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What Do Young People Learn from Coercion? Polygraph Examinations with Youth Who have Sexually Abused

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That kid coughed up a whole bunch of new victims when he knew we were going to polygraph him.
— Workshop presenter, 2012

Introduction

In the autumn of 2010, the Canadian Province of British Columbia suspended and then terminated the use of the penile plethysmograph within its Youth Justice system. This came in response to complaints about the possible harmful effects of examinations using the plethysmograph. The situation drew media attention across Canada (where the polygraph is only rarely used) and the provincial Office of the Representative for Children and Youth filed a report summarizing concerns (Turpel-Lafond, 2011). Among the points raised in their report was that the absence of documented evidence of any harm caused to these youth does not mean that such practices are not harmful. A comprehensive review of the B.C. Youth Sex Offender Treatment Program continues to this day.

Of relevance to all professionals is that many people outside our field have concerns that our assessment and treatment technologies can cause harm, even as many of us think we are doing the right thing. Many of us believe that if our efforts bring hope and safety to even one other person, it will have been worth it. A broader question remains unanswered: How do we account for our actions if the person we help is matched by another whom we have harmed?

This article considers adolescents who have sexually abused, and provides cautions against misuse of the polygraph. The number of professionals using polygraph examinations with youth who have sexually abused has doubled in the past 15 years, despite any meaningful empirical support for its use. Initial indications suggest that polygraph examinations can assist with obtaining detailed histories and monitoring supervision requirements. However, other areas of research (discussed in this article) indicate that professionals should use considerable, if not extreme, caution in employing intrusive measures, such as the polygraph, on youth.

Those interested in employing the polygraph should consider how and if they wish to employ this and other potentially coercive elements in their practice (Jenkins, 1990, 1994; Ryan & Deci, 2000). Are they seeking short-term compliance or long-term change? To what extent do coercive elements work to the detriment of long-term responsibility? How will introducing the polygraph influence the treatment culture of a particular agency, and how might professionals accommodate this in their program design? Finally, in an era in which professionals are increasingly under pressure to employ evidence-based practices, the evidence to support the use of polygraph with adolescents who have sexually abused remains weak at best. The author believes that no matter what the circumstances,

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adolescents deserve the highest level of care in their treatment.

Background

Professionals employing the polygraph with adults who have sexually offended quickly discover that it can prompt rapid disclosures (Ahlmeyer, Heil, McKee, & English, 2000; Heil, Ahlmeyer, & Simons, 2003), even as there little or no research indicating that polygraphy contributes to reduced sexual re-offense or increased predictive validity (Cook, 2011). Despite broader concerns documented in one large-scale analysis (National Academy of Sciences, 2003) and other reviews (e.g., Vrij, 2000), polygraph use has increased throughout the United States. McGrath, Cumming, and Burchard (2010) report that the use of polygraph with juveniles more than doubled in 14 years, from 22% of programs employing it in 1996 to 50% in 2010. Thehese dramatic increases in the United States are particularly noteworthy given that polygraph use has not been shown to reduce sexual reoffending. Also of concern is the absence of meaningful research on its use with juveniles, and its potential impact on them.

Many professionals have expressed concern that polygraphy is essentially a coercive measure seeming to reinforce the worldview that interpersonal coercion is acceptable, and therefore particularly inappropriate for use with individuals who have used coercion with harmful intent. Many critics charge that it is inherently deceptive because it is most effective when subjects believe it can detect their lies, when in fact it measures physiological changes (and not statements) in response to questions. Skeptics in numerous disciplines and jurisdictions note that it remains inadmissible in most legal proceedings. These concerns are at the forefront of broader research findings that punitive approaches to crime do not make it any less likely to happen again (Smith, Goggin, & Gendreau, 2002) and that coercive forms of treatment are less effective than voluntary approaches (Parhar, Wormith, Derzken, & Beauregard, 2008). Likewise, Lilienfeld (2007) reminds us that our treatments have the potential to cause harm.

Use of the polygraph with youth who have sexually abused has remained controversial (Chaffin, 2011; Hunter, 1999). Although Emerick and Dutton (1993) reported favorable results in obtaining information, Chaffin (2011) noted more recently the lack of subsequent research to support polygraphy with adolescents, especially given its potential negative impact on 1) the developmental trajectory of adolescents, and 2) the clinician's ability to establish trust and mutual respect with the adolescent, a cornerstone of effective treatment. He further challenges the field to find research demonstrating a cost/benefit ratio to warrant the potential harm of the polygraph examination experience. Chaffin suggests that we should only use polygraphy if it can be proven to lead to better treatment outcomes, prevent future victimization, and protect abusers from the all the consequences of abusing again. Currently, this research is lacking.

Despite these concerns, professionals often continue to extoll the virtues of the polygraph and the information it provides. This is despite any evidence that more information is necessarily better information. One might reasonably wonder whether it is the information that is helpful or the sense of confidence that the professional gains through its extraction. Likewise, is it the information or the apparent need for *confession* that is actually most valuable (e.g., Mann, 2011)?

Professionals typically employ the polygraph to obtain complete disclosures of sexually harmful behavior and to monitor adherence to treatment and supervision requirements. Although the National Task Force on Juvenile Sexual Offending stressed that polygraphs should be voluntary and occur with informed consent (NAPN, 1993), this is often not the case. In some cases, polygraph examinations are the norm for adolescents who have sexually abused (e.g., County of Shasta Juvenile Probation, 2006). In others, youth and their families experience considerable pressure to consent to evaluations. Given the numerous concerns and legal battles about the potential for unanticipated self-incrimination in the adult world (e.g., Blackstone, 2011), it is reasonable to ask whether adolescents and their families can truly provide informed consent.

A standing question has been whether the polygraph can be used effectively and reliably. In a position paper for the California Coalition on Sexual Offending, Hindman and Peters (2004) claim that " more than a decade of collective experience suggests that it is reasonable to use polygraph as a clinical tool with youth thirteen to eighteen years old and with developmentally disabled individuals." The authors include a list of cautions, including use of the polygraph with individuals who display poor reality testing, have cognitive or intellectual deficits, and appear unable to produce " Deception Not Indicated" charts even when independent information makes it highly unlikely they are being deceptive or have physical conditions that would prevent an accurate examination.

Although this certainly appears reasonable, it is important to expand our inquiry. Given our responsibility for the long-term well-being of young people, what is the best use of the polygraph? Just because a polygraph examination *can be* used in a given situation does not mean that it *should be*used.

Before considering polygraphy, treatment providers and agencies will need a detailed mission statement regarding their approach to the treatment of sexual harm. Although polygraph examination has come under increasing scrutiny with respect to individuals' rights against self-incrimination (Blackstone, 2011; Fox, 2005), legal challenges in juvenile cases have been less common. A healthy skepticism about the current state of interventions with youth who have sexually abused can also be helpful. Chaffin and Bonner (1998) caution professionals away from the belief that those working with youth who have sexually abused have found all the answers. Their examples of false professional beliefs include the assumptions that only abuse-specific treatment can reduce risk; that denial must be broken; that good treatment involves strong confrontation; that treatment must be long-term; and that deviant arousal and fantasies, grooming of victims, and deceit are all core features of this population.

A primary goal of treatment for youth who have sexually abused is promoting their ability to be responsible people. Decades of research remind us that human beings are better able to accept responsibility for behavior outside the perceived presence of external pressure (Cialdini, 2001) and that people are more persuaded by their own actions and discoveries than by what others tell them (Bem, 1972). Further, people are more motivated to change when it comes from their own decisions and choices, as opposed to others compelling them to change (Ryan & Deci, 2000). Given the literature about how people change, professionals should be very careful with the use of the polygraph.

Seven Reasons to Exercise Caution with the Polygraph

Reason #1: *Youth are different in their treatment needs and willingness to disclose information.*

Youth are inherently different from adults. Their personalities are still developing, they are not fully educated, and they lack sophistication in the ways of the world. In part, this is why they do not have certain rights until the ages of 18 and 21.

Research demonstrates that the sexual recidivism rates are lower for youth and that their risk indicators are often different from adults (e.g., Caldwell, 2002, 2010). Additionally, youth are typically more likely to engage in future non-sexual crime (Långstrom & Grann, 2000; Worling & Curwen, 2000). For this reason, assessment and treatment should focus on all forms of problem behaviors, including self-harm. Fortunately, youth are often very willing to self-disclose problematic thoughts and behaviors under the right conditions (Baer & Peterson, 2002; Lambie & Robson, 2006; Worling, 2006; Worling & Curwen, 2000; Worling & Långstrom, 2003; Zolondek, Abel, Northey, & Jordan, 2001).

Further, there is no reason treatment cannot focus on the relevant risk factors in a young person s life without a detailed accounting of every sexual experience the adolescent has had. An analogy

might be to the treatment of any other behavioral problem in which it is not necessary to chronicle every depressive thought the person has had. Certainly, it is important to engage in a comprehensive assessment of every youth in order to identify criminogenic treatment needs; professionals can ask whether it may be better in the long run to modify the circumstances so that the youth is more comfortable sharing this information. A further question for professionals to ask is to what extent treatment programs are actually set up to facilitate disclosure within a strong therapeutic alliance, as opposed to using the polygraph to meet the needs of professionals in a user-unfriendly environment?

Reason #2: More information is not always better information

Newcomers to risk assessment and management often believe that all information gathered is important to risk estimates. Research has demonstrated that this is not the case (Monahan, 1981; Quinsey, Harris, Rice, & Cormier, 2006). One adult actuarial scale, Static-99 (Hanson & Thornton, 2000), specifically excludes the information provided by polygraphy (Harris, Phenix, Hanson, & Thornton, 2003, p. 15); although, part of the reason for this is that polygraph data were not available for subjects in the instrument s original standardization sample. A recent study (Cook, 2011) found that new information produced via polygraph did not improve the predictive validity of Static-99.

Likewise, using information obtained by the polygraph to make inferences about behavioral and sexual proclivities may be less helpful due to the dynamism of adolescent sexual arousal (Hunter, Goodwin, & Becker, 1994; Nisbet, Wilson, & Smallbone, 2004; Prentky & Righthand, 2003). The inescapable fact is that the sexual interests and arousal patterns of adolescents are subject to change without notice.

Further, Worling & Curwen (2000) found that self-reported deviant sexual interests were predictive of sexual recidivism. Worling and Långstrom (2003) concluded that it is encouraging that the evidence to date in support of this factor is based on the results of clinical interviews and observation (p. 345), particularly in light of at least one small study where phallometrically assessed deviant arousal did not correlate with recidivism (Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001).

Finally, professionals might first wish to consider what the additive value of new disclosures will be. Focusing efforts on compelled disclosure of numbers of victims may actually be missing the point. There is simply no evidence that understanding, identifying, and managing risk factors requires an exact victim count.

As an example, a common argument in favor of the sexual history polygraph is that it can assist in safety planning. For example, before reuniting an adolescent with his family, professionals want to know if he has abused others in the home or neighborhood. Setting aside other issues, it is unclear how having this information actually contributes to safety. One might wonder whether all safety plans should not take into account that this may have been the case and that supervision by adults should be increased, even if only to prevent further allegations. Is an exact victim count from the past necessary to protect people (including the client) in the future? Is professionals' time not better spent crafting plans that will create safety and wellbeing for all?

Reason #3: Polygraph examinations have the potential to be re-traumatizing and may contribute to dysfunctional beliefs

Rates of victimization and trauma among youth who have abused can be very high (Crittenden, Claussen, & Sugarman, 1994; Schwartz, Cavanaugh, Prentky, & Pimental, 2006; Sisco, Becker, Sanders, & Harvey, 2006). Many of these youth have had little experience with supportive or pro-social adults. Professionals may wish to consider whether young people will view the professionals actions as helpful to change or as further evidence that adults are hostile, controlling, and punitive (Mann & Beech, 2003). After all, these attitudes themselves can act as risk factors, whether by fueling a sense of entitlement, or as part of a larger array of antisocial attitudes and beliefs. Ultimately, professionals will want to ask just what they are modeling for adolescents, and how they know they

are accomplishing it.

The polygraph uses fear and anxiety to compel people to tell the truth (Kokish, 2003; National Academy of Sciences, 2003). It is also vital to remember that the anticipation of a polygraph examination can also create fear, anxiety, and uncertainty, each of which can influence the treatment progress of adolescents. At the very time when professionals are essentially asking clients to build a new and better life, they are introducing an anxiety-provoking experience into the process. Given the tendency of these young people to have had very negative life experiences, polygraphy brings risks, including:

a) Emulating abusive environments, thereby sending the message that it is OK for adults to be coercive, intrusive, and fear inducing.
b) Providing the youth with cause to believe that he or she is a bad person (i.e., "If they re treating me like this, I must really deserve it". "I must be fundamentally bad and untrustworthy."). It is one thing for supportive adults to try to say otherwise, but actions often speak louder than words.
c) Communicating to the youth that adults either do not understand or care about him.
d) Over-disclosure by the youth in the hopes of "passing".

A useful question for professionals to ask is whether they are minimizing the harm done to clients even as they seek to prevent further minimization of harm by their clients? Decades of psychotherapy research have made it clear that the therapeutic alliance predicts the level of engagement and *vice versa* (Duncan, Miller, Wampold, & Hubble, 2010). The same research has also established therapeutic alliance as crucial to successful outcomes in therapeutic settings. When professionals describe the polygraph as a clinical tool , does this mean they have used it to replace clinical skills?

Reason #4: Those who have survived sexual abuse rarely wish to be identified by the polygraph.

Some professionals have advocated that the polygraph can obtain information on survivors who have not come forward to disclose sexual abuse. While some professionals may feel that those harmed may now be able to get help, not all survivors of sexual abuse need or want it. To this end, bringing victims to the attention of authorities may itself be highly intrusive and re-traumatizing. In the end, those who have survived sexual abuse should be free to disclose abuse —or not—at whatever time or in whatever place they choose.

Reason #5: Young people may have long-term treatment needs, but the polygraph may only have short-term utility

The goal of treatment for adults who have sexually offended is typically the simple stopping of abuse. Society presumes that adults are accountable for their actions and should use the skills learned in treatment for the rest of their lives. Other treatments are ancillary.

By definition, adolescents are young people in development. This is true across all aspects of their functioning: physical, psychological, familial, criminological, psychosexual, etc. Interventions are best aimed not only at stopping the abuse, but at helping them become responsible adults. The most successful interventions go beyond holding them accountable to teaching what accountability actually is and having them practice it (Prescott, 2011). These are among the reasons why juvenile courts have historically been rehabilitative, while adult court actions are more punitive and corrective (Trivits & Repucci, 2002).

Therefore, all interventions with young people must look at their long-term needs in order to guide them in desisting from crime. Polygraph examinations result in short-term compelled disclosures; how they actually contribute to a balanced, self-determined lifestyle in longer term is unknown (Wilson, 2009).

Reason #6: Disclosure is not always the same as honesty

There is no question that honesty is an appropriate goal of treatment, but is compelled disclosure really the same thing? Professionals and programs may wish to ask whether they are promoting honesty as a value or simply demanding disclosure. Many professionals have come across young people exaggerating, even fabricating disclosures of harmful behavior in the belief that this signals treatment progress. It is possible that promoting honesty as a value involves social judgments around when *not* to tell the entire truth (Ekman, 1992; Vrij, 2000). For youth who categorically deny the offenses for which they have been adjudicated, there may be aspects of adult deniers' programs (Brown, 2005; Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Serran & O' Brien, 2009) that can inform treatment strategies with youth before resorting to the polygraph.

Outside pressure on professionals to maintain community safety has never been greater. Professionals may wish to consider whether they are seeking disclosure due to outside pressure (e.g., to convince referring agencies that they are getting the truth) or to facilitate the youth's investment in his own treatment process and future. If the goal is a complete and honest accounting, professionals may wish to consider whether they can first obtain this through treatment interviews.

Reason #7: Interventions are more effective when they are science-based.

Proponents frequently point to the importance of disclosure in the treatment of sexual aggression. However, how much disclosure is actually necessary remains an open empirical question; to the present, there is no evidence that full disclosure is necessary to meaningfully reduce risk. Professionals considering the polygraph will wish to consider to what extent their judgments are effected by moral convictions and cultural beliefs in the importance of confession.

Likewise, professionals are under fierce pressure from outside agencies to ensure community safety. The polygraph can give the appearance that one has done everything they can to produce a safer client and community, but does it do so at the cost of other factors (e.g., therapeutic alliance and engagement) that actually have an evidence base in risk management?

Use and Misuse

Professionals will need to be familiar with ethical guidelines and standards for the use of polygraph as well as the ethics of their profession. Chaffin (2011) has observed that central to the ethical codes of many professional organizations are beneficence, nonmaleficence (avoiding harm to one s client), respect for autonomy, and justice. As an example, the World Medical Association has held that an ethical breach could exist for providers who are present at harsh interrogations (cited in Chaffin, 2011). While treatment for sexual aggression frequently involves waivers of confidentiality, professionals will wish to exercise extreme care before using the polygraph, especially with people who are in the custody of others. Chaffin further observes that the compulsory nature of treatment with mandated clients places a greater (not lesser) obligation on treatment providers.

Additionally, professionals who decide to use the polygraph should use care in selecting their methods. Craig and Molder (2003) reported that a number of examiners in their study used polygraphy with early adolescent populations including juveniles as young as seven, and that " more than half of the respondents do not use any special modifications when testing a juvenile, treating them exactly like an adult during the test" (p. 72). The conditions in which these polygraph examiners tested pre-adolescents are unspecified. The effect of these examinations on these young people is unknown.

Others have reported problematic use of the polygraph. Practitioner concerns have highlighted parents urging their son to fabricate material in order to pass the polygraph examinations that they

were required to pay for. Some programs have made passing the polygraph a condition of treatment progress and family reunification. Many professionals have described clients returning to incarceration after disclosing new information as a part of processes originally designed to be therapeutic. Professionals therefore need to provide safeguards against the polygraph becoming a barrier to investment in change, a false indicator of progress, or an inadvertent means of self-incrimination.

Considerations

Before (or instead of) employing polygraphy within clinical settings, professionals may wish to consider any or all of the following:

- Are there specific questions that only a polygraph examination can answer? What have providers not done that would ensure a meaningful understanding of the youth?
- Has the youth received a comprehensive assessment using empirically supported tools that describes risks and needs? Has that assessment spoken to the best ways that the youth can be motivated for treatment and long-term change? Does it speak to the young person' s learning style and other factors that will allow him or her to access the available treatment?
- What other methods are available that can be used prior to (or instead of) using the polygraph?
- Are there psychiatrically co-morbid conditions that will cause this young person to have an adverse reaction to the polygraph experience, whether in the short or long term? For example, while a polygraph examination may provide useful information in the present, how will it influence in the future a young person with a history of trauma or diagnosis on the Autism spectrum? Will the client recall it as a helpful experience or another example of coercive adults providing them with bad experiences? What steps will prevent the latter?
- Does the young person have other vulnerabilities? To what extent might a polygraph examination cause harm?
- What protections have adults put into place to protect against self-incrimination? Do these take into account that youth are inherently less able to provide informed consent than the adults who care for them?
- How does this polygraph examination promote the self-efficacy and long-term interests of this youth? Have all other options been exhausted?
- What is the young person s current level of investment in treatment, and how can adults increase it before (or without) using the polygraph?
- In the final analysis, is a polygraph examination truly the least restrictive intervention?
- Has the program or provider done enough to explore and promote those factors associated with desistance rather than resistance?

Conclusion

The use of polygraph examinations with juveniles, to the present, remains empirically unsupported and potentially counterproductive. One may reasonably ask whether we are really doing our best when we use a tool that may introduce more problems than it solves. How do coercive methods nurture healthy lives and safe communities? How does forced disclosure actually help survivors who have chosen not to come forward? Young people — regardless of their past behavior — deserve our highest standard of care. Perhaps more to the point, is this the best practice of which treatment providers are capable?

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