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MEMBER ARTICLE

JAIL AND MENTAL HEALTH STAFF: BRINGING THEM TOGETHER

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One of the most rewarding jobs that I had in my career was to supervise programs in both a community corrections center and inside a local jail. I worked with programs staff, religious staff, counseling staff, volunteers and mental health staff. I acted as a liaison between the parallel worlds of the sworn correctional staff and civilians whose mission was to help offenders or manage them in such a way as to promote safety and security for the staff, the inmate population, the inmates themselves, and the community.

As a jail supervisor, it was my duty to inform correctional officers how issues that civilian staff encounter (such as mental health issues) impacted everyone's jobs. We all know how difficult a jail correctional officer's job is with inmates who are not mentally ill but having to deal with the range of mental illness in jails today magnifies those difficulties. What is needed is understanding. The security or custody staff is the backbone of the safety aspect of the jail environment. Jail officers strive to keep everyone safe. Mental health staff also want good security and their goal is the effective management of the mentally ill inmate.

There's no question that civilian treatment staff and custody staff need each other. They must interact, giving each other the input and information needed to manage inmates who are mentally disordered. Proper management and information sharing can go a long way to prevent security disruptions and inmates from harming themselves and others.

Jail managers need to consider keeping communications and interactions clear between jail custody staff and mental health staff. This is generally done through training seminars, meetings, and in custody team roll calls. While these types of training venues may satisfy some training requirements in the agency, I think that a subject of this importance should be discussed at length at in-service training and in recruit training. An in-service training seminar about mentally disordered offenders should be at least 1 day in length. An ineffective training method, in my opinion, is online training. Online training does keep the officer on duty in the jail where training can be accessed on a personal computer, but it does not provide the insight, experience, and professional advice that can be given by a qualified corrections mental health professional interacting with trainees in a classroom. The subject is too important to gloss over. Also, personal interaction with mental health staff can reinforce the belief that civilian staff has an interest in security, they are not the enemy.

Agency staffs who are responsible for training jail officers and promoting communications between mental health and custody staff should address the following four issues:

1. The behavior of mentally ill inmates is not normal or expected and is often different than those who are not mentally ill. For example, a jail officer orders a mentally ill inmate to come out of his cell for a shower. A normal inmate will readily comply. A mentally ill inmate may stop, stare at the officer, or in one case that I remember, put his hands at his sides and clench his fists. That is the way that he might be processing that communication. I am not saying that officers should let their guard down because mentally ill people may unexpectedly act out or attack. The mentally ill inmate may need a minute or so to think about what to do. Use of force may be necessary, but veteran officers will tell you that the less force that is used in some cases, the more positive the results.

> *"Mental health staff, through innovative training scenarios and role plays, can increase jail officers' awareness of the mentally ill inmate."*

2. Mentally ill inmates often are confused and frightened. Are there any officers around who are calm, reassuring, and willing to help? Jail officers have many responsibilities on posts and are under pressure to maintain security. If

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INTERNATIONAL ASSOCIATION FOR CORRECTIONAL & FORENSIC PSYCHOLOGY

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MEMBER ARTICLE

BRINGING THEM TOGETHER (Continued from page 1)

jail officers are aware of how a mentally ill inmate may be anxious or confused, they can exhibit patience and empathy toward the inmate. Isn't it better to calm down a mentally disordered inmate than to risk a volatile verbal or physical reaction by being overly assertive? If jail officers are willing to calmly talk to the inmate, help them adjust to the jail environment, and watch out for their safety, future interactions could be very positive, making the jail officer's job easier.

3. Mentally ill inmates may want to be alone. They may remember being ridiculed or looked upon as different. They may not want to socialize or be housed with other inmates and they may be incapable of connecting with others like normal people do. It may be best not to force them to socialize or participate in group settings. As crowded as jails are, there are some mentally ill inmates that need to be left alone, but they still need to be closely observed.

4. Anger is a frequent by-product of mental illness. Researchers have found that people with mental illness may be frustrated with how tough life has become. Frustration breeds anger. The jail officer needs to manage aggression and hostility from inmates and this is sometimes stressful for everyone. When encountering the angry mentally ill inmate, the most natural response is to become riled up and attempt to strongly control the situation. This is usually the least effective response. A calm and controlled response generally works better than being forceful and aggressive. Talking calmly to the inmates and trying to get them to think about their behavior is better than an escalating argument.

The preceding suggestions served me well in my jail career. However, sometimes backup needs to be called. Some situations need to be contained and the jail officer cannot drop everything and spend a large amount of time with one inmate. Counts have to be taken, inmates have to be processed, inmates and cells have to be searched, the medical staff must make rounds, inmates have to be fed. The list is endless. Some mentally ill inmates can only be controlled by restraints, because their behavior may be extremely dangerous. In those cases, jail officers have to take the steps necessary to protect all who live and work in the jail.

What is needed is a thinking outside the box mentality. Mentally ill people are different and have to be handled in ways that are not overly aggressive, controlling, and authoritative. Mental health staff, through innovative training scenarios, and role plays, can increase jail officers' awareness of the mentally ill inmate. For example, videos that show handling of mentally ill persons and compact discs where trainees can listen to simulated voices that mentally ill people hear are two suggestions for training.

Finally, it must be emphasized that mental illness is not easily understood by people who have not experienced it. As human beings, all of us have our quirks, interesting habits, doubts, and fears too. Jail officers need to see that there is a human being, a person first, behind the mental illness of those inmates who are identified as mentally ill.

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*Gary F. Cornelius retired from the Fairfax County, Virginia, Office of the Sheriff after a 27-year career. He is the co-founder of ETC Consultants, LLC: Education and Training in Corrections with Timothy P. Manley, MSW, LCSW. Gary has worked as a jail correctional officer, classification director, and programs director. He has authored numerous books on corrections, including *The American Jail: Cornerstone of Modern Corrections* published by Pearson Prentice Hall and *The Art of the Con: Avoiding Offender Manipulation: Second Edition,* available soon from the American Correctional Association.

HAPPY NEW YEAR

ITEMS OF INTEREST

SURVIVING IN PRISON*

Serving time in prison isn't supposed to be easy. Surviving prison should be. That wasn't the case during much of the 1970s and '80s, during which time a prison riot in Attica, N.Y., left 43 dead and a riot in Santa Fe left 33 dead. As recently as 1980, the murder rate in prison was nearly 5 times as great as in the general population. "It was certainly a rougher time, where your emphasis was more on reprisal, retribution, punishment," said Shelby County, Tennessee, Sheriff Mark Luttrell, a former warden at three federal prisons and a member of the Commission on Safety and Abuse in America's Prisons. "We were a rudderless ship there for years and years without oversight." Faced with such staggering figures, corrections officers around the country quietly began changing their tactics. One by one, they took new approaches to handling gangs, using solitary confinement and dealing with inmates' mental-health issues. The result: From 2000 to 2003, the last year for which statistics are available, the homicide rate in prison remained below the national average, according to the Bureau of Justice Statistics. "We finally decided to take back control of our prisons," said Sergio Molina, a 22-year corrections officer in the Illinois Department of Corrections and a former warden. Like other government agencies, corrections departments are facing budget shortfalls that have led to staff shortages and overcrowding. The worst case is in California, where Governor Arnold Schwarzenegger says they have 100,000 prison beds to hold more than 170,000 inmates. Yet prison homicides have maintained a steady, downward trend, according to the U.S. Bureau of Justice Statistics. Bert Useem, a sociology professor at Purdue University in Indiana who has studied the issue, said there was no national drive to combat prison violence. Wardens each saw the violence in their prisons and decided to try new approaches. "I think the forecast (of continuing violence) itself played a role in moving people to take seriously the problem of violence in prison," Useem said. Although wardens across the country have adopted a variety of programs to spark a decline in prison murders, some general tactics have emerged:

Gang violence inside prisons has long been a major source of homicides, said Michelle Lyons with the Texas Department of Criminal Justice. In the mid-1980s, Texas began pulling confirmed gang members out of the general population and placing them in solitary confinement, Lyons said. The drop in murders was almost immediate. "It correlates almost directly with when we started segregating all the gang members," she said. In 1984-85, Texas had 52 homicides in its prisons, Lyons said. Since 2000, there have been 36. Other states are now using similar practices in dealing with gang members. In Illinois, corrections officials separate gang leaders from the general prison population. "We've basically cut the head off that monster," Molina said. "They may not have been the ones perpetrating the violence, but they were involved in calling the shots."

Corrections officials also changed security measures to combat violence. Maximum-security cells used to have curtains for privacy, but Molina said those were removed to eliminate the secrecy needed to commit violent acts. Inmates can no longer wear personal clothing, which eliminates the ability to identify one another through gang colors. Guards closely monitor cell and work assignments to ensure that groups of violent offenders are kept apart.

New York State Department of Correctional Services Commissioner Brian Fischer said prison officials rarely considered that inmates committing violent acts were suffering from mental problems. So he focused on that while serving as warden of Sing Sing Correctional Facility and later as department commissioner. "We've been more successful nationally dealing with the anger that many people come to prison with," Fischer said. He instituted group therapy programs and anger-management classes, which helped give inmates and guards have a better understanding of why they became violent. He said studies have found that most violent acts for inmates come in the first 5 years of their incarceration as they struggle to adjust to prison life, and the last 5, when they experience anxiety about returning to society. Understanding those kinds of issues has helped New York's prisons go from an average of three murders a year in the 1990s to one murder a year in the 2000s. "There was a recognition that we just can't continue to do what we always did before, and that is put them all together and pretend that they all get along," Fischer said.

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*Material taken from an article by Alan Gomez, USA Today.

ITEMS OF INTEREST

NEW MMP INSTRUMENT, THE MMPI-2RF CALLED THE "MOST SIGNIFICANT ADVANCEMENT IN CLINICAL PERSONALITY MEASUREMENT IN DECADES"

The University of Minnesota Press and Pearson announce the release of the MMPI-2-RF (Minnesota Multiphasic Personality Inventory-2-Restructured Form. The MMPI-2-RF represents the most significant revision of the MMPI instruments in nearly 20 years, building on the strengths of the MMPI(r)-2, the most widely used and researched test of adult psychopathology in the world. The MMPI-2-RF is psychometrically up-to-date and linked to current models of psychopathology and personality. The well respected and validated RC (Restructured Clinical) scales, introduced in 2003, are the foundation of the test. In addition to the nine RC scales, the test comprises 41 revised and new empirically validated scales. With 338 items, the MMPI-2-RF takes just 25-35 minutes for computerized administration or 35-50 minutes for paper-and-pencil administration.

Computer-based results are available in two reports: a Score Report and an Interpretive Report. A feature of both reports makes it possible for users to compare an individual's test results with means and standard deviations for test takers in 14 different settings. An innovative feature of the Interpretive Report is hover text, which shows on-screen the scale scores triggering each narrative statement and citations to research supporting the statement. Hand-scoring materials are also available. A detailed technical manual reports empirical correlates for various settings, including mental health inpatient and outpatient clinics, substance abuse treatment centers, criminal court proceedings, personal injury and disability evaluations, and public safety employment evaluations.

Authors Yossef S. Ben-Porath, Ph.D., and Auke Tellegen, Ph.D., have been introducing customers to the MMPI-2-RF test over the past 2 years through training workshops. As a result, customers have been anticipating the release of the instrument. Hope Goldberg, Ph.D., Department of Psychiatry, Olive View-UCLA Medical Center in Sylmar, California, said, "After using the RC scales for MMPI-2 profile interpretation for more than 2 years in both inpatient and outpatient settings, I believe the new MMPI-2-RF will be the most significant advancement in clinical personality measurement in decades. It will be the only adult personality measure I use in my practice." "We are eagerly looking forward to the MMPI-2-RF because it yields more information with fewer items and with sharpened specificity," said Ray King, Psy.D., Norman, Oklahoma. "The MMPI-2-RF will offer something to all users, but practitioners who deal with selection will particularly benefit from the cleaner scales that will be more defendable in the legal arena," said King.

The MMPI-2-RF test is one of several MMPI instruments published by the University of Minnesota Press and distributed by Pearson. "I am very excited about the publication of the MMPI-2 RF," said Carol Watson, president of Pearson's Clinical Assessment/North America business. "The authors have taken care to develop a top-quality instrument while we have enhanced our scoring and interpretive software to provide some practical new features, like hover text. It's time for psychologists to take a new look at MMPI instruments."

"Publication of the MMPI-2-RF is the culmination of the most recent major project in the research/development program on the MMPI instruments to which the University of Minnesota Press is committed," said Beverly Kaemmer, Associate Director and Test Division Manager of the Press. "One of the noteworthy contributions of test authors Tellegen and Ben-Porath is the Technical Manual." Customers who use Q Local scoring and reporting software will be sent a no-charge update CD, and are eligible for three free usages of the MMPI-2-RF. Additionally, MMPI-2 usages can be exchanged one-for-one for MMPI-2-RF usages at no charge. These limited time offers apply exclusively to Q Local customers; call (800) 627-7271 for more information. Mail-in and hand-scoring materials can be ordered online at pearsonassessments.com or by calling (800) 627-7271.

Pearson is the global leader in clinical assessment, providing a wide range of assessments for personality, behavior, ability, achievement, speech and language, and career interest. Our respected brands include the MMPI family of tests, the Beck inventories, the Millon inventories, the Wechsler family of assessments, the BASC family of products and the Kaufman family of assessments. Pearson's other primary businesses include Pearson Education, the Financial Times Group and the Penguin Group.

ITEMS OF INTEREST

EMPLOYMENT OPPORTUNITY

Wexford Health Sources, Inc. is searching for a Director of Mental Health. Wexford Health Sources, Inc. is one of the largest, privately held correctional facility healthcare providers in the nation. Providing customized healthcare and mental health services to correctional facilities since 1992, Wexford's portfolio includes statewide or major regional programs in 13 states. Their services stretch across the country in 120 facilities.

Wexford's reputation of providing customized programs is well established. As such, the Director of Mental Health will be responsible for providing clinical oversight and strategic direction for their mental health delivery program. As a key member of the leadership team, the Director of Mental Health will be the lead executive for all comprehensive programs in mental health. In this role, the Director also will be challenged to use the current mental healthcare infrastructure to pursue other lines of business, perhaps even outside of correctional health.

Wexford's leadership team is seeking a mental health professional with a minimum of 15 years in a combination of clinical practice, managed care, or forensic psychology. A seasoned business person who has managed a large mental health organization would be considered. Experience in the corrections industry will be highly valued.

Post graduation education required; Ph.D. preferred. Other advanced degrees such as an MBA, MHA or MPH would also be highly desirable.

Wexford's headquarters are in Pittsburgh, Pennsylvania, and this executive will be located at this office. Wexford offers a comprehensive and competitive compensation program.

Cejka Search has been exclusively retained to assist Wexford in recruiting this senior leader. If you are interested in learning more about this exciting and entrepreneurial organization and the Director of Mental Health position, kindly contact: Cathy Lee Jung, CEJKA SEARCH, Executive Search Division, cjung@cejkasearch.com, Telephone: (314) 236-4509

OFFENDER LETTERS TO GO ELECTRONIC*

By the spring of 2011, all Federal Bureau of Prisons (BOP) in the U.S. (and there are 114 prisons) are expected to have e-mail available for their offenders. The electronic push started in the BOP several years ago and it has reduced the amount of old-fashioned paper mail that can hide drugs and other contraband. Just as important, officials say, e-mail helps offenders connect regularly with their families and build skills that the offenders may use when they return to the community. The system that offenders use is not like programs used in most homes and offices. Offenders are not given Internet access, and all messages are sent in plain text, with no attachments allowed. Potential contacts receive an e-mail saying that an offender wants to add them to their contact list and must click a link to receive e-mail, similar to accepting a collect call. Once approved, offenders can only send messages to those contacts. Offenders can't type in any address and hit send. Offenders pay 5 cents per minute while composing or reading e-mails. Messages are also screened for keywords that suggest an offender may be involved in a crime or read by corrections staff like paper letters.

APA BANS INTERROGATIONS*

The American Psychological Association (APA) voted to ban its members from taking part in interrogations at the prison at Guantanamo Bay, Cuba, and other military detention sites where it believes international law is being violated. The ban means that APA members can't assist the U.S. military at the sites. Members can work at these sites for humanitarian purposes or with non-governmental groups, according to Stephen Soldz, a Boston psychologist. Doctor Soldz is founder of an ethics coalition that has long supported the ban. The new policy should take effect at the APA annual meeting in August 2009. There is talk from the new Obama administration, however, that closing Guantanemo may occur before the APA's August meeting.

*Material for these pieces was taken from a variety of news sources.

ITEMS OF INTEREST

CONFERENCES

2009 MENTAL HEALTH IN CORRECTIONS CONFERENCE

Location: Marriott Country Club Plaza, Kansas City, Missouri.
Dates: Tuesday and Wednesday, April 28 and 29, 2009.
Monday, April 27, 2009, Pre-Conference Workshops.

The keynote speaker will be Paul Gendreau, OC, Ph.D.; Professor Emeritus, University of New Brunswick. The title of his presentation will be—*What Works: Offender Treatment & Assessment & the Management of Prisons.* Doctor Gendreau has published extensively on "what works" in the assessment and treatment of offenders, (also see the CPAI-2000 which has been widely used to evaluate offender treatment programs), the effects of prison life, and is considered one of the preeminent scholars in the field of correctional mental health. One of the plenary speakers is Pete Earley. His topic is—*CRAZY: A Father's Search Through America's Mental Health Madness.* Earley is the author of the *Hot House*, a book about USP Leavenworth. His presentation relates to his experiences with his son's mental illness and contact with the criminal justice system. The Mental Health in Corrections Consortium has grown steadily over the years and we are confident that the MHCC 2009 will continue this trend. The MHCC is one of the preeminent national conferences devoted to correctional mental health and it is our belief and hope that the 2009 conference will be exciting and educational. Some student poster award winners will receive monetary awards for outstanding poster presentations. For more information, contact: bmoyer@forest.edu.

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MEMBER ARTICLE

REDUCING SHERIFF'S OFFICERS' SYMPTOMS OF DEPRESSION USING CRANIAL ELECTROTHERAPY STIMULATION (CES): A CONTROL EXPERIMENTAL STUDY

Ronald R. Mellen, Ph.D. and Wade Mackey, Ph.D.—*Contact: rmellen@jsu.edu*

This article examines the possibility of reducing depression and anxiety in sheriffs' officers using the Alpha-Stim SCS, a cranial electrotherapy stimulation (CES) unit. The dependent measures were the Beck Depression Inventory (BDI; Beck, 1996), the Beck Anxiety Inventory (BAI; Beck, 1990), and the Brief Symptom Inventory (BSI; Derogatis, 1993), which has both depression and anxiety scales. The treatment group used active Alpha-Stim SCS units to provide electrotherapy stimulation at the minimal therapeutic level (100 uA), while a sham control group of officers used inactive units (electric current was at a non-therapeutic level).

When depression scores from the treatment group were compared to the sham control group, significant improvements on the BSI Depression scale ($p<.01$) and the BDI ($p<.05$) scores were found. Results on the two anxiety scales were non-significant.

Because trends were noted in the remaining BSI scales, a Sign test (trend analysis) was completed. Ten of the remaining 11 BSI sub-scales indicated downward directions of difference ($p=<.01$) in the treatment group when compared to the control group. The finding suggested a broad trend toward reductions in the full range of clinical symptoms.

LITERATURE REVIEW

Research has shown stress levels are high in many criminal justice disciplines including jails, correctional facilities and law enforcement agencies (Van Blarcum, 2008; Scott, 2004; Griffin & Bernard, 2003; Zhao, 2002; Finn, 2000). Anti-anxiety medications, biofeedback, and progressive relaxation therapy are among the traditional techniques used to reduce stress. A relatively new approach for the treatment of stress in officer populations is CES.

The utility of Alpha-Stim SCS for the treatment of many clinical disorders has a 25-year history of supportive research. For example, there have been over 126 human subject studies, as well as, two meta-analyses establishing the efficacy of CES for treating mental disorders (Kirsch, 2002). In addition, the Alpha-Stim SCS has been cleared by the FDA for treating depression, anxiety, and insomnia. Below is a small sampling of studies where physical and mental disorders were successfully treated using CES.

Business executives Matteson and Ivancevich, (1986), **drug abusers** (Braverman, Smith, Smayda, & Blum, 1990), **alcoholics** (Krupitsky, Burakov, Karandashova, Katsnelson, Lebedev, Grinenko, & Borodkin, 1991), **subjects with migraine headaches** (Broatman, 1989), **outpatients with clinical levels of anxiety** (Overcash,1999), **the violent mentally retarded** (Childs, 2005) and **hospitalized patients** (Passini, Frank, Watson, & Herder, 1976) with a variety of mental health diagnoses.

In most studies reviewed in this article, mental health assessments were used for dependent variables. However, two of the studies employed biological measurements: EEG P-300 brainwaves; the MAO-B (an enzyme that slows break down of dopamine) and the neurotransmitter GABA (Gama-aminobutric acid). One additional study used biofeedback instruments.

As noted by Matteson and Ivancevich (1986), corporate middle management supervisors frequently report significant levels of stress. These mid-management supervisors, who were also pursuing MBA degrees at the University of Houston, formed the treatment group of a CES study. The CES was found to produce reductions in state anxiety, trait anxiety, depression, anger, fatigue, confused thinking, hostility, and a sense of dejection. In juxtaposition, the subjects reported increased energy, fewer health complaints, less sleep problems, less stress, and greater reductions in tension.

Outpatients (n=197) in Overcash's (1999) study reported high levels of anxiety. While most did not have histories of treatment for their anxiety (58%), about 26% had been refractive to anti-anxiety medications. All subjects completed pre-post self-assessments. Subjects were divided into three treatment groups using different pre- post-treatment biological measures:

Group 1: electromyogram (EMG)
Group 2: electrodermal response (EDR)

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Group 3: peripheral digit (middle finger) temperature, hand-thermal biofeedback

Pre- post-treatment assessments found significant reductions in subject stress levels in biological, as well as, psychological measures. At follow-up, 73% of the subjects were "well satisfied" with their treatment outcomes.

In another study (Brotman,1989), significant reductions in migraine headache symptoms were observed when a combination of CES and Quieting Reflex Training was utilized. Cranial Electrotherapy Stimulation was also effective with inpatient volunteers. In this early study by Passini et al. (1976), subjects (n=60) with a wide range of mental health disorders responded well to CES treatment. Their disorders included alcohol and drug dependence, manic-depressive episodes, organic brain disorders, and anxiety neurosis. The volunteer subjects were treated for anxiety and depression with the goal of improving coping skills and energy. The subjects, while still on psychotropic and other medications, experienced significant reductions in depression and anxiety. No side-effects were reported by the researchers.

One biological marker for high-risk drug abuse is the presence of low P-300 waves on the EEG. Braverman et al. (1990) used CES to treat substance abusers and found significant increases in P-300 amplitudes secondary to treatment. Specifically, there were positive changes in the Alpha, Beta, Delta, and Theta bandwidths. These results suggested CES produced positive global changes in the patients' cortical functioning and thus may have greater applicability than just depression, anxiety, and insomnia. There were no corresponding amplitude increases in the control group.

At the biochemical level, low concentrations of MAO-B (enzyme) and GABA (neurotransmitter) have been reported in alcoholic populations. The GABA is the main neurotransmitter that supports a person's ability to inhibit hostile emotions and actions. MAO-B works with neurotransmitters to strengthen a person's inhibitory response. Low levels of GABA and MAO-B weaken the inhibitory response and can lead to increased anxiety and depression, which can increase the likelihood of relapse. Krupitsky et al. (1991) found CES increased GABA and MAO-B levels in substance abusers. This increase in patients' blood levels provided them with greater ability to control their anger and aggressive behaviors. The GABA and MAO-B levels in the control group did not increase.

While many studies looked at CES as a treatment for various mental disorders, only three (Childs, 2005; Childs, 1995; Mellen & Mitchell, 2008) have demonstrated its utility in reducing violent behavior, an issue of particular concern in the criminal justice field. In other areas, such as using CES to reduce correctional officer stress, no studies have been published.

METHOD

Research Question

Would the application of CES reduce depression and anxiety in a county sheriff's jail security and patrol officer populations?

Subjects

The subjects were 21 volunteer officers from the sheriff's staff. These included jail security, patrol officers, investigators and administrators. Eleven officers were males, and 10 were females. Subjects were randomly assigned to either the treatment or control groups and were blind to group assignments.

Apparatus

The CES unit utilized in the present study was the Alpha-Stim SCS produced by Electromedical Products International, Mineral Wells, Texas. The unit is hand held (10 cm height; width is 7.5 cm; 2.3 cm depth) and uses a standard 9 volt battery to generate the appropriate current level. It is about the size of an early I-Pod and comes with two ear clips, one for each ear lobe that deliver the electrical current. In non-research settings, the range of electrical current is determined by the subject using a side-dial. The therapeutic range is from 100 to 500 uA (micro-amps). One hundred uA is the lowest therapeutic level and is approximately 80% as effective as the maximum 500 uA. Two timing settings are built into the Alpha-Stim, 20 minutes and 1 hour; however, it can be used for any time period.

While using the Alpha-Stim, the officers went about their daily office tasks. However, driving a car or heavy equipment was not recommended while using the Alpha-Stim. While it is not intended to replace pharmacological interventions, it can be highly effective, substantially less expensive and will generally produce fewer and less severe side-effects than many medications.

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As Giordano (2006) reported, the "microcurrent waveform activates particular groups of nerve cells that are located at the brainstem These groups of nerve cells produce the chemicals serotonin and acetylcholine which can affect the chemical activity of nerve cells at nearby and more distant sites in the nervous system" (see Figure 1). These actions modulate the brain and encourage the production of Alpha waves which help an individual focus and remain relaxed, an excellent mental state for handling on-the-job stress. As the picture below demonstrates, the Alpha-Stim modulates brain activity by increasing serotonergic activity (5-HT). This increase enhances the Alpha (8-13 Hz) bandwidth necessary for a relaxed and focused mental state. In juxtaposition, it also inhibits cholinergic and noradrenergic systems which are involved in the production of agitation and aggression (see Figure 1).

Dependent Variables

The BDI, BAI, and BSI were used as dependent variables. The BAI and BDI are both single dimensional assessment instruments.

The BSI is composed of a depression and an anxiety scale as well as measures of seven additional clinical scales. It also includes three global scales. The BSI clinical scales are:

Somatization: measures stress from physical ills.

Obsessive/Compulsive: measures thoughts and/or actions that are unremitting and unwanted.

Interpersonal Sensitivity: measures feelings of inadequacy and self-deprecation.

Depression: measures symptoms of clinical depression such as dysphoria, and a lack of motivation.

Anxiety: measures symptoms such as nervousness, tension, apprehension, and panic.

Hostility: measures anger and other related negative feelings.

Phobic Anxiety: measures irrational fears and avoidant behaviors.

Paranoid Ideation: measures suspiciousness, delusions, hostility, and thought projection.

Psychoticism: measures withdrawal, interpersonal alienation, psychosis, and thought dysfunctions.

The three BSI global scales are:

Global Severity Index (GSI): it is the most sensitive indicatory of stress.

Positive Symptom Total (PST): this scale gives the total number of symptoms endorsed by the test taker.

Positive Symptom Distress Index (PSDI): this scale provides information on a patient's tendency to minimize or exaggerate stress by the subject.

Administration of Treatment

Subjects in both the treatment and control groups completed 20 sessions using the Alpha-Stim SCS, and each session lasted 20 minutes. The Alpha-Stim units were loaned to the experimenters by Electromedical Products International, Inc. The experimental units were factory preset at the lowest therapeutic level (100 uA) preventing manipulation by subjects. The control group received a non-therapeutic level of current. The time of day for treatment was set by individual subjects and all sessions were completed while the officers were on-duty. All treatment and control group members received a $20 Wal-Mart gift certificate upon completion of 20 sessions and post-treatment assessments.

Only one subject was removed from the study. After the third session, the subject reported increased levels of agitation secondary to treatment. The literature was reviewed, covering approximately 5,000 subjects, and only one similar incident has been reported.

Pre-assessments were administered 2 days before treatments began. Because officers completed their treatments on different days, post-assessments were taken the week following each subject's final treatment session.

Hypotheses

1. The treatment group, compared to the sham control group, will have lower BSI anxiety scores.
2. The treatment group, compared to the sham control group, will have lower BSI depression scores.
3. The treatment group, compared to the sham control group, will have lower BAI anxiety scores.
4. The treatment group, compared to the sham control group, will have lower depression scores.
5. A trend analysis (Sign test) will demonstrate a significant difference between pre- and post-treatment on the dependent variables.

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CES... (Continued from page 11)

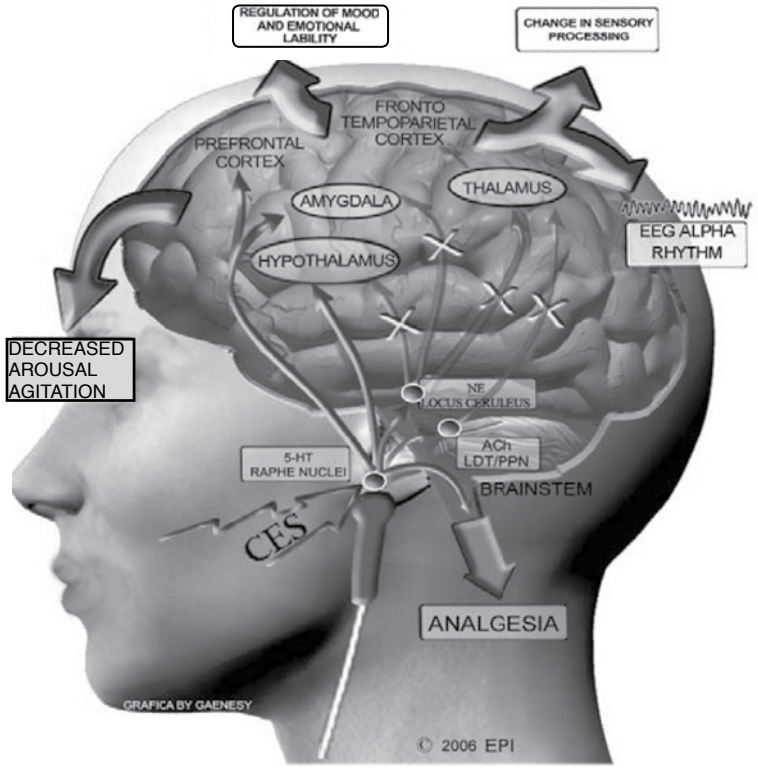

FIGURE 1: Pathways Activated and Inhibited by CES*

The above arrows indicate electro-current pathways in cortical and sub-cortical areas. CES not only activates areas of the cortex that calm a person down, but the "Xs" above present cortical and sub-cortical areas in which CES inhibits the thalamo-cortical activity which contributes to arousal and agitation (cholinergic and noradrenergic systems). *Electromedical Products International granted permission for the use of this picture.

TABLE 1: Comparisons of Mean Differences and Standard Deviations For Focal Group Versus Sham/Control Group Across BSI Sub-Scales, BAI and BDI

BSI Sub-Scales	M Focal	SD	M Sham/Control	SD	t-value (df=19)
SOM	.258 **	(.219)	.197 ‡	(.293)	0.51 n.s.
OC	.640 *	(.973)	.223 *	(.301)	1.54 n.s.
IS	.432 n.s.	(.929)	.075 n.s.	(.290)	1.15 na
DEP	.516 *	(.638)	-.138 n.s.	(.369)	2.77**
ANX	.439 n.s.	(.834)	.103 n.s.	(.601)	1.01 n.s.
HOS	.654 ‡	(1.050)	.268 n.s.	(.620)	0.99 n.s.
PHO	.164 n.s.	(.644)	.240 n.s.	(.440)	0.30 n.s.
PAR	.442 n.s.	(.906)	.320 **	(.215)	0.41 n.s.
PSY	.363 ‡	(.564)	.060 n.s.	(.280)	1.50 n.s.
GSI	.423 *	(.576)	.197‡	(.281)	1.10 n.s.
PST	9.366 *	(11.587)	2.800 n.s.	(6.620)	1.53 n.s.
PSDI	.372 *	(.496)	.026 n.s.	(.383)	1.71 n.s.
BECK A/I	4.636 ‡	(8.200)	4.800*	(6.560)	0.06 n.s.
BECK D/I	5.360 **	(5.32)	-.100 n.s.	(4.200)	2.49*

‡ p < 05 (1-tailed); *p<.05 (2-tailed); **p<.01

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RESULTS

As seen in Table 1, results of the two depression scales, BSI and BDI, confirmed Hypotheses 2 and 4. Hypotheses 1 and 3, regarding anxiety, were not supported. In Table 2, the results of the trend analysis (Sign test) are provided. Below the p <.01, demonstrated a strong trend toward reductions in all symptoms but two, BSI Phobia and BAI.

TABLE 2: Sign Test—Comparisons of Mean Scores for Focal Group Versus Sham/Control Group Across BSI Sub-Scales, BAI and BDI

BSI Sub-Scales	M Focal	M Sham/Control	M Differences	Direction of Differences
SOM	.258	.197	.060	Down
OC	.640	.223	.417	Down
IS	.432	.075	.357	Down
DEP	.425	-.138	.563	Down
ANX.	.561	.103	.458	Down
HOS	.655	.268	.387	Down
PHOB	.164	.240	.076	Up
PAR	.442	.320	.122	Down
PSY	.273	.060	.213	Down
GSI	.317	.197	.120	Down
PSI	9.360	2.800	6.560	Down
PSDI	.372	.026	.346	Down
Beck (BAI)	4.360	4.800	.440	Up
Beck (BDI)	5.360	-.100	5.460	Down

Number of differences down = 12; Number of differences up = 2;
Number of ties = 0;
Sign test: $p < .01$

DISCUSSION

Statistically significant results were found on both measures of depression (BDI, $p<.05$ and BSI, $p<.01$), and a Sign test demonstrated a very strong trend ($p.<01$) toward a reduction in other BSI symptoms. In the broadest sense, these results may support the theory that the Alpha-Stim SCS has a global modulating effect on brain dysfunctions. Officers struggle with many emotional issues and these results suggest CES may produce benefits, as noted below.

With reduced depression, officers could have more energy for productive activities. Reductions in other scales could have ramifications for officers' quality of life both on the job and at home. The lower Somatization scores may reflect CES's ability to provide officers' an improvement in their general sense of physical well being.

Reductions in Psychoticism would increase cortical control. Cortical control means officers would be better able to use logic-based thinking processes to control their emotions when dealing with highly intense jail situations.

Changes in the Obsessive/Compulsive scores may reflect reductions in excessive checking and double checking, as well as a feeling of being blocked by obsessive thinking patters. Such changes could lead to improved decision making.

With lower scores on Hostility, one could anticipate improved ability to handle the inherent challenges in their jobs and reduce the risk of officers over reacting.

Reductions in Interpersonal Sensitivity scores means officers experienced reduced feelings of alienation which would translate into a better workplace environment for the officer and his/her colleagues.

While officers must be vigilant, higher scores on Paranoia suggests a level of personal concern that goes beyond vigilance. Reducing these scores would help officers

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maintain the healthier levels of watchfulness. All three global stress indexes indicated reductions in stress for the officers.

Overall, the results were positive regarding depression scores and Sign test results. Results may have been stronger had the level of treatment not been permanently set at 100 uA. Also, the small N made achieving a statistically significant difference difficult. Finally, while the officers in this study had problems secondary to stress, their issues did not achieve clinical levels. The ability of CES to bring about change seems to increase as the severity of a patient's psychological dysfunction increases. Results suggest a follow-up study using a larger sample could produce even stronger evidence for the utility of CES as an inexpensive and effective treatment for reducing stress in law enforcement officers.

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ASSOCIATION UPDATES

CONGRATULATIONS DR. EDWIN I. MEGARGEE

In your former role as President of our Association, and for over 40 years as a teacher and researcher, your seminal contributions to psychology and criminal justice have benefited forensic psychologists, other mental health and correctional workers, students and research colleagues around the world.

In honor of your lifetime of contributions to our field, and on behalf of the members and Directors of the International Association for Correctional and Forensic Psychology (IACFP), we are extremely proud to confirm the beginning of what we expect will be a long series of lectures in your name.

The series is titled: *The Dr. Edwin I. Megargee Honorary Lecture Series,* and is scheduled to take place each year at the International Community Corrections Association's (ICCA's) Annual Research Conference.

The first lecture, *The Use of Risk and Needs Assessment in Evidence-Based Sentencing*, was the featured event at the ICCA luncheon banquet, October 20, 2008, at the Millennium Hotel in St. Louis, MO. The speaker was the Honorable Michael Wolff, a sitting Justice and former Chief Justice of the Missouri Supreme Court.

DOCTOR ROBERT R. SMITH PRESENTS

Doctor Robert R. Smith, *The Correctional Psychologist (TCP)* Executive Editor, presented the keynote address for the Alabama Department of Corrections Executive Leadership Conference, November 12-14, 2008, in Huntsville, Alabama. Smith's keynote was titled: *Integrity and the Importance of Valuing Every Human Being.* He also conducted two workshops at the conference, one on Rational Cognitive Therapy, a therapy that he and his colleague, Dr. Victor S. Lombardo, *TCP* Associate Editor, co-founded, and another workshop on behavior modification

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