Exploring Critical Incidents and Post-Traumatic Stress Among UK Prison Officers: Prevalence, Risk, and Protective Factors

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This report details a research project exploring the experience of post-traumatic stress among prison officers in the UK, with participant recruitment supported by the Prison Officers' Association (POA). It outlines the project methodology and key quantitative and qualitative findings, offering recommendations for stakeholders or others with professional or personal interest in this area, and areas for further exploration.

Background

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that can develop after experiencing or witnessing a traumatic event. It is characterised by symptoms such as reliving the event through flashbacks or nightmares, avoiding reminders of the trauma, and heightened alertness or feeling 'on edge'. These symptoms are often accompanied by changes in thoughts and mood, which might include shifts in how the individual sees themselves and other people (e.g. "no one can be trusted"), feeling emotionally numb, or the opposite, feeling overwhelmed by negative emotions like anxiety, sadness, or guilt. Many people who experience a traumatic event may go through some of these difficulties in the aftermath of the event but will generally get better after a few weeks. For some people, these symptoms may continue long afterwards, or there may be a delay of months or even years before symptoms appear.

Critical incidents are defined as threatening situations beyond routine experience, with the potential to overwhelm an individual's coping resources (Ruck et al., 2013). Whilst many occupations risk exposure to potentially traumatic events, those working in high-stress jobs with repeated exposure to critical incidents are recognised as being at higher risk of developing PTSD (Andersen et al., 2019). Other potential factors contributing to the development of PTSD include past adverse life experiences, lack of social support, and occupational factors such as work-related stress, long hours, and poor workplace relationships (Lee et al., 2020; Marmar et al., 2006; Weiss et al., 1995). Working in a prison environment presents unique challenges. Alongside other 'high stress' occupations, such as ambulance workers and police officers, prison officers have been found to have below-average outcomes in physical health, psychological well-being, and job satisfaction compared to other job roles (Johnson et al., 2005). Research in the United States has found the prevalence of PTSD among corrections [prison] officers to be higher than rates found in the general population, military, and law enforcement, affecting between 19 and 33.7% of officers (Denhof & Spinaris, 2016; James & Todak, 2018).

Prison safety has declined significantly over the last decade, with self-harm rates remaining at historically high levels and violence against both staff and prisoners continuing to rise (Prison Reform Trust, 2025). This suggests that prison officers face increased vulnerability of being exposed to events that may contribute to

the development of PTSD. However, there has remained little to no published research exploring the current prevalence of PTSD among UK prison officers. Improving understanding of this issue therefore appears to be a valuable area of inquiry, and a crucial step in ensuring access to evidence to inform prevention and treatment interventions at both organisational and individual levels. PTSD is also associated with an increased risk of other mental health disorders, suicidal behaviour, substance abuse, and poor physical health outcomes (Sareen, 2014) – further highlighting the need for early identification and access to appropriate support.

About this research

This research project employed a mixed methods design to investigate the prevalence of PTSD symptoms among UK prison officers, addressing a significant gap in the existing literature and enhancing theoretical understanding of post-traumatic stress within this population. The study aimed to identify risk and protective factors contributing to the development of PTSD symptoms in prison officers who have experienced critical incidents in the course of their work. Additionally, it explored the influence of personal and organisational factors, such as workplace environment and access to support systems, which were highlighted as moderating factors in the development of PTSD among US corrections officers by James and Todak (2018). Data collection involved an online survey to capture measurable data through a set of questionnaires while semi-structured interviews provided deeper individual and contextual insights into officers' experiences.

Study one: A quantitative exploration of prevalence, risk, and protective factors for PTSD symptoms among UK prison officers

The online survey was completed by 436 prison employees (334 men [74.7%], 113 women [25.3%]). All participants worked across prisons in England, Wales, and Scotland.

Table 1 presents a breakdown of participant demographics. While terminology and banding differ between private and public sector prisons, as well as between England, Wales, and the Scottish Prison Service, responses have been grouped into the most appropriate categories overall to better allow for meaningful comparison between groups.

Participants completed questionnaires measuring exposure to previous traumatic experiences (*Life Events Checklist for DSM-5 - LEC-5*); exposure to critical incidents at work (*Critical Incident History Questionnaire - CIHQ*); work environment (*Work Environment Inventory - WEI*); self-esteem (*Rosenberg Self-Esteem Scale - RSE*); resilience (*Brief Resilience Scale - BRS*); and PTSD symptoms (*PTSD Checklist for DSM-5 - PCL-5*).

Table 1: Online survey participant demographics

Demographic	n (%)
Gender	
Male	334 (74.7%)
Female	113 (25.3%)
Ethnicity	
White (English, Welsh, Scottish, Northern Irish, British, Irish, Gypsy or Irish Traveller, Roma)	431 (96.4%)
Asian, Asian British, Asian Welsh (Indian, Pakistani, Bangladeshi, Chinese, any other Asian background)	2 (0.4%)
Black, Black British, Black Welsh, Caribbean or African	1 (0.2%)
Mixed/Multiple ethnic groups	6 (1.3%)
Any other ethnic group	7 (1.6%)
Employment status	
Full-time	408 (91.3%)
Part-time	31 (6.9%)
Grade	
Operational Support Grade/Band 2	16 (3.6%)
Prison Officer/Band 3	235 (52.6%)
Senior Officer/Band 4	110 (24.6%)
Custodial Manager/Band 5	66 (14.8%)
Senior Manager/Governor	14 (3.1%)
Other	2 (0.4%)

Category	
Cat A/Maximum Security	98 (21.9%)
Cat B/Long Term High Security Estate (LTHSE)	116 (26.0%)
Cat C	104 (23.3%)
Cat D	28 (6.3%)
Female Closed	38 (8.5%)
Female Open	4 (0.9%)
Young Offender Institution (YOI)	23 (5.1%)
Other	35 (7.8%)
Main work location	
Residential Wing	212 (47.4%)
Induction Wing	12 (2.7%)
Specialist wing or treatment service, e.g., Therapeutic Community or Psychologically Informed Planned Environment (PIPE)	25 (5.6%)
Reception	23 (5.1%)
Visits	5 (1.1%)
Healthcare Wing/Inpatient Unit	6 (1.3%)
Segregation Unit	15 (3.4%)
Close Supervision Centre (CSC)	6 (1.3%)
Escorts/Externals	1 (0.2%)
Gym	16 (3.6%)
Offender Management	23 (5.1%)
Operational Support/OSG	19 (4.3%)
Security	23 (5.1%)
Safety	6 (1.3%)
Other	53 (11.9%)
Length of service (years)	
Less than 1 year	5 (1.1%)
1–2	24 (5.4%)
3–5	44 (9.8%)
6–10	74 (16.6%)
11–15	43 (9.6%)
16–20	60 (13.4%)
More than 20	197 (44.1%)

Study two: Exploring critical incident exposure and PTSD symptoms among UK prison officers through semi-structured interviews

Semi-structured interviews complemented the online survey in study one, facilitating deeper exploration of officers' experiences with critical incidents, trauma symptoms, coping strategies, and workplace support.

Study two aimed to explore the following research questions:

- What is the nature of the traumatic incidents that prison officers are exposed to and how is this relevant to the development of PTSD?
- How do prison officers cope with PTSD and incident-related stress?
- What support mechanisms are available to prison officers and how do they experience them?

Nineteen participants (14 men [73.7%], 5 women [26.3%]) with a mean age of 44.16 years (SD = 12.13), took part in the interviews. All were currently employed across prisons in England, Wales, or Scotland, except for one recent retiree. Participants had a range of 3 to 36 years of experience working in the prison service, with a mean of 208.63 months (SD = 126.84) or 17.39 years. All identified themselves as being from a white ethnic background (including White English and White Scottish). For further breakdown of interview participant demographics see Table 2.

Participants were randomly selected from 160 individuals who expressed interest in completing a follow-up interview after engaging with the online survey in study one. Email invitations were sent in blocks of 10 until the quota of 20 participants was reached. Of 79 invitations sent, 25 responded, yielding a 31.6% response rate.

Interviews lasted between 60 to 90 minutes and were conducted over Microsoft Teams. An open-ended interview schedule (e.g., "When you are responding to an incident, what helps you to prepare?") ensured consistency across interviews while allowing for flexibility in responses. Questions covered predisposing factors (e.g., operational experiences, prior training), exploration of specific incidents and peri-traumatic experiences (e.g., fear for safety, physical reactions), and post-incident trauma symptoms, processing of events, and accessing workplace support.

Interview transcripts were analysed using thematic analysis (Braun & Clarke, 2006), chosen for its benefits in providing a flexible and adaptable framework for analysing qualitative data, whilst offering detailed insights into participants' perspectives. Five overarching themes were identified to address the research questions.

Table 2: Semi-structured interviews participant demographics

Demographic	n (%)
Gender	
Male	14 (73.7%)
Female	5 (26.3%)
Category	
Cat A/Maximum Security	5 (26.3%)
Cat B/ Long Term High Security Estate (LTHSE)	6 (31.6%)
Cat C	1 (5.3%)
Cat D	3 (15.8%)
Female Closed	1 (5.3%)
Young Offender Institution (YOI)	1 (5.3%)
Other – including specialist/regional roles	2 (10.5%)
Main work location	
Residential Wing	7 (36.8%)
Induction Wing	3 (15.8%)
Visits	1 (5.3%)
Healthcare Wing/Inpatient Unit	1 (5.3%)
Segregation Unit	1 (5.3%)
Escorts/Externals	1 (5.3%)
Offender Management	1 (5.3%)
Safety	2 (10.5%)
Dedicated Search Team (DST)	1 (5.3%)
Union Representative	1 (5.3%)
Grade	
Operational Support Grade/Band 2	1 (5.3%)
Prison Officer/Band 3	13 (68.4%)
Senior Officer/Band 4	1 (5.3%)
Custodial Manager/Band 5	4 (21.1%)

Key quantitative findings

Prevalence of PTSD symptoms

- With the data collected in study one, PTSD symptom prevalence was measured using a PCL-5 (PTSD Checklist for DSM-5) cut-off score of 38 or above. This more conservative cut-off had been recommended for classification of PTSD in comparable studies (James & Todak, 2018; Murphy et al., 2017).
- Using this cut-off score, 51.7% of the sample met the criteria for clinically significant symptoms of PTSD based on their self-report. The mean PCL-5 score across the sample was 37.91 (SD = 21.29). It is important to note that the PCL-5 questionnaire is used to assess symptom severity and is not intended to be used on its own to diagnose PTSD.

Contributing factors

- Although most demographic factors did not show significant differences in PTSD symptoms, staff in the category of '6–10 years' experience had higher PCL-5 scores than those within the 'over 20 years' category.
- Age was negatively correlated with PCL-5 scores, indicating that older staff generally reported fewer symptoms of PTSD.
- Previous trauma exposure correlated with higher PCL-5 scores. This suggests that staff who reported greater exposure to traumatic experiences in their personal history often reported higher levels of PTSD symptoms.
- Greater cumulative critical incident exposure strongly predicted higher PCL-5 scores. Thirteen critical incident types were correlated with increased PCL-5 scores, with those involving exposure to direct harm, intentional injury, or assault often linked to higher levels of reported PTSD symptoms.
- The incidents most commonly experienced by officers included: witnessing suicide attempts; serious assaults on prisoners; receiving serious threats; and witnessing colleagues being injured. Additionally, 80.6% of participants reported encountering a deceased body at least once during their work.
- Work satisfaction scores negatively correlated with PCL-5 scores, suggesting lower levels of PTSD symptoms were reported among those who perceived their work environment as positive and supportive.
- Meanwhile, work frustration scores showed a strong positive correlation with PCL-5 scores, suggesting higher work frustration was associated with higher levels of PTSD symptoms among the sample.
- Higher self-esteem and resilience scores were negatively correlated with PCL-5 scores, suggesting that these factors were associated with lower levels of PTSD symptoms.

Interview responses

From the semi-structured interviews, five overarching themes were identified to address the research questions and are presented with illustrative examples below. The number of participants endorsing each theme is captured within parentheses.

Theme 1: Familiarity, and perceived ability to deal with the critical incident as a pre-cursor to trauma (n=18)

Within this theme, many officers described frequent exposure to extreme situations, including severe self-harm, suicide, extreme violence, and other life-threatening scenarios.

> *…what affected me then was seeing too many staff, too many of my colleagues being assaulted. Witnessing violence not just on staff, prisoner on prisoner. Witnessing death, prisoner on prisoner... One of the hardest things I've had to do when I look back and troll through everything was having to restrain somebody who was trying to hurt themselves. Cutting people down or trying to hang themselves that's hard work [Officer A]*

Many felt unprepared by their initial training for handling complex mental health and medical emergencies, lacking the knowledge and skills needed for the unpredictable and extreme situations they could be dealing with.

> *If I think back to my original POELT [Prison Officer Entry Level Training] training…I would say that that didn't prepare me at all for working in the prison [Officer B]*

> *I wanted to know if they've got a mental health, what are their reactions? How's the best way to approach them?... You know, sometimes you just need a bit more training and understanding because as you probably know, your first reaction to someone with mental health is the one that they remember [Officer L]*

> *The self-harms are the really traumatic events because you can prepare for anything else, but nothing will fully prepare for stuff like that and definitely not an afternoon, won't prepare you for it… And that was back in 2018 when I did my initial training. They spoke about how people would self-harm. And people might take their own life. But it's not really discussed like how extensive, how like messy it is, how dramatic it is, what will happen after, that was never discussed [Officer J]*

The impact of indirect or secondary trauma, such as in the context of reviewing case files, incident footage, or being present in the incident control room was also noted.

> *Even though we're not prisoner facing all we listen to is self-harm. Suicide. We're always in regional prevention suicide meetings where there's a lot of negativity and morbid information that we take on [Officer I]*

> *I need to control the incident. I need to work out what emergency services to ring sometimes, and you're watching it on the camera and you can't go there or do anything [Officer Q]*

Reading through sex offender stuff can be quite difficult. And I feel like some sort of guidance should be given on that… there should be people checking up, everything's all right, with what you're reading and stuff and that you feel OK enough to be dealing with them [Officer H]

Theme 2: The longevity of impact following exposure, including trauma symptoms (n=17)

Officers reported experiences of symptoms consistent with PTSD, including flashbacks, nightmares, avoidance, negative changes to their thoughts and mood, heightened anxiety, and hypervigilance.

After that, like all the flashbacks started happening and like, well, I started having audible flashbacks first, and I started even hearing general alarms and cell bells. Like sat in me living room, and I'd hear one [Officer R]

After that death in custody, I had sort of very vivid dreams, and I was half asleep at night and waking up… I drank some water, and it was literally like I thought the bloke that was having the CPR [cardiopulmonary resuscitation] was next to my bed [Officer P]

One minute I was really angry. Really angry. And then I'll be crying. And then I tried to come back to work. After a few weeks. And I lasted all of about half an hour. Where the anxiety just kicked in within about half an hour, being in work. Going to lock myself in a toilet. And then that was it. Then I was off for probably about five months after that [Officer G]

The way I'll sit to do my job… is a lot different to how I was in the day. I'm more wary if it makes sense. More I'm trying to think, alert that something could go wrong. I'm ready for it… Yeah, if there's trouble there, I'm more aware. Which is awful cos at times I'll just come home and I'm shattered from constantly being on edge [Officer E]

It's a really weird feeling. You already feel negative about yourself. All these feelings that you feel after and then you feel even more negative, you feel like maybe I can't. Maybe I can't do my job then because I'm like this. It makes you feel worse [Officer J]

It was the doing CPR on a rigid corpse when there was no way of bringing him back, cos he was long gone. So yeah, I'm no medical professional, but rigor mortis and everything had set in, and he is not coming back, and it just couldn't logically sit in my head that I was basically destroying an old man's body for nothing [Officer O]

Officers reported that traumatic incidents continued to affect them long after the event, including changes to their working behaviours and impact on personal relationships. They found it difficult to share experiences with family and friends who did not understand the nature of their work.

Every day, every time you unlock a door, yeah. It never goes away. It's never far away [Officer C]

It made me very hard at one point so that, that changed me from being quite a soft grey person in a corner, as I've been described, to becoming hard and I didn't even realise it [Officer G]

I find it hard to be empathetic to people who are moaning about, like, mundane things that happen at work. I'm like, well, yeah, but I'm. I do think that if things are difficult, I stay away from people who don't understand what's going on [Officer S]

*But for me to just offload onto one of my colleagues, I wouldn't want to put that on them anyway. Same as I never discussed it with my wife because I wouldn't want to discuss those incidents with her because she doesn't need that **** in her life [Officer B]*

It was sort of a year to 18 months of not good times, it nearly caused a family breakdown because I just, I couldn't really speak to anybody. I'd just go and sit in the car for hours on a night… the only reason I didn't end up taking my life was because of my son [Officer O]

Theme 3: Conforming to perceived expectations around the officer role and coping with distress (n=15)

Many officers described a sense of emotional numbness or detachment as a coping mechanism, needing to suppress emotions to be able to function in their work.

We are portrayed as being these strong people, not worried, not scared, not bothered by these things, where a lot of us it does bother us. Like a lot of my colleagues, some of my colleagues have ended their own lives [Officer J]

But initially when I first started, then seeing somebody cut their arm in front of you or the neck in front of you, that's, it's quite hard to take initially, but then you just seem to just get used to it. Just something like you come into work and if it happens, it happens. If they're done, they're done [Officer K]

I'm very good at just shutting things away. We have a bit of a saying here that we're a bit dead inside, so we don't react to things the way normal people would. Because it isn't normal seeing people try to kill themselves with like blue faces, you know like almost dead… and then you go and just make a cup of tea for somebody. So that isn't normal behaviour. But that's how we behave [Officer S]

Many relied on dark humour and camaraderie with colleagues to manage stress and normalise their experiences. Shared humour made challenging situations more manageable, less overwhelming and fostered a sense of belonging.

Well, the biggest thing for me from day dot of starting has always been the banter. It's dark, it's twisted, but that's the way people get through the day… it can burst that little bubble of overwhelming sort of panic and just bring it back down to a level and get you back in the room and straight back onto it [Officer O]

You don't realise I don't think at the time that the amount of stress that you're under and we all have different coping mechanisms… I mean our sense of humour is appalling. But it is how we deal with things, you know [Officer D]

Several participants mentioned compartmentalising their experiences and ‘leaving things at the gate’, though acknowledged that this could ‘spill over’ with time.

> *I always think with this job you come in the gates in the morning, and you can be whoever you need to be. And when you leave, you leave it all here [Officer S]*

> *My way of dealing with trauma is to put it in a box and lock it away. And don't think about it. So of course, at some point your box becomes full and you've got to process it [Officer B]*

> *I've got a very robust character, but even then I still wax and wane at times and the older I get, the more the waning becomes longer. That's the way I put it. The robustness doesn't seem to be, it's like, it keeps spilling over a bit more [Officer F]*

Officers needed to normalise their experiences, downplay traumatic events, and maintain a "roughty toughty" attitude to stay strong and appear unbothered. One officer noted that this culture promotes a collective silence around emotional struggles, potentially making it difficult to seek help or express vulnerability.

> *And you’re sat there in front of your colleagues and then you're like, well, no, if he's alright, I'm alright. It's, you know, a room full of testosterone and bravado and they turn around going ‘has anybody got any problems?’. Oh yeah, this is the one place I'm going to mention I've got a problem [Officer R]*

> *I don't think they want to feel like they're weaker than someone else, because when you're in that establishment, you're know you've got a hard face, you've got to be hard with this. We're dealing with like a really hard environment. Don't let anyone see your emotion [Officer I]*

> *I don't feel comfortable in talking about stuff that, especially if it has affected me it's, and you could say it's a bit of a bravado thing, it is but you know it's we're roughty toughty screws aren't we, we shouldn't have to, but I get it I know that's not the right way to look at it [Officer B]*

Theme 4: Perceived effectiveness of support agencies, including accessibility in the long-term (n=19)

Many officers reported inconsistent access to support services, such as being missed from post-incident debriefs or un-actioned referrals. Some expressed scepticism about the effectiveness of workplace support, feeling it resembled a ‘tick box exercise’ rather than a genuine effort to address their needs, and questioned the appropriateness and confidentiality of peer-led interventions.

> *That happened in 2022, November. I've still not had any contact about the TRiM [Trauma Risk Management]. So that's it. Feels to me you've got your mental health allies, your care team, your TRiM, all that they offer you is a tick box exercise… My partner had a death in custody on nights a few weeks ago. Took them five days to phone him up and ask him if he wanted TRiM [Officer I]*

> *It's just really awkward because it was someone that's at work. I feel much more uncomfortable because it's the judgement thing. You don't want to disclose something to someone, and even though it's confidential, you don't want to have that feeling ‘OK, I'm going to see them at work’ and I feel like they would judge me for feeling that way or whatever [Officer J]*

I think there's sort of a stigma relating to the care team and the TRiM that they're more official and that they would sort of go running back to management, which I could say is wrong, isn't it, but it's the belief that it's that [Officer D]

Opinions on the effectiveness of group versus individual support varied. However, those in specialist roles often highlighted the benefits of regularly offered structured support interventions such as IPD (Individual Professional Development), a peer-led group supervision designed to offer those in high-risk areas opportunity to reflect on the impact of their work.

It takes away the doubt that you might have in your head of 'oh did I miss something?', is there something there? It takes away from it being isolated or individual for me and brings it into a team context where everybody can see we all make mistakes [Officer N]

Because you're talking to your colleagues and that's not. That's not an easy thing to do, to tell your colleagues that actually, that really that hit a chord with me. I struggled with that. It's not easy from my background, it's not an easy thing to do. That's why we have the CID [Critical Incident Debrief] and the senior psychologist, actually somebody you can approach separately if you want to talk about feelings about an incident, they're the people you go and speak to [Officer B]

Those who accessed therapy through employee assistance programmes, particularly Eye Movement Desensitisation and Reprocessing (EMDR), generally spoke of this positively. However, they often faced barriers in referrals being actioned, dissatisfaction around the limited number of sessions provided, and difficulties accessing additional episodes of therapy or support from other services.

I got help through work… they got me in touch with a therapist and I had EMDR therapy. Which at the time helped, it enabled me to sort of put it to sleep, where I could start sleeping again. I could start being normal and moving on [Officer E]

About five months later occy health referred me for some EMDR therapy. But then they didn't activate the referral on their end. So, for three more months, I sat in limbo. Mental health wouldn't touch me outside, doctors wouldn't touch me outside, they put me on antidepressants, changed them a couple of times [Officer O]

The importance of accessible, ongoing support - beyond immediate post-incident debriefs – was highlighted, with many viewing recovery as a long-term process or acknowledging that issues may arise later due to cumulative effects.

Sometimes... it doesn't strike you at that time. It could be two or three years down the line. It could be the next incident that triggers it off because of the first incident. So there's different trigger points for different people [Officer C]

You are offered support soon after the incident. But I know from my personal experience that I've struggled with it since then and that happened in 2022, and it's 2024 now, when I still sometimes struggle with it and there's no support there for that [Officer J]

Theme 5: Barriers to individualised support following incident exposure (n=18)

Some officers described supportive managers who actively checked on their wellbeing and facilitated access to support.

> *He was quite supportive. Well, very supportive. Put me on restricted duties. When I first went back, when the CBT [Cognitive Behavioural Therapy] started, at first I was allowed to do it from home but then go to work. But I think the first two sessions completely threw me. And in the end, he allowed me to work from home when I was having them sessions, which helps you know cos then then I could have the session. I could stay at home [Officer M]*

In contrast, others felt that managers or those who were not present at the incident often failed to appreciate the distress and trauma they had faced, leading to feelings of being 'just a number' in the system and feeling undervalued.

> *A comment got made to me "Well, I don't understand why you need therapy again. You've had this two years ago. Why do you need it again?" … I'm just a size 10 boot, easily replaceable and that's how management or the system… the system makes you feel [Officer A]*

> *So, one day I was working on there and nothing particular happened, but I was just struggling with it. And I went up to one of the supervisors and said, look, I need to switch, I need to be somewhere else. I just can't do it today. And they said "You have to get over it at one point or another" [Officer J]*

> *In that time they had used a de-fib on him. He'd come back to life, which was great. So the manager then came in… but I was shaking quite a bit and was like "They're going now. Can you still go on the escort?" ... I think a manager realistically should have looked me up and down and said go home. We'll sort out someone to take you home [Officer Q]*

Discussion

This research looked at factors that may increase or reduce the risk of prison officers developing PTSD after exposure to critical incidents at work. It included two parts: an online survey to measure self-reported levels of PTSD symptomology and other personal and workplace factors; and semi-structured interviews to understand officers' personal experiences of incidents and the support they received.

Prevalence of PTSD symptoms

More than half of the officers surveyed self-reported elevated levels of PTSD symptoms, with 51.7% meeting the cut-off score of 38 on the PCL-5, indicating clinically significant symptoms. This prevalence is notably higher than rates reported in comparable studies of U.S. corrections officers, which range from 19% to 34% (Woodfield et al., 2023). While the prevalence rate in the current study is elevated, it is perhaps unsurprising given the inherently stressful and risky nature of prison work. Previous research in similarly high-stress roles has shown that chronic stress and repeated exposure to potentially traumatic incidents are recognised risk factors for the development of PTSD (e.g., Andersen et al., 2019).

Relationship of PTSD with other factors

Older age was associated with lower levels of PTSD symptoms, and staff in the category of '6–10 years' experience had higher PCL-5 scores than those with 'over 20 years' experience. This suggests that age or greater occupational experience may contribute to coping with critical incidents. This aligns with findings from study two, where officers described feeling their initial training had not prepared them for dealing with critical incidents, but that their instinct and ability had developed over time. The term 'jail craft' is commonly used among officers to refer to the knowledge and experience of prison work that helps them to maintain order and manage the demands of their role (Peacock et al., 2018). However, in study two, many officers also noted that their 'roughty toughty' attitude had become more ingrained and could discourage them from seeking help. Therefore, while developing 'jail craft' could aid in coping with critical incidents, it may be that this also reinforces expectations for officers to suppress their struggles.

On the other hand, in study one higher levels of self-esteem were found to mitigate PTSD symptom severity. Many studies note that self-esteem often peaks and remains stable in middle age (Reitz, 2022). This may suggest that older age and longer service, where this combines with improved 'jail craft', can collectively buffer against the development of PTSD.

Critical incident exposure

The more frequently officers were exposed to critical incidents, the higher their reported levels of PTSD symptoms. Incidents with the strongest correlations tended to be those involving direct harm (e.g., 'being seriously injured intentionally'), suggesting experiencing a sense of personal threat may impact on subsequent development of PTSD. This is in line with literature suggesting that direct exposure to threatening situations can create a vulnerability to developing PTSD (Andersen et al., 2019).

In study two, some officers also experienced PTSD symptoms following indirect exposure, such as witnessing violent incidents towards others. This indicates that other factors may also influence the relationship between incident exposure and PTSD. For instance, in study one, perceived severity of incidents showed a small positive correlation with PCL-5 scores. This may highlight the role of subjective judgements, consistent

with existing theoretical models (e.g., Cognitive Model of PTSD [Ehlers & Clarke, 2000]), whereby how an individual thinks about or interprets an event can contribute to the development of PTSD.

Other personal vulnerabilities may also contribute to the development of PTSD among prison officers. For example, greater exposure to previous trauma outside of the work-role correlated with higher PCL-5 scores – suggesting that a history of past trauma may heighten vulnerability to developing PTSD after new incidents are experienced at work. This aligns with existing literature, which highlights that cumulative direct and indirect trauma exposure can increase the risk of developing PTSD (da Silva et al., 2024; Even et al., 2024).

Work environment

Workplace culture and support appeared relevant to PTSD symptomology across both studies. In study one, higher work frustration scores correlated with higher PCL-5 scores, particularly where work-related issues impacted personal relationships and wellbeing. In study two, officers often described a culture of stigma and emotional suppression to meet perceived expectations in their role. The Job Demand-Control-Support (JDCS) model explains how work environment demands, role autonomy, and social support affect staff wellbeing (Häusser et al., 2010). Consistent with this, study one showed that officers with higher work satisfaction scores, including feeling understood and supported by management, reported lower levels of PTSD symptoms. Study two reinforced this, where officers who felt recognised and valued by management described more positive experiences of help-seeking and support. Overall, these findings suggest that work satisfaction and appropriate support may help protect against PTSD among prison officers.

Strengths and limitations of this research

This research highlights an important but under-studied topic. Using surveys and interviews provided a comprehensive overview of that challenges prison officers face. The large sample size of participants who volunteered to take part, and high rate of PTSD symptoms reported, potentially emphasise the significance and relevance of this issue.

However, the study is not without its limitations. For example, the research included only those who had volunteered to take part (rather than all currently employed prison officers nationwide). This might mean the findings represent only those already affected by PTSD, more than the general prison officer population. Furthermore, this research focused specifically on the relationship between prior trauma history, critical incident exposure, work environment, self-esteem and resilience, and the development of PTSD – meaning the findings may not necessarily account for other factors that could be at play.

Finally, trauma is a complex experience, which may not be fully captured in self-report surveys. The PCL-5 questionnaire cannot be used in isolation to diagnose PTSD, and therefore can only be used to provide an estimate of the degree of symptoms of PTSD reported by participants in this sample.

Recommendations

In terms of practical implications, it seems important to encourage a preventative and proactive approach to addressing trauma among prison officers and creating more supportive work environments. The recommendations below are likely to be of relevance for any individual or organisation supporting prison staff.

Awareness

- There were no significant differences in PTSD symptoms based on demographic factors such as gender, ethnicity, staff grade, or assignment location. This suggests that PTSD can affect *any* staff member regardless of their background, grade, or work location. This highlights the need for support initiatives to be available to *all* employees, rather than just those in roles that are deemed to be more high risk.
- Staff at all levels could therefore benefit from increased education on how post-traumatic stress can develop, and signs and symptoms associated with PTSD. It is important to communicate that PTSD is a normal response to significant or extreme events, it is treatable, and many people recover entirely with the right support.

Improving support

- Officers reported that debriefing was not always offered consistently. However, there is generally mixed evidence around the effectiveness of debriefing, with some research suggesting that debriefing may actually increase the risk of developing post-traumatic stress symptoms (Stileman & Jones, 2023).
- Ensure that post-incident support is easily accessible and offered consistently to all who may have been directly or indirectly impacted by an incident.
- Considering the availability longer-term care - beyond immediate post-incident support - may help address the potentially delayed onset of the aftereffects of trauma.

Leadership and work culture

- Job-related frustrations, such as feeling unsupported by management or placed in unnecessary danger, were linked to higher reported PTSD symptoms. This suggests that organisations should prioritise fostering a culture of trust and openness between colleagues and supportive leadership, ensuring staff feel safe and valued in their roles.
- Organisations should aim to normalise discussions around metal health and trauma to reduce stigma, encouraging openness and compassionate responses to those who may experience PTSD.

Training and mentoring

- Many staff reported feeling their routine training does not prepare them adequately for the incidents they face at work.
- It is of note that more experienced and/or older staff often reported lower PTSD symptom scores, which perhaps presents an opportunity for mentorship programs to be developed that pair experienced staff with newer employees. This may help facilitate knowledge transfer and emotional support, guiding newer staff in managing the unique challenges of their roles.
- This may further promote a culture of openness, reduce stigma, and increase acceptance of emotional or mental health difficulties between colleagues.

- Higher self-esteem and resilience were associated with lower rates of PTSD symptoms. Therefore, initiatives that foster personal and professional growth among staff may encourage a sense of empowerment and support their wellbeing.
- This may include training programs aimed at upskilling staff and improving confidence in identified areas of training need, stress management workshops, education on post-traumatic stress for both frontline staff and managers, and improving peer support networks, which could help staff to develop the skills necessary to navigate the stresses of their roles more effectively.

Evaluating current initiatives

- The subjective experiences of workplace support initiatives such as TRiM, Care Team, and Mental Health Allies were mixed. Many officers seemed to lack confidence in the expertise of those delivering these interventions and doubted their use of such services would remain confidential. Building trust in these programmes could increase their effectiveness.
- Those in specialist roles with access to additional mental health training or support, such as IPD groups, or an allocated psychologist, consistently spoke highly of their experiences. Officers working in locations like healthcare or detox wings reported that they were not eligible for the same support as 'discrete unit' staff even though they were also exposed to complex or challenging prisoners. It may be worthwhile for organisations to find ways to replicate these initiatives for all staff groups, recognising the risk of developing PTSD for those at any grade and working on any location.
- Those interviewed were less certain on how to improve delivery or encourage individuals to access workplace support. Further research and evaluation of current initiatives, understanding what works, or exploring barriers to accessing current support may therefore be of value.

Conclusion

This study offers valuable insight into the prevalence, risk and protective factors associated with the development of PTSD among UK prison officers, an area that has previously been under-researched. The findings indicate elevated levels of PTSD symptomology reported in this group, with cumulative frequency of critical incident exposure, workplace frustrations, and prior trauma history as significant predictors of poorer outcomes. Protective factors including work satisfaction, resilience, and self-esteem seem to moderate PTSD symptoms, which highlights areas where further support or interventions may be worthwhile. The qualitative data provided more in-depth and personal insights into the impact of officer culture on coping with incidents and experiences of workplace support.

Overall, the results emphasise the importance of more dedicated interventions and supportive work environments for prison officers. Future research should continue to explore the unique challenges faced by this group and identify ways to develop more effective interventions.

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