An exploratory study on risk of alcohol consumption and psychopathological symptomatology in police officers

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Abstract

Alcohol consumption has been identified as a worrying reality in police professionals, and it appears to be associated with various adverse consequences, such as increased levels of anxiety, depression, somatization, with repercussions at work level. At the same time, police elements are among the professionals subject to higher levels of stress, being highlighted the following factors: shift work, incomprehension of the population, lack of participation in decisions due to hierarchical structure, distance from family and friends and involvement in complex court proceedings. This study aimed to explore the relationship between risk levels of alcohol consumption among Public Security Police (PSP) professionals and psychosocial work variables, expectations and reasons for alcohol consumption, as well as the coexistence of psychopathological symptomatology. In a sample of 309 police officers, we have identified a low risk of harmful alcohol consumption, with 75.7% of the sample presenting a low risk and 5.8% presenting a medium / high risk. The latter had a higher incidence of psychopathological symptoms, greater reasons for consuming alcohol and higher expectations regarding the consumption of this substance.

Keywords: police officers, risk levels of alcohol consumption, psychopathological symptomatology

An exploratory study on risk of alcohol consumption and psychopathological symptomatology in police officers

Alcohol abuse is a matter of concern in the general population due to its impact on health and social problems. The World Health Organization (WHO, 2018) reports that more than 3 million people have died as a result of harmful alcohol use in 2016. Also, according to that report, harmful use of alcohol causes more than 5% of all diseases. In recent years, special attention has been paid to the impact of alcohol consumption in the workplace due to its effects on productivity, increased absenteeism and accidents (WHO, 2010).

Although the police profession is considered as one of the most stressful in the world by many authors (Dantzer, 1987; Kroes, 1976; Dewe, O'Driscoll & Cooper, 2010; Bureau of Labor Statistics, 2016), in Portugal studies are still scarce. In the case of police forces, there is evidence about the relationship between work and symptoms of stress (Malasch-Pines & Keinan, 2006; Moon & Maxwell, 2004; Teixeira, 2012). Several studies have identified police population as one of the jobs with the highest levels of alcohol consumption (Davey, Obst, & Sheehan, 2000; Violanti, Slaven, Charles, Burchfiel, Andrew & Homish, 2011), although its relationship with depression, anxiety and stress has been a remotely discussed topic, both internationally and in Portugal (Chopko, Palmieri & Adams, 2013, Ferreira, 2013; Violanti, Marshall & Howe, 1985).

A study carried out in Australia by Richmond, Wodak, Kehoe & Heather (1998) mentions that 48% of male police officers and 40% of female police officers stated that they had consumed excessively or had had high/harmful alcohol consumption in the past 3 years. In another study, also conducted in Australia, it was mentioned that 33% of men and 24% of female police officers acknowledged their involvement in high-risk/harmful alcohol consumption and 3% had obtained values that put them at a level of alcohol

dependence (Davey et. al., 2000). Ballenger et al. (2010), in a California police population, have established that 18.1% of men and 15.9% of women acknowledged they had experienced adverse consequences of alcohol consumption, and 7.8% of the sample met criteria for alcohol abuse or dependence over the years. In another study (Gershon, 2002) with a sample of senior police officers, it was acknowledge that perceived work stress was significantly associated with alcohol abuse, increased anxiety, depression, somatization, posttraumatic stress symptoms, burnout, chronic low back pain, and inappropriate aggressive behaviour.

Expectations and demands that are made by the population towards police officers, as well as organizational factors such as shifts, time pressure and inadequate resources also seem to have contributed to the high levels of stress encountered (Collins & Gibbs, 2003; Teixeira, 2012). In accordance, Liberman (2002, cit. in Wang, Inslicht & Metzler, 2008) reinforces that previous studies have shown that routine occupational stress or stressful working conditions have adverse effects on mental health.

As a result, police officers may suffer psychological after-effects, which include an increased risk of trauma-related symptoms, depression, alcohol use disorders and stress-related medical conditions (Price, 2017; Wang et al., 2010).

Recently, the relationship between stress and alcohol consumption in police forces has been receiving some attention in the scientific literature. Different variables have been investigated, either together or separately. Violanti et al. (1985) have identified alcohol consumption, either as one of the most serious consequences of professional stress that police officers face, or as a way of coping with their own stress. In harmony with this, Gonçalves (2012) emphasizes alcohol dependence as one of the consequences of stress.

According to Dantas, Brito, Rodrigues, and Maciente (2010), police career expectations are generally high at first, but over the years give way to the perception of

limitations and obstacles, resulting in negative effects such as increased stress and higher alcohol consumption. In a study on police stress, Agolla (2009) analysed symptoms and coping strategies in ten (10) Botswana Police stations, having identified symptoms such as agitation, difficulty in concentration, reflective thinking, depression, anxiety, loss of appetite, relational distance, lack of energy, associated with factors such as alcohol and tobacco abuse. Accordingly, Violanti et al. (1985), in an investigation conducted to find the relationship between police stress, coping strategies and alcohol use, have determined that stress boosts alcohol consumption about twenty (20) times more than other variables studied (emotional dissonance and "cynicism"). According to the authors, the failure of some coping strategies may influence the use of alcohol. Gershon, Lin, and Li (2002), in a study with Brazilian police officers over 50 years old, have associated work stress with alcohol abuse (60%) and symptoms of post-traumatic stress, burnout and chronic low back pain.

Other studies emphasize the impact of burnout on the personal and occupational well-being of the lives of police officers, associating high burnout values with various psychopathological disorders and risk behaviours associated with alcohol consumption (Burke & Mikkelsen, 2006; Demerouti, Bakker, Nachreiner & Ebbinghaus, 2002; Gana & Boblique, 2000). Blau (1994, cit. in Oliveira & Queirós, 2012) argues that police officers in the United States manifest more somatic symptoms, greater anxiety, and greater vulnerability to alcohol consumption. Regarding the existence of emotional problems among police officers, Anshel (2000) points out that there are more divorces and a high rate of psychoactive substance abuse. Moreover, Chopko, Palmieri, and Adams (2013) have concluded that there is a significant association between alcohol use and traumatic suffering. Because police officers are more likely to be exposed to traumatic situations, Chopko and Schwartz (2012) have also raised the question of whether alcohol

consumption changes according to the variety and frequency of trauma. According to the authors, the various forms of stress inherent in police work contribute to alcohol abuse among police officers.

The association between alcohol abuse and depression is often mentioned in the literature. According to the World Health Organization (WHO, 2010), major depressive disorder is among the most debilitating disorders, and it is estimated to become the second leading cause of disabling illness. Chen, Chou, Chen, Su, Wang, Feng, Chen, Lai, Chao, Yang, Tsai, Tsai, Lin, Lee & Wu (2006) report that rates of major depressive disorder and levels of symptoms of depression are higher in the police force than in the general population. As predictive factors for depression they have found out family problems, work-related stress (performance-related), peer pressure on performance, and high workload, with depressed police officers having poorer quality of life.

This study aims to identify prevalence of alcohol consumption in the Portuguese Public Security Police (PSP), to examine the relationship between risk of alcohol consumption and psychosocial risks at work, expectations and reasons for alcohol consumption, and to analyse the relationship between risk of alcohol consumption and psychopathological symptomatology (depression, anxiety and stress).

Method

Participants

A total of 309 PSP officers were interviewed, positioned into various Police Commands at national level. The sample was predominantly male (82.8%), and ages ranged from 23 to 59 years, with an average of 44.12 and standard deviation of 8.37.

Regarding the remaining sociodemographic characteristics, in schooling, the category “up to the 12th grade” (61.7%) predominated, followed by the “up to the 9th grade” category (16.9%), being the university attendance the less predominant category

(5.2%). Regarding marital status, there was a predominance of married individuals (75.3%), while for the existence of children, respondents with descendants predominated (80.5%).

Regarding the distribution by professional category, it was established that the majority of respondents belonged to the category of Principal Agent (47.4%), as opposed to the minority of Officials (8.1%). The years in the current position ranged from less than one year to 36 years, with an average of 15.6 years, predominating in the year of admission to PSP the years 1998 and 1999. A low percentage of the sample (14%) indicated that they were working over 50 km away from the household residence, i.e. being displaced from their family residence. Regarding the specificity of police work, the majority of the sample (80.8%) reported performing operational duties, and 68.5% of respondents indicated working in shifts.

Medidas

An anonymous and confidential self-completed questionnaire with 6 question groups was applied, which included psychological assessment tools adapted to Portuguese and used to study the variables in question, namely the Copenhagen Psychosocial Questionnaire (COPS-OQ, Kristensen, 2002; Kristensen, Hannerz, Hogh & Borg (2005), adapted by Fernandes, Amaral, Pereira, Bem-haja, Pereira, Rodrigues, Cotrim, Silverio & Nossa, 2011); the Depression Anxiety Stress Scale (DASS, Lovibond & Lovibond, 1995); the Alcohol Outcome Expectancies Scale (AOES, Leigh & Stacey, 1993); the Drinking Motives Questionnaire (DMQ, de Cooper, 1994; Fernandes-Jesus, Beccaria, Demant, Fleig, Menezes, Scholz & Cooke, 2016); and the Alcohol Use Disorders Identification Test: Self-Report Version (Babor, Higgins-Biddle, Saunders & Monteiro, 2001). Moreover, this questionnaire included sociodemographic and professional questions, namely age, sex, existence of children, marital status, year of joining PSP, years in the

current position, level of education, professional category, distance between the place of exercise of duties and household residence, exercise of operational duties, shift work and absenteeism in the previous year.

In the specific case of the Copenhagen Psychosocial Questionnaire, not all subscales or dimensions of the instrument were used, but within them all items were considered in order not to interfere with the psychometric quality of the dimensions (Negreiros, Queirós & Pereira, 2017).

The Copenhagen Psychosocial Questionnaire aims to assess psychosocial risks at work and in its reduced version it consists of 41 items rated on a scale of 1 (Never) to 5 (Always), organized into the dimensions of labour requirements (e.g., work pace, quantitative, cognitive or emotional demands), work organization and content (e.g., possibility of development and influence one may have on work, its significance, and commitment to work), social and leadership relationships (e.g., superior support and leadership quality, rewards and recognition, predictability and transparency of the professional role played), work-family interface (e.g., job satisfaction or insecurity and conflict between work and family), values in the workplace (e.g., social community at work, justice, respect, vertical trust), personality (through perception of self-efficacy), health and well-being (e.g., depressive symptoms, difficulty sleeping) and finally offensive behaviours (e.g., harassment, threats, exposure to workplace violence).

Symptoms of depression, anxiety and psychological stress were assessed by the Depression, Anxiety Stress Scale consisting of 42 items rated on a scale from 0 (did not apply to me) to 3 (applies to me most of the time).

Expectations regarding alcohol consumption were assessed using the Alcohol Outcome Experiences Scale, which consisted of 34 items rated on a scale from 1 (not likely) to 6 (extremely likely) and organized into the following factors: social facilitation,

fun, sexual desire and stress reduction (translators of positive expectations) as well as aggressiveness, negative emotions, physical symptoms and difficulties in concentration and performance (which reflect negative expectations).

The reasons for consuming alcohol were assessed through the Drinking Motives Questionnaire consisting of 18 items rated on a scale ranging from 1 (almost never or never) to 5 (almost always or always) and organized into positive emotion factors (or improved emotional states), coping, compliance and social interaction.

The prevalence of alcohol consumption and risk level was assessed by Alcohol Use Disorders Identification Test: Self-Report Version consisting of 10 questions that assess the frequency of alcohol consumption, alcohol behaviours and problems caused by drinking. Consumption risk is calculated by numerical value and by category (low, moderate or high risk).

By using a sample of highly specific professionals (police elements), Cronbach's Alpha was calculated as a measure of internal consistency of each scale and subscale.

Table 1

Cronbach's Alpha by scale and dimension of questionnaires used

Dimensions	*Cronbach's Alpha*
Labour Requirements	0.662
Work Content Organization	0.544
Social Relations Leadership	0.717
Work-Family Interface	0.795
Workplace Values	0.720
Self-efficacy personality	-----
Health and well-being	0.907

Offensive Behaviors	0.814
COPS-OQ	0.626
Depression	0.919
Dysphoria	0.850
Loss of Hope	0.873
Depreciation of Life	0.868
Self-depreciation	0.666
Loss of Interest	0.756
Anhedonia	0.663
Inertia	0.574
Anxiety	0.893
Autonomous Activation	0.809
Muscle Effects	0.736
Situational Anxiety	0.765
Subjective Anxiety Experience	0.769
Stress	0.941
Difficulty Relaxing	0.809
Nervous Activation	0.808
Getting easily worried / annoyed and impatient	0.914
DASS	0.965
Social facilitation	0.909
Entertainment	0.916
Sexual Desire	0.927
Reduced Tension	0.896

Aggressiveness	0.819
Negative Emotions	0.792
Physical Symptoms	0.882
Concentration and Performance Difficulties	0.890
AOES	0.969
Coping	0.861
Social Interaction	0.873
Improvement of Emotional States	0.924
Compliance	0.704
DMQ	0.938
Use	0.558
Addiction	0.676
Problems resulting from use	0.773
AUDIT	0.765

Procedure

This study was authorized by the National Director of the Public Security Police on July 3, 2015, according to the request by the PSP Psychology Division through Service Communication no. 447/DP/2015.

It was used a printed questionnaire, which took about 30 minutes to complete, in anonymous and confidential format. It was also used a duplicate informed consent document to safeguard the individual's freedom to participate in the investigation. The questionnaires were collected in group at two moments - psychological re-evaluation and training activities on the subject of Suicide Prevention conducted by the PSP Psychology

Division - both determined by ministerial order of 2007, within the National Suicide Prevention Plan (Health Ministry, 2008), between September 2017 and March 2018.

The results were analysed using the IBM SPSS Statistics version 23 program and the statistical analysis was based on the assumptions recommended by several authors (Pestana & Gageiro, 2008; Field, 2009) for this type of sample, variables and study objectives, corresponding to a descriptive analysis (frequencies, average and standard deviation), correlational analysis and analysis of variance.

Results

Descriptive and correlational analysis

Regarding the descriptive analysis, low values of depression and anxiety were found, with depression averaging 1.23 (on a scale from 1 to 4) and anxiety averaging 1.22 (on a scale from 1 to 4). Stress had a slightly higher value, with an average of 1.46 (on a scale from 1 to 4).

Regarding psychosocial factors at work, the dimensions with the highest averages and perceived as most positive, include “personality” (related to the perception of self-efficacy), “work organization and content” (e.g. possibility of development and influence one can have at work, meaning it has, commitment to work), “values in the workplace” (e.g. social community at work, fairness, respect, vertical trust) and “social and leadership relationships” (e.g. support from immediate superiors and quality of leadership, rewards and recognition, predictability and transparency of the professional role played).

Expectations regarding alcohol consumption have been defined as beliefs - whether positive or negative - regarding the effects of alcohol on behaviour, mood and emotions. The results for this variable indicate that the highest values were recorded in expectations “fun” with an average of 2.98 (on a scale from 1 to 6), “difficulties in concentration and performance” with an average of 2.77 (on a scale from 1 to 6), “social facilitation” with an

average of 2.63 (on a scale from 1 to 6) and "stress reduction" with an average of 2.51 (on a scale from 1 to 6). In this sample, positive expectations of consumption were valued above all, albeit moderately (averages close to 3 on a scale of 1 to 6).

Regarding the reasons for consuming, the highest values were obtained in the components "social interaction" (with an average of 1.7, on a scale of 1 to 5) and by "improvement of emotional states" (with an average of 1.56 on a scale of 1 to 5).

Regarding the prevalence of alcohol consumption, 24.6% of respondents indicated drinking one to two times a month, 23.3% indicated drinking one or less times a month, 15.2% indicated drinking two to three times a week, 14.6% indicated drinking 4 or more times a week and 12% indicated never drinking. In the general analysis of the results, at the level of regular alcohol consumption patterns, there is a low percentage of subjects with regular consumption. Specifically, a vast majority of respondents (74.1%) reported drinking none, one or two glasses of one alcoholic beverage per day, and 46.3% of respondents reported never drinking 6 or more glasses of alcohol on a single occasion, as opposed to just 1% of the sample who reported doing so every day or so.

Regarding the risk of harmful alcohol consumption for the entire sample, there was a significantly low average (3.47, on a scale with a maximum value of 36 points). Indeed, the analysis of the risk of excessive consumption, taking into account the categorization of the AUDIT questionnaire (Babor et. al., 2001), showed that 75.7% of the sample had a low risk (risk below 8), 5.2% has a medium risk (risk between 8 and 15), and there are virtually no situations that constitute a high risk - only 0.6% of the sample presented a risk greater than 16.

For the purpose of statistical analysis, the three risk levels identified through the application of the AUDIT questionnaire were regrouped into only two levels - low level and medium / high level, referring to the values presented in the tables for this regrouping.

The correlational analysis showed that there are statistically significant positive correlations (Table 2) between the professional category and the CPQ workplace values dimension, as well as in relation to expectations about the effects of alcohol "social facilitation" and "sexual desire" (both positive) and "physical symptoms" (negative). There is also a statistically significant negative correlation between the professional category and the labour requirements dimension of the CPQ. Marital status has only a positive correlation with values in the workplace.

Table 2

Média, desvio padrão e correlação entre variáveis

Dimensions	*M*	*DP*	Marital Status	Gender	Status	Age range[1]
Depression	1.23	.346	.008	-.018	.004	.050
Anxiety	1.22	.299	-.023	-.014	.033	.080
Stress	1.46	.451	-.004	.041	-.023	.051
Labour Requirements	3.22	.551	-.079	.057	-.156**	-.088
Work Content Organization	3.78	.451	.039	-.041	-.043	.025
Social Relations Leadership	3.62	.672	.064	-.072	.079	.074
Work-Family Interface	3.38	.870	.090	-.038	.041	.095
Workplace Values	3.62	.654	.115**	-.018	.117**	.090
Self-efficacy personality	4.16	.716	.003	.063	.001	-.056

[1]The age range reflects the division of the sample into three groups according to age: up to 35 years old, 36 to 45 years old, and over 45 years old.

Health and well-being	2.29	.727	.005	.094	-.019	.091
Offensive Behaviours	1.62	.666	-.064	.073	-.004	.008
Social facilitation	2.63	1.154	.043	.056	.159**	.024
Entertainment	2.98	1.198	.012	.080	.112	-.075
Sexual Desire	2.31	1.148	-.004	.023	.177**	.052
Reduced Tension	2.51	1.294	.005	.067	.104	.036
Aggressiveness	1.63	.875	-.101	-.048	.111	.049
Negative Emotions	1.92	1.045	-.005	-.004	.118	.095
Physical Symptoms	2.46	1.280	.017	.008	.132*	-.029
Concentration and Performance Difficulties	2.76	1.298	-.014	-.004	.075	-.086
Coping	1.20	.485	-.084	-.012	.027	.064
Social Interaction	1.70	.693	-.064	.066	.044	.007
Improvement of Emotional States	1.56	.741	-.115	.052	.019	.025
Compliance	1.15	.353	-.084	-.009	.027	.009
Risk Levels	1.07	.258	-.006	.025	-.007	.099

*p<.050 **p<.010

There were also statistically significant positive correlations of risk level with all psychopathological indicators, with the “health and well-being” dimension of CPQ, with all expectations regarding alcohol consumption, except in the “fun” category, and with every reason to consume alcohol (Table 3).

Table 3

Correlation between risk level and other dimensions

Dimensions	Risk Level

Depression	.292**
Anxiety	.305**
Stress	.338**
Labour Requirements	.064
Work Content Organization	-.087
Social Relations Leadership	-.117
Work-Family Interface	-.055
Workplace Values	-.124
Self-efficacy personality	-.107
Health and well-being	.221**
Offensive Behaviours	.069
Social facilitation	.210**
Entertainment	.131
Sexual Desire	.212**
Reduced Tension	.210**
Aggressiveness	.286**
Negative Emotions	.332**
Physical Symptoms	.173*
Concentration and Performance Difficulties	.134*
Coping	.364**
Social Interaction	.283**
Improvement of Emotional States	.275**
Compliance	.280**

∗p<.050 ∗∗p<.010

Comparative analysis

For the comparative analysis according to the risk level (Table 4), and due to the lack of normality of the variables studied and the large difference in size of the two groups compared, the nonparametric Mann-Whitney test and the parametric t of Student tests were used, and statistical differences were found in the same variables. To better illustrate the comparison between groups, we opted to use the averages (procedure that parametric tests allow).

In terms of psychopathological symptomatology, depression (1.21 versus 1.62), anxiety (1.20 versus 1.56) and stress (1.44 versus 2.03) values are higher in individuals in the medium/high risk group than in the low risk group.

Regarding psychosocial risks at work, it appears that the dimension "health and well-being" (which assesses overall health, stress, burnout, sleeping problems and depressive symptoms) is higher in the medium/high risk group than in the elements of the low risk group (2.26 versus 2.91), with no statistically significant differences between the groups in the remaining dimensions.

Results on the expectations regarding alcohol consumption indicate that individuals in the medium/high risk group have higher expectations, positive or negative, compared to the elements of the low risk group, except for the expectation of fun, which does not present statistically significant differences between the two groups.

The reasons for consuming alcohol studied presented higher values in the medium/high risk group than in the low risk group.

Results indicate that there are no statistically significant differences in the demographic variables analysed – gender, age range, marital status and professional category – depending on the level of risk.

Table 4

Comparison of averages in their various dimensions with risk level

Dimensions	Low Risk (*N*=234)	Medium/High Risk (*N*=18)	T-Test *student*	*Sig*	*Sig Mann Whitney U Test*
Depression (1-4)	1.21	1.62	-3.100	.006**	.000***
Anxiety (1-4)	1.20	1.56	-3.342	.004**	.000***
Stress (1-4)	1.44	2.03	-5.591	.000***	.000***
Labour Requirements (1-5)	3.21	3.34	-.994	.321	.414
Work Content Organization (1-5)	3.77	3.61	1.360	.175	.306
Social Relations Leadership (1-5)	3.64	3.35	1.837	.067	.140
Work-Family Interface (1-5)	3.38	3.19	.865	.388	.258
Workplace Values (1-5)	3.65	3.35	1.962	.051	.065
Self-efficacy personality (1-5)	4.17	3.89	1.226	.236	.248
Health and well-being (1-5)	2.26	2.91	-3.569	.000***	.000***
Offensive Behaviours (1-5)	1.58	1.75	-1.080	.281	.171
Social facilitation (1-6)	2.59	3.47	-3.184	.002**	.001**
Entertainment (1-6)	2.98	3.56	-1.952	.052	.051
Sexual Desire (1-6)	2.24	3.15	-3.207	.002**	.003**
Reduced Tension (1-6)	2.46	3.46	-3.203	.002**	.003**

Aggressiveness (1-6)	1.55	2.46	-3.167	.005**	.001**
Negative Emotions (1-6)	1.81	3.06	-5.207	.000***	.000***
Physical Symptoms (1-6)	2.39	3.18	-2.593	.010*	.010*
Concentration and Performance Difficulties (1-6)	2.73	3.36	-1.990	.048*	.032*
Coping (1-5)	1.15	1.79	-2.655	.016*	.000***
Social Interaction (1-5)	1.65	2.36	-4.289	.000***	.000***
Improvement of Emotional States (1-5)	1.52	2.26	-3.224	.005**	.000***
Compliance (1-5)	1.12	1.48	-2.559	.020*	.000***

*p<.050 **p<.010 ***p<.001

Discussion/Conclusions

Alcohol consumption in police elements has been identified as an important problem, with consequences not only on the mental health of individuals, but also in the organizational plan, with effects on productivity, absenteeism and work motivation. Kirshman (2000) states that police professionals have unique risks and dangerous habits, such as controlling emotional processing, combined with a mental willingness to "solve the problem and move on", which raises stress levels and consequently anxiety levels, for letting loose of problems rather than facing them. Excessive vigilance often leads police professionals to look for extreme ways to relax, such as excessive alcohol consumption. Due to the difficulty of access to these professionals for data collection (Rosa, Passos & Queirós, 2015), there are no national studies on this subject with this population, and they assume particular importance, since emotional stability and the suppression of negative emotions at work are fundamental to the exercise of the multitude of functions assigned to

police professionals, such as enforcing the law, providing for comfort or providing for social assistance (Tung, Yi, Mei & Mee, 2018).

The present study aimed at identifying the prevalence of alcohol consumption and the presence of psychopathological symptoms in a sample of police officers from the Public Security Police in Portugal.

Regarding the prevalence of drinking, 74.1% of the sample recognized drinking from 0 to 2 glasses a day, 46.3% indicated never drinking more than 6 glasses a day and 1% said to drink every day or almost. For the total sample, the risk of alcohol consumption found is low, with an average of 3.47, on a scale that has a maximum value of 36 points. Violanti, Slaven, Charles, Burchfiel, Andrew & Homish (2011), in a study with US police officers using AUDIT, found an average of 5.64 (low risk < 8) for the total sample, i.e. considering the whole sample, 77.5% of police officers self-reported a low risk of alcohol consumption. This result coincides with data obtained by Lindsay (2008) in another study, where 73.7% of the police officers were in the low risk group in AUDIT. On the other hand, Davey, Obst and Sheehan (2000), in a sample with Australian police officers, found that 63.5% of the sample scored in the low risk range of alcohol consumption, 33% scored in an average risk and only 3.5% scored in the risk range for alcohol dependence. Although some authors (e.g., Pendergrass & Ostrove, 1986; Territo & Vetter, 1981) report that alcohol consumption in the police population is higher than in the general population, in this study we have found lower alcohol consumption figures (75.7% of the sample with a low risk, and 5.8% with a medium/high risk) compared to the general Portuguese population (SICAD, 2017). In the IV National Survey on Consumption of Psychoactive Substances in the General Population (SICAD, 2017), the results, assessed through AUDIT, showed that 42% of the resident population in Portugal, between 15 and 74 years old, was not at risk or had low risk of alcohol consumption, 15.5% exhibited a

medium/high risk, and 0.8% exhibited evidence of addiction symptoms. For Violanti et al. (1985), the use of alcohol in police forces is underestimated, as its consumption can have consequences for both the organizational structure and the individual. Kroes (1976) states that police officers do not recognize their dependence on alcohol. According to those authors, the police organization seems ambivalent about the problems with alcohol consumption, placing, above all, the burden on the individual and not on the organizational structure.

The results of this study also reinforce the association between risk of alcohol consumption and the presence of psychopathological symptoms, the latter being higher the higher the alcohol consumption.

Although the overall results regarding the prevalence of psychopathological symptoms in the sample were low, statistically significant differences were found between the low risk group and the medium / high risk group, with the largest difference regarding stress (1.44 versus 2.03). These data corroborate the results found in previous studies with this population, associating stress to alcohol consumption (Violanti et. Al, 1985; Blau, 1994, cit. in Oliveira & Queirós, 2012).

The low values found in the level of depression, anxiety and stress may be related with the fact that the elements are aware of the impact of their daily work on their physical health, but a lower perception of the impact on their mental health (Tung Au, Yi Wong , Mei Leung and Mee Chiu, 2018). These results seem to suggest a devaluation of the symptoms of emotional stress by the population studied.

As for the demographic variables analysed – gender, age range, marital status and professional category – the results indicate no statistically significant differences according to the risk level. Concerning the gender variable, the result of this study is consistent with

that of other police population investigations (Ballenger et al., 2010; Davey et al., 2000), where no differences were found either.

A study by Davey et al. (2000) points to a higher level of risk of alcohol consumption between the ages of 18 and 25 years. In this particular study, ages ranged from 23 to 59 years, which may account for the absence of differences.

Given that police officers from the Public Security Police perform their duties in a very specific context, facing various organizational challenges that make them more vulnerable to physical and psychological hazards at work, this study also sought to find the relationship between consumer risk of alcohol and psychosocial risks at work. There were only statistically significant differences in the "health and well-being" dimension (which assesses overall health, stress, burnout, sleeping problems and depressive symptoms), which is higher in the medium / high risk group that in the low risk group elements. Thus, we can state that, in this sample, no risk factors were identified in the organization that could enhance alcohol consumption, but only the reinforcement of psychopathological symptoms as contributing to excessive consumption.

Both the expectations regarding alcohol consumption and the reasons to consume presented higher values in the medium / high risk group, except for the "fun" expectation, which did not present statistically significant differences between the two groups. Although the results obtained are to some extent expected – given their specificity – the execution of this study broadens horizons in the acquisition of knowledge, especially in a population so little studied regarding the problem of alcoholism.

Finally, studies on this subject are necessarily limited by the fact that the consumption of alcohol by police officers has invariably disciplinary and professional consequences, which raises the possibility that the prevalence found in this study did not correspond to the reality of alcohol consumption in the PSP Institution.

The fact that were psychologists from the PSP Psychology Division conducting the study may also have contributed to the participants' defensiveness in the answers given, possibly due to concerns about the confidentiality of the data collected, although these were duly clarified. Police culture encourages a self-image of "armour" in police officers, with the expression of emotion perceived as a sign of weakness (Twersky-Glasner, 2005). For some authors (e.g., Kureczka, 2002), police officers have difficulty trusting others and therefore isolating the expression of their feelings. In the same vein, our practice and professional experience have shown us that the theme of mental health, and all that is implied, is still subject to stigma in the security forces, which has conditioned greater critical assumption on the subject, as well as seeking expert support.

Results suggest that a more psychoeducational approach, with emphasis on health promotion, in the well-being of the police population, could include: a) programs in the approach to the promotion of healthy lifestyles (food, sleep hygiene, physical exercise, hobbies), b) promotion of support programs and training strategies in the area of stress, anxiety and depression, c) creation of alert strategies for symptoms resulting from critical incidents experienced by these professionals, d) reduction of stigma associated with seeking help and clinical advice when psychological distress exists.

In future investigations, given the characteristics of the population studied, it appears to be necessary to conduct further research, with different methodologies namely qualitative.

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