The Experience of Post-Traumatic Stress Disorder in Ex-Prison Officers

Joanna Binley

Abstract

The role of a prison officer is diverse, challenging, and often dangerous. Prison officers are exposed to a multitude of potentially traumatic events, including prisoner on prisoner and prisoner on staff violence, and witnessing self-harm and suicidal behaviour. However, no literature has yet explored the experiences of PTSD within ex- or serving UK prison officers, and it remains a topic seldom raised in the public eye. The current study aimed to raise awareness of, and better understand, ex- and serving prison officers' experiences of PTSD. Twelve ex-prison officers from the UK participated in semi-structured telephone interviews; which explored their PTSD diagnosis, workplace reactions to PTSD, support they received, coping methods, and reflections on their current place and experiences. Thematic Analysis was used to analyse the data, and identified 4 major themes: little support available, importance of diagnosis, prison culture, and major impact of PTSD. This study develops an understanding of the experiences of ex- and serving UK prison officers with PTSD, and highlights the necessity of a support network for this group. Future research could estimate prevalence rates of PTSD in UK prison officers. Implications and future research suggestions are discussed in more detail below.

Introduction

In recent years, the staff turnover rate amongst prison officers in England and Wales has been increasing (Ministry of Justice, 2020), this could be because the occupation carries a range of potential health consequences, both physical and mental (Ellison & Caudill, 2020).

Firstly, prison officers are frequently exposed to illicit substances, experience more psychosomatic health issues (Schaufeli & Peeters, 2000), and are at a heightened risk of assault (Ferdik & Smith, 2017; Fusco et al., 2021) than most other occupations. Aside from a decrease over the past year in both prisoner on prisoner and prisoner on staff violence due to the Covid-19 pandemic, prisoner to staff assaults have been steadily rising in recent years (Ministry of Justice, 2021). Thus, it is probable violence levels will revert back to pre-pandemic levels once prison regimes return to normality and prisoners are out their cells more.

Secondly, prison officers have higher rates of mental health disorders than many other occupations (Kinman et al., 2017). Research has shown correctional officers experience higher levels of job stress (Butler et al., 2019) and burnout (Bell et al., 2019) than other occupations. Furthermore, the most common reason for sickness in prison staff in England and Wales was attributed to 'mental and behavioural disorders' (Ministry of Justice, 2020). However, most of the research on UK prisons has explored the mental health of prisoners (Tyler et al., 2019), rather than the individuals who care and manage the prison population.

Steiner and Wooldredge (2015) explored stress in prison officers and applied Johnson and Hall's Job Demand-Control-Support model (1988). The authors argued many prison officers experience high job demands – their tasks range from simple roll checks to dealing with complex and emotive situations (Steiner & Wooldredge, 2015). Additionally, if officers

perceive a lack of control over their jobs and daily tasks, and experience little support from their colleagues and supervisors, stress levels increase (Steiner & Wooldredge, 2015). Steiner and Wooldredge (2015) found prison officers had greater levels of stress than other occupations. High stress levels could in turn be contributing to absenteeism rates amongst prison officers, particularly as increased stress is a significant predictor of PTSD (Boudoukha et al., 2013).

Burnout, a long term reaction to stress, typified by emotional exhaustion, depersonalisation, and lacking feelings of personal accomplishment (Maslach et al., 2001), is also more common in prison officers (Lambert et al., 2015). Both burnout and emotional exhaustion have been found to be significant predictors of PTSD (Boudoukha et al., 2013; Jaegers et al., 2019; Lambert et al., 2015). Therefore, it is disappointing that much of the literature surrounding burnout in prison officers focusses on the causes of burnout, rather than its potential consequences, such as PTSD (Lambert et al., 2015).

Moreover, Ellison and Caudill (2020) highlight prison officers experience a constant threat of violence, either to themselves or those around them, and found this consistent threatening ambiance to be more stressful than direct victimisation. The result could be the development of a state of hypervigilance, found to be common amongst correctional officers (Trounson et al., 2016) and a critical symptom of PTSD (Kimble et al., 2014).

In addition to the threat of violence, prison officers are exposed to a range of potentially traumatising events (PTEs). Many prison officers witness violence, self-harm incidents, drug overdoses, and attempted and completed suicide (Fusco et al., 2021). Witnessing such traumatic events is associated with the development of PTSD symptoms (Spinaris et al., 2012). It is important to consider how prison staff manage seeing such traumatic events in

their workplace, with Walker et al. (2017) suggesting many prison officers employ a 'façade of capability', wherein they pretend to be undisturbed by traumatic events.

Similarly, Barry (2020) applied Hochschild's (1983) theory of 'emotional labour' to prison officers to explain their emotion management at work. Hochschild's theory (1983) argues individuals induce or suppress feelings to adhere to a situation's 'feeling rules'. Hochschild argued feeling rules are within every workplace, and are set according to an organisation's culture, values, and history. Feeling rules dictate which emotions are appropriate for each setting (Hochschild, 1983). Barry (2020) argued that the feeling rules of prison work determine emotions such as fear, sadness, and anxiety as unacceptable, and to express these in or about the workplace would be inappropriate. Indeed, Crawley (2004), and later Barry (2020), found prison staff felt they would be viewed as weak by colleagues or managers if they broke these feeling rules. With prison staff adhering to feeling rules which dissuade them from speaking out about struggling mentally, it is imperative to determine how ingrained feeling rules are within officer mentality.

Internationally, suicide rates are higher amongst correctional officers than the general population (Frost & Monteiro, 2020). The New Jersey Suicide Task Force (2009) discovered rates of suicide to be double that of police officers and the general population. They estimated an average life expectancy for correctional officers as 59 years old (New Jersey Suicide Task Force, 2009), in comparison to the UK's general population life expectancy of 79 and 83 years for men and women, respectively (Morgan & Rozée, 2020). The reason for these elevated rates of suicide could be due to higher levels of PTSD which has been associated with increased levels of suicide (Gradus et al., 2010). Despite this troubling notion, at the time of writing, the researcher found no available statistics attesting to suicide rates amongst UK prison officers, nor was there research exploring suicidal ideation or intention amongst officers.

Therefore, with high levels of burnout in prison officers, combined with the exposure to multiple PTEs, and the emotional labour prison officers conduct, it seems likely there would be high levels of PTSD in UK prison officers as these have all been found to be significant PTSD predictors (Barry, 2020; Boudoukha et el., 2013; Wright et al., 2006). Furthermore, it could be that PTSD is a major cause of the elevated suicide rates amongst prison officers (Frost & Monteiro, 2020).

Similarly, Fusco et al., (2021) found approximately 33% of the correctional officers they studied screened positively for PTSD, whilst Jaegers et al. (2019) found over half the officers they studied in American jails had PTSD symptoms. High levels of PTSD were also identified in prison officers in Australia (Trounson et a., 2016), France (Boudoukha et al., 2013), and Canada (Stadnyk, 2003). Furthermore, James and Todak (2018) estimated correctional officers faced levels of PTSD equivalent to those of Iraq and Afghanistan war veterans. Whilst Spinaris et al. (2012) found 27% of the correctional officers they studied fully met the criteria for a diagnosis of PTSD, in comparison to 14% of New York Fire Fighters post-9/11 (Perrin et al., 2007). Therefore, the existing research on this topic suggests prison officers experience PTSD at a higher rate than the English general population's rate of 4% (Fear et al., 2014). It is probable UK prison officers experience PTSD rates similar to their international counterparts.

Disappointingly, to date, there has been no study exploring the prevalence of PTSD in UK prison officers. A small body of research highlighted the serious consequences of PTSD in prison officers, for example, elevated levels of substance abuse (Crawley, 2004), memory impairment, obesity, and depression (Spinaris et al., 2012). With mounting evidence suggesting prison officers in the UK could be suffering from elevated rates of workplace caused PTSD (Regehr et al., 2021), and are dealing with PTSD's consequences, it is unclear why little research has been conducted on the specific topic of PTSD in prison officers

internationally, and why none has focused on it in the UK. Instead, research has focused primarily on job stress and burnout amongst prison officers (Butler et al., 2019), or the wider mental health consequences, rather than PTSD in particular (Crawley, 2004; Wright et al., 2006).

As PTSD can be long lasting and persistent (APA, 2013), it is likely ex-prison officers could still be suffering from PTSD. Furthermore, Doron-LaMarca et al. (2015) found combat veterans who experienced multiple traumas when surrounded by danger over a prolonged period of time, were more likely to have long lasting PTSD than individuals who developed PTSD from a singular event. This could be how many prison officers develop PTSD: from multiple traumas in a dangerous environment over a protracted period of time, thus, many ex-prison officers may have long lasting PTSD. Therefore, including the experiences of ex-prison officers with PTSD would be a valid way to learn about PTSD in serving officers. Moreover, it was hoped that involving individuals no longer enveloped within the 'feeling rules' of prison work would encourage more participants to participate and speak openly about their experiences of PTSD.

Therefore, with so many prison officers being exposed to PTEs in their workplace (Fusco et al., 2021), it is imperative to be aware of the dangers of this exposure, and to better understand their experiences of PTSD. This study's aims were to raise awareness of the issue of PTSD amongst UK prison officers and ex-prison officers, and to develop a better understanding of their experiences, as this is under researched within academia. Thus, the study's research question was 'What are the experiences of PTSD in ex-prison officers in the UK?'.

Method

Design

The study was a semi-structured interview with open-ended questions. Interviews were conducted via telephone and were audio-recorded.

Participants

Selection criteria included ex-prison officers over age 18 with PTSD. Participants were excluded if they did not have a diagnosis of PTSD from at least their GP. Participants were 12 ex-prison officers: 2 females and 10 males. Participants' ages were collected via age brackets. 2 individuals were in the 41-50 age bracket, one was in the 71-80 bracket, and the remaining participants were in the 51-60 bracket, the average age bracket. One participant had worked as a prison officer for between 6 and 10 years, all other participants had 20 years' service.

8 participants had served in England and Wales and had worked in prison categories ranging from A to D (Category A prisoners are those 'whose escape would be highly dangerous to the public or the police or the security of the state and for whom the aim must be to make escape impossible', Category D prisoners pose a lower risk and can 'be reasonably trusted in open conditions' (Grimwood, 2015). 2 participants had served in Northern Irish Category A prisons, housing prisoners posing a similar risk to Category A prisoners in England and Wales (Grimwood, 2015). 2 participants had worked in maximum security prisons in Scotland, with 'prisoners for whom all activities and movements require to be authorized, supervised and monitored by an officer' (Grimwood, 2015). All participants had worked with adult male prisoners, one had also worked with adult females, and male and female young offenders.

Materials

Participants received an information sheet (see Appendix C), and a link to an online consent form and demographics survey (see Appendices D and E). The researcher used an interview

schedule to ensure consistency between interviews (see Appendix F). Interviews were recorded using a Dictaphone. Participants received a debrief sheet (see Appendix G).

Procedure

The study was advertised through the Prison Officer Association's (POA) communication channels via a circular sent to POA members (see Appendix H), including serving and ex-prison staff. Participants who expressed interest in the study contacted a POA administrator, who forwarded their contact details to the researcher. Each potential participant was contacted and given more information on the study via telephone call or email. Individuals were then sent a detailed participant information sheet. After they had read the information sheet, participants were sent an online consent form and demographics questionnaire, once completed, interviews were arranged.

Semi-structured interviews began with the researcher gaining additional verbal consent to participate. The interview had 6 sections, 'Getting a diagnosis', 'Workplace reactions', 'Support', 'Coping with PTSD', 'Leaving', and 'Reflection on current place and experiences', to gauge a more comprehensive overview of the participants' experiences. Open-ended questions such as "How would you describe your experience of getting a diagnosis?" and "How would you describe the support network available for ex-prison officers with PTSD?", encouraged discussion. Supplementary prompts were used when needed to explore a participant's response in greater depth. Interviews were audio recorded and - after a 2-week period to allow participants time to withdraw their data prior to anonymisation - were transcribed verbatim (see Appendix I). No individuals withdrew their data. Interviews ranged in duration from 23 minutes to 161 minutes, the average interview was 68 minutes long. After the interview, participants were sent a debrief sheet.

Data Analysis

As this study sought to understand ex-prison officers' experiences of PTSD, Thematic Analysis (TA; Braun & Clarke, 2006) was used to analyse the interview data to identify main themes of experience. As Clarke and Braun (2017) highlighted, TA allows for a systematic generation of themes and codes from complex qualitative data whilst maintaining the richness and depth of participants' interviews. TA is not used for a particular theoretical approach and instead is used for various epistemological paradigms (Braun & Clarke, 2006). Due to its flexibility, it was used to report the reality of the participants - the study had a realist epistemological approach as it argued one can obtain true knowledge of a topic from individuals' experiences. An inductive approach was adopted as the interview data informed the themes and codes, rather than the researcher suggesting themes influenced by existing theories or the researcher's beliefs.

TA was conducted based on Braun and Clarke's (2006) guidelines. Firstly, Braun and Clarke (2006) advise familiarisation with the data: the researcher listened to the interview recordings, read, and reread the transcripts. For phase two, codes were generated from the data (see Appendix J). Codes were semantic (participants' words were seen as the true nature of what the participant meant) in order to maintain the integrity of what participants were saying, rather than what the researcher could have interpreted by casting assumptions around possible underlying meanings of participants' words (Braun & Clarke, 2006). During the third stage, similar codes were grouped together to form initial themes. Phase four included the reviewing and refining of themes, this involved considering how well codes formed themes together and the accuracy with which they represented the data. After review, themes were named and defined, this phase included the development of sub-themes. For the final phase of TA, the researcher explored how the themes related to existing literature on PTSD in ex-prison officers.

Ethical Considerations

Coventry University granted ethical approval. The British Psychological Society's Code of Ethics (2018) was followed. Individuals with PTSD may become distressed when discussing particular trauma 'hotspots' (Grey & Holmes, 2008). Therefore, to protect participants from the study causing psychological harm, detailed information sheets ensured participants' consent was informed and they knew of any potential distress. The study used no deception and the researcher was transparent with participants regarding the study's aims and potential distribution.

Participants were reminded they could stop the interview at any time and could withdraw their data within 2 weeks after the interview. Participants did not have to answer or detail anything they did not wish to. Each participant received a debrief form with details of the Samaritans' crisis line and a specialist trauma counselling service if they felt distressed by participation.

Results & Discussion

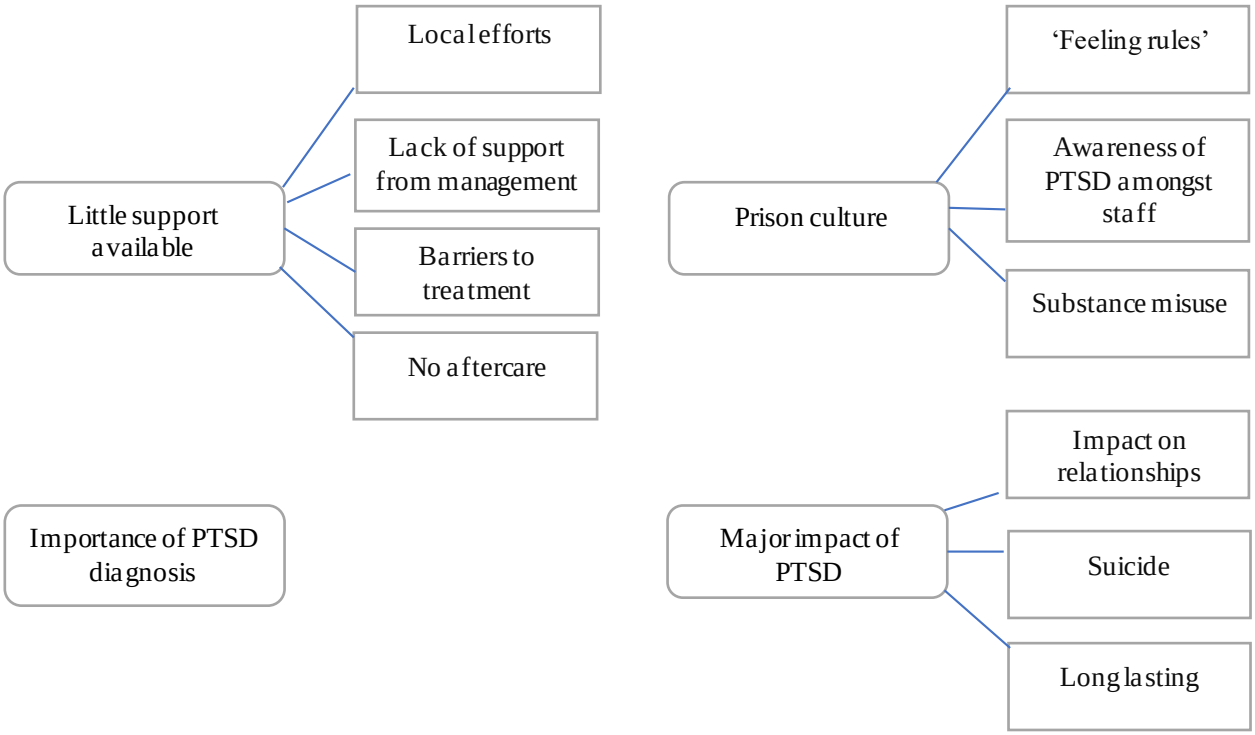

Figure 1. Thematic map showing overarching themes generated from the data and the sub-themes within them.

Theme 1: Little support available

Local, not national efforts

Support available for officers and ex-officers with PTSD was inconsistent nationally across prisons. This localisation applied even to basic forms of support, such as debriefs after major incidents.

> *I was never invited to the critical debrief. Everybody else got invited… [I] never even got invited…Everybody knew I was the one dealing with the core incident. (Participant A)*

This is particularly concerning as research has shown prison officers who are part of a critical debrief have lower levels of post-traumatic stress symptoms than those who are not (Ruck et

al., 2013). Sweeney et al. (2018) further highlighted the importance of debriefs, particularly as a method to encourage officers to consider their emotions, and to discuss them with peers, potentially reducing stigma surrounding struggling after a PTE.

Others were offered informal conversations with a serving officer in the 'Care Team' (officers at each prison who provide 'post incident peer-support'), as dictated by the Prison Service Instructions explaining what should be offered post-incident (HMPPS, 2018).

> *Now, if there's an incident, the care team will go to that person…and will actually sit down with them and tell them if they get flashbacks…to come back to them. (Participant A)*

Whilst the guidelines surrounding post-incident care appear focused on protecting against the development of PTSD (HMPPS, 2018), there is little clarity on supporting an officer who has already developed PTSD from their work. This seemed dependent on their location and having a '*good boss*'.

> *If you had a particularly good boss they might say 'you're not doing so great are you? We'll cover your shift, go home'. (Participant G)*

Only five participants were offered formal psychotherapy organised by their workplace. All five had received Eye-Movement Desensitisation and Reprocessing Therapy (EMDR), shown to be successful in treating PTSD (Khan et al., 2018). The remaining participants either organised their own therapy or went without treatment, which could be detrimental to their long-term health as this means their PTSD symptoms would be less likely to reduce than somebody receiving treatment (Morina et al., 2014).

Lack of support from management

Participants described managers who seemed to have little understanding of how to deal with PTSD diagnoses amongst staff. The majority of participants felt unsupported by management during their time as an officer and once they raised they were struggling with PTSD.

> *I was sat at home all this time just not getting anything from anyone, the managers just didn't know how to deal with [PTSD]. I felt like a pariah. (Participant D)*

> *[After a prisoner nearly killed a prison officer] there wasn't even anyone there at the end of the day from senior management, to just say 'look are you okay?' and the next morning… [no one said] 'you doing okay?'. (Participant K)*

Some managers offered support in ways which showed little understanding of their employees' experiences of PTSD, and this ultimately led to them feeling unsupported.

> *They said that they would give me a break by putting me on to another block...but I'm in charge of a wing again. So they didn't do anything to help my situation. (Participant B)*

Feeling managers did not understand them well, was previously reported amongst English prison officers (Walker et al., 2017).

Others experienced an explicit lack of support from management and had their concerns dismissed.

> *It [PTSD] doesn't exist, nobody suffers from PTSD according to senior management. Nobody wants to talk about it. Nobody is willing to acknowledge it. (Participant L)*

> *One of the governors rang me…he said 'you mentioned that there's a lack of support from senior management? That's not my job'. I said 'really? I've been assaulted in your prison, I've got 30 years of service behind me, I've done good work, and you're saying it's not your job?' (Participant I)*

> *I had a manager tell me the more fraggled ['fraggle', is used amongst officers to mean an individual with workplace caused mental health issues] you are the better you're doing your job. Another senior manager told me being a fraggle was a badge of honour and he told me to pull myself together. (Participant L)*

This was a particularly disturbing finding due to the hierarchical arrangement of prison staff: prison officers could be unable to seek help from occupational health services if their own manager is unsupportive or dismissive of their concerns, as the occupational health service often relies on line manager involvement (HMPPS, 2018).

When participants had their PTSD recognised, they felt support was a bureaucratic exercise without any real care behind it.

> *There's a falseness if they [managers] do ask you how you are after an incident, you know they've done it because their tick box told them to. It means nothing. (Participant E)*

This supports Steiner and Wooldredge's (2015) finding that the less supported officers felt by supervisors, the higher their stress levels: participants in the current study found it distressing they were offered little support by managers. Moreover, Ellison and Caudill (2020) suggested experiencing support from supervisors was a protective factor against stress in correctional officers. Similarly, James and Todak (2018) found more positive relationships with supervisors were linked with less symptoms of PTSD in American correctional officers. Thus, it is reasonable to query whether the current participants may have been more protected from developing PTSD had they felt supported by their managers. The current findings add credence to Walker et al.'s (2017) argument that the behaviour and attitudes of managers are extremely influential to the feelings of officers and ex-officers.

Barriers to treatment

This subtheme began addressing Walker et al.'s (2017) suggestion that research explore why prison staff may feel unable to access psychological support. Participants highlighted multiple barriers which stopped them, or others, from successfully receiving treatment. Firstly, being expected to arrive in work and carry out their job before or after their psychotherapy session was a logistical and emotional barrier for staff, which discouraged them from engaging in treatment.

> *They'd [work] say to you 'oh when's your appointment' and you say '11' and they'd say 'oh right well come in for the morning then and then leave'... and I'd say 'well no because I'm not going there in my uniform'...It was an inconvenience for them and that's why a lot of staff just went 'ugh I'm not doing this'. (Participant D)*

Managers did not seem to understand psychotherapy can be emotionally draining (Lowe & Murray, 2014), particularly due to the nature of PTSD psychotherapy, during which patients discuss aspects of their trauma in depth and can result in them feeling vulnerable (Grey & Holmes, 2008).

Secondly, when individuals had not been offered sufficient psychotherapy through their workplace, they had to find alternative treatment. Usually, this meant the NHS, however this equated to long waiting times. A fortunate minority had paid for and received private treatment, but this is unlikely to be a viable option for many serving and ex-officers.

Thirdly, the organisation of treatment by occupational health caused difficulties. For example, if a psychotherapist felt an officer required more sessions of EMDR, the psychotherapist had to apply get more funding. Sometimes these applications were rejected, resulting in individuals receiving an inadequate amount of therapy. Alternatively, if the applications were accepted, time delays in getting extra sessions felt disruptive.

> *The best thing I've seen the service do is when they started funding some of the actual EMDR. The worst thing they did is fund partially, so they say, 'well you can only have 6 sessions and we're not paying anymore'…It was like 'we're gonna help you a bit, but we're not here to help you all of it'. (Participant D)*

> *It took so long to get more [EMDR] sessions, it felt as if I'd lost any sort of good stuff we'd been doing [in therapy] because I lost the flow of the sessions because it was interrupted by requesting more. (Participant K)*

Erekson et al. (2015) found more frequent psychotherapy sessions (less time between sessions) resulted in a greater reduction of symptoms. Similarly, Gutner et al. (2016) found PTSD symptoms were reduced to a greater extent with higher session frequency. Thus, the current study's finding that participants felt delayed treatment sessions were detrimental to their recovery, is well supported by existing literature. Furthermore, these results support Walker et al.'s (2017) finding that English prison officers often have difficulty accessing therapeutic support via their workplace.

No aftercare

Most participants felt there was no formal aftercare for ex-officers suffering from PTSD, and believed this was an essential, but missing, element of 'duty of care'. This lack of aftercare formed an important aspect of their experience with PTSD. Informal social media pages had been set up by ex-officers.

> *[There's] nothing at all. I think that's a really big thing that's missing. That would be really beneficial…On social media there are pages for ex-officers to show each other they're not alone and support each other, but it's a social media page at the end of the day. (Participant K)*

Whilst social media pages offered some camaraderie, disappointingly there was no structured support network available across England, Wales, and Scotland, such as support groups or telephone support. Telephone peer support amongst American veterans was found to result in reduced PTSD symptoms (MacEachron & Gustavsson, 2012).

Two participants spoke about an organisation supporting ex-prison officers on an ongoing basis and highlighted how valuable this service was. However, this was only available to ex-officers in Northern Ireland.

> *They're brilliant. It's really only for retired prison officers. But they do trips away every year…someone is always on the end of the phone. If there's anything you need done or anything they can do for you…[they] give me a call once a month. (Participant B)*

Participants would have appreciated even a simple conversation with a senior manager after they finished their service, the lack of which they felt showed nobody cared about their experiences.

> *The duty of care is just missing and the after care is not there… I've never received a phone call from senior management. (Participant E)*

> *It was just hand your uniform in and you're away. That was it. All the 27 years I did and I got nothing, nobody gave a damn about what had happened. Nobody brought me in and talked with me. (Participant F)*

This supports Beck's (2016) finding that withholding gratitude from employees harms managers relationships with them. Their many years of service and their exposure to a multitude of PTEs during this time, combined with the job's demanding nature, resulted in participants feeling they should have been given more care after their service ended. This is supported by Tait's (2011) typologies of prison officer approaches to care which revealed

officers within the 'damaged' typology – those who had experienced trauma followed by a lack of aftercare in their role - were more negative and hostile towards prisoners. Thus, a lack of aftercare following trauma could impact on both ex-officers' experiences of PTSD, but also serving officers' job performance.

Theme 2: Importance of diagnosis

The majority of participants reported difficulty in recognising they had PTSD, for some, this went on for many years. Many of them did not understand what they were experiencing, simply attributing it to how prison work had '*changed them*'.

> *I was quite surprised, I never thought of PTSD…I just thought that was me and how I'd become. (Participant G)*

It was only once interviewees had sought help from a medical professional that they realised they had PTSD.

> *[A psychiatrist] told me I had PTSD and that I'd had it a long time and I just hadn't realised. (Participant F)*

> *The doctor said it was depression and anxiety… a while after that they came up with PTSD because I wasn't depressed…I couldn't switch my head off, it was like a video playing in my head. [Getting diagnosed with PTSD was] very tricky. PTSD isn't as well known in this country as it is in say America for example. The doctors don't know as much about it. (Participant L)*

It is concerning many individuals reported struggling to recognise they had PTSD, particularly as Kelmendi et al. (2016) found individuals with PTSD's prognosis worsens if diagnosis happened more than 5 months after trauma. Thus, if prison officers are delayed in receiving a diagnosis due to not realising they have PTSD, their prognosis could be poorer.

Perhaps due to their difficulty in recognising their PTSD, many participants felt gaining a formal diagnosis was an important experience. For some, this diagnosis allowed them to finally feel understood. Similarly, Hundt et al. (2019) found a diagnosis of PTSD can often allow individuals to feel validated, this certainly seemed the case of the current study, with the diagnosis affording participants an understanding of their feelings and behaviour.

All participants encouraged other officers or ex-officers suffering to seek help from a medical professional. Many described how the PTSD 'crept' up on them due to not recognising it or speaking to anybody about it.

> *The minute there's something not right, ask for help, otherwise it will consume you. It creeps up on you. It's like pouring water into a glass slowly, once it overflows it's too late, you have to not let the glass overflow. (Participant L)*

Clearly, participants felt if PTSD went unrecognised, things would end up worse for the individual, potentially due to a lack of treatment. This supports the argument that if PTSD remains untreated, individuals suffer without intervention or support to devastating ends, such as substance abuse, and suicide (Conard & Sauls, 2014).

Theme 3: Prison Culture

Feeling rules

Many participants felt part of being a prison officer was '*getting on*' with things, and not discussing how they felt, particularly if they were struggling with their mental health. 'Feeling rules' (Hochschild, 1983) applied not just amongst staff, but also around prisoners: participants spoke of needing to appear a certain way in front of prisoners, otherwise there could be dangerous consequences.

> *In prison work, you've got to put up a front all the time…Even if you're scared, you have to put on this persona of 'you can handle it, you can do this'. (Participant K)*

> *You have to be on the top of your game every day, you can't let it slip even for a moment, if you do the prisoners will have you, they're predators, I mean you're working with murderers for God's sake. If you seem weak, you can very easily find yourself in a dangerous situation. (Participant I)*

This supports Barry's (2020) application of Hochschild's (1983) 'feeling rules' to prison work: fear, anxiety, and sadness, were seen as unacceptable and often participants highlighted how it would have appeared inappropriate had they displayed these emotions. The notion of seeming '*weak*' to other staff was raised by multiple participants and was something all viewed as crucial to avoid. One could seem weak by avoiding working on prison wings after witnessing trauma, or by expressing emotions discouraged by the feeling rules (Barry, 2020; Hochschild, 1983). This supports Crawley (2004) and Wright et al.'s (2006) previous findings that appearing as weak due to not displaying the 'correct' emotions in the workplace could leave staff feeling isolated. Walker et al.'s (2017) argument that prison officers employ a 'façade of capability' is also supported here as the participants felt they had to '*put up a front*' that showed them as able to witness traumatic experiences and be unaffected by these.

Staff spoke of using humour to deal with their emotions from work, many drew attention to their use of '*dark humour*'. The use of humour appeared to fit within the feeling rules in place – it was not appropriate to feel sadness or fear about their work, but officers and ex-officers were expected to joke about it.

> *You don't talk much, but you laugh about stuff, deep down I think we all felt the same, we all felt scared and depressed…but we didn't want to show it to anybody. [Mental*

> *health] was never talked about…Nobody ever talked about how they felt. (Participant F)*
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> *Now, not being in the prison I feel I can breathe, I'm not putting on a face all the time…You put on a face and you pretend it's not bothering you, everything you've seen and witnessed and been a part of, you pretend. You switch off to an extent and it creeps up on you and eats you up. You divert things and pretend it's fine and you use humour as the way out of it all. (Participant H)*

Whilst this may seem difficult to comprehend to others, the use of dark humour is a well-documented phenomenon amongst prison staff (Schmidt, 2013). Humour is thought to help officers create a group dynamic (Nielsen, 2011; Schmidt, 2013), an essential aspect of prison work. The current study found it was a critical aspect of the experience of PTSD in ex-prison officers: humour provided a method of managing emotions whilst not deviating from existing feeling rules.

Awareness of PTSD amongst staff

All participants believed PTSD was experienced by many serving and ex- officers and spoke of the multitude of PTEs they and their colleagues had endured. However, interviewees highlighted how officers rarely discussed their struggles with PTSD amongst each other.

> *I think a great many of them [colleagues] had PTSD…It's laughed off and there's a 'shit happens' approach. (Participant G)*

This was in line with the previous finding that feeling rules dictated what people felt able to share with one another and supported previous literature (Barry, 2020).

Participants said many of their colleagues or ex-colleagues with PTSD had not been formally diagnosed. Often, participants only realised other staff may have been experiencing PTSD as

they looked back on their service and noticed their colleague's behaviour had matched their own. Only a small number of participants had been told by colleagues they also had PTSD. It was clear that despite a prison culture which discouraged individuals from discussing their struggles, participants remained aware of PTSD amongst staff and this formed an integral part of ex-officers' experiences.

> *I have known quite a few [colleagues with PTSD]. [Some] have actually been diagnosed… a lot haven't… but I know that they definitely do have it. (Participant L)*

> *I know for a fact that there are [prison officers] on duty still working there that are struggling with PTSD. (Participant I)*

This suggests that the prevalence of PTSD amongst serving and ex- prison officers could be higher than already estimated (James & Todak, 2018; Regehr et al., 2021). For example, if many individuals actually have PTSD but have not been highlighted as suffering from it, they would not contribute to existing estimates, resulting in a lower actual prevalence rate. Furthermore, these results add credence to the argument that PTSD may be just as widespread within officers in UK prisons as it is internationally (Regehr et al., 2021).

Substance misuse

Participants spoke of how substance misuse was entwined with the culture amongst prison staff. Nearly all participants reported excessive alcohol consumption during their time as an officer and one mentioned misusing prescription drugs. Substance misuse appeared to serve as a way of managing the emotions the PTSD and their jobs caused.

> *I ended up drinking a lot more than I realised, it was almost a case of wanting to still be in a haze when you go to work next morning. (Participant H)*

> *I was drinking a lot, taking prescription drugs. My wife had some strong co-codamol from the doctors, so I'd come home from work and have a couple of co-codamol just to calm down a bit, that became the norm. (Participant K)*

Participants' substance misuse was not seen as abnormal by their peers, or representative only of the current sample; instead, it formed part of the 'prison culture': participants highlighted other officers drank large amounts of alcohol and drug usage amongst staff was mentioned by two participants.

> *There was a massive culture of drinking in the prison, heavily drinking, we all kind of masked it [trauma] behind that. (Participant D)*

> *I was telling [colleagues] I was drinking every night, that I was having a glass of wine every night, they were saying 'oh well I wouldn't worry about that', then you think 'wait a second, what are you doing every night, how much are you drinking ?', they're telling you not to worry about it. (Participant A)*

The majority of participants spoke retrospectively about drinking heavily – this was no longer something they engaged in and seemed primarily tied to when they were working as an officer. Therefore, this supports the argument that substance misuse formed part of the prison culture and was accepted as an appropriate way of managing one's emotions.

> *When I retired, within 2 weeks I'd stopped drinking…At one time I was drinking a bottle a day, maybe even more. I'd go home at night and just start drinking, and on my days off, that's all I wanted to do. (Participant F)*

This finding supports existing literature which highlighted the high substance use levels amongst individuals with PTSD (Head et al., 2016). Head et al. (2016) found military personnel with PTSD, who had held a combative role, were more likely to misuse alcohol than individuals in a non-combat role with PTSD. This is important to the current study's

finding as prison officers could be argued to be in a 'combative' role – their work is physically demanding and they can be faced with extreme violence and aggression (Fusco et al., 2021). Thus, their likelihood of alcohol misuse could be higher than individuals in the general population with PTSD not caused in a combative role. Similarly, Conard and Sauls (2014) and Crawley (2004) found substance misuse levels to be high amongst prison officers.

Theme 4: Major Impact of PTSD

Impact on relationships

All the ex-prison officers interviewed reported how PTSD had impacted their relationships with family and friends. Many reported feeling angry and emotionally numb, leading to them socially withdrawing from their loved ones, key symptoms of PTSD which heavily impacted their experiences (APA, 2013).

> *I don't want to see anybody, I don't want to meet anybody, my marriage broke up…I'm quite angry at times. (Participant B)*

> *I became very angry at times…not talking to anybody. Just sitting down and drinking and not talking to my wife…I wasn't a very nice person for a period of time, put it that way. (Participant C)*

> *I was short-tempered. I couldn't be bothered talking to people. I didn't worry about things, I didn't care about things. (Participant F)*

As well as impacting their own behaviour towards loved ones, the PTSD influenced how participants' loved ones felt and behaved towards them. For example, participants spoke of how their families had difficulty understanding and anticipating the ex-officer's moods.

> *If you're having a bad day you don't want anyone near you. I know others [with PTSD] who don't have a family anymore, they have lost everything because of the PTSD. It*

> *takes a massive toll on loved ones, they're worrying about how you are that day, whether very dark thoughts are going through your head, sometimes they feel shut out because of how you are…the PTSD causes me to become very distant…I will sit there and not say anything or forget where I am and think I'm in work again. (Participant L)*

> *I'd come home from work and [Participant K's family] didn't really know what I was going to be like, whether I was going to fly off the handle or drink myself into oblivion. (Participant K)*

Relational problems are well grounded within existing research on PTSD (Campbell & Renshaw, 2018). In particular similarity with the current finding, Ray and Vanstone (2009) found individuals with PTSD often reported their emotional numbing and anger negatively impacted upon their romantic relationships. Furthermore, researchers have found prison officers experience difficulties with their family relationships (Lambert et al., 2014). Thus, this finding illustrated how a major aspect of serving and ex- prison officers' experience with PTSD was the impact it had on their relationships.

Suicide

Many of the interviewees spoke about suicide and demonstrated it was a key aspect of their, and other officers', experiences with PTSD. Some participants spoke openly about how they had had suicidal ideation and intent and talked explicitly about plans they had had previously.

> *Because things were going so wrong, I had planned to throw myself in front of a train. I worked out that if I threw myself sideways into a train, the driver wouldn't be as affected. That's how deep I went. (Participant A)*

Others spoke more implicitly about feeling suicidal.

> *I didn't like where my mental health took me…I still have thoughts about what I might have done, and then that would have been it, the end. [PTSD] took me right to the edge and I feel guilty about that. I said to my psychologist 'I'm not sure that any work you do with me would ever get rid of that feeling'. (Participant I)*

Many of the participants discussed how they knew colleagues or ex-colleagues from their time as an officer who had committed suicide, and they believed this was due to these individuals suffering from PTSD.

> *A lot of people in our job have killed themselves…they didn't know what was wrong with them, just had a gun and took the easy way out. (Participant F)*

> *I had some really really dark thoughts, I felt suicidal…I've lost two really good friends to suicide, both prison officers. (Participant K)*

Whilst it is impossible to speculate over the cause(s) of an individual's suicide, it was clear the participants attributed their own suicidal ideations and intention to their experiences of PTSD. Furthermore, suicidality is a well-documented phenomenon amongst individuals with PTSD (Gradus et al., 2010), and has been shown to be higher in prison officers than other occupations (Milner et al., 2017; New Jersey Police Suicide Task Force, 2009). Therefore, PTSD majorly impacted ex-prison officers' lives by their own, or their colleagues', suicidality.

Long lasting

All the participants reported ways in which they still struggled with their PTSD, despite no longer being employed as a prison officer. Many of the participants described that they had irreversibly changed since developing PTSD.

> *PTSD changed everything for me. I used to be the lead in the house, now I'm almost like a child…I also forget everything…I can't process more than one task at all…I'm the opposite to what I was…I've accepted that I might never get better, which takes a lot of difficulty. (Participant A)*

> *I'm not coping now, if I were to be brutally honest. Sometimes I won't go out the house or I'm fearful about going out. (Participant D)*

Positively, the majority of participants had experienced reductions in their PTSD symptoms since stopping working as a prison officer. Still, multiple interviewees discussed how their continuing PTSD made them feel as if their time as a prison officer was never far from their mind, and many had to adjust their behaviour outside the prison around members of the general public due to this.

> *It's like a cloak over me, best way to describe it. I'm hypersensitive over my surroundings all the time. I see prisoners around me all the time… I see people and think they're an ex-con…I haven't really left the job in head. (Participant D)*

> *Things are better. I'm still on edge. I still have bad dreams. I still sit thinking about the day it happened. I always have it in my head…I always make sure I can see the door, so it's still built into me. (Participant F)*

PTSD is a mental health disorder which can be long lasting (APA, 2013). Without treatment, PTSD remission rates vary (Morina et al., 2014), and even with the use of anti-depressants commonly used for managing symptoms of PTSD, Berger et al. (2009) estimated only between 20-30% of individuals achieve a full recovery from PTSD. However, Morina et al. (2014) suggest that the true lifetime recovery rates are lower than research suggests due to methodological issues. For example, PTSD symptoms can vary at different time points, and

researchers would need to conduct extensive longitudinal studies to find accurate PTSD remission rates.

Therefore, with uncertainty surrounding recovery rates from PTSD, it is important to consider how the current results suggest that PTSD for prison officers may be particularly long-lasting compared to members of the general public suffering from PTSD. This could be due to the way prison officers' PTSD could develop. Often, the interviewees had not solely experienced one trauma and developed PTSD from this, but had experienced multiple PTEs over prolonged periods of time, amidst an environment with the constant threat of victimisation (Ellison & Caudill, 2020). This supports Doron-LaMarca et al. (2015)'s finding that military personnel with multiple traumas in a persistently dangerous environment experienced longer lasting PTSD than PTSD caused by a single trauma. Certainly, for the current study's participants, the long-lasting nature of their mental health disorder was an integral part of their experience of PTSD.

Conclusion

Limitations

Limitations include that these individuals are ex-prison officers, and they could be recalling their time as an officer with a more negative mindset if they are still suffering from PTSD; this could misrepresent the common experiences of serving prison officers. Indeed, prison officers who had more years of service were more cynical about their job than new staff (Morrison & Maycock, 2021). However, Morrison and Maycock (2021) found even officers who had less than 2 years of service began to be cynical and disillusioned with their job, suggesting that it is unlikely to be only officers and ex-officers with years of experience who felt this way. This suggests the current study's findings could be representative of the experiences of many other officers, with or without many years of service.

Also, participants volunteered for the study. These volunteers may have felt more aggrieved by their experiences and more motivated to talk about them than others who did not experience a lack of care for example. Therefore, there could be a volunteering bias which could misrepresent the wider population of ex-prison officers (Salkind, 2010). However, the study's aims were not to speak for every individual who has worked as a prison officer, but instead were to raise awareness and understanding of the experiences of those who specifically developed PTSD from the role.

One key limitation of the current study was that many individuals expressed interest in participating in the study and believed that they had PTSD, however, they had not received a formal diagnosis so were unable to participate. Whilst it is not uncommon for studies to require formal diagnoses as part of their inclusion criteria (Hundt et al., 2019), one of the findings of the current study was that many individuals experienced difficulty in receiving a diagnosis. Therefore, it is possible many ex-officers truly have PTSD but have no formal diagnosis and were then underrepresented within the study resulting in a less comprehensive understanding of the experiences of PTSD in UK ex-prison officers.

Implications

This study raises awareness and develops understanding of the experiences of ex-prison officers in the UK who suffer from PTSD. Practical implications include the study being presented to the POA's senior members. The results could be shared with many POA members, therefore this study could possibly encourage more ex- and serving prison officers to talk to one another about their experiences of PTSD. This could help to reduce the feeling rules (Barry, 2020; Hochschild, 1983) within prison work.

Additionally, the study highlights the need for more support available for both serving and ex- prison officers with PTSD. This could be via formalised support groups or telephone peer

support provided by workplaces or the POA. This would provide a much-needed safe space for ex- and serving officers to speak about their experiences away from the feeling rules of the workplace with others who understand what they have been through.

The current study highlights the lack of support participants perceived from managers. Thus, this study demonstrates the need for management to receive training on recognising and managing PTSD amongst prison officers they supervise. Training should include education surrounding what treatments are available, and how these can impact staff, such as how it would be best for individuals to have a period of recuperation after their emotionally draining psychotherapy sessions (Lowe & Murray, 2014). This would contribute to the 'cultural shift' Walker et al. (2017) called for within prison officers and senior management in order for staff to feel more able to admit their mental health struggles and when they need support. If managers provided better support for their staff and ex-employees with PTSD, they would be leading by example, which Walker et al. (2017) argued was essential for the cultural shift to occur.

Future research should focus on exploring the relationship between PTSD and work as a prison officer. Quantitative research methods, such as surveys, could be sent to serving prison officers and could explore the prevalence rates of PTSD in UK prison officers, as there has yet been no such study. The Posttraumatic stress disorder checklist (PCL-5) (Weathers et al., 2013) could be sent to officers to estimate prevalence rates. An estimated prevalence rate of PTSD in UK prison officers would continue raising awareness of this topic and could encourage more officers to open up about their own experiences if they feel it is something many others also suffer from. This could aid in bringing about the cultural shift so needed amongst prison staff (Walker et al., 2017).

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