Evaluation Report

Date: 12/20/88

Client: Michael Cody

Relevant Background Information:

The client is a 57 year-old, caucasian, Catholic priest referrred to the Center for Prevention of Child Molestation by his minister for evaluation of his sexual interests. The client reports a 20 year history of fondling and masturbation of female children ages 8 - 12.

The client is the older of two children. He was reared in a home with no religious upbringing. He reports that his family had an average income and never experienced any severe financial hardships. Both parents were described as alcoholics and he reports that his mother may have been mentally ill. No incidences of physical or sexual abuse within the home were reported. The client was an above average student and completed eight years of college.

The client reports a history of abuse of alcohol and prescription drugs, although denies current problems with either. He also reports a prior diagnosis and treatment of manic-depression although he is currently not taking medication for this problem.

The client reports approximately 20 - 40 female victims between the ages of 8 and 12, and one male child victim. He engaged in kissing, fondling, and mutual masturbation with the victims. Typically, the client engaged in long-term relationships with children he knew well. This behavior began when the client was 28 and he reports that it has been several years since his last sexual contact with a child. He reports that he currently fantisizes and masturbates to sexual fantasies of fondling young girls on a daily basis.

Laboratory Evaluation

The client was evaluated in our sexual behavior laboratory. This evaluation is not designed to separate pedophiles from non-pedophiles. It is designed to measure the current sexual arousal patterns of admitted pedophiles to determine whether or not they might benefit from our treatment program.

The client's sexual arousal response was assessed by means of a device called a penile transducer. The penile transducer is a small, mercury-filled, rubber loop which is worn around the penis. This device can detect changes in penile circumference which are expressed as changes in electrical resistance. These minute resistance changes are amplified, converted, and shown as a pen tracing of the response. These values are expressed in terms of percentage of full erection (0-100%).

The client participated in the procedure for evaluating arousal patterns on the parameters of sexual development and sex of the subject. In this procedure he viewed thirty-six (36) slides for two minutes each while his erection response was being monitored electronically. These slides are divided into twelve categories according to sexual development and sex of the subject: male and female children and adults. There are five categories of sexual development in children (Category 0, approximately ages 0-4; Category 1, approximately ages 5-7; Category 2, approximately ages 8-11; Category 3, approximately ages 12-14; and Category 4, approximately ages 15-17) and one for adults (Category 5, ages 18 and older). Before each presentation he was instructed that if he felt himself becoming aroused, to let that happen. He was also told that he will occasionally be asked to describe, in detail, the slide he had just seen.

The results of this assessment procedure are as follows:

SLIDE ASSESSMENT

	MALE CHILD	FEMALE CHILD
Category 0	*	*
Category 1	*	*
Category 2	*	*
Category 3	*	*
Category 4	*	*
Category 5	*	*

* Responses less than 20% of a full erection are considered insignificant.

The client responded with insignificant arousal to all slides.

The client also participated in the procedure for evaluating arousal patterns on the parameters of sex of the victim and the amount of force used to complete the act. In this procedure, he listened to three-minute audio tapes describing an increasing use of physical force by the offender to effect a sexual relationship with a child. The tapes are divided into the following categories: 1. Fondling a consenting child; 2. Mutually consenting intercourse with a child; 3. Psychologically coercive non-consenting intercourse with a child; 4. Rape of a child; 5. Sadistic sexual assault of a child; 6. Aggressive non-consenting and non-sexual assault of a child; 7. Mutually consenting intercourse with an adult. There are two separate sets of these tapes: one describing sexual activities with males and one describing sexual activities with females. Before each presentation he was instructed that if he felt himself becoming aroused, to let that happen. He was also told that he will occasionally be asked to describe, in detail, the audiotape he had just heard.

The results of this assessment procedure are as follows:

PEDOPHILE VIOLENCE AUDIO ASSESSMENT

	HOMOSEXUAL	HETEROSEXUAL
Fondling	*	21%
Mutually Consenting	*	*
Non-Consenting	*	*
Rape	*	*
Sadistic	*	*
Aggressive Non-Sexual	*	*
Consenting Adult	*	*

* Responses less than 20% of a full erection are considered insignificant.

The client responded with minimal arousal to audiotaped descriptions of fondling a female child. He responded with insignificant arousal to all other audiotaped descriptions of sexual activity.

Summary and Recommendations:

This client was cooperative and open throughout this evaluation. He showed no significant arousal to any of the stimuli presented. This happens with about 20% of the clients who undergo this procedure. Lack of responsivity to the sexual stimuli presented may be due to any of a number of factors including age, medication, fatigue, discomfort with the procedures, active suppression of arousal, or an absence of sexual attraction to the stimulus materials. Unfortunately, when a client is non-responsive, it is difficult, if not impossible, to know which of the above reasons is responsible. Therefore, under these conditions, the evaluation is deemed invalid.

Based on this client's extensive history and disclosure of current deviant masturbatory behavior, we recommend that he not be allowed unsupervised contact with children. The client claims that he uses masturbation to fantasies of sexual activity with children as a coping technique to avoid acting out sexually with children. Howevér, in our experience, deviant masturbation only serves to reinforce sexual attraction to children not to decrease it. Therefore, we recommend that this client enter and actively participate in a specialized sex offender treatment program to learn more adaptive coping responses for this problem.

We would recommend that you exert extreme caution in the interpretation of the results reported above. These data are psychophysiological measures of sexual arousal and should not necessarily be construed as indicators of motivation, or lack of motivation, to act upon that arousal. The results are, therefore, at best an approximation of the person's sexual arousal and propensities. We strongly urge that you not use these measures alone as clinical indices or predictors.

Candi Osborn, M.A.
Laboratory Coordinator
Center for Prevention of Child Molestation

Katurah Jenkins-Hall, Ph.D.
Clinical Director
Center for Prevention of Child Molestation