Sexual Abuse: A Journal of Research and Treatment, Vol. 10, No. 1, 1998

Suggested Clinical Uses of Polygraphy in Community-Based Sexual Offender Treatment Programs

Gerry D. Blasingame[1]

A literature review was conducted to evaluate the research findings regarding the use of polygraphy with sexual offenders. Inconsistent empirical data from various studies provide a challenge to the validity and reliability of the polygraph procedure. Treatment program utility was nonetheless enhanced by the disclosures made during the preparation process before the actual examination. Empirically based standards for the use and interpretation of polygraph results were found to be lacking. Guidelines for the responsible use of polygraphy in community-based treatment for sexual offenders are proposed. Finally, issues needing further research are identified.

KEY WORDS: polygraphy; sexual allegations; sexual offender treatment; sexual offending.

INTRODUCTION

Polygraph testing, and even the knowledge of an impending examination, often can have a profound effect on the disclosures made by offenders in treatment. Since community safety is the first consideration in community-based treatment of sexual offenders [Association for the Treatment of Sexual Abusers (ATSA), 1993], the availability of a tool to assist in monitoring the behavior and treatment compliance of these clients is desirable. While the polygraph has been found to be useful for the purpose of increasing disclosures (Edson, 1991; Emerick & Dutton, 1993), not all treatment providers have embraced the use of polygraphy due to questions about validity, reliability, and admissibility in court proceedings.

[1]Sexual Offender Rehabilitative Treatment (SORT) Program, 3462 Bechelli Lane, No. A, Redding, California 96002.

1079-0632/98/0100-0037$15.00/0

The treatment community seems polarized about the use of polygraphy. According to the Safer Society national survey (Knopp, Freeman-Longo, & Stevenson, 1994), only 24% of programs responding use the polygraph with some clients. A significant number of these were located in the Pacific Northwest (Schwartz & Cellini, 1995). Of concern is the potential that some users may over rely on the polygraph as the backbone of a treatment program while others fail to use it at all. Hopefully, this review will help enable treatment providers to develop a consensus about guidelines for the use of polygraphy in community-based sexual offender treatment programs.

UTILITY OF POLYGRAPHY AS A TREATMENT TOOL

The usefulness of polygraph examinations has been supported in several studies (Edson, 1991; Emerick & Dutton, 1993; National Task Force, 1993). Clinicians can benefit from polygraphy long before the client actually takes the examination. The preparation process itself has lead many offenders to disclose additional victims, paraphilias, and acts committed that may otherwise have been withheld without the impending full disclosure polygraph examination (Edson, 1991; Janes, 1993). Clinicians need to give the client ample opportunity to disclose pertinent details prior to the actual examination (Blasingame, 1994; Edson, 1991). An important factor that also facilitates these additional disclosures is the granting of a form of immunity or agreement not to prosecute further on similar acts committed prior to adjudication (Schwartz & Cellini, 1995). Without this immunity, the process becomes vulnerable to challenge by defense attorneys due to self-incrimination concerns. This immunity appears to be an equally powerful tool in facilitating additional disclosures.

These are other ways in which the polygraph can be useful. Tests often are used periodically to confirm the accuracy of disclosures made, i.e., "Have you truthfully reported . . .?" Used as a treatment tool, the polygraph is a method of increasing the accountability of an offender living in the community (ATSA, 1993). Clients are advised that they will be tested about their honesty in reporting compliance with treatment issues. This seems to exert a strong deterrent effect (Edson, 1991; Lundell & Holmes, 1993). Other issues to test might include contact with minors, use of alcohol or other drugs, sexual conduct, and other probation or parole violations. Periodic monitoring increases accountability, particularly when combined with other methods of monitoring the client's behavior in the community (ATSA, 1993; National Task Force, 1993).

POLYGRAPHER AND PROCEDURAL VARIABLES

A number of variables can be identified that affect examination results and their use. Even the tone of voice and manner in which the questions are read can affect the outcome (Thomas Gray, personal communication, Dec. 27, 1995). Without true standardization among polygraphers, it is possible to incriminate those being truthful and overlook those who are lying (Brett, Phillips, & Beary, 1986). While within schools of training, protocols are consistent, comparison of different approaches reveals significant differences that may affect examination outcomes (Abrams, 1989).

It is vital that the polygraph examiner both be competent as a polygrapher and have a reasonable level of expertise involving sexual offender issues (Abrams, 1991; Harvath, 1977; National Task Force, 1993). Raskin, Barland, and Podlesny (1976) reported one study in which one polygrapher was accurate only 53% of the time, while others were 100% accurate, all from within the same school of training. Examiner experience may be an important variable (Horvath, 1977; Raskin *et al.*, 1976). The examiner should work in partnership with the treatment providers and probation or parole officers (Edson, 1991; Schwartz & Cellini, 1995). Janes (1993) reported that only 33 states have laws involving regulation or licensing of polygraphers. Inconsistencies in these areas create problems with developing standardization and improvement of interrater reliability.

Several other potential therapist and examiner variables can be identified. Partnership roles between therapists and polygraphers vary and will impact the decisions made regarding lines of questioning. Therapist experience and style in preparing offenders for polygraphs are unexplored variables. Dependent on the training, experience, and theoretical orientation of the examiner, the questions may be formulated and presented differently. In addition, interviewing and follow-up decisions vary from examiner to examiner. The rules for interpretation of charts vary as well, dependent on the polygrapher's determination of whether the client was cooperative during the procedure (Abrams, 1989). While these variables are acceptable for therapeutic purposes, they are problematic in court. These variables also create difficulty in performing comparative studies.

If polygraphy is to be considered a valid psychological test, a higher level of consistency and standardization is needed. Janes (1993) cites a 1986 policy statement by the American Psychological Association indicating that polygraphy does not meet its standards for educational or psychological testing. It is incumbent on treatment providers and polygraphers to provide sufficient standardization, validation, and reliability data that are empirically based and to define more accurately the degree to which the polygraph results can be relied on in the decision-making process. Without such data, polygraphy and

its use in sexual offender treatment programs will remain open to debate (National Task Force, 1993; Schwartz & Cellini, 1995).

CLIENT VARIABLES AND EXCLUSIONS TO POLYGRAPHY

Several client variables affect the feasibility and outcome of polygraph examinations. These include severe mental disorders, mental retardation, medical conditions, drug or alcohol intoxication, the use of countermeasures, i.e., specific efforts to confound the outcome of the test, and refusal to follow directions (Abrams, 1989; Lundell & Holmes, 1993). A client's trust in the polygrapher is also of importance (Raskin *et al.*, 1976).

Clients with psychoses, hallucinations, or delusions, or who are taking medications for such disorders, are not good candidates for testing. Given the heightened level of stress during the examination itself (Backster, 1969), psychotic symptoms may be exacerbated (Abrams, 1989; Lundell & Holmes, 1993). Clients who are bipolar, are experiencing major depression, or have paranoid disorders may also be excluded from testing when active symptoms might lead to excessive reactions (Abrams, 1989).

Several anxiety disorders may interfere with results as well. However, Abrams (1989) suggested that most of these will lead to inconclusive findings rather than outright failures or invalid findings. Anecdotally, many clinicians doubt that clients with panic attacks, obsessive-compulsive disorder, or posttraumatic stress disorder are suitable for polygraph testing. Some innocent persons with inappropriate apprehension or anxiety disorders may be more likely to produce false positive results. Those with anxiety disorders may misinterpret neutral cues as threats and be prone to excessive reactivity. Multiple personalities, dissociative disorders, and amnesia have also been noted as increasing the problems in administering and interpreting polygraph examinations (Abrams, 1989; Raskin *et al.*, 1976).

While discussing inconclusive results, Backster (1969, p. 1) noted problems related to outside issues:

> It now seems apparent that this is caused by the subject's anticipation of a question involving some outside factor. With such a person the outside issue, about which he is so apprehensive, is much more important to him—or more directly affects his well being—than does the reason for the polygraph examination.

Another concern involves the blurring of issues when questions explore *intent.* As an example, Abrams (1989) notes that a client cannot rationalize away the act of molestation. Abrams suggests that questions involving *intent* should be avoided as much as possible. Certainly it would be reasonable not to use questions such as this to avoid having to deal with the confounding variables involved in the questioning procedure.

Personality-disordered clients have often been assumed to be able to deceive the polygraph due to lack of remorse and presumed comfort with telling lies. Research has not supported this assumption (Abrams, 1989; Raskin *et al.*, 1976).

Accuracy in testing clients with IQs between 65 and 80 was found to be 71% (Abrams, 1989). Validity rates of 57% with 10 year olds were found, although improved rates were found with 11 year olds, at 83%, 12 year olds, at 96%, and 13 year olds, at 94% (Abrams, 1989). Abrams suggested that polygraphs can be administered to those with average intelligence who are 11 years or older.

Clients with medical conditions such as hypertension and heart or respiratory problems need to be have consent from their physician prior to testing. Some polygraphers will not test pregnant women due to the increased level of liability to the polygrapher. Clients who are sleep deprived may also be excluded (Lundell & Holmes, 1993).

Drug abuse by a client prior to the polygraph may require postponement of the examination due to ethical issues involved with testing an intoxicated person and the effects drugs may have on the test. However, there is support from some polygraphers (Hess, undated), indicating that those using drugs can be evaluated successfully. Clearly, use of medications, drugs, or alcohol would have the same effect *throughout* the procedure, not only on relevant questions (Kent Dacre, personal communication, Oct. 10, 1995).

Some clients claim to know how to deceive the polygraph. Clients have reported that scratching their fingers, biting their cheek, and putting tacks in their shoes are ways to alter results. Various countermeasures have been studied. Abrams (1989) reported that relaxation and dissociation, biofeedback, and hypnosis have all been found to reduce validity. Abrams also reported that experiments training subjects to use toe pressing and tongue biting during control questions and relaxation during relevant questions reduce the accuracy from 84% to 34%. It should be noted that there may be a significant difference between laboratory studies with those who have little to risk and field studies where outcomes are potentially life changing.

SUGGESTED GUIDELINES FOR THE USE OF POLYGRAPHY WITH SEXUAL OFFENDERS

Based on the information reported above, it is evident that guidelines for usage and decision making are needed. The following proposed guidelines are suggested for therapists and treatment program use in community-based programs and for polygrapher and procedural development. Suggested guidelines for community-based treatment providers include the following.

(1) A nonprosecution agreement must be in place through the district attorney or corrections department to prevent challenges of self-incrimination. Judges, probation officers, and child protective services personnel must also support this arrangement.

(2) The treatment team should use the polygraph as only one of several ways that offenders are monitored in the community. Other methods such as electronic surveillance, client self-reports, spousal or parental reports, drug testing, and probation officer house calls are important as well.

(3) Treatment teams should avoid overreliance on any of the technological or psychological tools used in offender treatment until empirical data consistently support the validity and reliability of instruments used. Therapists using the polygraph should corroborate their information with other sources before ascribing guilt or attributing deception. *Polygraph results alone are not sufficient evidence to determine facts or to be the basis for termination from treatment.*

(4) The treatment team should recognize the risk of false positives which could incriminate innocent persons. The risk of false negatives is also a concern, as deceptive persons may not be detected or may be granted privileges that escalate risk factors.

(5) The treatment team should not rely *solely* on polygraph findings in case management or legal decisions. Therapists using the polygraph need to recognize the nonobjective aspects of polygraphy. The placebo effects are valuable in the treatment process. Therapists should recognize the utility of polygraphy without ascribing excessive authority to its results.

(6) Treatment team members should refrain from threats or legal sanctions on the basis of polygraph results. The use of such threats may exacerbate a stress reaction and increase the risk of false-positive results. Clients who are court ordered into treatment programs should not be considered to give truly informed, voluntary consent when their only other option is incarceration. Retractions or attempts at countermeasures may result from coercive pressure. Such threats or coercion will also increase the likelihood of challenge by defense attorneys.

(7) Therapists and treatment programs using the polygraph must note that some clients are unlikely to test accurately. These clients include those with psychotic symptoms, active manic-depressive or dissociative symptoms, panic disorders, or mental retardation (IQ below 80) and those below the age of 11.

(8) Treatment team members should work in conjunction with polygraphers in developing protocols for preexamination interviewing, question formulation, interpretation, reporting, and use of results. Polygraphers who are more than technicians are more effective as treatment team partners.

(9) Polygraphers should use control question techniques. They should avoid the use of observational information and use numerical ratings whenever possible. When potentially deceptive reactions are noted, polygraphers should work with clients to ascertain factors which might contribute to a false-positive outcome and restructure questions to provide more accurate and reliable examinations.

(10) Polygraphers should avoid the use of *intent* questions. Questions that focus on behavior are more desirable and more accurate. Since intent is frequently an interpretation issue for clients, the focus of questioning must be about truthful reporting of behavior. All questions should be reviewed with the client prior to the actual examination.

(11) When retesting clients who have failed previously, polygraphers may benefit from utilizing the guilt complex test (Abrams, 1989). Since the technique is used rarely, it should be done only after collaboration with the treatment provider or probation officer.

(12) Polygraphers should communicate with the treatment team or provider when there is risk of a false-positive or false-negative results, based on client protest or other corroborative information. While most deceptive people will protest, polygraphers can often learn additional information by posttest questioning of the client.

(13) Polygraphers are encouraged to develop a systematic confidence rating which can be communicated to treatment providers to assist in defining the authority that should be ascribed to a given test result.

(14) Polygraphers are encouraged to develop interschool and intertheory techniques that are appropriate for a sexual offender population. This would increase interrater reliability, validity, and standardization.

(15) Polygraphers should assist in developing empirically based guidelines for the use of psychophysiological measurement as a treatment tool. They should participate as a treatment team member, attending trainings that are specific to sexual offender treatment and becoming involved in research projects whenever possible.

(16) Polygraphers should be encouraged to participate in state and local coalitions or chapters of organizations such as ATSA.

CONCLUSIONS

The usefulness of polygraphy has been demonstrated in many treatment settings. The process of preparing clients for the polygraph examination leverages significant amounts of information from those who might otherwise not be forthcoming. The use of periodic polygraphs may have a strong deterrent effect with clients. While the research data do not demonstrate sufficient consistency in measuring validity and interrater reliability

thus far, much of the evidence is strongly supportive of the use of this process.

While the polygraph can be an extremely valuable tool, it cannot be used in isolation. Clinicians will need to continue to utilize a number of other sources of information in monitoring offenders who live in the community. Guidelines have been proposed to suggest the responsible use of polygraphy in community-based treatment programs. Such programs should collaborate with polygraphers in developing further research. Most of the present research is dated and contains significant methodological flaws. Without better research methods, the use of polygraphy will remain a controversial proposition. Further definition of the variables involved in the polygraph process is needed. Future research should also address issues such as measurement of varied emotional reactions, development of control questions, and appropriate use of results in the clinical and legal decision-making process. Therapist and polygrapher variables also should be further examined.

Other forms of technology, such as voice stress analysis, the penile plethysmograph (Howes, 1995), and the new Abel Assessment for Sexual Interests (Abel, 1994), continue to be subjected to critical review and evaluation. Protocols and procedures continue to be developed for the use of some of these instruments (G. G. Abel, personal communication, July 6, 1995; ATSA, 1993). Psychological tests are held to high standards of validity and reliability, with standardized requirements for administration and interpretation. Even tests that *do* meet these standards of performance are often seen as having marginal value for a sexual offender population. Treatment providers using polygraphy within their programs should demand the same empirical support for this tool that is required of other forms of technological or psychological methods of assessment and intervention.

REFERENCES

Abel, G. (1994). *Abel assessment for interest in paraphilias.* Paper presented at the annual conference of the Association for the Treatment of Sexual Abusers (ATSA), San Francisco, CA, Oct.

Abrams, S. (1989). *The complete polygraph handbook.* Lexington, MA: Lexington Books.

Abrams, S. (1991). The use of polygraphy with sex offenders. *Annals of Sex Research, 4,* 239-263.

Association for the Treatment of Sexual Abusers (1993). *The ATSA practitioner's handbook.* Beaverton, OR: Author.

Backster, C. (1969). *Technique fundamentals of the tri-zone polygraph test.* San Diego, CA: Backster School of Lie Detection.

Blasingame, G. (1994). *Sexual offender rehabilitative treatment: Program manual.* Redding, CA: SORT Program.

Brett, A., Phillips, M., & Beary, J. (1986). Predictive power of the polygraph: Can the "lie detector" really detect liars? *Lancet, March,* 544-547.

Edson, C. (1991). *Sex offender treatment.* Medford, OR: Department of Corrections.

Emerick, R., & Dutton, W. (1993). The effect of polygraphy on the self report of adolescent sex offenders: Implications for risk assessment. *Annals of Sex Research, 6*, 83-103.

Hess, C. (undated). *Observations regarding the effects of specific drugs on polygraph tracings*. San Diego, CA: Backster School of Lie Detection.

Horvath, F. (1977). The effect of selected variables on interpretation of polygraph records. *Journal of Applied Psychology, 62*, 127-136.

Howes, R. (1995). A survey of plethysmographic assessment in North America. *Sexual Abuse: A Journal of Research and Treatment, 7*, 9-24.

Janes, B. (1993). Polygraph: A current perspective. *Interchange*, June. Denver, CO: National Adolescent Perpetrator Network.

Knopp, F. H., Freeman-Longo, R., & Stevenson, W. (1994). *Nationwide survey of juvenile and adult sex-offender treatment programs and models*. Orwel, VT: Safer Society Press.

Lundell, R., & Holmes, S. (1993). *Polygraph handbook for probation/parole officers and treatment providers*. Medford, OR: Polygraph Associates of Oregon.

National Task Force on Juvenile Sexual Offending (1993). The revised report from the National Task Force on Juvenile Sexual Offending, 1993, of the National Adolescent Perpetrator Network. Reno, NV: *Juvenile and Family Court Journal.*

Raskin, D., Barland, G., & Podlesny, J. (1976). *Validity and reliability of detection of deception*. (Contract 75-NI-99-0001, National Institute of Law Enforcement and Criminal Justice, U.S. Department of Justice). Salt Lake City, UT: University of Utah.

Schwartz, B., & Cellini, H. (1995). *The sex offender: Corrections, treatment and legal practice*. Kingston, NJ: Civic Research Institute.