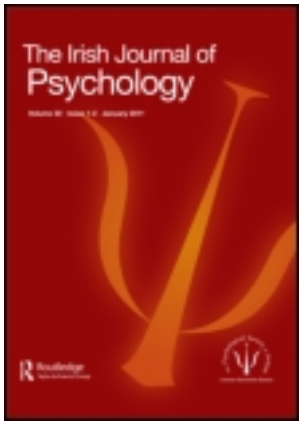

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Ten years on, living with the 'psychological troubles': retired police officers in Northern Ireland

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The Psychological Therapies Department within the Police Rehabilitation and Retraining Trust (PRRT) was established in Northern Ireland in 1999 to provide a specialist clinical service to retired police officers who have been psychologically affected through their experiences as a serving officer. The past decade has brought with it a more stable political climate and the prospect of peace in Northern Ireland. The objective of the present study therefore was to establish the current level of psychopathology among retired officers, which in turn would help inform service provision. Out of a randomly selected sample of 3000 retired officers, 972 responded to a postal questionnaire, which incorporated the General Health Questionnaire (GHQ-12), the Modified PTSD Symptoms Scale -Self Report (MPSS-SR), and the Beck Depression Inventory (BDI). Results found that 25% of respondents viewed retirement as a trigger to their current problems. Overall, 55% of respondents scored clinically on at least one of the psychometric measures: 27% of respondents scored clinically on the MPSS-SR measure of post-traumatic stress, 50% were found to have some form of depression ranging from mild to moderate, to severe on the BDI, and 41% of survey respondents scored clinically on the GHQ-12. In addition 49% of respondents reported experiencing intrusive thoughts recently. The results suggest that there is still a considerable level of psychopathology among the retired police population of Northern Ireland.

Keywords: retired police officers; political conflict; cumulative trauma; PTSD; depression; paramilitaries; psychopathology; traumatic event; psychometrics

Introduction

In the 40 years from 1969 to 2009, approximately 11,917 police officers have been injured and 303 have died as a direct result of the political conflict in Northern Ireland (Police Service Northern Ireland [PSNI], 2009). Police officers worldwide are often faced with repeated exposure to traumatic situations, due to the nature of their work. However, in addition to the normal occupational hazards of policing, officers in Northern Ireland also have to contend with the constant threat of paramilitaries. So great was the threat that Interpol statistics have shown that a police officer in Northern Ireland was at more personal risk than in any other police service in the world (Ryder, 1989). Retired officers fear that they are still potential targets, a realistic fear given that some retired officers have indeed been targeted (Patterson, Poole, Trew, & Harkin, 2001).

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The nature of the job

An inherent part of police work, as with all emergency service personnel, is encountering incidents involving human pain, suffering, and fear, almost on a daily basis. Police officers are a first port of call for most traumatic situations. They are often exposed to death and critical injuries or required to use reasonable force to prevent death or injury to either themselves or their colleagues. Exposure to such events may potentially increase one's vulnerability to a number of mental health problems, perhaps post-traumatic stress disorder (PTSD) in particular. According to the DSM-IV (American Psychiatric Association [APA], 1994), a diagnosis of PTSD requires meeting certain criteria, the chief among them being the stressor criterion (A1 and A2). This entails exposure to a traumatic event that involves: actual or threat of death or serious injury, or a threat to the physical integrity of self or others, and involving a response of intense fear, helplessness, or horror. It is clear how officers, due to the nature of incidents they are confronted with, could meet this stressor criterion.

Political, cultural, and social factors of a country may influence an individual's exposure to, and appraisal of traumatic events. PTSD rates among police officers therefore, vary from country to country (Kessler, 2000; Shalev et al., 1998). In the US alone prevalence of PTSD among officers fluctuates 12–35% (Mann & Neece, 1990). In a Dutch study, Carlier, Lamberts, and Gersons-Berthold (1997) examined PTSD symptoms in 262 officers following a critical incident on duty. Results indicated that 7% of these officers had developed PTSD, whilst a further 34% had PTSD symptoms but were subclinical. Similar to officers in Northern Ireland, Israeli police have also had to contend with political conflict. Malach-Pines and Keinan's (2006) study focused on Israeli border police during the height of the Palestine uprising – the Intifada, and found that one-quarter of the participants in this study reported experiencing symptoms of PTSD, such as intrusive thoughts/images, or flashbacks. In Northern Ireland, Wilson, Poole, and Trew (1997) examined the impact of a range of potentially traumatic events on a cohort of police officers. They found that following a critical incident, 5% of officers fulfilled the criteria for PTSD, whilst 25% had mild to moderate depression. Another study (Patterson et al., 2001), examined the level of psychopathology among retired officers in Northern Ireland. Results indicated that 16% of those medically retired and 6% of those retired normally had PTSD relating to incidents experienced as a serving officer.

In a world, where distressing events occur with such frequency, it is likely that many of us will experience a traumatic incident at some point in our lives. In fact, a US study found that two-thirds of American adults have experienced at least one traumatic event in the course of their lives (Norris, 1992) while a Northern Irish study found that similarly 66% of the general population had experienced at least one traumatic event (Ferry et al., 2008). It might appear that the rates are similar however, Norris' (1992) study considered the frequency of 10 traumatic events in comparison to the 28 included by Ferry et al. (2008), which could have contributed to the rate of trauma prevalence in this study. Despite this, Green (2004) states that PTSD among police officers is likely to be 'four to six times higher than the general public'. Police differ in that throughout a career they accumulate multiple exposures to traumatic situations. Green et al. (2000) compared severity of symptoms associated with various types of traumatic experiences occurring alone and with multiple exposures. They found that those who experienced multiple traumas had

significantly higher symptoms than all other groups. In a US study examining how exposure to trauma can accumulate over an officer's career, Weiss et al. (2001) reported that in an average career, officers encountered 25 recently dead bodies, 14 decaying corpses, 10 sexually assaulted children, colleagues badly injured twice, and officers themselves shot at once, and injured more than once. Interestingly in a sample of New Zealand police officers, Stephens and Miller (1998) found that trauma experienced whilst on duty was more strongly related to PTSD symptoms than trauma experienced when off duty.

Northern Ireland – policing through the troubles

In addition to 'normal' policing duties, from the late 1960s onwards officers in Northern Ireland have had to develop military-like skills, in order to cope with the intense political conflict that dominated life in the region. According to Weitzer (1985), during the height of the 'troubles' the Royal Ulster Constabulary (RUC), the name given to the police force in Northern Ireland at that time, evolved into a 'formidable militarised security force', with counter-insurgency and security issues being the predominant policing concerns. Since the mid-1990s progress towards peace has been aided by ceasefires from both Republican and Loyalist paramilitary organisations. In recognition of this development and in an attempt to better represent both sides of the community, the RUC was reconstituted into a new police service – the Police Service for Northern Ireland (PSNI), in 2001. The past decade has seen Northern Ireland enjoy a more stable, albeit fragile, political climate allowing for downsizing, and demilitarisation of the police force. However, sporadic paramilitary activity continues such as intimidation, punishment beatings, rioting, within-community paramilitary feuds, and intelligence gathering (Gilligan, 2006). Officers also face a very real threat from paramilitaries both on duty and off duty (Black, 2004).

Many of the critical incidents that officers would have experienced throughout the 'troubles' could have been classified as 'war trauma'. In a study involving Australian Vietnam veterans, analysis revealed that combat experiences comprises of four elements: direct combat exposure, exposure to death and injury, exposure to civilian death and injury, and exposure to mutilation (O'Toole, Marshall, Schureck, & Dobson, 1999). Countless officers in Northern Ireland who served during the 'troubles' would have encountered all four components. Furthermore, Prigerson, Maciejewski, and Rosenheck (2001) state that men who report combat trauma as their worst trauma, are more likely to have lifetime PTSD, delayed PTSD symptom onset, and to be unemployed, fired or divorced, compared with men who reported other types of trauma as their worst experience.

The psychological impact of violent conflict is now widely recognised among health professionals. De jong, Komproe, and Van Ommeren (2003) assessed respondents from post-conflict regions in Algeria, Cambodia, Ethiopia, and Palestine, with the aim of establishing the prevalence of mood disorder, somatoform disorder, PTSD, and other anxiety disorders. They found PTSD and other anxiety problems to be the most frequent problem. Muldoon and Downes (2007) conducted a telephone survey of 3000 adults, representative of the population in Northern Ireland and the border counties of the Republic of Ireland. They found that 10% of respondents had symptoms severe enough to warrant a diagnosis of PTSD. These individuals had higher overall experience of the 'troubles'. In addition, an analysis of

presenting problems of retired police officers in Northern Ireland attending psychological services in the Police Rehabilitation and Retraining Trust in October 2009, found that 83% of clients presented with difficulties relating to the 'troubles' (McCabe, 2009).

Retirement – the psychological impact of a life transition

The duration of the conflict in Northern Ireland and the downsizing of the police force in more recent years means that many officers who served through the brunt of the 'troubles' are likely to be retired now. Retirement in itself is a significant life transition and can be a potential trigger to psychological distress (Kim & Moen, 2002).

Kim and Moen (2002) conducted a longitudinal study investigating the relationship between retirement transitions and psychological well-being. The study found that the long-term retirees reported the highest number of depressive symptoms among men. In another study Bossé, Aldwin, Levenson, and Ekerdt (1987) examined psychological symptoms in a sample of 1513 older men. Analysis of variance found that retirees reported more psychological symptoms than did workers, even when severity of physical illness was controlled for. They found that men, who retire early before age 62, or late after age 65, may experience more emotional distress. They went on to suggest that those who retire early, perhaps due to financial inducements, may find themselves out of sync with their peers, whereas those who retire late, may have really enjoyed their career, deferred retirement as long as possible, and therefore become distressed by not working.

It would seem, whilst retirement eliminates the stresses of a demanding career, it also isolates individuals from their social network of colleagues, and some may experience a certain loss of identity. The social identity model of stress proposes that individuals who categorise themselves as part of a particular group may be protected from stress through receiving social support from this group (Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; McGarty, Haslam, Hutchinson, & Turner, 1994). Muldoon and Lowe (2012) review the influence of social identity on PTSD, they conclude that identification with a group is fundamental to appraisal of a traumatic experience, and discuss how strong identification with a group can be harnessed as a protective factor against PTSD.

The current study

Due to the uncertainty of the level of personal threat that continues to impact them because of their career in the police, retired officers in Northern Ireland may be reluctant to use existing statutory mental health services. The Psychological Therapies Department within the Police Rehabilitation and Retraining Trust (PRRT) was established in 1999, in response to a pressing need to provide a specialist clinical service for retired police officers, and their families, who have been psychologically affected through their experiences as serving officers. PPRT celebrated its tenth anniversary in 2009, and in acknowledgement of this the Department of Psychological Therapies initiated this study to help inform service provision for the future, taking into consideration the significant steps taken in the progress towards peace in the past decade, and the potential benefits of this for the mental health of this police population. The aims of the current study were therefore:

- to ascertain the current level of psychopathology among retired police officers in Northern Ireland
- to create an understanding of the impact of retirement, and the role it may play in reactivating or triggering PTSD, depression, or anxiety
- to use the findings of the research to inform future service provision

Method

Participants and sampling

Three thousand randomly selected retired police officers, who had served in Northern Ireland, were invited to participate in a postal questionnaire in March 2009. Names and addresses of retired police officers were obtained through PSNI Occupational Health and Welfare. All of those invited to participate in the study were former members of the PSNI or the RUC, in some cases officers may have served in both the RUC and the PSNI. The Full Time Reserve (FTR), were integrated into both RUC and PSNI forces, and was established in 1970 as an auxiliary group of police officers who support regular officers, chiefly in security related work.

Of the three thousand questionnaires distributed, 972 surveys were completed and returned, representing a response rate of 32.4%. The majority of respondents were male (92.4%) and the mean age of respondents was 59 years, the average age of retirement from service was 50 years, and the average length of police service was 26 years. Eighty-seven per cent of the respondents were married or cohabitating and almost 21% had been previously married. Eighty-seven per cent also reported that they found their service in the police extremely-moderately enjoyable. Over half (55%) of the respondents had served in the RUC only, and the remainder had served in both the RUC and PSNI.

There are four different categories which retirees fall into: *normal retirement* for those who had sufficient pensionable service to retire; *medical retirement* for those who were physically or psychologically unfit to continue working within the police; *Patten retirement* for those who took a severance package to facilitate efforts to downsize the police force as recommended by the Patten Report; and those who retired from the *FTR*. Frequencies for these categories are reported in Table 1.

Table 1. Breakdown of respondents by retirement category and force served in.

Served in	Medical [*N* (%)]	Normal [*N* (%)]	Patten [*N* (%)]	FTR [*N* (%)]	N/K [*N* (%)]	Total [*N* (%)]
RUC only	213 (40.1)	178 (33.5)	129 (24.3)	5 (0.9)	5 (0.9)	530 (54.5)
RUC & PSNI	92 (21)	23 (5.2)	281 (64.1)	41 (9.5)	1 (0.2)	438 (45)
Served in N/K	2 (50)	0 (0)	1 (25)	1 (25)	0 (0)	4 (0.4)
Total	307	201	411	47	6	972

Note: Percentage within force served in.
RUC, Royal Ulster Constabulary; PSNI, Police Service of Northern Ireland; FTR, Full Time Reserve; N/K, Not Known.

Materials

For the purpose of this study a modified version of a questionnaire which had been developed by the Psychological Therapies department for an earlier study was used (Patterson et al., 2001). The questionnaire attempted to assess the impact of both the policing career and retirement on the individual. The questionnaire was originally developed based on a study of the available literature, and research from the RUC's Occupational Health, as well as the personal experience of therapists working with this unique population. The questionnaire consists of three sections, which broadly covered:

- Demographics, career, and circumstances leading to retirement
- Hobbies and health – including interests outside the home and health behaviours
- Psychological and physical well-being – including a physical symptoms checklist, and the following psychometrics: General Health Questionnaire ([GHQ-12] Goldberg, 1978), part 1 of the Post-traumatic Stress Diagnostic Scale ([PDS] Foa, 1995), Modified PTSD Symptoms Scale Self-Report ([MPSS-SR] Falsetti, Resnick, Resick, & Kilpatrick, 1993), Beck Depression Inventory ([BDI] Beck, 1978) and the Fear Questionnaire ([FQ] Marks & Mathews, 1979).

Five fears/avoidances which can be quite common among the police population were added to the standard FQ, in order to create a more accurate assessment of avoidance, these were as follows: *Enclosed spaces, Being alone in the dark, Certain noises for example, fireworks, Certain smells, and Intimacy*. The FQ was also tailored in that it had two boxes after each statement, one in which respondents rated their current level of avoidance, and the other in which they rated their level of avoidance during service. Part 1of the PDS (Foa, 1995) assesses the type of traumatic events an individual has experienced or witnessed; participants were also asked to indicate whether or not each trauma had been experienced in relation to their career as a police officer.

For the purpose of this study scores from the FQ were divided into four categories representing various levels of stress and anxiety. The categories were as follows: 0–25 hardly at all; 26–50 mild to moderately troublesome; 51–100 moderately to severely troublesome; 101–202 severely troublesome.

Procedure

Each of the selected retired officers received a postal questionnaire, which they were invited to complete anonymously. Pre-paid envelopes were provided to return completed questionnaires. A sensitively worded covering letter outlining the objectives of the study also accompanied each questionnaire. A free 24-hour telephone counselling service was offered to recipients, as well as contact details to PRRT's Psychological Therapies Department, should recipients have any queries in relation to the survey, or become distressed by the questionnaire. This study was approved by both the Board of Directors and Senior Management Team within PRRT. Further ethical approval was not deemed necessary as this study is essentially a needs analysis, and therefore considered as part of routine service procedure.

Once the questionnaires had been gathered, psychometrics were scored according to their respective marking schemes, and data was then entered into SPSS. This

analysis concerns only codable answers; therefore, if participants did not complete one of the psychometrics fully or, they completed it incorrectly, it was recorded as 'incomplete data'.

Results

Three thousand questionnaires were distributed, and the following results are based on the 972 surveys which were completed and returned. As the majority of respondents were male (92.4%) analyses were not concerned with gender differences in responses. Table 2 presents the distribution of age and years of service across retirement groups. There was a significant difference in current age ($\chi^2 = 353.84$, df = 3, $p < .001$), retirement age ($\chi^2 = 315.90$, df = 3, $p < .001$), and number of years service ($\chi^2 = 244.48$, df = 3, $p < .001$), across retirement categories. As the results indicate (Table 2) the greatest difference was between those who retired on medical grounds and those who retired normally. The medically retired were on average 13 years younger on retirement than those who retired normally, and had on average served nine years less than the normally retired.

The breakdown of conditions leading to medical retirement were as follows: 53.3% physical condition; 30.4% psychological condition; 16.3% both psychological and physical conditions. Therefore, of the 307 respondents who retired medically, 46.7%, in total, had psychological difficulties which contributed to their retirement.

As illustrated in Figure 1, 38% of respondents perceived that more than three-quarters of their service were spent in 'high-risk stations'. The following list illustrates respondents' exposure to various types of trauma experienced via their career, as categorised by the PDS part 1: Serious accident, fire, or explosion – 88.7%; other traumatic event – 43.1%; non-sexual assault by a stranger – 42.9%; non-sexual assault by someone familiar – 17%; life-threatening illness – 10.9%; military combat or war zone – 9.1%; natural disaster – 7.7%; sexual assault by a stranger – 5.9%; sexual assault by someone familiar – 2.7%; child sexual abuse – 1.1%; imprisonment – 1%; and torture – 0.7%.

Psychopathology and Ill-health

Results show that 45% (n = 423) of survey respondents reported that they had developed a physical or psychological problem, that was not present at the time of retirement. Of these 423 retired officers, 73.8% state they have developed a physical problem, 16.9% report a psychological problem, and 9.3% both physical and

Table 2. Mean ages of respondents and length of service, by retirement category.

	Medical	Normal	Patten	FTR	All respondents
Current age	56 (10.55)	72 (6.95)	56 (5.16)	59 (7.29)	59*** (10.04)
Age at retirement	44 (8.95)	57 (5.54)	51 (3.52)	55 (5.76)	50*** (7.67)
Years of service	21 (8.12)	30 (8.07)	29 (3.53)	22 (6.14)	26*** (7.52)

Note: Figures in brackets are standard deviation.
FTR, Full Time Reserve.
***$p < .001$.

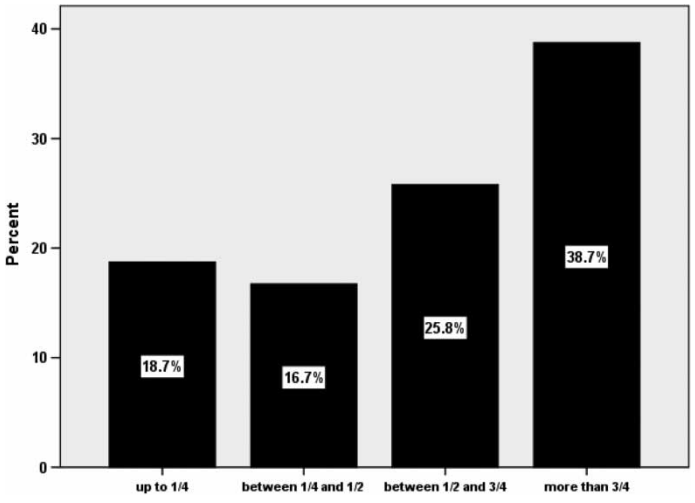

Figure 1. Service spent in 'High-risk stations'.

psychological problems. Furthermore, 25.1% of respondents viewed retirement as a trigger to their current problems.

Fifty-five per cent of respondents scored clinically on at least one of the psychometric measures. There were significant differences in psychopathology across the four retirement categories: GHQ ($\chi^2 = 103.01$, df = 3, $p < .001$); BDI ($\chi^2 = 113.53$, df = 3, $p < .001$); and PTSD ($\chi^2 = 125.67$, df = 2, $p < .001$). As illustrated on Table 3, the medically retired were more likely to score clinically on all three psychometrics.

Twenty-seven per cent of respondents scored clinically on the MPSS-SR measure of post-traumatic stress. For the purpose of this study, a subclinical range between 35 and the clinical cut-off of 45 was considered. Six per cent of respondents scored within this subclinical range. Furthermore, half of the survey's respondents were found to have some form of depression, as measured by the BDI. Severity of depression ranged from mild to moderate, to severe as illustrated in Figure 2.

Ninety-three per cent of respondents who scored clinically on the MPSS-SR, also scored within a clinical range for depression. Further analysis found that there was a significant relationship ($\chi^2 = 238.38$, df = 2, $p < .001$) between PTSD and depression, in that respondents who suffer from clinical PTSD tend to also suffer from depression.

Forty-one per cent of survey respondents scored clinically on the GHQ-12. Seventy-eight per cent of respondents who scored clinically on the MPSS-SR, also

Table 3. Breakdown of clinical percentages for three scales by retirement category.

	Medical	Normal	Patten	FTR	All respondents
GHQ	20.3% (193)	6.2% (59)	12% (114)	1.9% (18)	41%*** (384)
MPSS-SR	16.5% (144)	1.7% (15)	7.8% (68)	0.8% (7)	27%*** (234)
BDI	23.8% (224)	7.1% (67)	17.7% (166)	1.7% (16)	50%*** (473)

Note: Figures in brackets are *n*
***$p < .001$.

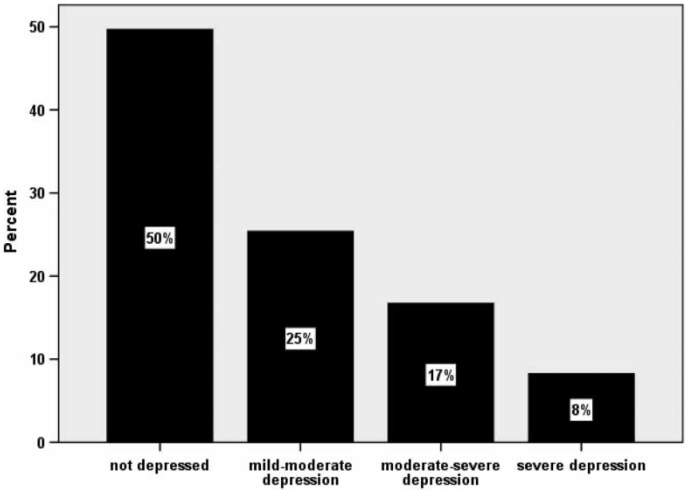

Figure 2. Bar chart illustrating the breakdown of BDI results.

scored clinically on the GHQ-12. There was a significant relationship ($\chi^2 = 189.434$, $df = 2$, $p < .001$) between PTSD and general well-being, in that respondents who scored within a clinical range on the MPSS-SR were likely to report their general health and well-being as being poor.

The average score of perceived stress and anxiety, as measured by the FQ, during service was 26.5, and the average score of perceived stress and anxiety at present was 42.9; Wilcoxon signed-rank test found this difference to be statistically significant ($z = 11.170$, N-Ties $= 720$, $p < .001$). This suggests that retired officers feel that they are more anxious and stressed during their retirement than they were during their career (Figure 3).

PTSD and retirement

Overall, 236 respondents scored clinically on the MPSS-SR measure of PTSD. Chi-squared analyses found significant differences in marital status between respondents with PTSD and respondents without ($\chi^2 = 15.92$, $df = 3$, $p \leq .001$). Although the majority of respondents in both groups were married/cohabiting, 10.2% of those with PTSD were divorced/separated in comparison to 4.5% of those without PTSD. Significant differences were also found between those who scored clinically on the MPSS-SR and the remaining respondents, in relation to whether or not they initiated their retirement ($\chi^2 = 18.97$, $df = 1$, $p \leq .001$). A much larger percentage of respondents who scored clinically for PTSD than non-clinical reported that they did not initiate their retirement, 45.5% versus 28.4%. Those who scored clinically on the MPSS-SR also differed significantly ($\chi^2 = 73.64$, $df = 1$, $p < .001$) from other survey respondents in that 49% viewed retirement as a trigger to current problems in comparison to only 19% of the rest of the respondents. Furthermore, those with PTSD reported certain traumas more. A significantly greater number of those with PTSD reported exposure to the traumas listed in Table 4.

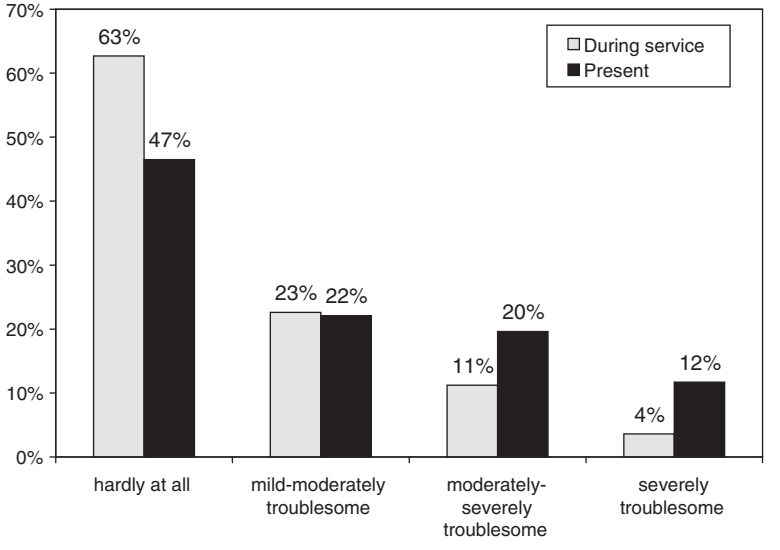

Figure 3. Bar-chart illustrating differences in levels of stress and anxiety, as measured by the FQ.

Age at retirement and mental health

Respondents who scored clinically on the psychometrics tend to have retired significantly earlier than those who were not clinical (see Table 5). The present study found that respondents who currently suffered from depression, retired on average four years earlier than those who are not depressed ($\chi^2 = 64.76$, df = 1, $p < .001$). Similar results were found for those suffering from PTSD, who retired on average 5 years earlier than those without PTSD ($\chi^2 = 73.08$, df = 1, $p < .001$). Respondents who scored clinically on the GHQ were also found to have retired on average 3 years earlier than those who were non-clinical ($\chi^2 = 24.37$, df = 2, $p < .001$).

Discussion

The present study attempted to assess the impact of both the policing career and retirement on the psychological health of retired officers in Northern Ireland. The study was also designed to inform future service provision. Of the four retirement categories, Patten and medical were best represented by respondents. The dominance

Table 4. Trauma exposure in clinical and non-clinical respondents.

Type of trauma experienced (including personal life and policing career)	Clinical MPSS-SR (%)	Non-clinical MPSS-SR (%)
Serious accident, fire, or explosion	97	91**
Non-sexual assault by someone familiar	30	20**
Non-sexual assault by a stranger	58	44**
Life-threatening illness	29	23**
Other traumatic event	69	47***

**$p < .05$; ***$p < .001$.

Table 5. Mean age of retirement of clinical and non-clinical respondents.

Mean age of retirement	BDI	MPSS-SR	GHQ
Clinical	48 (7.97)	46 (8.10)	48 (8.09)
Non clinical	52 (6.81)	51 (7.05)	51 (7.15)
P	<.001	<.001	<.001

Note: Figures in brackets are standard deviation.

of these two categories could signify the high proportion of officers whose physical and mental health suffered as a result of their career, as well as the attractiveness of the Patten severance package as a method of downsizing the police force. There was a significant difference in current age, retirement age and, years of service across retirement categories; the average retirement age for normal retirees was 57, medical retirees retired on average 13 years younger at 44, and served on average nine years less than normal retirees. Respondents who retired under Patten opted for early retirement, and respondents who served in the FTR were reserve officers, which is likely to have a bearing on their retirement age, and number of years service. Normal retirees therefore are the most appropriate respondent group to compare medical retirees, to assess the impact of their physical or psychological difficulties. Patterson et al. (2001) reported similar findings, and given that compulsory retirement age within the UK is 65, results suggest that regardless of retirement type, police officers tend to retire younger than their peers in other occupations.

Results found that 38% of respondents perceived more than three-quarters of their career within the police were spent in 'high-risk stations'. This finding is not surprising given that police stations, like the officers themselves, were prime targets for paramilitaries throughout the conflict; in 1972, for example, as many as 271 police stations were attacked (Weitzer, 1985). In spite of the often perilous nature of their job, a large proportion of respondents reported that they found their career to be extremely-moderately enjoyable, furthermore one-quarter viewed retirement as a trigger to their current problems, which suggests that these respondents may have found the retirement transition difficult. Retirement brings with it a number of losses, as well as the obvious decrease in income, one's career can give a sense of purpose, and is often central to an individual's perception of their identity, retirement may also isolate an individual from their social network of work colleagues (Kim & Moen, 2002). Of the respondents who reported they developed difficulties since retirement, over one-quarter had developed psychological problems. Results also suggest that those with PTSD found the retirement process more difficult than those without, with almost half viewing retirement as a trigger to their current problems, in comparison to only one in five of the other respondents. Although, it is unclear if these respondents would have scored within a clinical range for PTSD prior to retirement, or if retirement exacerbated underlying symptoms, this result may provide further evidence for the influence of social constructs in PTSD development. Some retired officers may have equated their personal identity with being a police officer and enjoyed the sense of belonging and comradeship of the police force, and retirement may have interfered with or weakened this identification. Muldoon and Lowe (2012) describe the protective influences of groups and social identification against PTSD development. Schnurr, Lunney, Sengupta, and Spiro, (2005) found that older male veterans with full or partial lifetime PTSD have greater symptom increases during retirement.

Her Royal Majesty's Inspectorate of Constabulary (HMIC, 2004) reported that in England and Wales during 2003–2004, there were 3 medical retirements per 1000 officers. In comparison, of the 972 respondents in this study, 307 were medically retired, although it is important to note that all these respondents did not retire in the same year. HMIC (1997) also reported that, in England and Wales just over one-quarter of medical retirement among police officers is due to psychological ill-health. The current study found that almost half of medical retirees had psychological difficulties which contributed towards their retirement. The difference in the percentages of psychological ill-health leading to medical retirement between Northern Ireland, and other areas within the UK, may well be a repercussion of the political conflict in the region. In the period 2001–2002 alone there were 318 terrorist-related bombings *(this figure includes hoax devices, and controlled explosions)* and 358 terrorist-related shootings (PSNI, 2009). Exposure to such incidents is not typical of 'normal' policing duties.

The finding that over half of respondents scored clinically on at least one of the standardised measures is substantial in itself. It suggests that more than half of the retirees had some form of psychological ill-health, ranging from mild to moderate depression, to severe depression and PTSD. The finding that the medically retired were more likely to score clinically on the GHQ and MPSS-SR, and suffer from severe depression than respondents in other retirement categories is not surprising, considering that almost half of the medically retired reported psychological difficulties as a factor towards their retirement. Furthermore, almost, 70% of medical retirees incurred physical injuries or conditions, which may increase their vulnerability to psychopathology. Hyer, Summers, Braswell, and Boyd (1995) reported health status to be one of many moderating variables, which may influence the expression of PTSD symptoms.

The current study also found a significant difference in retirement age between those who scored clinically on each of the psychometrics and those who did not. Respondents who scored within a clinical range on the MPSS-SR, BDI, and GHQ, tended to retire younger than respondents scoring within a non-clinical range on each of the psychometrics. With the exception of the medical retirees, it was not possible to determine from the present study whether poor mental health influenced the decision to retire early, or if retirement triggered mental health difficulties.

According to research from the Department of Health Social Services and Public Safety, 16% of men in Northern Ireland showed signs of a mental health problem by scoring highly on the GHQ (DHSSPS, 2007). The current study found that over 40% of respondents scored within a clinical range on the GHQ. These findings would suggest that the mental health of the retired police population differs from the population in Northern Ireland in general. However, more than one in five of those who scored clinically on the GHQ retired medically, and previous studies have reported that normal retirement from the RUC is no more detrimental to psychological health than membership of the Northern Ireland community as a whole (Patterson et al., 2001).

Results from the BDI indicated that half of the retired officers were currently depressed. Whilst those with severe depression were more likely to have retired medically, depression in itself was by no means unique to medical retirees. Kim and Moen (2002) reported that men, who are long time retirees, tend to report higher depressive symptoms, in comparison to the newly retired and those who are still working. They found that change in financial, personal, and social resources explained the link between retirement status and psychological well-being.

The study yielded interesting results in that retirees scored significantly higher stress and anxiety levels at present, than they did for their retrospective rating of stress and anxiety felt during service. Although caution must be taken in relation to the accuracy of retrospective self-report, it appears that retired officers feel they have more symptoms of anxiety now than during their career. One explanation for these findings may be that, as serving officers, respondents simply 'got on with the job', and played the role of police officer, the comradery among officers may also have served as a buffer against anxiety. Retired from the police, the risk of a personal attack from paramilitary groups in Northern Ireland still exists, to a greater or lesser extent. Removed from the alliance of their colleagues, retirees may feel more vulnerable than they felt prior to retirement. Patterson et al. (2001) found in focused interviews with retired RUC officers that several interviewees expressed fears that they were still potential targets for paramilitary groups.

The prevalence of PTSD among retired officers (27%) appears greater than among the general population of Northern Ireland. Muldoon and Downes (2007) reported a 10% prevalence rate of PTSD among adults in Northern Ireland, and border counties of the Irish Republic, subsequent to the 'troubles'. Whereas Ferry et al. (2008) reported that less than 5% of the general population in Northern Ireland had experienced PTSD in the last 12 months. However, more than half of respondents in the current study that scored within the clinical range for PTSD had retired medically. The prevalence of PTSD among officers who were not retired medically does not appear to differ greatly from that of the general population. This is similar to findings by Patterson et al. (2001) who reported that 16% of medically retired, in comparison to 6% of normally retired RUC officers, had symptoms characteristic of PTSD. The present study also found a further 6% of respondents to have subclinical PTSD symptoms. Subclinical PTSD, or partial PTSD as it is sometimes referred to is the term given to those who have clinically significant symptoms of PTSD, but do not fully meet the diagnostic criteria. Carlier and Gersons (1995) suggest that individuals with partial PTSD require more or less the same level of care, as those who have met the diagnostic criteria.

Respondents who scored clinically on the MPSS-SR were found to be more likely to suffer from depression and report their general health and well-being as poor. Comorbid depression occurred in a significant majority of PTSD respondents, which may be an indicator of greater symptom severity and lower levels of functioning (Shalev et al., 1998). Just over three-quarters of PTSD respondents also scored clinically on the GHQ, indicating that retirees with PTSD tend to have poorer general health, although the ageing process may be a contributing factor. Results also indicated that respondents with PTSD were less likely to have initiated their own retirement, and had a higher divorce rate than other respondents. Those who did not initiate retirement are likely to have been deemed 'medically unfit to work', and so retirement for these respondents was unplanned. Unsurprisingly chronic symptoms of PTSD or indeed any psychological disorder can put a strain on marital relations, which in some cases may lead to divorce. These results reflect findings from Prigerson et al. (2001) who state that men, who report combat trauma as their worst trauma, are more likely to be fired, or divorced, than men who report other traumas as their worst.

The types of trauma officers experienced whilst on duty were also explored within this study. The dominance of the 'serious accident, fire, or explosion' trauma category, reported by almost 89% of respondents, may be accounted for by the numerous bombings that took place throughout the course of the 'troubles'. As

might be expected, a higher percentage of respondents with PTSD reported experience to each trauma category than other respondents. Significant differences were found in respondents' overall experience to the following traumas: serious accident, fire, or explosion; non-sexual assault by someone familiar; non-sexual assault by a stranger; life threatening illness; and other traumatic event. Respondents scoring within the clinical range for PTSD were more likely to have experienced each of these five trauma categories.

Methodological issues

The current study has a number of limitations. Firstly, the large representation from the medical and Patten retirement categories may indicate some response bias. Officers who were turned down for medical retirement but felt unable to continue working within the police, may have retired under Patten. Individuals in both retirement categories may therefore have had a greater personal interest in the subject of the questionnaire, if they have suffered physically or psychologically as a result of their career. According to the leverage-salience theory (Groves, Singer, & Corning, 2000) the survey topic is a factor in the decision to participate. This study also attempted to capture the main types of trauma that officers were exposed to throughout their career; however, given that 'other traumatic event' was the second most common trauma type selected by respondents, it is likely the measure used in this study was simply not broad enough or specific to the police career. Previous studies have found that the death of a known police officer is among the top three traumatic events related to higher PTSD symptoms among the police (Stephens & Miller, 1998; Violanti, 1996). As there was no specific category for 'death of a colleague' in the measure employed in this study, it is possible this trauma type may be accounted for by the popularity of the 'other traumatic event' category. A further limitation of the present study is that whilst rates of exposure to different trauma types were measured, frequency of exposure to each trauma type was not. Nonetheless, the very nature of policing together with the high proportion of respondents who reported experience to a number of different traumatic events, would suggest that many of the retirees had multiple trauma exposure. It is important to acknowledge the significance of cumulative trauma, as individuals with cumulative trauma exposure are thought to experience more severe PTSD symptoms (Green et al., 2000).

Conclusion

The present study found that over half of retired officers are currently experiencing symptoms of psychopathology. There is evidence to suggest that the retirement process may exacerbate symptoms, and highlights the need for clinical awareness of retirement as a life transition, and hence a potential trigger for underlying psychological symptoms. Medical retirees were found to be more likely to suffer from psychological ill-health, than other retirees. Given the high rate of psychopathology among this population, and that analyses of presenting problems of PPRT clients suggest that over 80% of psychological difficulties are related to the political situation in Northern Ireland (McCabe, 2009) it would seem that the psychological effects of the 'troubles' are still very much present for retired officers and their families.

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