**Section 1905.150 Psychophysiological Tools**

Treatment providers and evaluators shall recognize that the usage of psychophysiological tools may be utilized in the assessment of offenders in relation to treatment progress, compliance with supervision, and support effective risk management and risk reduction. The following will detail each type of psychophysiological tool.

a) Phallometry

1) Phallometry is a specialized form of assessment used in treatment with individuals who have committed sexual offenses. Responsible use of phallometry results requires at least a rudimentary understanding of how phallometry works and its advantages and limitations. As with any instrument or procedure, treatment providers are familiar with current literature and obtain appropriate training before using or interpreting phallometric testing results. Examiners receive training in phallometric testing in order to become knowledgeable about the technical aspects of the equipment and the appropriate protocols for conducting phallometric testing specific to the equipment being used. Examiners are also familiar with the research evidence on the reliability and validity of phallometric testing.

2) Phallometric testing using penile plethysmography involves measuring changes in penile circumference or volume in response to sexual and nonsexual stimuli. Circumferential measures (measuring changes in penile circumference) are much more common than volumetric measures (measuring changes in penile volume), which are used in only a few laboratories worldwide. However, there is good agreement between circumferential and volumetric measures once a minimal circumference response threshold is reached. Therefore, circumferential measures are the focus of this subsection (a).

3) Phallometric testing provides objective information about male sexual arousal and is therefore useful for identifying deviant sexual interests during an evaluation, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment.

4) Phallometric test results are not used as the sole criterion for determining deviant sexual interests, estimating risk for engaging in sexually abusive behavior, recommending that clients be released to the community, or deciding that clients have completed treatment programs. Phallometric test results are interpreted in conjunction with other relevant information (for example, the individual's offending behavior, use of fantasy and pattern of masturbation) to determine risk and treatment needs. Phallometric test results are not to be used to draw conclusions about whether an individual has committed a specific sexual crime. As well, there are limited data available regarding the use of plethysmography with clients who have developmental disabilities and clients with an acute major mental illness. Therefore, treatment providers need to exercise caution in using phallometry with these populations and in interpreting and reporting phallometric results.

5) Prior to testing, examiners screen clients for potentially confounding factors such as medical conditions, prescription and illegal drug use, recent sexual activity, and sexual dysfunction. Clients with active, communicable diseases, particularly sexually transmittable diseases, are not to be tested until their symptoms are in remission.

6) Specific informed consent for the testing procedure and release forms for reporting test results are obtained at the beginning of the initial appointment. Laboratories have a standard protocol for fitting gauges, presenting stimuli, recording data and scoring.

7) Examiners use the appropriate stimulus set to assess sexual interests that are the subject of clinical concern. For example, examiners use a stimulus set with depictions of children and adults to test clients who have child victims or who are suspected of having a sexual interest in children. At a minimum, examiners have at least two examples of each stimulus category. Stimuli that are more explicit appear to produce better discrimination between individuals who sexually offend and control subjects than less explicit stimuli. It is important to ensure that the stimuli are good quality and avoid any distracting elements.

8) Treatment providers are aware of the applicable legislation in their jurisdiction regarding the possession of sexually explicit materials. If permitted to use visual stimuli for testing of sexual interest in children, examiners use a set of pictures depicting males and females at different stages of physical development, ranging from very young, prepubertal children to physically mature adults. The use of neutral stimuli, such as pictures of landscapes without people present, may increase the validity of the assessment. The inclusion of the neutral stimuli serves as a validity check because responses to sexual stimuli that are lower than responses to neutral stimuli might indicate faking attempts. Faking tactics include looking away from or not listening to stimuli. Audiotaped stimuli may also be used to assess sexual interest in children; if used, these stimuli clearly specify the age and sex of the depicted individuals.

9) For testing of sexual arousal to nonconsenting sex and violence, examiners using audiotapes include stimuli describing consenting sex, rape and sadistic violence. Stimuli depicting neutral, nonsexual interactions are also included. Stimuli can depict males or females, children or adults.

10) The phallometric testing report includes a description of the method used for collecting data, the types of stimuli used, an account of the client's cooperation and behavior during the testing, and a summary and description of the client's profile of responses. Client efforts to fake or other potential problems with the validity of the data or the interpretation of results are also reported.

11) The three most common means of scoring plethysmograph data are standardized scores, percentage of full erection, and millimeter of circumference change. Those using phallometric assessment are aware of the advantages and disadvantages of each scoring method. Research has found that standardized scores (e.g., z scores) increase discrimination between groups. Transforming raw scores to standardized scores for subjects who show little discrimination between stimuli can, however, magnify the size of small differences between stimuli. Raw scores, millimeter of circumference change, or scores converted to percentage of full erection may be clinically useful in the interpretation of results.

12) Deviance indices can be calculated by subtracting the mean peak response to nondeviant stimuli from the mean peak response to deviant stimuli. For example, a pedophilic index could be calculated by subtracting the mean peak response to stimuli depicting adults from the mean peak response to stimuli depicting prepubescent children. Thus, greater scores indicate greater sexual arousal to child stimuli.

13) Because the sensitivity of phallometric testing is lower than its specificity, the presence of deviant sexual arousal is more informative than its absence. Results indicating no deviant sexual arousal may be a correct assessment or may indicate that a client's deviant sexual interests were not detected during testing.

14) Research indicates that initial phallometric assessment results are linked with recidivism. Repeated assessments can be helpful to monitor treatment progress and to provide information for risk management purposes.

b) Viewing Time

1) Viewing time is a specialized form of assessment used in the treatment of individuals who have committed sexual offenses. Responsibly using the results of viewing-time measures requires treatment providers to have at least a rudimentary understanding of how viewing time measures work, as well as their advantages and limitations. As with any instrument or procedure, treatment providers should be familiar with current literature and obtain appropriate training before using or interpreting viewing time testing results.

2) Unobtrusively measured viewing time is used as a measure of sexual interest. The relative amount of time clients spend looking at pictures of children (who can be clothed, semiclothed or nude) is compared to the time that the same adult spends looking at pictures of adults. Research suggests that, as a group, individuals who have offended against children look relatively longer at stimuli depicting children than adults. Unobtrusively measured viewing time correlates significantly with self-reported sexual interests and congruent patterns of phallometric responding among nonoffending subjects. Little is known, however, about the value of retesting using viewing time as a measure of treatment progress.

3) As with any test, specific informed consent for the test procedure and release forms for reporting results are obtained prior to beginning testing. Examiners have a standardized protocol for presenting the stimuli, recording and scoring. Examiners are familiar with the reliability and validity of the test. In particular, it is important that examiners know the degree to which the viewing time measure being used has been validated for the client population being assessed. This technology has primarily been used to identify sexual interest in gender and age. As well, there is limited information specific to the use of viewing time with clients with developmental disabilities.

4) For testing sexual interest in children, examiners have a set of pictures depicting males and females at different stages of development, ranging from very young children to physically mature adults. It is important that stimuli are of good quality and avoid any distracting elements. Treatment providers who use sexually explicit stimuli are aware of applicable legislation in their jurisdiction about possession of these materials.

5) The test report includes a description of the method used for collecting data, the types of stimuli used, an account of the client's cooperation and behavior during testing, and a summary and description of the client's responses. Client efforts to fake or other potential problems with the validity of the data or the interpretation of results are also included.

6) As noted in this subsection (b), viewing time is not to be used as the sole criterion for determining deviant sexual interests, estimating a client's risk for engaging in sexually abusive behavior, recommending whether a client be released to the community, or deciding whether a client has completed a treatment program. Viewing time test results are interpreted in conjunction with other relevant information (for example, the individual's offending behavior, use of fantasy, the pattern of masturbation) and are never to be used to make inferences about whether an individual has committed a specific sexual crime.

AGENCY NOTE: Viewing time is a more accepted practice with juveniles and less intrusive than phallometry or polygraphy.

c) Polygraphy

1) Polygraph testing involves a structured interview during which a trained examiner records several of an examinee's physiological processes. Following this interview, the examiner reviews the charted record and forms opinions about whether the examinee was nondeceptive or attempting deception when answering each of the relevant questions.

2) Post conviction Sex Offender Polygraph Testing is a specialized form of general polygraph testing that has come into widespread use in the United States. Although all principles applicable to general polygraph testing also apply to post conviction sex offender testing, its unique circumstances generate additional challenges. Using post conviction sex offender testing responsibly requires treatment providers to have at least a rudimentary understanding of how polygraphy works, its advantages and limitations, and special considerations related to its integration into sex offender work. This subsection (c)(2) serves as a brief introduction to these issues. As with any instrument or procedure, treatment providers should be familiar with current literature and obtain appropriate training before using or interpreting polygraph results.

3) Post-conviction sex offender testing is intended to serve two objectives:

A) To generate information beyond what can be obtained from other self-reported measures; and

B) To explore and support compliance and gauge progress with respect to supervision expectations and treatment expectations and goals.

4) Some research indicates that the polygraph exam can lead to clients providing increased information regarding their offending; however, test validity and reliability often vary widely across studies. Therefore, it is important for providers to become informed about types of tests that produce the most accurate findings. As well, it is possible that some of the information obtained through post conviction sex offender testing might be fictitious, representing an accommodation to pressure for disclosures. The second objective of post conviction sex offender testing (enhanced supervision and treatment compliance) has received only limited empirical attention.

5) The American Polygraph Association, the National Association of Polygraph Examiners, and other polygraph associations have developed standards for certifying polygraph examiners who work in sex offender management and treatment, as well as standards for administering sex offender tests. Some states also regulate post conviction sex offender testing standards and procedures. Treatment providers are familiar with laws, state regulations, and association guidelines governing post conviction sex offender testing where they practice. Treatment providers work with examiners who meet certificate requirements and adhere to procedures recommended by a relevant polygraphists' organization.

6) Four types of post conviction polygraph exams are commonly performed with sex offenders:

A) Instant/Index Offense Tests are designed to explore and clarify discrepancies between the offender's and the victim's descriptions of the conviction offenses.

B) Sexual History Disclosure Tests are designed to facilitate a client's disclosure to their treatment providers of sexual history information, which may include sexually abusive or offense-related behaviors.

C) Maintenance/Monitoring Tests are designed to explore potential charges, progress and/or compliance relative to treatment, supervision and other case management goals, objects and expectations.

D) Specific Issue Tests are generally designed to explore a client's potential involvement in a specific prohibited behavior, such as unauthorized contact with a victim at a particular time.

7) Polygraph test accuracy is believed to be greatest when examiners focus on highly specified (i.e., single issue, narrow and concrete) questions. Treatment providers cooperate with examiners in structuring tests that are responsive to program needs without unnecessarily compromising accuracy considerations.

8) Limits of confidentiality are fully disclosed to clients prior to polygraph testing. Clients are informed in writing about how the results of polygraph exams will be used and who will receive the results. Clients are informed about the possible consequences to them as a result of the polygraph exam.

9) There is very limited empirical research on the use of polygraph with clients who have developmental disabilities and clients with low/borderline IQs. Therefore, additional caution is advised if treatment providers use polygraph in the management and treatment of these clients.

10) Polygraph charts are not the only means of monitoring offenders' behavior and are not to be the sole basis for significant case decisions. Examiner and examinee characteristics, treatment milieu, instrumentation, procedures, examination type, base rates of attempted deception in the populations being tested, and other idiosyncratic factors can affect accuracy and usefulness. Likewise, when questions are not highly specific, there is reason for concern regarding the results of polygraph testing for monitoring purposes.

11) Treatment providers' primary purpose for collecting sexual history information is the increased ability to design clinical interventions and other management strategies. The usefulness of post conviction sex offender polygraph testing as a clinical tool derives from its ability to elicit historical information, allowing psychosexual behavioral patterns to be more fully revealed, better understood and, therefore, more effectively managed and changed. Client disclosures of potentially incriminating information to mandated reporters can, however, lead to future prosecution. Treatment providers inform clients, in writing, of this potential dilemma and how it is addressed in their jurisdiction and program.

12) Polygraphy is not used as the sole criterion for determining deviant sexual interests, estimating a client's risk for engaging in sexually abusive behavior, recommending whether a client be released to the community, or deciding whether a client has completed a treatment program. Polygraph results are interpreted in conjunction with other relevant information to make these decisions. Polygraph results should be one of the many variables for treatment providers to utilize when changing a client's status in treatment.