 (0.4–1.2)	.80 (0.3–1.8)	.61* (0.4–1.0)	3.40* (1.0–7.1)									
Sick leave last year	3.70*** (2.4–5.8)	2.31*** (1.7–3.1)	1.36* (1.0–1.8)	1.78** (1.3–2.5)	1.48 (0.9–2.3)	2.04** (1.2–3.5)	2.04** (1.2–3.5)	1.40 (1.0–2.0)	1.49 (0.8–2.8)	2.52*** (1.8–3.4)	4.16** (1.7–8.6)									

p<0.05, **p<0.01, ***p<0.001

†The model is also adjusted for additional variables: marital status, rank, use of alcohol to cope, and self reported health. The variables were removed because they did not show significant results.

women had significantly less contact with occupational health practitioners than men did (OR 0.7, 95% CI 0.5–0.9).

Anxiety among police at a cut-off score of 8 was related to contact with a chiropractor (OR 1.85, 95% CI 1.3–2.7), and a cut-off score of 11 was related to contact with a general health practitioner (OR 3.7, 95% CI 1.3–10.9) and physiotherapist (OR 2.3, 95% CI 1.2–4.3). Depression at a cut-off score of 11, on the other hand, was related to significantly less contact with a physiotherapist (OR 0.3, 95% CI 0.1–0.6), and significantly more contact with a psychologist or psychiatrist (OR 4.2, 95% CI 1.1–16.4). The same pattern was shown for serious suicidal ideation.

Being on sick leave by police was related to contact with nearly all kinds of physicians. Having subjective health complaints was overall related to contact with a chiropractor (OR 3.0, 95% CI 2.3–3.8) and physiotherapist (OR 3.8, 95% CI 3.0–4.6).

The use of medication by police to cope was related to contact with a psychologist or psychiatrist (OR 5.8, 95% CI 3.0–11.1).

There were no significant interaction effects among police between problems with anxiety, depression, serious suicidal ideation and gender according to contact with a psychologist or psychiatrist.

Discussion

Police reported their health to be overall good. This is not surprising, as the police are often regarded as a group selected by their physical fitness²⁴. However, there are indications that the health of police is not necessarily as good as expected; for example, police officers have been found to have high rates of heart disease and high blood pressure in most studies^{25–29}, but not all³⁰.

Women police sought more help from professionals than men did, when controlled for other factors. This is in accordance with women in the general population^{6, 11}. Thus, in a masculine environment such as the police, the gender difference in help-seeking seems to persist.

General practitioners and occupational practitioners were contacted most by the police in relation to all health problems. This is reasonable, as these helping professions are easily available, and may refer clients to specialized care. However, the symptom distribution clearly tended to subjective health problems such as musculoskeletal pain. Thus, it seems that police present their symptoms as somatic pain, even when the level of mental distress is reportedly high. Probably, the symptoms are not only *presented* as somatic symptoms, but also are regarded as such. This may represent a particular challenge to professional helpers.

Surprisingly, small differences among police were found between age groups. A general finding, also in the present study, is that the proportion of those who reported

their health to be good decreases with age¹⁷. The results may indicate more appropriate help-seeking behaviour among the younger age group, but a cohort effect or report bias may also be relevant. General practitioners were contacted more than occupational health practitioners in all age groups, especially in the youngest age group. The results may reflect general attitudes in the police sample towards acceptance of having both physical and mental problems, and changed attitudes towards professionals, like availability, mistrust and concern about anonymity¹⁰, which may result in a reluctance to seek help.

In a previous analysis using the same sample, we showed that police had somewhat lower scores on both HADS anxiety and depression subscales than the general Norwegian population (Berg, submitted). Consequently, lower scores were expected on seeking contact with health professionals such as a psychologist or psychiatrist. However, female police reported having contacted these professionals as much as women in the general population. Less than 10% of those reporting anxiety or depressive symptoms or serious suicidal ideation had contacted a psychologist or psychiatrist. Accordingly, most people with an anxiety disorder and/or depression in the general population do not seek help for their mental disorders³¹.

The case level of anxiety symptoms among police was related to contact with a chiropractor, physiotherapist and general practitioner in the multivariate analyses. This concurs with the reasoning that police probably tend to contact health professionals for reasons other than mental distress. Subjective health complaints, on the other hand, were related to contact with nearly all the health professionals with the exception of psychologists or psychiatrists. However, in general it is also well known that depressive symptoms may be hidden and shown as somatic symptoms³².

Serious suicidal ideation among police was only related to contact with a psychologist or psychiatrist, although the prevalence of contact was low. In a previous study of the police sample, personal and family problems were mainly related to serious suicidal ideation and suicide attempts among police¹³. The present study may indicate that the difficulties to which police attribute these problems are seen as private, or the symptoms may not be recognized. This is also in line with general findings on help-seeking and suicidal behaviour^{33, 34}.

Generally, police report more subjective health complaints but fewer mental problems than the general population, as shown in a previous report on the same study sample (Berg, submitted). The findings indicate that the threshold is high for contacting a psychologist or psychiatrist, but low for contacting a chiropractor and physiotherapist.

Strengths and limitations

The strengths of this study are that it is the largest

investigation of police conducted so far. It is nationwide and it represents all occupational levels in the police service. Further, the study applied several validated international instruments. The large number of respondents made multivariate analyses feasible. The comparison with data from the general population of Norway is also a strength.

A limitation of the study is the cross-sectional design, which prevents us obtaining direct evidence of causality. The response rate was limited, which may question the representativity of the study. The Norwegian Police Union represents most of the police profession. In this study, there were no significant differences between our study sample and the membership of the Police Union in terms of managers and middle managers, but non-management personnel were underrepresented. However, the percentage differences were small, and the significance is influenced by the large number of respondents. Thus, the participants in this study are fairly representative of the members of the Police Union. Further, we refer to the study on Norwegian police of Mikkelsen *et al.*, of which some are published^{35–37}, who had identical questions regarding suicidal behaviour, subjective health complaint, and anxiety and depression. However, our study is not representative of the total police population, which makes it difficult to generalize from the study findings to the whole Norwegian police service.

Help-seeking in the last 12 months was assessed, whereas, for example, serious suicidal ideation was assessed across the respondent's lifetime. It is recommended to emphasize the past year's prevalence instead of lifetime prevalence to increase reliability. The study gave no opportunity for checking of information with general practitioners or hospitals. Reporting bias may also be a problem as, for example, anxiety and depressive symptoms are socially undesirable topics, particularly in a masculine milieu. The external generalizability of the data may also be limited. Policing in Norway differs from that of many other jurisdictions. For example, police are normally unarmed and traditionally the level of crime has been low. On the other hand, there are several similarities between police populations, such as the male-dominated culture and a reluctance to seek help.

Conclusions

There are several important findings in this study. First, Norwegian police consider their health to be good, female police seek more help than male police do, and help-seeking is generally unaffected by age. Moreover, general and occupational practitioners are the most frequently contacted health professionals, while psychologists or psychiatrists are rarely contacted, even by people who report serious suicidal ideation. Police report a relatively high level of subjective health complaints, and they seek

more help for this than others.

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