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Mark Chaffin

Abstract

Polygraph interrogations are used by half of all surveyed juvenile sex offender (JSO) treatment programs in the United States. This is a distinctive and controversial practice that is rarely if ever used with other juvenile delinquent populations, and that is rarely used or is banned from JSO treatment programs in other countries. Clinical polygraphy is an ethically sensitive issue because it involves mental health therapists in involuntary coercive interrogations of minors. This article reviews core mental health professional ethics principles for juveniles. JSO polygraphy is used as an illustrative issue for applying human rights principles to a practice in light of its benefits, risks, and available alternatives.

Keywords

ethics, polygraph, juvenile sex offender

There is a very old joke that has been told about many different professions. As the story goes, two men decide to take a balloon ride. They quickly end up drifting off course and are soon lost over unfamiliar terrain. Spotting a third man standing on the ground, one of the men in the balloon shouts down, “Can you tell us where we are?” The man on the ground answers, “You’re high up in the air.” One man in the balloon says to the other, “He must be an ethicist.” “How can you tell?” asks the second man. “Well,” says the first man, “the answer he gave me was absolutely correct in principle, but of no practical value whatsoever.” At this point, the ethicist standing on the ground shouts up, “You must be a practitioner.” “How did you know that?” asks the man in

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the balloon. The ethicist shouts up, “Well, because you have no idea where you are or
where you are going and now you expect me to give you an instant solution to your
complicated dilemma.”

Sometimes, when researchers or practitioners seek guidance on ethical matters, we
are like the men in the balloon. We want answers that are not really ethical answers.
We want practice standards answers. These are not equivalent. Both intend to govern
practice but in different ways. Practice standards are limited, practical, concrete, oblig-
atory, and prescriptive. They may or may not be ethical. Ethical principles are broad,
abstract, and aspirational. They often require interpretation in applying them to a par-
ticular dilemma or practice. Practice standards can tell us which practices are locally
expected and customary. Ethics, on the other hand, considers how these practices fit
within a larger moral framework of basic human rights and dignity, fairness, benefi-
cence (doing good), nonmaleficence (not doing harm), and the bounds within
which human autonomy and personal agency should be respected or may properly be
breached (Ward & Syversen, 2009). Ethical principles offer both a bigger picture of
our practices and a set of core moral principles against which our practices regularly
need to be juxtaposed.

The focus of this article is clinical ethics with juveniles, particularly the ethics of
juvenile sex offender (JSO) polygraphy. The purpose is not to settle whether we should
use the polygraph with juveniles or not, nor to resolve the decade-old JSO polygraph
controversy (Hunter & Lexier, 1998). There are several polygraph controversies.
There is the scientific controversy about the polygraph itself, which is widely regarded
as pseudoscience by many and probably most scientific researchers (National Research
Council, 2003). There are clinical controversies. Then there are the ethical issues,
which is the focus here. Some might argue that because practice standards addressing
polygraph use with JSOs have been written this is a settled question. However, anyone
can find like-minded peers who can come to consensus about a mutually favored exist-
ing practice, then legitimize those practices by writing them down as standards. This
does not make the practices ethically sound. Ethical soundness lies in deriving prac-
tices from core ethical principles, which is a very different process than legitimizing
existing practices by codifying them in standards. Just as no amount of rhetorical
alchemy can transmute clinical lore into hard data, so can no number of published
procedures transmute practice standards into sound ethics.

**Ethical Principles, Offenders, and Juveniles**

Ethical practice rests on core ethics principles. Different wordings but similar core
principles are found across the ethics codes of different professions (e.g., American
Academy of Child and Adolescent Psychiatry [AACAP], 2009; American Psychological
Association [APA], 2002; Association for the Treatment of Sexual Abusers, 1997;
National Association of Social Workers, 1996). Whether these exact terms are used,
the core principles of ethical clinical practice are beneficence (promoting the
patient’s welfare and delivering treatment that benefits the patient), nonmaleficence
(avoiding harm to the patient), respect for autonomy (respecting the patient’s self-determination and personal agency), and justice (treating the patient fairly; Ratner, 2002). Related principles include nondeceptiveness, faithfulness to the role of healer, and respect for privacy and confidentiality. Ward and Syversen (2009) argue that respect for human dignity and agency are the core values from which all other ethical principles can be derived. Human dignity can have different meanings but broadly implies the moral right to a fulfilling life, to personal agency or autonomy, to liberty, to respect, and to recognition of value beyond simply being a means to achieve the ends desired by others. Dignity also implies reciprocal obligations to respect these same rights in others and to be accountable when reciprocal obligations are violated. When it comes to minors, autonomy and personal agency are complicated by their dependency, but in this case, autonomy is not so much voided as it is partially transferred to parents or other proxies who are empowered to act on the child’s behalf and to guard the child’s interests. Incursions into autonomy are usually permitted only under special circumstances, such as where an adult individual’s capacity to determine their own best interest is clearly impaired (e.g., civil commitment), where a parent grossly fails to act in the child’s interest (e.g., child abuse cases) or where accountability is demanded under criminal law (e.g., legal offenders). For offenders, autonomy is partially but not fully eroded by accountability demands. For example, although a legal offender may have limited choice about undergoing rehabilitative treatment, and lessened privacy rights in that treatment, their status as an offender does not void their right to beneficent and nonmaleficent treatment, their rights to some choices concerning their own treatment, or their right to be treated honestly, fairly, and with dignity in those treatments (Levenson & D’Amora, 2005; Ward, Gannon, & Birgden, 2007).

As offender therapy is often compulsory, this places a greater, not a lesser, obligation on treatment providers. Under normal circumstances, patients (or their parents in the case of juveniles) can choose to leave treatments they find aversive, unhelpful, disrespectful, or harmful. However, when autonomy is eroded, so is this privilege. This places an increased ethical obligation on JSO providers to ensure that beneficence, nonmaleficence, and respect for persons are maintained, and that the tilted balance of power is not abused. In offender therapy, the line between accountability and treatment can easily become blurred. Holding juvenile offenders accountable and delivering punishment is the job of the justice system, not treatment providers. Treatment providers and juvenile justice authorities can and should collaborate on cases but providers need to remain mindful that it is never their role to investigate, catch, prosecute, judge, or punish or to impose on privacy or autonomy beyond what is necessary to achieve the defined treatment purposes (Glaser, 2003).

A particularly treacherous ground for confusing health care and criminal justice roles is information or confession extraction. Procedures to extract confessions seem to hold a particular sensitivity in the health care ethics literature, especially if the procedures are coercive or harsh. The World Medical Association (WMA; 1975) held that a breach could exist for health care providers by simply being present during harsh
interrogations. These prohibitions apply, “whatever the offense of which the victim of such procedure is suspected, accused or guilty” (WMA, 1975). Interrogation-related ethics codes most directly pertain to out-and-out torture; however, they do also apply to psychologically coercive and degrading procedures. Specific procedures were listed by the APA (2008) in the wake of the Abu Ghraib and Guantanamo controversies over so-called “robust” interrogation. These included absolute prohibitions against mental health professionals participating in techniques such as the use of mind-altering drugs, exploitation of religious beliefs or psychopathology, fear tactics, simulated drowning or faked executions, and the use of humiliation. The ethics committee of the association will not consider any justifications that psychologists might offer for participating in any way in these practices (APA, 2009). The point of this paragraph is not to equate JSO polygraph interrogations with water-boarding but to demonstrate the heightened sensitivity with which the health care ethics literature views participation in interrogation.

Stricter limits and cautions should apply to interrogation techniques used with children and teenagers. Even manipulative or deceptive verbal interrogations have been judged improper by the courts when used with children. For example, in a case before the Kansas Supreme Court, a 10-year-old boy suspected of illegal sexual behavior was interrogated by the police in a deceptive and suggestive manner in the absence of legal counsel or parents. The youngster was told that his guilt was already proven and that if he would only admit to the accusations, he would be released to return to school. The court ruled that the confession thereby extracted was both questionable in its validity and improperly harmful to the child (264 Kan. 417, 955 P.2d 1302).

One soundly established ethical principle is that special considerations apply to minors, including minors in juvenile justice settings (Zerby & Thomas, 2006). Persons below the age of 18 years are considered vulnerable populations (for example, see subpart D of 45 CFR part 46 in U.S. federal regulations). Minors are viewed as vulnerable for several reasons, not only because of their dependency but also because they are more susceptible to exploitation, intimidation, coercion, and incursions on their fundamental human dignity. Indeed, it is this principle that makes all forms of adult sexual behavior with minors morally wrong irrespective of its illegality or the actual harms inflicted (Ondersma et al., 2001). The vulnerability of minors has more recently been affirmed by brain and cognitive science research that has buttressed long-standing legal and ethical views that minors possess weaker judgment and decision-making capacity, have a less-well-formed future-orientation, are more susceptible to external influences and pressure, tend to underestimate the risks inherent in choices, and modulate their emotions less than adults (Scott & Steinberg, 2008).

Foremost among the special principles governing ethical practice with juveniles is a developmental perspective (AACAP, 2009). The developmental principle holds that the younger the minor and the less their capacity, then the greater their dependency, vulnerability, and right to special considerations. Minors have less capacity to guard their own welfare and so depend on others to guard it for them, which is also known as paternalism. This means that responsible adults should adopt a paternalistic stance
toward the welfare of minors in their charge. Paternalism was one of the main foundations of our juvenile justice system. A little over a century ago when the juvenile justice system in the United States was first born, it was proposed that juvenile offenders who had previously been treated the same as adult criminals should now be treated, “as a wise and merciful father handles his own child” (Mack, 1909).

The developmental principle also emphasizes that development, vulnerability, and dependency are processes. Youth do not achieve adult cognitive maturity in a quantum leap on their 16th or 18th birthday, but rather vulnerability tapers gradually across childhood and into late adolescence or early adulthood. Legal classifications, which are categorical in nature, do not fully capture this process. For example, the legal age of consent for sex might be 16 years in many jurisdictions, but this does not imply that grown adults who have sexual relations with 16 year olds are behaving ethically despite the legality of their behavior. So we should question any legalistic arguments that JSO polygraphy with older juvenile populations is ethically equivalent to polygraphy with fully grown adult offenders based on some arbitrary age cut-point in law or practice standards.

The developmental principle also modifies the nonmaleficence imperative. We know that minors are susceptible to developmental insults and, therefore, the actions taken with minors can impact their life-course development in more profound ways. Because of this, we strike the ethical balance between community protection and patient welfare differently with JSOs than we do with adult sex offenders. The more vulnerable the juvenile, the greater caution we should exercise about actions that might harm them. For example, reunifying an offender with family should give relatively greater weight to the offender’s need to be in the home if the offender is a child rather than an adult (Chaffin et al., 2008). In striking these balances, the rights and interests of offending youth are not preemptory. They are simply accorded greater weight in the balance than we accord those of fully formed and less vulnerable persons. Similarly, the developmental principle suggests greater attention to the example we set for impressionable juveniles. If JSO treatment providers engage in domineering, vindictive, deceptive, or disrespectful practices, these actions might socialize youth in undesirable ways, and therefore, we have an ethical obligation to consider the example set. Ultimately, we best teach youth to respect human rights and dignity by modeling respect for human rights and dignity (Jenkins, 2006).

It is contextually interesting to note that long-established paternalistic and developmental perspectives on juvenile offenders came under considerable political and popular fire around the end of the 20th century in the United States. The dominant political narrative of our recent past was of juvenile delinquents as “super-predators” who were, if anything, more callous and vicious than their adult counterparts. The political narrative of the 1990s denigrated the paternalism of the traditional juvenile justice system as weak or merely a slap on the wrist, and advocated for adult time for an adult crime (Scott & Steinberg, 2008). The movement pushed for harsher sanctions for juvenile delinquents, was pessimistic about their prospects for rehabilitation, and voiced little concern for their fundamental human rights. Youth advocates borrowed from...
other political slogans of the day, and with a certain irony called this movement “the war on children.” It was during this same era that we saw wholesale trickle down of adult sex offender policies and approaches to JSOs, including the uptake of polygraphy. The punitive and pessimistic perspectives toward juvenile delinquents seem even more deeply entrenched when it comes to JSOs (Zimring, 2004), as witnessed by their recent and unprecedented inclusion along with adults on lifetime public sex offender registries in the United States (U.S. Public Law 109-248, 2006). It may be important to consider this cultural and political context when thinking about the rise of JSO polygraphy in the United States.

**JSO Polygraphy**

Polygraph interrogations are employed by 50% of 373 JSO treatment programs surveyed in the United States (Safer Society, 2009). This is up from 22% in 1996, following a trend established among adult sex offender treatment programs where reported use rates currently approach 80%. Despite criticisms leveled against JSO treatment models for being inappropriately derived from adult sex offender practices and assumptions that are factually wrong for teens (Chaffin, 2008; Letourneau & Miner, 2005), the trickle down of polygraph use from adult sex offender to JSO treatment settings appears to be surging forward. At least it is in the United States. The popularity of juvenile polygraphy appears to fade dramatically at the Canadian border—none of the 15 Canadian programs surveyed by Safer Society (2009) used the polygraph. This is a sizable and significant difference (Fisher’s Exact Test, \( p < .001 \)) between two adjoining nations that otherwise share common professional society affiliations, a common body of clinical and scientific knowledge, and endorse similar professional ethics principles. In the United Kingdom, the Offender Management Act of 2007 disallowed a polygraph condition for offenders below age 18 (Part 3, Section 28, Subsection 2b). Polygraphy in United States JSO programs also contrasts sharply with regular juvenile delinquency practice in the United States. I searched publication databases available through the U.S. Office of Juvenile Justice and Delinquency Prevention, PsycInfo, PubMed, and MedLine for the past 50 years and failed to locate published research describing routine mandatory polygraphy with nonsexual delinquents. Certainly there are other subgroups of juvenile delinquents aside from JSOs who pose risk to the community and who are known to lie, yet JSOs are virtually alone in being subject to polygraph interrogations. Also, given that serious nonsexual delinquents commit future sex offenses at rates comparable to those of JSOs released from the same juvenile institutions (Caldwell, 2007), it would appear that application of the polygraph to JSOs represents not only a distinctive practice, but one that is not directly related to sex crime risk. In short, juvenile polygraphy and the local practice standards that mandate or favor it are unusual practices that some JSO providers embrace and others do not, and that appear to be most heavily concentrated in one country. Even within the United States, some states polygraph juveniles routinely, whereas others do not. A practice that is localized, unusual, and distinctive is not automatically unethical, but it certainly merits closer scrutiny.
The Nature of Polygraph Interrogations

Scrutiny should begin by considering the basic nature and purpose of the procedure itself. The purpose of polygraph interrogations is to extract confessions. The prospect of extracting confessions holds an enduring allure across human history, including for one of the earliest developers and champions of the polygraph, William Marston, who also was known for creating the Wonder Woman comic book (Cross & Saxe, 2001). As you may recall, Wonder Woman’s primary weapon was a magic lasso of truth that could compel confessions. Most of us dislike lying, and the prospect of breaking liars can be emotionally seductive, especially when it comes to individuals believed to have committed serious transgressions for which society legitimately seeks accountability. The polygraph might seem to some like just deserts for wrongdoers. We have all heard from the occasional polygraph proponent who appears to enjoy vindictively humiliating and dominating wrongdoers. However, it would be a mistake to paint the entire practice and its practitioners with this overly broad brush. JSO polygraphy also can have a beneficent logic model. We know that legal offenders can be less than frank about their past and current behavior, and clinical work with legal offenders of all kinds has long struggled with this fact. If accurate histories were made available to us, the logic model goes, the quality of our clinical assessment and treatment should improve. Plus, there might be a useful deterrent effect. Youth might think twice about rule violations if they believe that there is no escaping the watchful eye of the polygraph (see Foucault, 1975). If this logic model is correct, the pain of future victimization might be prevented, hidden victims might be helped, and JSOs themselves might be spared the consequences of a sex crime career. These are beneficent goals.

The Polygraph and the Continuum of Coercion

The complexity arises because the method for reaching these goals requires coercion, deception, and circumventing personal agency. Although some practice standards specify an informed consent procedure before polygraphing, this can hardly be characterized as free or genuine consent because the alternative to signing the consent form is sanctions. The polygraph is fundamentally a coercive interrogation tool for extracting involuntary confessions. Some might object to characterizing polygraph testing as interrogation, but I would argue that the term is precisely apt and that other characterizations are disingenuous. If the procedure did not extract confessions, it would not be used. Reports advocating polygraph use invariably cite the fact that some individuals will confess to vast numbers of bad acts as prima facie evidence of the polygraph’s value (Ahlmeyer, Heil, McKee & English, 2000). The accuracy of these confessions, which is not precisely known, may be beside the point for establishing that the procedure is an interrogation. It seems euphemistic to claim that the polygraph is employed beneficently in the interest in promoting an honest and open therapeutic atmosphere, or to provide youth with a welcome opportunity to demonstrate their honesty. In fact, these rationalizations seem similar to the sorts of cognitive distortions that often are disabused in offender therapy itself. The question is not
whether polygraphy is a coercive interrogatory tool, but where along a continuum of interrogation techniques it lies.

There is a wide continuum of different interrogation and questioning techniques designed to extract confessions or other sensitive personal information. They span a wide range of coerciveness and raise a correspondingly gradated range of ethical concerns. Techniques range from very low coercion approaches such as routine clinical interviewing or questioning, to building rapport and gaining a subject’s trust, to confronting someone with concrete evidence, to using suggestion and pressure tactics to wear down resistance, to deception, to the polygraph, to the use mind-altering drugs, to so-called “soft torture” techniques such as sleep deprivation, and finally on to out-and-out brutality and torture. Most of us would agree that the lower end of this continuum is benign and lies well within customary ethical practice boundaries with a few exceptions, such suggestively questioning young children or highly vulnerable persons. The highest end of this continuum, which is sadly a part of our human heritage and still quite popular in some quarters, is inherently unethical to the point that the information retrieved is so contaminated by the violations of human dignity involved that the utility of the extracted information becomes irrelevant. The first step in thinking clearly about the ethical implications of juvenile polygraphy is to accept that the technique belongs somewhere on the interrogation continuum, not apart from it.

**Risk of Harm**

Maleficence, or risk of harm, is one consideration distinguishing practices along the continuum. Deliberately harming young patients violates the nonmaleficence principle. For example, if a mental health treatment provider sets out to coerce incriminating confessions from a juvenile, intending that this will result in the juvenile’s prosecution or sanctioning, this would be maleficent. Even though polygraph confessions may not be directly admissible in court, the chain of events the confession initiates could easily eventuate in sanctions. JSO polygraph practice standards caution against this. Therapists, polygraphers, and juvenile officers may strike formal or informal agreements that youth will not be sanctioned based solely on the information extracted during a polygraph interrogation (Blasingame, 1998; Colorado standards, section 7.161). Obviously, these agreements cannot be guaranteed or absolute, especially given that the standards address harms attributable “solely” to the polygraph, which could be interpreted fairly narrowly. It is possible that polygraph believers may vastly overvalue the significance of a deceptive polygraph result and then act with confirmatory biases, eventuating in harm. The fact that these clauses exist in practice standards suggests that practitioners see the potential for harm and wish to avoid it. In other contexts, practitioners appear less concerned about this issue, and advocate in favor of sanctioning adult inmates who “fail” a polygraph (Ahlmeyer, Heil, McKee, & English, 2000). To my knowledge, this recommendation has not yet trickled down to JSOs, although we might worry given our history. The extent of JSO polygraph initiated sanctions not well documented. Clinical observers have not described any epidemic of prosecutions
flowing out of JSO polygraph interrogations, so we might estimate that these harms are rare, although we do not precisely know.

Another potential harm is that the procedure might elicit false confessions. The objective harms due to false confessions are the same in many ways as those for valid confessions, but with the added injustice, psychological distress, and loss of human dignity that any coerced surrender of self and truth entails. Minors might be especially vulnerable to how false confessions could become internalized or molded into a pejorative self-image or pessimistic world view. We do not know how many JSOs have been coerced into false confessions by the polygraph because it is an insufficiently studied question. There is anecdotal evidence. In my own clinical practice with youth transferring from programs requiring the polygraph, I have regularly heard unsolicited accounts of false confessions from youth, supported by accounts from parents who advised their child to falsely confess to additional crimes to bring a stop to the string of repeated polygraphs and its associated financial burden. These reports are anecdotal and unverified and, therefore, establish little beyond raising the question. Polygraph believers might voice their confidence that false confessions cannot be a prevalent problem because they would be surely detected by the polygraph itself and, therefore, could not be false, but this logic is disturbingly circular.

How Should Potential Harms Be Evaluated?

It is important to note that we set a sensitive threshold when it comes to evidence of harm. Documenting a treatment’s harm has a lower threshold of proof than proving its benefit (Lilienfeld, 2007). In this regard, an evidentiary double standard exists. Benefits require rigorous confirmation before they are accepted by science. This is what defines evidence-based practice. When it comes to harm, a series of adverse events can be sufficient to raise concerns, especially if there also is an absence of reasonably clear benefits. We as a field are simply not collecting sufficient data about JSO polygraph interrogations on either account. We have very little, if any, data from either the youth themselves or their families about their experiences with the technique and any harms they might have experienced. We especially need studies that ask juveniles and their families about harms confidentially and free from any perceived risk of retaliation.

Comparisons With Related Practices

An interesting exercise for locating juvenile polygraphy along the continuum of information extraction techniques is to compare it with neighboring practices, especially those about which there is clearer ethical consensus. First, we might ask how polygraph interrogations differ from a neighboring but far more accepted and routine juvenile delinquent monitoring practice–drug screen urinalyses. Mandated screening for illegal drug use is a staple of juvenile probation. It is used with both JSOs and with nonsexual delinquents. It is sometimes a part of juvenile substance abuse treatment,
and a cornerstone of contingency management-based treatment protocols. Contingency management has solid scientific research documenting that it benefits patients (Stanger, Budney, Kamon, & Thostensen, 2009). Drug screens may help parents and other adults paternalistically protect the youth from dangerous behaviors over which the youth may exercise inadequate self-control. The prospect of detection may act as a deterrent to engaging in risky drug use behavior. We accept that the net benefits of drug testing delinquent or addicted youth outweigh the intrusiveness and erosion of autonomy involved.

There are similarities between drug screens and clinical polygraph interrogations along all the dimensions just described. Both are monitoring. Both may serve as a deterrent. Both are believed by some practitioners to be a useful treatment tool. However, there also are key differences. Drug screens used as part of contingency management programs have controlled trial evidence documenting benefits, whereas polygraphy does not. Drug screens do not involve deception and are fundamentally fair—they measure the presence of illegal drugs with little bias and with a scientifically known error rate, whereas many scientific observers believe that the polygraph is fundamentally based on deception or pseudoscience (Cross & Saxe, 2001) and may be biased against anxiety prone individuals, immature individuals, naive individuals, or others (National Research Council, 2003). The error rate of polygraph confessions among JSOs is unknown, so it is difficult to interpret the results fairly. Drug screens collect physical evidence of a single type of violation—illegal drug use. JSO polygraph interrogations can be far more open-ended and expansive, including extracting confessions about private thoughts and sexual fantasies. The invasion of privacy involved is, therefore, greater. Paying for drug screens places a relatively small financial burden on families; whereas paying for polygraph interrogations may place a substantial one, especially given that some practice standards require that families pay for repeated polygraph interrogations until the payee (i.e., the polygrapher) determines that the confession was sufficient (i.e., the test was “passed”). A failed drug screen may be factually rebutted by obtaining a second opinion test, but this is less of an option with a failed polygraph given that different examiners may use different procedures, questions, and techniques and that interpretation may be less reliable (National Research Council, 2003). However, these differences are not the most fundamental one. The most fundamental difference is that drug screens capture physical evidence left behind by a transgression, but polygraph interrogations seek confessions from transgressors. There are fundamental ethical differences between collecting physical evidence left behind by a violation and extracting confessions.

To better understand this fundamental difference, let us compare the polygraph with another neighboring practice—this time, let us ask how polygraph interrogations compare with sodium pentathol or so-called “truth serum” interrogations. The later are not accepted as ethical practices with any population, regardless of criminal status, at any age. The use of mind-altering drugs in interrogation has reaped international human rights condemnation even when used on the battlefield with known terrorists (APA, 2008), so it certainly would never be considered an ethical practice for
mental health providers to condone with minors. Proponents of the technique in India, where it is used by justice authorities, characterize it as just another useful tool in the pursuit of justice (Jesani, 2006), similar to characterizations of JSO polygraphy in the United States. There is one obvious risk distinguishing sodium pentathol from polygraph interrogations—the polygraph does not cause occasional respiratory or cardiac crises requiring medical rescue. Proponents of sodium pentathol interrogation might argue that this is only a risk if sodium pentathol is used incorrectly, just as polygraph advocates might argue about some of the polygraph’s potential harms. However, any reasonable assessment of either technique must anticipate less than perfect use. Both techniques seek to diminish personal agency and the ability to resist interrogation, but via different mechanisms—sodium pentathol diminishes the mental capacity to resist interrogation, whereas the polygraph uses the threat of lie detection (or this illusion) to accomplish a similar goal. Differences aside, there are several discomforting similarities. These include extracting confessions as the primary goal, weak regard for validity by the scientific community, intrusiveness, the potentially broad scope of privacy invasion, limited replicability, unknown error rates, reliance on a person’s involuntary physiology to overpower personal agency, conflation of acquiescence with truth telling, potential incursions on human dignity, and the substantial burden and expense involved in both.

In thinking about what implications we might draw from this exercise comparing JSO polygraphs with two neighboring practices, we should consider that the polygraph seems to fit in between drug screen urinalysis on one hand and sodium pentathol interrogation on the other. One of these neighbors is considered an ethical practice with juvenile offenders, whereas the other would result in automatic expulsion from major professional societies. Given the location of polygraphy in this ethically gray area, it is no mystery why it is classified as controversial and why our field should not become overly comfortable with its use, especially with juveniles.

**Risks in the Context of Beneficence**

Few JSO treatment practices are totally free from risk and many are intrusive, but we accept them because they also offer the promise of benefits. In any utilitarian analysis, both sides must be considered. In offender populations, both direct benefits to the patient and benefits to the community are important to consider. For example, we accept the practice of placing delinquent youth in residential rehabilitation facilities even though these facilities commonly risk exposure to delinquent peer influences, create institutionalization, weaken family connections, and constrict normal development. We accept these risks because there is also some promise of direct benefit for the youth and protection for the community. Sex crimes are a serious matter. The possibility of sparing future victims this burden is a self-evident ethical good and one of the most powerful considerations in any ethical deliberation about sex offender treatment procedures. Paternalistically, we also understand that stopping sexually abusive behavior before it becomes habitual is in the best interest of JSOs themselves.
Therefore, any technique found to deliver these two important benefits (preventing victimization and preventing youth from developing a sex crime career) must be judged more positively than one that does not. The key is balancing the risk–benefit ratio. To evaluate this balance requires that we know what the benefits are. Unfortunately, we do not know the benefits of JSO polygraphs, or even if any exist, because adequately designed studies measuring incremental benefit have not been conducted. At this point, an informed risk–benefit calculation does not appear possible. No amount of clinical lore or logic models can fill this evidentiary deficiency. Anecdotes can no doubt be produced, but as the popular aphorism reminds us, “the plural of anecdote is not data.” The fact that we cannot estimate a reasonable risk–benefit ratio is itself a serious ethical short-falling for our field as a whole. It is less than responsible when a field embraces unusual, coercive, and intrusive practices with minors without simultaneously undertaking the rigorous testing needed to judge whether intended benefits actually exist.

**Alternatives**

The final consideration is whether the potential benefits of polygraph interrogation could be accomplished using alternative means that risk fewer potential harms and raise fewer human rights concerns. If comparable benefits could be delivered by less intrusive, more scientifically sound, or less ethically concerning methods, then we should adjust our assessment of the polygraph’s ethical status accordingly. By analogy, we would weigh the ethics of involuntary electroconvulsive shock therapy differently today than we did in the 1950s, in large part because today we possess better and less concerning alternatives. An analogy within the JSO treatment field is the use of viewing time measures as an alternative option to plethysmography. Viewing time measures might be selected to accomplish similar purposes in a less invasive manner. Certainly there are alternative methods for monitoring delinquent youth and gathering sensitive information. These include improving the interviewing and interpersonal skills of providers, increasing parental vigilance, minimizing opportunities for violations, and building an atmosphere of trust that encourages discussion of sensitive material. Alternative models, based on respect and trust, are described as yielding substantial disclosure of sensitive clinical material (Jenkins, 2006).

Multisystemic therapy (MST), which is currently the only evidence-based treatment for JSOs, specifically excludes polygraph monitoring, and relies on increasing parent/caregiver monitoring (Henggeler et al., 2009). In a Chicago trial, MST was found to yield better outcomes than standard JSO group therapy (Letourneau et al., 2009). The standard therapy may have included routine polygraphy. State JSO practice standards for the standard therapy emphasized using the polygraph, required all treatment providers to have training in polygraphy, and strongly endorsed collaboration with polygraphers (20 Illinois Administrative Code Ch. VII, Sec. 1900). Polygraphy was specifically waived for study youth who were randomized to MST (Letourneau, E. J., personal communication, 2010). The findings are not a specific test of polygraphy itself but do demonstrate that alternative approaches can substantially improve outcomes without needing it.
The Future

Much like the answer given to the men in the balloon, none of these arguments definitively answers the practical question whether JSO treatment providers should use the polygraph or not. It is plain that I view the ethical concerns as substantial and have chosen to exclude it from my practice, as have my closest colleagues. Given the prevalence of JSO polygraphy, it also is plain that many credible and thoughtful professionals view matters differently. Although I disagree with their conclusions and their logic, I do not question their sincerity or their commitment to good practice. Part of the difficulty in coming to any consensus is that so many critical pieces of information are missing, which is itself an ethical shortcoming for the field. As things stand, we can only speculate about how future science might inform our analysis.

It is possible that JSO polygraphy might eventually prove to be harmless and deliver benefits to juveniles and the community above and beyond our best alternatives. If future research were to demonstrate this, then the size of these benefits could be weighed against the ethical concerns in a more informed risk–benefit analysis. Some current nonusers might reasonably choose to adopt the polygraph if hypothetical future science looks attractive and if the risks and ethical problems seem manageable. Current JSO polygraph users presumably have opted not to wait for future science or believe that we already have evidence enough. Some may polygraph reticently in light of the unknowns. Others may content themselves by believing that the polygraph is just another useful tool and that more tools are always desirable. These providers should not be so content. It is quite possible that polygraphy is not only ethically concerning but iatrogenic. There is abundant precedent in juvenile justice and mental health outcome research for practices with plausible logic models and legions of true believers to prove worthless or harmful (Lilienfeld, 2007). If rigorous future research fails to demonstrate substantial incremental benefit, documents harms, or fails to demonstrate clear superiority over less concerning alternatives, then continued use would seem difficult to justify. One aspect of the beneficence principle is that it is unethical to offer treatments that do not deliver benefits. This would be especially the case if the practice is ethically gray to begin with, is invasive, is involuntary, is applied to minors, and reasonable alternatives exist. If future research fails to document benefits, then many current JSO polygraph users would no doubt reconsider and discontinue its use. However, I suspect that a core of staunch proponents would continue to enforce polygraph interrogations on their juvenile charges regardless of what future science might find. Under this scenario, professional organizations concerned with the ethics of JSO treatment will face a difficult and potentially divisive debate.

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