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SC Court of Appeals

STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

Appeal from Florence County

Honorable Bentley Price, Circuit Court Judge

IN THE MATTER OF THE CARE AND
TREATMENT OF ROBERT BRIAN SHARP,

APPELLANT.

APPELLATE CASE NO. 2024-000553

RECORD ON APPEAL

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STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS NONJURY
COUNTY OF FLORENCE)

IN THE MATTER OF THE CARE AND TREATMENT OF:

ROBERT B. SHARP

RESPONDENT.

TRANSCRIPT OF RECORD

2022-CP-21-01382

February 26th - 28th, 2024

B E F O R E:

THE HONORABLE BENTLEY PRICE, Judge.

A P P E A R A N C E S:

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Transcribed by Pamela E. Green, from DCRP

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P R O C E E D I N G S

THE COURT: All right. What we're gonna do now, as I indicated before, ladies and gentlemen of the jury, is I'm gonna ask you specific cases (sic) about the two individual trials that we're going to try this week, and, if you -- if any of these questions apply to you, if you'll please just stand and indicate how they apply to you, and then I'll -- we'll discuss it a little bit further.

All right. So, at this point in time, I'm gonna allow the -- I'm gonna allow the State to introduce itself and the parties in which it represents, and then I'm gonna ask you if you have any common knowledge of any of these attorneys or anyone that is participating in the trial with them. And then I'm going to allow the defense the exact same courtesy, allow them to introduce themselves, and the parties in which they represent.

We'll begin with the State.

MR. FISHER: My name is Jim -- James "Jim" Fisher. I work with the Office of the Attorney General. And with me today is, and through this trial, will be Andy Powell. He's an attorney with the Attorney General's Office. We represent the State.

MR. WILSON: My name's Ralph Wilson. I'm a private

attorney who works primarily out of Horry and Georgetown and Florence Counties and I represent Robert Sharp, who is the, the respondent in this case.

THE COURT: All right. Is anybody familiar with anybody that works at the A.G.'s Office or these two attorneys that are representing the State in this case?

(WHEREUPON, there was no response.)

THE COURT: All right. Has anyone ever been represented by Mr. Wilson or anyone in his firm or is anyone familiar with Mr. Sharp, please stand.

(WHEREUPON, there was no response.)

THE COURT: All right. There are none.

I'm going to read you a list of potential witnesses. If you know who any of these people are, if you'll please stand and indicate how you know them.

All right. Doctor Emily Gottfried, PhD director of sexual behaviors clinic and lab of the Medical University of South Carolina.

Doctor Marie Gehle, psychiatrist -- chief psychologist at the South Carolina Department of Mental Health.

(WHEREUPON, there was no response.)

THE COURT: Phillip Wren from the Cottageville -- in Cottageville, South Carolina.

(WHEREUPON, there was no response.)

THE COURT: Corbett Stone. Works for the Reforms Unanimous Florence Baptist Temple.

(WHEREUPON, there was no response.)

THE COURT: And Randy Sharp, a retired law enforcement officer and chaplain now with the Kershaw Correctional Institution.

(WHEREUPON, one juror responds at this time.)

THE COURT: All right. Your name -- your juror number?

THE JUROR: 60.

THE COURT: All right. Who do you know?

THE JUROR: Corbett Stone. He goes to the church I attend.

THE COURT: All right. And how do -- you know Mr. Stone through your church?

THE JUROR: Yes, sir.

THE COURT: And knowing that Mr. Stone may be a potential witnesses in this case, would that affect your ability to be fair and impartial in any way in this case?

THE JUROR: No, sir.

THE COURT: You may be seated.

All right. I'm going to ask you a, a series of questions. If any of these apply to you, as indicated, please stand up and let us know.

All right. Does any member of the jury panel know

anything about the sexual offense of which Mr. Sharp was convicted?

If so, what is the nature and extent of the knowledge that you have?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Has any member of the jury panel or any of your friends or relatives ever been a victim of a crime of violence, if so, please stand.

(WHEREUPON, there was no response.)

THE COURT: There are none.

Has any member of the jury panel or any of your friends or relatives ever been accused of a crime of violence?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Has any member of the jury panel or any of your friends or relatives ever been accused of a crime of violence?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Has any member of the jury panel or any of your friends or relatives been a victim of sexual assault?

If you don't want to answer that question right now in front of everybody, you can hang tight.

(WHEREUPON, there was no response.)
THE COURT: There are none.
Does any member of the jury panel have any religious or closely held beliefs that would not allow you to render a verdict in this case?
(WHEREUPON, there was no response.)
THE COURT: There are none.
Does any member of the jury panel or member, member of your family or has any member of the jury panel or your family ever worked in the field of psychiatry, psychology, or have training in either of those fields?
(WHEREUPON, there was no response.)
THE COURT: There are none.
Has any member of the jury panel ever been involved in or have training in prison ministry, prison outreach, or any other program involving incarcerated persons?
(WHEREUPON, jurors respond at this time.)
THE JUROR: Juror number?
THE JUROR: Juror Number 32.
THE COURT: Yes, sir.
THE JUROR: I'm 28 year military police retired. One, I have been qualified investigator victim for the military. I was an undercover drug agent for the military. I also in -- investigated for gang task force personnel. I'm a 95 Bravo to the military police

secondary 95 Charlie, which is incarcerated personnel.

THE COURT: And what do you with those incarcerated persons?

THE JUROR: Take care of them. They're in -- they're the ones that are incarcerated at Fort Lewis knowing -- make sure -- count all the schemes and stuff like that they do for scenario in doing to make sure that they within accept the counter court and make sure that they follow the rules.

THE COURT: All right. And would that in any way affect your ability to be fair and impartial in this case?

THE JUROR: Not at all.

THE COURT: You may be seated.

Yes, sir.

THE JUROR: Juror Number 143. I'm retired from the South Carolina Department of Corrections. My 25 years, I did 12 years in contraband and we work a lot of -- with sex offenders.

THE COURT: All right. Understanding that this is a commitment hearing, would that in any way affect your ability to be fair and impartial?

THE JUROR: No, sir.

THE COURT: You may be seated.

Does any member of the jury panel, either personally or have a friend or family member, know of someone that is

or has been involved in a voluntary or involuntary civil commitment proceeding?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Are there any members of the jury panel who are related by blood or marriage to any other member of the jury panel?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Would the fact that Robert Sharp has been convicted of a sexual offense and has completed his sentence prevent anyone from being able to render a fair and impartial verdict in this civil commitment case?

(WHEREUPON, there was no response.)

THE COURT: There are none.

Is there any member of the jury panel who believes that he or she could not be fair and impartial based on the nature of this proceeding?

(WHEREUPON, there was no response.)

THE COURT: There are none.

All right. Ladies and gentlemen, this is a civil proceeding as I indicated before. As we indicated, Mr. Sharp has been convicted of a crime and that is not for you to worry about whatsoever. That has long since been passed.

Okay. This is a civil commitment to determine whether, in fact, Mr. Sharp should be committed based on his current conditions. Further -- and past the sentence that he's already served.

Knowing that, can anyone not remain fair and impartial in this case?

(WHEREUPON, there was no response.)

THE COURT: There are none.

All right. Anything as to the voir -- further voir dire from the State?

MR. FISHER: Nothing further, Your Honor.

THE COURT: All right. Anything from the defense?

MR. WILSON: Nothing further, Your Honor.

THE COURT: All right. Has anyone been a victim of a sexually violent crime that they'd like to come up and speak to me personally without discussing it amongst the peers?

(WHEREUPON, there was no response.)

THE COURT: There are none.

All right. I think we're good.

All right. Just to dispel the, the murder mystery, what's going on is that I've excused some people. And so you came in obviously alphabetical order and you -- it has to be a jury of your peers. So now we are randomizing you based on the, the people that were selected or the people

that were selected to stay and those that were allowed to leave.

Back in the day, as y'all've probably seen on some of the movies, used, used to put your name in like a little pill bottle and turn the little wagon wheel and then they would pull it out. True story. I tell this to every jury cause it's fairly interesting. It's pretty funny and Morgan likes the story. So I always just tell it to make her laugh.

But I -- I've never seen it done and except one time. I was a solicitor which say -- means a prosecutor in Charleston County and we tried a guy for murder. But it was a death penalty case and he wouldn't let up on anything.

So he wanted the, they jury to be selected that way, and by, by the rules, it's still the law. And so we did it that way.

But the law says that you have to either one of two people select a jury that way. Neither -- you have to have a minor or you have to have a blind person.

Well, minors aren't allowed in the courtroom. So we dispelled with that one years ago. And the other one is a blind person.

Well, it was very difficult usually to find a blind person. Shockingly enough though, we had a blind person

that worked at the Clerk's Office.

All right. He actually worked in the courthouse in Charleston County. The question is what did the blind man do for the Charleston County Clerk's Office or courthouse?

Everybody always says what she's doing, a stenographer, but that's not right. Here's the shocker. He stocked vending machines for the courthouse. Blind as a bat. Couldn't see a thing.

So I never understood how he did it. But he, he retired and, finally, one of the court reporters that was in Charleston County for 30 years said that, of all things, every single bottle that had -- that you touch or can has Braille on it and he -- I never would of known. I mean who would of guessed that.

But that's how he did it and I tell you right now I put a dollar in, hit Mountain Dew, Mountain Dew came out. So he, he figured it out. I don't know how he did it but he did it. He, he spent 25 years doing it and retired.

(Pause.)

THE COURT: So what they're doing is they're just getting the, the randomization of, of all the jurors and then we're gonna give the attorneys a little bit of time to look it over. So, I'll give everybody a little bit -- about five or ten minute break and then we'll come back and we'll select a jury.

In criminal cases we do it much differently. We bring you up one by one and you stand there awkwardly while they talk amongst each other. You either get excused or accepted.

But, if you get excused, you never know, for the rest of your life, why you weren't good enough to serve on that jury. You'll never know. This one you'll never know either because it's, it's anonymous.

So --.

THE BAILIFF: Judge, I have one juror who needs to speak with you.

THE COURT: All right. One second.

Hold on because, if something happens, this may change it, Melissa.

THE CLERK: Okay.

THE COURT: Y'all hold on with the list. Hold one second.

All right. Bring them up.

THE BAILIFF: Number 97.

(WHEREUPON, the following takes place outside the hearing of the courtroom.)

THE COURT: All right. You have to stand, stand right here, ma'am, so we can hear you.

THE JUROR: So, I -- yeah. So you had mentioned about knowing a family member or a friend or a person was

not convicted.
THE COURT: Accused.
THE JUROR: It was my, it was my ex-husband about 10, 12 years ago.
THE COURT: Okay. Would that affect your ability---
THE JUROR: No.
THE COURT: ---to be fair and impartial?
THE JUROR: No, it won't.
THE COURT: All right.
THE JUROR: I was divorced then. So --.
THE COURT: Okay. You can be seated. Thank you, ma'am.
(WHEREUPON, the following takes place within the hearing of the jury venire.)
MR. WILSON: What was that juror's number?
THE COURT: I thought 97. But I could be wrong.
MR. WILSON: Thank you.
THE COURT: What was it?
THE CLERK: Ninety-seven.
MR. FISHER: Ninety-seven.
THE COURT: Okay. I was right.
All right. You can pass them out.
All right. We're selecting from one to twenty. It's four and four.
How many alternates do you want?

Two?
MR. FISHER: Two.
MR. WILSON: Two's fine.
THE COURT: Sounds good.
All right. I'll give y'all about five or ten minutes.
Okay. Y'all can just kind of talk amongst yourselves. I'll be right back.
(WHEREUPON, a short recess was taken at this time.)
THE COURT: All right. Thank you very much. Please be seated.
Y'all ready to roll?
MR. FISHER: Yes.
THE COURT: Y'all ready?
MR. WILSON: I'm ready. We're ready.
THE COURT: Okeydoke. Madam Clerk, they said they're ready to go.
THE CLERK: Okay. Ms. Rexis, is everybody back in?
Is all the jurors---
THE BAILIFF: As far as I know.
THE CLERK: Plaintiff strikes first using marginal numbers.
MR. FISHER: Ten.
THE CLERK: Plaintiff struck 10.
MR. FISHER: Yes, ma'am.

THE CLERK: Defendant.
MR. WILSON: Strikes four.
THE CLERK: Four.
Defendant struck four.
Plaintiff.
MR. FISHER: Three.
THE CLERK: Plaintiff struck three.
Defendant.
MR. WILSON: Thirteen.
THE CLERK: Defendant struck 13.
Plaintiff.
MR. FISHER: Nine.
THE CLERK: Plaintiff struck nine.
Defendant.
MR. WILSON: Eighteen.
THE CLERK: Defendant struck 18.
Plaintiff.
MR. FISHER: Seven.
THE CLERK: Plaintiff struck seven.
Defendant.
MR. WILSON: Sixteen.
THE CLERK: Defendant struck 16.
For your first alternate, 20 through 22.
THE COURT: No, 20 --.
THE CLERK: I mean 21 through 23. Sorry, judge.

THE COURT: That's okay.
MR. FISHER: Twenty-one.
THE CLERK: Plaintiff struck 21.
MR. WILSON: Twenty-two.
THE CLERK: Defendant struck 22.
For your second alternate.
MR. FISHER: Twenty-six.
THE CLERK: Plaintiff struck 26.
Defendant.
MR. WILSON: Twenty-five.
THE CLERK: Defendant struck 25.
Gentleman, please check your strikes.
Plaintiff struck three, seven, nine, ten --
MR. FISHER: Yes, ma'am.
THE CLERK: -- 21 for the first alternate and 26 for the second?
MR. FISHER: That's correct.
THE CLERK: Okay. Defendant struck 4, 13, 16, 18, 22, and 25.
MR. WILSON: Correct.
THE CLERK: Okay.
(WHEREUPON, the jury panel was seated at this time.)
THE COURT: All right. Anything as to the selection of the jury from the State?
MR. FISHER: Nothing further, Your Honor.

THE COURT: Anything from the defense?

MR. WILSON: Nothing, Your Honor.

THE COURT: All right. All right. Ladies and gentlemen, what we're going to do at this point in time is we are going to continue to do jury selections. And so y'all do not need to be here. Y'all've been selected for the case of this trial.

Just real briefly, I'm gonna allow you to go and ask that you be back here and we'll begin around two o'clock.

All right. So give you time to make some phonecalls, grab some lunch, come on back. We'll start at 2:00.

I usually err on the side of letting you out a little earlier. I, I will not go past 5:00. I promise you that. People have lives and they got things that they got to do past 5:00 and I know that. I will assure you that we will -- we will be the first ones to happy hour. Let's just say -- let's put it that way.

All right. So y'all are free to go. If you'll just go with this wonderful gentleman right here, he'll show you how to get in and out and we will see you at 2:00.

I'm not gonna swear them till we get back in case something were to happen. Just -- it would ruin the whole pool.

(WHEREUPON, the following takes place outside the presence of the jury.)

THE COURT: All right. Y'all are free to go. We'll see y'all back here at two o'clock.

No, not y'all. Just the parties. We got to switch out the attorneys.

MR. FISHER: Judge, can Mr. Wilson and I approach briefly?

THE COURT: Sure. Hold on for a second. Stay seated.

(WHEREUPON, a bench conference was held out of the hearing of the jury at this time.)

(WHEREUPON, this case was in recess until 2:00PM.)

THE COURT: All right. Thank you very much. Please be seated.

All right. Are we ready to go?

MR. FISHER: State's ready, Your Honor.

MR. WILSON: We're ready, Your Honor.

THE COURT: All right. I've read the motions in limine for the record.

Who would like to begin?

MR. FISHER: Judge, I, I certainly don't mind. But I think the motion to dismiss should be going forward because, if Your Honor were to grant that, then obviously the whole thing would, would stop. So, I think the -- if Mr. Wilson's good with it, I suggest we start with that one.

THE COURT: All righty.

MR. WILSON: I have no objections to that, Your Honor.

THE COURT: All right. Be happy to hear from you.

MR. WILSON: Thank you.

MR. FISHER: Judge, before we proceed any further though, I am gonna invoke the rule.

THE COURT: All right. Mr. Wilson, are any of your witnesses in here?

MR. WILSON: Yes.

THE COURT: All right. They'll need to be -- he's asking that they be sequestered.

MR. WILSON: Your Honor, um, I'm not sure what the purpose of, in this case, what the purpose of, of removing witnesses from the courtroom are in this particular case.

Here there are going to be two primary witnesses which they're going to be Doctor Gottfried and Doctor Gehle. The only other witness that I may call is the defendant but -- the respondent in this case, I may call him.

I, I don't -- and, and, and I would specifically say to this Court that the State has a report which was issued by Doctor Gottfried. I need Doctor Gehle in this courtroom---

THE COURT: I---

MR. WILSON: ---to listen to her testimony.
THE COURT: I'll allow the experts to stay in.
MR. WILSON: All right.
THE COURT: Do you have any lay witnesses that are in the courtroom?
MR. WILSON: Only the father.
THE COURT: Is he planning on testifying?
(WHEREUPON, Mr. Wilson had a discussion with the witness at this time.)
MR. FISHER: And, judge, if -- as Mr. Sharp is leaving the courtroom, I, I think Mr. Sharp needs to be advised not to talk to anybody about this case.
THE COURT: He understands.
MR. SHARP: Okay.
THE COURT: All right.
MR. WILSON: The Court give me just one second please, Your Honor.
THE COURT: Yes, sir.
(Pause.)
MR. WILSON: Your Honor, my first -- my motion to dismiss is based on the -- on this fact, that, under the statute, which is 44-48-10 et sec, it sets out certain procedural rules that must be followed in order to, to protect the defendant and to protect the, the process. And one of those rules is, is that, when -- once probable

cause is found, and once we send or it's -- once a letter is sent to an expert, in order for that expert to do an examination of the defendant or an evaluation of the defendant, let me put it that way, that they have 90 days in order to have that occur. And if it does not occur within that 90 day period, there is a provision which allow them to ask the Court for an extension of time provided they are able to show good cause for that extension.

My position here is that, with Doctor Gottfried, that was not done as far as I'm aware.

Now, my understanding is, on January 4th of 2022, if I make no mistake it was, that that report -- Doctor Gottfried was retained by the State in order to conduct this evaluation. This evaluation -- and there was correspondents between her and the Attorney General's Office after her retention to, to do this. The problem I'm having is she's surpassed the 90 day period for doing the report and getting it back to, to both sides.

The report was not issued, even though she was retained January the 4th of 2022, that report was not issued until, if I make no mistake, December 31st, I think that's the right date, December 31st of 2022.

Let me look at my notes again just to make sure. I apologize.

This -- the, the probable cause hearing was held on August the 26th of 2022. The Prosecutor's Review Committee received the case from -- on, on May the 20 -- May 23 of '22, and, on June 20th of '22, a vote of three to zero determined that there's probable cause. It was then sent to, to the Circuit Court where probable cause was found.

The report -- the respondent's evaluation was done on September the 20th of '22 and a report was issued December the 28th of 2022. On January 4th, which is where, where I was going with this, January 4th of 2023, an independent evaluation was requested by Don Zelenka, the deputy attorney general for the State of South Carolina, and that report was done by Doc -- Doctor Gottfried.

That report was not issued until May 31st, nearly five months later, and, and the statute only provides for 90 days unless you get a continuance after showing good cause to this Court.

So, my position would be, Your Honor, that, that being the case, that the State failed to prosecute the case in a timely fashion. No request for a continuance was made as far as I'm aware, and, if that is correct, then we would be entitled to a dismissal.

THE COURT: All right. Mr. Fisher.

MR. FISHER: Judge, if I may?

I don't know if you want to mark this as an exhibit to provide for the Court a timeline with supporting exhibits and I'd like to go through each one of those.

(WHEREUPON, the timeline with attached exhibits was marked as State's Exhibit No. 1 for identification purposes only at this time.)

MR. FISHER: On March 14th, 2023, that's when Mr. Sharp, the respondent in this case, that was his max out date. That's the day he, he was gonna be released from custody.

The multidisciplinary team, on May 19th, 2022, found probable cause.

On June 20th, 2022, the Prosecutor Reviews Committee found probable cause. The Prosecutor Review Committee, so the Court is aware, is made up of a prosecutor, a solicitor, a public defender, a judge, and two professionals. They found probable cause on June 20th.

On July 13th, 2022, a petition was filed.

On August 18th, the, the Court found probable cause to continue to detain Mr. Sharp, the respondent, and on August 22nd, 2022, James Falk, who is no longer with us, was appointed and that's Exhibit 1.

On August 25th, 2022, a probable cause hearing to

have Mr. Sharp evaluated was submitted to or executed by the Court.

On August 20 -- I'm sorry. The, the hearing was August 25th and then the order was signed by the Court on August 26th, 2022.

The case went to the Department of Mental Health for an evaluation. It ultimately was Doctor Gehle who was -- and Gehle's spelled G-E-H-L-E. Doctor Gehle did the evaluation.

If you look at Exhibit 2, you'll see that Doctor Gehle moved for the continuance on October 28th, 2022, and the Court found good cause. I think that the basis was that there was a sheer volume of evaluations that had to be done and Doctor Gehle couldn't get to all of them. So she needed more time.

On December 28th, 2022, Doctor Gehle's report was issued. So, it took Doctor Gehle about four, four and a half months to get her evaluation done.

On January 4th, 2023, chief assistant, and that would be Mr. Zelenka, Zelenka is spelled Z-A-L-E-N-K-A, that -- Mr. Zelenka approved getting a second opinion, and, on January 4th on that same day, the attorney who was representing Mr. Sharp, James Falk, we provided him with an independent evalua -- with a request or a notice of an independent evaluation and we subsequently filed

that notice with the Court on January 9th, 2023.

On May 9th, Exhibit 4, James Falk died and I've got the obituary as part of the exhibit there.

Most importantly, on May 16th, 2023, the law changed and this will be the last exhibit. What I did was I took the old statute and the new statute. So, the offending conduct of was -- of which Mr. Sharp is now complaining, it wasn't the rule. It wasn't the law prior to that. There was no 90 days.

The 90 days actually took into, into effect -- went into effect May 16th of 2023. So, there was no timetable. But, nonetheless, on May 31st, 2023, Doctor Gottfried issued her report.

So, from the time Doctor Gottfried was retained as an independent expert to the date the, the report was issued by Doctor Gottfried, it was about four and a half months, the same as DMH professional asked for, and I've got both the old statute and the new statute and what's -- just draw your attention to the fact that the law changed. There was no 90 day provision prior to May 16th, 2023.

Now, on June 5th, I began trying to get this case onto a trial docket and then my predecessor, Suzanne Shaw, tried to get it onto a trial docket. We ran into a lot of resistance and none of it created by the Office of the Attorney General.

Initially there was some confusion, not anybody's fault, not -- and not anybody's fault. I want to make that clear. I don't want Mr. Wilson to think somehow I'm a, you know, I'm attacking him, which is not my goal. My goal is, is for everyone to understand and remember that his son, Ralph Wilson, Junior, was appointed. But it was Ralph Wilson, Senior that needed to get the file. He needed to be brought in. He needed to have a, a letter of retention.

So, ultimately, we lost about a month with the wrong Ralph Wilson but nonetheless.

On June 5th I was trying to get it onto a trial docket. On June 26th, Mr. Wilson, Senior, was finally appointed and I've got that as Exhibit 6.

On June 27th, coincidentally, Doctor Gehle amended her report.

On June 30th, we, we submitted, the Attorney -- Office of the Attorney General, and my predecessor and I, put all of this on a trial docket. On June 30th, when we put -- we filed our motions in limine. We filed our jury instructions. We filed everything. We asked for Mr. Sharp to be transported for this trial. Mr. Wilson asked for more time.

Now, I, I owe it to tell you, judge, I've only spoken to Mr. Wilson a handful of times. Probably two or three

times. I don't get to talk to Mr. Wilson. I talk to his office. A woman over there by the name of Denise. She seems lovely. But I need to hear from Mr. Wilson.

And so I was at my wits' end and I did everything I could to put this case onto a trial docket. Unfortunately the judge, and that is one of the exhibits, Judge Hocker continued this case unilaterally. He ordered this -- the Office of the Attorney General to get in touch with Mr. Wilson's office to see what the status was and with -- then we found out, from Mr. Wilson's office, that he was out of the country on vacation and he had a -- I'm not familiar with this term but an order of protection.

He advised the Court that he was not available during that trial week. And so the case was ultimately pulled off the trial docket at Mr. Wilson's request.

Exhibit 10, you'll see an order or, or an email from Judge Hocker pulling the case off the trial docket. Now it was set for trial on July 31st and we would have been here July 31st. But we couldn't be here because Mr. Wilson wasn't even in the country.

On August 3rd through 24 -- one, it's Exhibit 11, and it's a long email string, where I finally asked for the intervention of Judge Nettles to get this case onto a trial docket and Judge Nettles agreed to have a status conference cause I couldn't get any answers out of Denise.

Denise, of course, works for Mr. Wilson. I don't get to talk to Mr. Wilson. I only get to talk to Denise. I know another lady by the name of Kendall. I don't know even -- I couldn't identify either of these ladies.

But, nonetheless, then I got a -- an, an email from the clerk, the chief assistant clerk here in Florence County cause I put, I put it on a trial docket and I'm loathed to put a case on a trial docket without the consent of the opposing party. But I couldn't -- I don't get to talk to Mr. Wilson.

So, I put it on a trial docket and I think her name is Ms. McCutcheon. She sent back an email to me saying do I have the consent of, of Mr. Wilson and I didn't. I did not. So, I set it on a status conference to try and get the case to move and finally I got an email from Denise, and it's in the packet, and Denise said that Mr. Wilson has agreed to today as a court date, as our trial date to begin. That's the only way I got onto a trial docket for today.

You'll see multiple emails, Exhibits 10, 11, 12, 13, where I'm in contact with Mr. Wilson's office constantly trying to get this case onto a trial docket. Judge Nettles finally set it for a status conference. But, unimportantly, Judge Nettles no longer had jurisdiction. I -- there was a reason in there and, and I don't

remember.

So, we are kind of back at square one tying to get this case back onto a trial docket and then Judge Hocker unilaterally just took it off the trial docket and here we are.

You'll see October 25th, October 30th, and the November 3rd string emails backing up everything I'm saying. But the -- probably the most salient point in all of this is May 16th, 2023, when the statute changed.

We went from no 90 days. There was no timeframe or time limit and it doesn't even say what the, what the remedy is. But it certainly isn't dismissal. But, nonetheless, at -- on the 16th, the law changed.

Within two weeks Doctor Gottfried's motion, I'm sorry, report was issued to the Court and we been trying to get this case onto a trial docket ever since.

Judge, I, I don't know where it's written that you get to create a delay, which is exactly what has happened, and then be a victim of the very delay that you created.

THE COURT: I understand. I'm gonna make this a part of the record as an exhibit.

(WHEREUPON, State's Exhibit No. 1 was received into evidence at this time.)

MR. FISHER: And, nonetheless, for all the reasons I've just explained to the Court, I ask that the motion to

dismiss be denied.

THE COURT: All right. Anything further, Mr. Wilson?

MR. WILSON: Yes, sir.

Just, just so the record's clear, each time that I was contacted about having this trial and I informed the, the Attorney General's Office repeatedly that I had a pending murder trial in Horry County and that that's where I was and that's what I was gonna be doing. In fact, I had three consecutive trials in Horry County during that timeframe.

He was made aware of that. We sent him a copy of not only of the fact that I was gonna be in those trials but I also sent him a, a -- the date and time and name of the cases so that there would be no dispute or misunderstanding about what was going on.

But he is absolutely correct about the fact that he didn't get to talk to me as much as he wanted to. I don't dispute that one bit. But -- and that was because I was in trial and I could not stop what I was doing. And I actually remember saying to them if -- fine. If you can get the Court to release me from the murder trial that I have, then fine. I will come and do a trial with you. But I can't be but one place at one time and that is the case.

And so, so, you know, I, I take some umbrage at the

fact that this delay is now being blamed on me when I was only doing what I'm suppose to be doing. It is not my responsibility to make sure that a case is tried in an appropriate time.

That falls upon the State. That's their burden, and if he wanted Judge Nettles or any other judge to supersede the judge in Horry County and, and schedule a trial for me, then that's fine with me. I, I can't be in but one place.

THE COURT: All right.

MR. WILSON: And, and, and I don't think that the defendant or that the respondent in this case, Your Honor, is to be held accountable for the fact that I'm unavailable. That ain't -- that's not his doing.

He didn't appoint me to this case, and, and let me say this lastly and I'll done be done. I wasn't appointed in this case until I think it was May of, of last year. May.

So I've had this case now for what, eight months, seven or eight months at most. So, so to -- this case has been going on for a year and a half prior to my getting involved.

THE COURT: All right. All right. I find that there was no wrongdoing on either part, that it was obviously just a clerical issue. But I also find that there's no

prejudice whatsoever to the respondent at this time.

So I'm gonna deny the motion to dismiss.

All right. What's next?

MR. WILSON: Your Honor, I -- also, at this time, I would make a motion in limine for and ask for a Council hearing in regards to the testimony of Doctor Gottfried and my, my reasoning for that, Your Honor, is, is that there is a lot of, for lack of a better word, there is a lot of misinformation, disinformation about the tests or some of the testing that she did. Specifically what we call the PPG test, the penile test, if you will.

It is our belief, Your Honor, that that test has not been vetted, that there is -- that there is no Court case that I'm aware of where evidence has been produced of the legitimacy of the test, of the, the legitimacy behind the theory of the test, and whether or not that test should be allowed in court.

In fact, in fact, and if the, if the Court has read my brief, we cite several cases where these -- this testimony has not been allowed. And even if it has been allowed, it's been overturned on, on, on, on appellate review. In almost every instance where it has been allowed, it's been overturned on appellate review.

Now, as far as I know, there is no South Carolina Supreme Court case directly on point. But there is a

Court of Appeals case where, South Carolina Court of Appeals case, where this testimony had been admitted in the trial level and, at the Court of Appeals level, the Court of Appeals reversed it and that case now, I think State versus Gregg, I think it's still on appeal with the Supreme Court. I'm not a hundred percent certain about that.

Be that as it may, my point is simply this, Your Honor, that this test is like the polygraph examination. It purports to, based on your reaction, it's (sic) purports to tell whether or not you are, in this case, a sexual predator or whether or not you are or whether you're not. And, and, and, and just like a lie detector test measures your, your, your sweat glands and what -- measures whether or not you're fidgety or whatever it is, this is what, this is what this test purports to do.

There is no standardization of this test across the country. There's not even standardization of the test within South Carolina.

All of those things, I think, we are -- we should be allowed to fret out prior to presenting this information to the jury. The, the, the danger, Your Honor, with presenting it to the jury is that they're lay people and they may want to trust testimony from an expert witness, you know, who presents a, a, a theory to them that they

don't fully understand or even comprehend. I don't fully understand it and I've been doing this for a long, long time.

So, so to ask 12 people on a jury to fret it out for themselves and figure out whether or not this test is real or whether or not the, the, the, the, the -- whether or not there's peer-review for these tests, whether or not -- all of these things need, need to be determined prior to a jury hearing any of this testimony.

These are very serious allegations because what happens is, based on the report from these doctors, these people end up going for what they call treatment. But they're there sometimes for years and years and years, and, yes, there is some mechanism that they've now put in place for some kind of review. But those reviews are usually a year, a year and a half, sometime two years. I have people now who have been -- reviews that are pending.

My point, Your Honor, though is, is that before we even get to that point, before a jury can hear it, we, we need to go through these steps under Council. So I'm asking -- or State versus Council.

So, I'm asking the Court to allow us to have a Council hearing where we fret out these issues prior to presenting this information to the jury so that the Court -- and I don't know whether His Honor has done these

cases before or not. But the -- so this Court can make a determination as to whether or not this testimony ever should reach the ears of a juror. Because once, once that information is, is, is, is, is, is given to the jury, we don't know how they're going to take it. We don't know how they're going to understand it and I don't think there's any real scientific basis for this in the first instance.

So, I, I would ask the Court to, to make my, my motion a part of the record and I, and I want to submit it and had it filed. But I'm asking the Court to make it a part of the record. I've also submitted a, a, a brief on the issue and I would ask the Court to make that a part of the record as well.

THE COURT: Yes, sir.

MR. FISHER: Judge, Natalie is the test admissible. It was admitted in a, a trial that we just did a month ago.

I'm looking at Mr. Wilson's motion and the request for a Council hearing and I think we should have a Council hearing. But let me tell you why.

I went through every case that Mr. Wilson cited in his motion -- in his first motion in limine and it, it, it talks about Council and I'll talk about that in a second.

But in the, in this case, this is the Gentry v. State

case -- now this is Mr., Mr. Sharp's motion. So I assume he's got copies of the case law. But I'm gonna give, give this to the Court.

What gave the, the Court heartburn was the proponent of the scientific, scientific evidence has the threshold burden of proving reliability. That goes back to Frye. That goes back to Daubert and, of course, in South Carolina, we, we call it Council.

And, in each one of the cases that are cited in the motion as in like, like in Gentry, the PPG was not rejected because it wasn't unreliable. It's because the proponent of it failed to prove, prove the reliability, lack of certainty. But once the procedure has been recognized, and it has, then it's admissible.

On Page 2 of Gentry, once a procedure has been recognized -- oh, I'm sorry. Gentry is cited at 213 Georgia Ap 24. It's a 1994 case. It's also cited at 443 Southern second -- S.E.2d 667. And the Court said in this opinion that, once a procedure's been recognized in a substantial number of courts, a trial judge may judicially notice, without receiving evidence, that the procedure has been established with verifiable certainty or that it rests on the laws of nature.

In other words, what they're saying is the proponent has the burden of proving that it's reliable and I submit

it has.

In another case cited by the respondent, this is State v. Spencer, this is in his motion. Sorry.

Did I give you two?

MR. WILSON: I think so.

MR. FISHER: Spencer?

MR. WILSON: Yeah, I got it right here.

MR. FISHER: Spencer is cited at 459 S.E.2d 812. It's a 1995 case. Twenty-five years ago. Some of us that's hard to believe. But it is 25 years ago.

In this case, the Court went to great lengths to establish that the PPG was not to be used as a form of guilt. This was a criminal case and the PPG was being offered to show that somebody committed a sexually violent act. That's not what it's intended to do.

What it's in -- the PPG is, is intended to do is see if there is sexual arousal. It's a data point. It's one of many data points to see if Mr. Spencer was sexually aroused. It's to be used as a data point as to whether or not Mr. Sharp is sexually aroused at prepubescent children and I submit he is.

Another case set -- cited by Mr. Sharp's attorney is the Billups case. Billups is cited at -- it says -- it just says Matthew Edward Billips, B, as boy, I-L-L-I-P-S. It's the Commonwealth of Virginia and, in this case, what

they tried to do is use the PPG to show that the respond -- the defendant in that case, again a criminal case, we're in a civil courtroom, engaged -- whether a juvenile engaged in forced sodomy with another child.

What the Court said was that the experts who prepared the report could testify. But the, but the burden of reliability rests with the proponent of the PPG and they failed to show that it was reliable.

The next case I have is United States v. Powders. Again another case that was cited. I'll give you a copy in a minute.

MR. WILSON: That's all right. I'm good. I have mine.

MR. FISHER: This is, again, cited in Mr. Sharp's motion in limine.

The Court went on to say the PPG is not admissible because it was being offered to show -- let me back up a little bit.

The first Powers, which is cited at -- it's a United States Court of Appeals case Fourth D -- Fourth Circuit case, and what Powers said was -- Powers was offering the PPG. He sought to admit it as evidence that he was not a pedophile. But he failed to prove the threshold requirement that it's reliable.

So, absent any, in this case, Council hearing, which

is why I think we do need a Council hearing, but failing to prove the reliability before using this new at that time scientific evidence was within the sound discretion of the Court.

The next case offered by Mr. Sharp is the United States v. White Horse. White Horse is cited at 177 F. Supp. 2d 973.

What White Horse did was it referred us back to Powers, which, again, says the, the proponent of the scientific evidence has the burden of proving the reliability of the scientific procedure, and because -- in, in White Horse, the Court came right out and said because the defendant in that case, cause he was using it to show that he was not a pedophile, that the defendant offered no evidence as to the threshold issue of reliability.

The Court went on to talk about this Able Assessment, which is an, an entirely different task to determine sexual deviancy. But the Court said, in Page 3 of, of the, the case, the Supreme Court in Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 and 113 South -- Southern Court 2786, that Daubert established four nonexclusive factors to determine whether a particular expert's method of ol -- methodology satisfies Rule 702 and then it goes on to say the first.

Whether the theory or technique has been tested, and pursuant to a Council hearing, I submit that it has been tested.

Whether the theory or technique has been subjected to peer-review and publication. It has been subject to peer-review and publication and we're gonna find that out via a Council hearing.

Three. The known or potential rate error of the methods used and the existence and maintenance of standards controlling the technique's operation. I fully anticipate qualifying Doctor Gottfried as an expert in not only the use and administration and as a tool in the PPG.

And then the fourth is whether the theory or method has been generally accepted by the scientific community and it has. I've got numerous publications, and as a matter of fact, I just got some more today saying that it meets the Daubert test and, in this case, whether or not it meets the Council criteria.

All of these cases say the same thing. All of these were, were cited in Mr. Sharp's memorandum and in his motion in limine. I'm not offering any new cases. I'm just trying to explain what they mean. And to just take a blurb out of a case and say well, it's not reliable is, is, is not what these cases represent at all.

THE COURT: Well---

MR. FISHER: The next one I've got is left wood -- Leftwich v. State. It's cited at 538 S.E.2d 779. It's a 2000 case. None of these cases, none of these cases claim the PPG is unreliable. They're saying the proponent failed to meet his burden.

In other words, they offered nothing and then -- what I find it interesting about the Georgia case is that if it were read -- the -- this, this really kind of boggles my mind frankly. But if it was acceptable within Courts in the State of Georgia, they wouldn't even have a Council hearing, which I thought was rather an interesting scenario.

Again, in Leftwich, what they say is that they, that -- that the, the proponent failed to offer anything as to its reliability.

Judge, the last case I've got -- well, I've got two more. Here's the actual Council case and Council is cited at 335 South Carolina. It's a Supreme Court case and Council recognizes the four criteria for reliability.

I'm reading from Headnote Number 23 just to cut to the chase.

In concern -- in considering admissibility of scientific evidence, Courts look at several factors to determine reliability including publications and peer-review of technique, prior application of method

to -- of -- to type of evidence involved, the quality control procedures ensured -- used to ensure reliability, and, fourth, the consistency of method with recognized scientific laws and procedures and then it just refers us back, as, as I said before about Rule 702, which is the Supreme Court -- United States Supreme Court interpretation of, of Daubert.

Judge, there was a -- I'd submitted a memorandum of law and I referred back directly to -- I don't know what I did with it. Here it is. And I submitted this to the Court explaining what I've just argued that it is reliable, that it is subject to peer-review.

But, most importantly, in the State of -- in the case of the State of South Carolina v. I believe it was Pough, P-O-U-G-H, Judge Coble, after a Council hearing, made a determination -- I, I provided a -- you with a copy of his transcript that says it -- that he did find that -- it reliable and that the State has met its burden of reliability and that it was admissible.

Now, I'm ready to proceed on the Council hearing cause I think we need to do it. I think, in the case of Bilton, which is B-I-L-T-O-N, also cited by Mr. Sharp, the use of the PPG gave the Court heartburn because one, it was -- it's what they called conduit testimony.

What happened in Bilton was Doctor Swan was able to

testify as to Doctor Bill Burke's raw data and conclusion. So, it wasn't based on direct knowledge. So, that's a -- that was a -- conduit testimony was very difficult in the Bilton case.

The second thing is, again, it goes back to what I've been saying. The proponent of the PPG has the threshold responsibility of proving the reliability before it is entered -- before a jury is allowed to hear it.

A, a -- this is -- these cases are hard. They're hard for anybody.

But the question then becomes is it gonna be helpful to the trier of fact. This one data point in the use of the PPG, is it gonna be helpful for them to understand the ultimate issue in the case and that's whether or not Mr. Sharp has been convicted of a sexually violent offense, a qualifying offense, and, two, when he's likely to reoffend.

The use of the PPG is not the be all, end all. But what it does do is help the juror under -- the jury understand why Mr. Sharp is likely to reoffend.

THE COURT: All right. Let me ask you this.

Who will be your first witness, Mr. Fisher?

MR. FISHER: Doctor Gottfried.

THE COURT: All right. How long do you think the Council hearing will take?

MR. FISHER: Two hours.

THE COURT: So do I need to release the jury for the day?

MR. FISHER: Yes.

THE COURT: Bring them out.

I'm gonna go ahead and have the clerk swear the jury so they can be impaneled. So if something were to happen to one of the jurors, I could put in an alternate.

(WHEREUPON, the following takes place within the presence of the jury.)

THE COURT: Madam Clerk.

(WHEREUPON, the jury panel was placed under oath at this time.)

THE COURT: All right. Ma'am, what is your last name?

(WHEREUPON, one juror raises their hand.)

THE COURT: Yes, ma'am.

THE JUROR: Tanner.

THE COURT: Ms. Tanner, you are sitting in the Madam Forelady's seat. So I'm gonna appoint you to be the forelady of the jury.

Okay. Your role and responsibility is very difficult at this time which is to make sure nobody discusses the case cause you don't know anything about the case.

Fair enough?

Any emergencies that arise or something comes up, reduce it to writing, give it to me, and I'll handle it. That's it.

All right. All right. Ladies and gentlemen, let me explain kind of just how we're gonna proceed forward.

First off, let me introduce you to everybody cause none of y'all indicated that y'all've been on a jury. Maybe you have before but not in the past three years.

This is our wonderful court reporter. She's taking everything down. So, if you ever hear her speak up and say slow down or speak up, it's because she has to take everything down.

All right. You've already met our wonderful bailiffs. There's also our wonderful bailiffs in the back.

Our deputies here as well and you've met most of the Clerk's Office and they'll be with us -- their role and responsibility is to run the courthouse and courtroom.

This is Morgan. She is my law clerk. You'll see us send notes back and forth a lot. We'll Skype sometimes. So, if you see us typing, that's what we're doing. We're talking to each other. It has absolutely nothing to do with this case.

All right. Ninety-nine times out of ten it's a problem that has arisen back in the office or where are we

gonna go to lunch today. Those are usually the two big issues.

All right. So that's all we're addressing. So don't worry about what we're doing up here. She'll leave a fair amount. That's because I'm asking her to go do something for me and then when -- she returns. But, again, it has nothing to do with this case.

All right. So, what I do want to let you know or, or, or charge you on is is that while you've been back there for the past 45 minutes is that I am the sole and exclusive judge of the law.

All right. That's all I do. And in a, in a trial, what that means is that it's my role and responsibility to find out what evidence is admissible and what evidence is not admissible and I'll rule on that.

Now, you've seen this in the form of TV shows where somebody objects, overruled, or they yell out stuff like that, correct?

That's because the judge has the sole and exclusive right to determine what evidence is going to be heard by the jury and let me explain why.

Y'all are the sole and exclusive judges of the facts of this case, all right, and I have no opinion whatsoever of the facts. To be honest with you, I don't know what most of the facts in this case even are. I didn't know

what we were trying until I got here this morning. So that shows you what our role and responsibility is.

Okay. And so, at the end of the case, I am going to charge you on the law and you'll hear the lawyers talk about that a lot. What that means is I'm gonna read to you what the State of South Carolina says the law is because that's what I tell you that it is. You have the facts. You nail the two together to make your decision. That's how the jury system works.

Fair enough?

Well, in doing so, the attorneys have brought to my attention that there is a matter of law that I need to bring up. I will do this a, a fair amount throughout the trial if, in fact, they have objections that I need to take up outside of your presence. But they said that these are -- arguments were gonna take up a fair amount of the afternoon and I don't want to keep you here if we're not gonna get that much accomplished, maybe, you know, 20, 30 minutes worth of, of work. I don't think it's fair y'all sit back there for a while.

So, what I'm gonna do is I'm gonna go ahead and let you go for the afternoon. If you'll be, be back here tomorrow morning.

We're gonna start at 9:30 sharp and, at that time, what you will find is we are going to allow the State to

give a opening statement. That's not to be considered evidence by you. It's what they believe that the evidence is gonna show throughout the trial.

I'll allow the defense to do the same and then I'll ask the State to call their first witness and we'll get rocking and rolling. But what I'm gonna do now is I'm gonna do all the legal work today so we can start first thing with the trial tomorrow.

Fair enough?

9:30. See you then and, no, I'm not gonna call your loved ones and employer and tell them that I let y'all out of here early. So you -- y'all do what y'all need to do.

(WHEREUPON, the following takes place outside the presence of the jury.)

THE COURT: All right. Anything before we get started?

MR. WILSON: Yes, sir.

THE COURT: All right.

MR. WILSON: Your Honor, I need to go back and make sure that, that I included this. I know it's in my, in my memorandum and it's in my motion. But I did not argue the invasiveness of the process of this PPG test and I want to put that in the record as well.

This test, Your Honor, I think violates the Fourth Amendment protection for defendants in and -- or for any

person because of the sheer nature. And when, when we go through this Council hearing, I will do my best to bring out the aspects of that which show the Court that this test is demeaning, it's humiliating, and that no person should be subjected to it involuntarily and that's what you have in this situation because each person who the Court sends is sent pursuant to a Court order.

They're not there voluntarily to ask that it be done. They're being ordered by a Court to have this test conducted and I think that it's invasive. I think it violates the Fourth Amendment and that's in my brief. It's in my, my motion and I would ask the Court to, to make a ruling on that at the appropriate time.

I think that would be well after the Council hearing once the evidence is presented and the process is displayed to the Court.

THE COURT: All right.

MR. WILSON: And, and, Your Honor, lastly -- and I'll be done before we start the Council hearing.

I ask that all of the motions that I have filed, including the memorandums and brief, that all be made a part of the record.

THE COURT: Not a problem. So ordered.

MR. WILSON: Thank you, Your Honor.

THE COURT: Call your first witness.

MR. FISHER: Judge, before I call my witness -- first witness, I want to remind everybody this is not a criminal case. This is a civil commitment case. It's the Civil Rules of Procedure. Not the criminal rules.

And, with that, I do want to, for the record, at the end of my argument, I quoted Bill -- Bilton. This is a 432 S.C. 157. I wanted to make this a part of the record as well. I cited to it but I did not provide a copy to the Court. So that's what I'm doing now.

THE COURT: All right.

MR. FISHER: With that, the State would call Doctor Gottfried.

THE CLERK: Please place your left-hand on the Bible and raise your right-hand.

DOCTOR EMILY GOTTFRIED, being first duly sworn, testified as follows:

THE CLERK: Please be seated. State your name for the record.

THE WITNESS: My name is Doctor Emily Gottfried. G-O-T-T-F-R-I-E-D.

DIRECT EXAMINATION

BY MR. FISHER:

Q. Good afternoon, doctor.

A. Good afternoon.

Q. Can you please tell the Court where you're employed

and in what capacity?
A. Yes. I'm an associate professor of psychiatry and behavioral sciences at the Medical University of South Carolina in Charleston. I also serve as the director of the violent sexual behaviors clinic as well at MUSC.
Q. And how long have you held that position?
A. I was hired at MUSC the Summer of 2015. So, a -- just over nine years.
Q. And prior to that, what were you doing?
What were, what were your positions?
A. Prior to 2015?
Q. Uh-huh. (Affirmative).
A. So, prior to 2015 I did a postdoctoral fellowship in forensic psychology. Prior to that I did a one year predoctoral clinical psychology internship in forensic psychology and then, prior to that, I was working on my PhD.
Q. Now, what are your, what are your duties as a director of the SBCL?
A. In the sexual behaviors clinic and lab, I oversee all of the operations. So I select the tests and measures that we use. I conduct clinical and forensic evaluations. I do some treatment, treatment planning.
I order supplies. I arrange the trainings. I train students. I give lectures and teach classes relevant to

sexual behavior to a variety of students at MUSC and then I oversee research in the lab as well.

Q. What kind of research do you do?

A. Broadly, I do research on paraphilic disorders, the accurate assessments of sexual offense risk prediction and assessment more in general.

Q. And have you ever been published in any peer-review articles or presented at any conferences?

A. Yes.

Q. And where were they and could you explain that to the, to the Court?

A. I believe I have 33 peer-review publications in scholarly journals. I have six book chapters like in texts or scholarly edited works and I have one that's in press. So I have seven of those.

I've presented I believe about 70 times at scientific national, international conferences across the country on research and then I also give simulated lectures on topics related to sexual behavior.

Q. Did you just get back from one of those conferences?

A. I did.

Q. What was the conference on?

A. Last week I was in Denver for the American Academy of Forensic Sciences conference.

Q. And did you present at that---

A. I did.
Q. ---conference?
A. Yes.
Q. And do you sit on any international committees or collaborations?
A. I do.
Q. Can you please explain those for the Court?
A. So, I am a member of an international standardization group working on plethysmography. That includes primarily researchers but also clinicians from the United States, the U.K., Canada, Russia, and then Czech Republic where we, for the last couple years, have been really working on trying to develop the standards so that the various countries and jurisdictions are more uniform.
Q. What is -- what would be the holdup with something like that?
A. So there are, there are a couple holdups.

So I'd say one of the biggest issues is that current jurisdictions have different laws. So, for example, Canada has a medical exemption to their child pornography laws. In the United States, if I were to present somebody with something that could be child pornography, I could go to federal prison for that. We don't have any kind of exemption from that.

A lab that I work with often in Canada, has been

around for a very long time, has been doing PPGs, a lot of them for a long time, and they use pictures of children that would be considered child pornography in the United States.

So, one issue that we have with the standardization is when different countries and jurisdictions have different laws, and then you have a group of people who have been doing a test in a way for a long time, they're -- and it's been working for them, is they're really reluctant to want to change their methods because we know the U.S. couldn't do that.

Another issue with standardization is the use of cut scores. So, when you decide how to interpret a test, like what makes the test clinically significant or positive or negative, you have to select where you're going to cut the, the score. And so, my argument is that that should be dependent on the reason for the test.

So, if you're doing penile plethysmography for treatment, you could use a much lower cut score. That means it would show that more people had arousal. But if you're doing an evaluation that's going to court or the person is being considered for civil commitment, that is a much more serious issue and we need a much more conservative cut score. I think those are the two issues that we have with some of the standardization.

Q. Can you describe what the PPG is and, and, and how it works?

A. So, penile plethysmography is a zoological (phonetic) objective measure of male sexual arousal and how it works is an examinee sits in a private room by themselves. They are shown an instructional video and they're given instructions as how to place the penile gauge around his penis.

So they sit in a room by themselves. They have a gauge placed on them. They're covered up and then they're presented with stimuli, that could be visual and/or audio or they're just listening to it, and they are presented with a variety of sexual stimuli and we are looking at changes to the circumference of the penis in response to presentation of the different stimuli.

So, some of it features consenting adults, descriptions of them having sex. Some of them describes scenarios of a man having sex with a child.

And so we're comparing their physiological responses with changes in their -- the circumference of their penis looking at arousal and blood flow. We're comparing it within themselves.

So, what that means is I'm looking to see if the person is aroused and how much by consensual adults having sex consensually and then also comparing their responses

to neutral nonsexual stimuli as well.
Q. Now, how many PPG administration tests have you been a part of?
A. I have ordered just about a hundred PPGs and I have personally done the clinical interpretation I'm gonna say between 77 and 80 subparts of the PPGs.
Q. Is there a standard test performed as part of sexually violent predator cases?
A. In, in general is there a---
Q. Yes.
A. ---a standard?
Q. Yes.
A. I, I would say no. In, in South Carolina there's no quote or -- well, in South Carolina there are no guidelines that says these are the standard tests that you administer.
Q. Okay. Now, is there a standard -- is there a standardized -- ex -- explain to the Court the standardization of the PPG.
A. So, I think what you're asking me is, in, in our lab at MUSC, we do all of our PPGs standardized. So, any adult man who is referred for a sexual behavior evaluation of any type undergoes a PPG exam. It's a standard part of my evaluation.
So that's for treatment. That's at a pretrial level.

We don't use it in court. But sometimes I'll have an attorney ask for an evaluation of, of a man that has been charged with but not yet convicted of a sexual offense. They want some more information about that person. They get a PPG.

So any adult man who comes to our lab gets a PPG and then at -- every, every test is administered in the exact same way.

So, anyone who does the administration, the interpretation, they all have to have undergone the training. They're certified in their tasks and then we use a really long examinee checklist where the technician who administers the PPG goes through each item and makes sure that every test is being administered and interpreted in the exact same way.

Q. Explain to the Court the training that you've been provided on the PPG.

A. It's been a while since I've done the training. But the training consists of both a classroom portion and then I guess you call it hands-on portion. So the classroom describes the history of the PPG, the reliability, the validity, all of the research behind it, you know, the Daubert standards, the, the report writing.

So, yeah, all of the classroom parts and then, with the, the trainers, certified trainer, you have to

administer PPGs in his lab and then you spend the whole day doing the interpretation after you've received that classroom instruction. And then prior to getting certified as a clinical analyst, somebody who can interpret PPGs, you have to submit I believe it was three, three PPGs that you administered in your own lab. You have to submit the interpretations so that they can confirm that, that you did it correctly.

THE COURT: How long ago did you attend that training?

THE WITNESS: I believe 2017.

THE COURT: That's fine.

Q. So how many---

A. 2018.

Q. How many times in your career have you requested or performed the -- a PPG?

A. About a hundred.

Q. Let's talk a little bit about the reliability.

How long is, is the PPG been used and in what context?

A. So, the PPG was developed in the 1950s and I guess it was formerly Czechoslovakia and they used it to try to differentiate between men who were being drafted into the Czech Army.

I, I guess some men would say that they were gay or

homosexual, which was a disqualifying factor in the military over there at that time. And so they found that the PPG could reliably discriminate between men who were heterosexual from men who were not. And then shortly after that they determined that the PPG was also really useful in looking at abusive nonconsent -- nonconsensual sexual arousal.

And so it's been around since the '50s and used in this purpose.

Q. And has the PPG been peer-reviewed?

A. Yeah.

Q. And has it been accepted by the -- BlueCross, BlueCross and BlueShield of Texas?

A. Yes, it's my understanding they have a document describing different types of plethysmography and penile plethysmography is listed on there where they give general, general definitions and then refers the proceedings insured to check their coverage for in -- infants (phonetic) and, and the like.

MR. FISHER: Judge, I've got a list of exhibits and this would be Exhibit 1 and I'm going to approach the witness in a second.

(WHEREUPON, the BlueCross BlueShield of Texas Plethysmography Report was marked as State's Exhibit No. 2 for identification purposes only at this time.)

Q. Mr. Wilson, this is the first document. They're numbered one through --.

MR. WILSON: Okay.

Q. Take a look at that.

Do you, do you recognize --?

A. Yes, I've seen this before.

Q. And how do you recognize it?

A. It's BlueCross BlueShield of Texas and it's the document regarding the coverage for plethysmography and modalities considered medically necessary.

Q. So it's been a -- for insurance purposes, specifically as it relates to impotence, has it, has it been a recognized tool?

A. Well, this goes over all the different types of plethysmography. On the third page it describes that penile plethysmography is a noninvasive test for measuring the variation in the volume of the penis and in the amount of the blood present or passing through it. Refer to the medical policy on evaluation of impotence for coverage information.

Q. So, BlueCross and BlueShield uses it?

A. Yeah. They mention it in the, the coverage information.

MR. FISHER: Judge, did you accept the first exhibit for the motion to dismiss as Exhibit 1?

THE COURT: I did.

MR. FISHER: Okay. Well, I'm gonna mark this as Exhibit 2 if that's all right and present that to the Court.

(WHEREUPON, a letter from the Department of Mental Health was marked as Plaintiff's Exhibit 3 for identification purposes only at this time.)

Q. Has the PPG also been recognized by the Department of Health?

A. The Department of Mental Health?

Q. Yeah, the Department of Health and Human Services.

A. The PPG hardware and I guess the software that we use has been approved by the FDA as being (inaudible).

Q. Yes.

A. Yes.

Q. I'm showing you what's gonna be marked as State's Exhibit 3.

Do you recognize that?

A. Yes.

Q. How do you recognize that?

A. This is the FDA approval of the Limestone Technologies health test professional suites and device that we use for the PPG.

Q. And who is Limestone?

A. Well, Limestone was the company that manufactured and

sold the PPG hardware and software that we use. I -- they recently were -- sold or operating under a, a different name. But, historically, they've always been Limestone Technologies.

Q. But it is recognized by a FDA?

A. Yes, they obtained FDA approval.

MR. WILSON: Your Honor, marking that as State's Exhibit 3.

(WHEREUPON, the PPG reference page was marked as State's Exhibit No. 4 for identification purposes only at this time.)

Q. Now, I'm marking Exhibit 4 and, again, as it relates to reliability, do you recognize State's Exhibit 4?

A. Yes.

Q. What is that?

A. This is the reference section of PPG articles, peer-reviewed, scholarly works that I rely on in my continued decision to use the PPG in my evaluations of adult men charged with or convicted of sexual offenses.

Q. And how many are there on that list?

A. They're not numbered. Two, four, six, eight, nine, fifteen, eighteen.

About 35.

Q. Okay. Thirty-five, for the record, articles or --?

A. Yes. A couple might be chapters from scholarly

texts. But the other research articles from other journals.

MR. FISHER: Submitting it to the Court, State's Exhibit 4, which is the articles and peer-review of the PPG.

Can you talk briefly about the meta-analysis, the large meta-analysis, that's been done on the PPG?

A. Yes.

So, in 2019, Ian Calhoun's (phonetic) colleagues published a very large meta-analysis looking at the validity of using penile plethysmography specifically with men aroused by children. Like they're aroused by children. It had a huge sample. It's not on e -- I find -- I'm looking at my notes.

So, for a meta-analysis, that's when you take the results of lots of the studies and you put, put them together and do statistic -- statistical analyses in a specialized way. That's what the meta-analysis is. It was taking the results from all of the different studies.

I'm sorry. I just wanted to find the number of subjects that we have.

So he had subjects from 4,700 men who had committed sexual offenses against children. He had almost 2,100 men who had not committed sexual offenses against children. He had 541 men who went on to sexually reoffend. He had

almost 2,200 men who had a sexual offense but then never went on to reoffend and then he had a group of men who had no sex -- no known sexual offenses whatsoever.

And so it was a very large meta-analysis. There are a lot of findings from the study. But I think what's most relevant here is that he demonstrated that penile plethysmography can reliably discriminate between men who have sexual interests for children versus men who do not and that the effect sizes from that meta-analysis were just as large or larger than the other meta-analyses in looking at all of the risk factors for sexual recidivism.

Q. Can I have that -- the exhibit back?

A. All right.

Q. Oh, it did -- I already gave it to the clerk. Sorry.

Specifically how is the PP -- PPG used in precommitment cases?

A. So, I use penile plethysmography as one data point in my precommitment evaluations.

So, we know that having paraphilic sexual arousals -- so, for example, if you have pedophilic disorders, you're sexually aroused by prepubescent children and you've acted on that before. We know that paraphilic arousal is a well-documented risk factor for sexual recidivism.

We also know that a lot of people who are undergoing for petitive (phonetic) evaluations have a -- probably

really understandable and well-founded reason for why they're not totally forthcoming about what they're aroused by. And so, because of the relationship between paraphilic sexual arousal and sexual recidivism, it's really important to have an objective way to measure this.

If somebody came and said I'm aroused by children, I've acted on this, then a PPG probably wouldn't be necessary. But the majority of, of people that I evaluate don't come in and initially say that. It's, it's -- if they say it, it's usually after we discussed the results of the PPG.

Q. Now, in re -- regard to the PPG, you also talked a little bit about your lab.

(WHEREUPON, the PPG instructions were marked as State's Exhibit No. 5 for identification purposes only at this time.)

Q. Would you take a look at State's Exhibit 5?

A. Yes.

Q. What is that?

A. This is the sexual behaviors clinic and lab penile plethysmography, PPG, administration instructions. So this is the checklist that the PPG technician goes through and follows during the administration of every PPG examination in my lab.

Q. So, not only has it been standardized within the

industry and, and become reliable, but you have your own standards?

A. Yes. And this is based on how a PPG should be administered.

So, through Limestone Technologies, our lab is -- has both a research certification and a clinical certification. The research is the highest level of certification that you can get and it just means that you do everything standardly and that you could share data merged databases in the Limestone data collection because you're following all the standards.

Q. What is the Limestone gathering collection?

What is that?

A. I, I don't really know the state of it right now. But the hope was, when they were developing these certain certifications as certifying labs, was that labs that, you know, had the highest standards did everything, you know, on the checklist exactly the same way that -- so we could create a dataset so that we could look at PPG data across sites. So we are able to do that. I, I don't know the status of putting those data together.

Q. But you've got the highest standardization -- highest certification?

A. Yes.

MR. FISHER: Your Honor, I'd like the Court --

State's Exhibit 5.

Judge, at this time I'm gonna offer Doctor Gottfried as an expert in the PPG.

THE COURT: Same objection?

MR. WILSON: Subject to cross-examination, Your Honor.

THE COURT: All right.

Q. Is the PPG supported by any books?

A. Yes.

Q. And can you at least tell us one of those books?

A. There is a, a book about doing sexually violent predator evaluations. I believe that's (indiscernible) in 2019. There's a chapter on doing PPG for precommitment evaluations in that.

But in the Diagnostic & Statistical Manual for Mental Disorders, the DSM that's published by the American Psychiatric Association, PPG is discussed there in relation to paraphilic disorders. If you look at the general sexual literature, PPG is used very standardly when you're diagnosing impotence. If someone is being considered for a penile implant or another type of treatment for erectile disfunction, PPGs are often administered.

So they're kind of routinely talked about in general sexual health textbooks as well.

Q. You, you mentioned the sexually violent predator book.
A. Yes.
MR. FISHER: Showing you -- I think we're up to six, judge.
(WHEREUPON, excerpts from a chapter on sexually violent predator information was marked as State's Exhibit No. 6 for identification purposes only at this time.)
Q. What's been marked as State's Exhibit 6?
Do you recognize this?
A. Yes.
Q. What is that?
A. This is the Sexually Violent Predators, a Clinical Scientific Handbook and that was published in 2019. It's the, the -- a photocopy of the cover and then also Chapter 15 from that book.
Q. And what does that handbook say about the penile -- the PPG?
A. So, it, it says that there is value to administering a PPG. It has both treatment value and risk assessment value, the value of when using it for making a diagnosis and it's with -- specifically about connecting sexually violent predator evaluations.
Q. Would that be both precommitment and annual reviews?
A. I, I believe so. I, I, I don't recall a lot about

annual reviews in this book and not in this chapter. But they, they specifically discuss precommitment evaluations as well as using it as a treatment tool. But PPG has a lot of value for both of those scenarios.

Q. I might have asked this question before but how many PPG evaluations have you done for precommitment, which is what we're here for is a precommitment trial?

A. I have at least ordered a PPG in every precommitment case that I've done. Let's see if I have to write down how many precommitments. I'm trying to -- about 56.

Q. And you've found it reliable in those tests?

A. Yes, like I wouldn't use it if I didn't think it was a reliable account.

Q. Doctor Gottfried, I'm showing you what's gonna be marked as State's Exhibit 7.

(WHEREUPON, the DSM-5-TR article was marked as State's Exhibit No. 7 for identification purposes only at this time.)

Q. I'm showing you what's called a DSM-5-TR.

Are you familiar with this book?

A. I am.

Q. How are you familiar with this book?

A. So, that is the authority, the source, that psychiatrists, psychologists, anyone with a license to diagnose mental illnesses, that's typically the book that

they use. It's publish by the American Psychiatric Association. The latest version was published in 2022. So we're on Line 5, the text revision, and anyone who can diagnose mental illnesses, that is the book that they most commonly use in the United States.

Q. So, anybody -- any psychologist/psychiatrist is gonna refer to this book?

A. Yes.

Q. I'm showing you what's been marked as State's Exhibit 7. Take a look at this and tell me what it is.

A. So, the first page is a photocopy of the cover of the DSM-5-TR and then you have a photo, a photocopy of Page 795, which is part of the paraphilic disorder chapters specifically describing pedophilic disorder.

Q. What does that book say about the PPG?

A. So, in this sections -- let's see.

Under diagnostic markers, it says psychophysiological measures of sexual interests may sometimes be useful when an individual's history suggests the possible presence of pedophilic disorder that the individual denies strong or preferential attractions to children. The most thoroughly researched and longest used of such measures is penile plethysmography although the sensitivity and specificity of diagnosis may vary across cites which frequently use different stimuli procedures and scores.

Q. The most highly researched?
A. The most thoroughly researched and longest used of such measures. I think you, you gave me another exhibit with that.
Q. Oh, I was looking for the -- thank you.
Is this all the pages?
A. That should be it then. Yes, it is.
MR. FISHER: For -- this is Exhibit 7, Your Honor.
Is, your lab, is it certified to administer the PPG?
A. Yes.
Q. What kind of equipment do you have for the PPG?
A. The hardware that we use is from Limestone Technologies. It's the test and then we also get the software from Limestone as well.
Q. Can you -- change of subjects a little bit.
Can you please explain to the Court what Real Child Voices in the Marshall test is about?
A. So those are the two stimuli sets that we use for our PPGs. So they -- a different stimuli.
So, in Canada, they use some visual stimuli that we wouldn't be able to use in the U.S. because it would be child pornography. So, standardly, we administer two different sets with multiple trials to the same person.
The Marshall is an older set. It was developed by Bill Marshall. It's, it's audio only and it is a male

monotone voice describing a variety of sexual situations, you know, between adult men and children, consenting adults, mutual nonsexual childs (sic) and the level of activity described in the Marshall set range from persuasive to coercive to violence, sexually violence.

So that's one of the stimuli sets that we use and then the other one is the Real Child Voices or the RCV stimuli set. That is -- it was developed later but it's not -- it's been around for a while now. And instead of it being a monotone male voice, they incorporated actor's voices from a sound stage that they kind of splice in to different sexual scenarios.

So you hear some children's voices. You hear women's voices. They're sound effects. One of the child is describing something happening in a bar. You can kind of hear glasses clinking and then it's, it's what you call a slide plus audio modality.

So it will show a picture, not child pornography, but a, a, a photograph and then they'll hear the, the audio. So that's the slide plus audio.

Q. And what, what are the stimuli?

What is it intended to do or what does it -- what does it indeed do?

A. So, the stimuli are the sexual descriptions and the mutual nonsexual and the consenting adults. It's the

actual stimuli from the test that the person is going to listen to.

Q. As far as Limestone goes, are you able to separate the software from the hardware?

A. I have been asked this before and I -- I'm not quite sure what the answer to that question is. Like even for the sets that came with when we purchased the hardware or the software, but I guess I don't, I don't know enough about computers to say whether or not you could separate them.

Q. Well, let me ask you this.

Is there any way for somebody to give you false positives?

Is there a way for someone in the lab to alter the, the test?

A. No. But you wouldn't get false positives from the stimuli. The -- like the, the scenarios are in the computer. So, we -- I don't think you can alter them. We don't alter them. I'm not, not sure if that answers the question.

(WHEREUPON, the Limestone reference page was marked as State's Exhibit No. 8 for identification purposes only at this time.)

Q. Well, I'm gonna show you what's been marked now as State's Exhibit 8.

Do you recognize that?
A. Yes.
Q. What is that?
A. This is a list of peer-reviewed publications that use the Limestone PPG in, in the study.
MR. FISHER: I'd ask that State's Exhibit 8 be received as well.
So, yeah, ultimately, the, the, the question I've got is is there -- is there a -- you know, I understand you buy from Limestone both the software and the hardware.
So, is there any -- is it a set protocol?
Is it a set system or are you able to go in and somehow manually manipulate it and, and, more importantly, manipulate the results?
A. We -- you can't manipulate the results because the results are numbers.
So, where a lab might differ on what they're calling clinically significant would be what they have selected as the cut score as being clinically significant or interpretable. But the number, the raw data itself, whatever lab you administer that PPG in, you're gonna get that number because it's -- the string gauge is measuring the circumference of the penis. And so that number is not gonna change. But perhaps the clinical analyst's interpretation of it might. But the number would be

constant.
Q. When you say the interpretation of the number, what do you -- what are you referring to?
A. So, we're looking at millimeters of change from where they started at the beginning of the trial to their maximum level of arousal. And so those are represented in numbers. It's raw data. So, those numbers are always going to be those numbers.
Q. You, you talked about cut score and you also used the word conservative.
What is, what is a cut score and, and what is, what is considered a conservative number?
A. So, for any test, not just PPG, but any test that you have, you have to decide where essentially you're going to cut the test to say this is positive or this is negative. This is clinically significant, this isn't. And so you have to decide if you would rather have false positives or false negatives.
So, no matter what test you have, a human has to decide what is gonna make it clinically significant or interpretable. And so because, at MUSC, this is only one data point in Abel time methods, it's a comprehensive evaluation that I do, I use a much more conservative cut score and that is because I would rather miss somebody -- so, so, for example, if I am testing somebody who has

sexual arousal to children and I miss them, so they have that arousal but the PPG shows that they weren't aroused by it, I would rather miss that person than the opposite, which would be that I'm saying somebody's aroused by children that they are not actually.

And, and the reason I would rather miss that is because it's only one data point that I'm assessing what they're aroused by in, in multiple different ways.

And so I choose a conservative cut score. So it's much harder to get a positive result than a, a, a lower cut score because it's just one data point and because these are really serious evaluations with big consequences. And so I, I choose to be more conservative.

Q. What would be a conservative cut score?

A. So we use anything 5-millimeters of change and above as being clinically significant arousal.

Q. But does everybody use 5-millimeters?

A. No.

Q. So, for instance, what do they use in Canada?

A. In Canada, they use 1-millimeter of change. But Canada also doesn't have a sexually violent predator act. So -- but they do use it in criminal court and proceedings.

(WHEREUPON, the reference page for the MUSC lab was marked as State's Exhibit No. 9 for identification

purposes only at this time.)
Q. I'm showing you what's been marked as Exhibit 9.
Do recognize that?
A. Yes.
Q. What is that?
A. So these are two references from peer-reviewed publications where they discuss our lab specifically. So, both of these papers were comparing international sexual behavior labs and our lab was discussed in these two peer-reviewed publications, our, our methods at our lab.
Q. And are your methods in your lab accepted by others within your community?
A. Well, this -- these papers underwent the peer-review process and the experts who reviewed them thought that it, it met the standard. So I, I didn't say yes.
Q. One second.
(Pause.)
MR. FISHER: Presenting to the Court Exhibit 9. At the end I'm gonna ask to move all of these into evidence but --.
What are the instructions you give to a person who's about to undergo a PPG?
What do you tell them?
A. Well, we go through the whole checklist, checklist. I need my notes.

But I mean essentially -- so, when they come for a PPG or when they come for their evaluations to get started, we go over a really long consent form with them. The consent form is six or seven pages. It goes over every test that they might get.

They read each section. They ask questions. They initial each section. If they agree with it, they sign the consent form and then the day that they come in for a PPG, every day they come back, they sign what's called a rereading of that consent form where they're again consenting to each part of the evaluation.

So, on the day of the PPG, they would sign the rereading of the consent form. They would then meet with the tech who is going to give them the standardized instructions, explain the test, answer questions. They're then going to be told to use the restroom. Then they are taken into the private PPG room where they're played the instructional video for the PPG that's included in the Real Child Voices stimuli set.

While they're watching the video, the tech is in the other room preparing and then, after the video, the tech or this might actually -- step comes before this one on the checklist. The tech gives them like a flexible ruler where they're instructed to measure themselves in private.

After they're covered up, the tech comes back. The

tech selects the appropriate size gauge based on the measurements. The person watches the instructional video. The tech comes back in and answers any questions. They can watch the video as many times as they want to until they're clear on the instructions.

It's gonna tell them what to expect, what they are to do and not do while undergoing the PPG. And while they're watching the video, the technician is going to do the calibration.

So, every test, you can not start the PPG unless the gauge has been calibrated three times. Like the machine will not let you start the PPG. So it is reading the gauge to make sure that it is appropriately calibrated, that if it's reading at 90 millimeters, then it's actually at 90 millimeters to kind of use this cone to calibrate it at different millimeters.

Let's see. Then the tech would come in, answer any other questions. Then -- and then the, the test would start.

So, the person's in the room by themselves. The tech is in the next room. There's a camera that's monitoring them from the chest up so the tech can, can see them on the screen. There's an intercom. So the tech is communicating with the examinee, giving them instructions, reminding them they have to do some tasks like press a

button when the scenario becomes sexual or violence. That helps us to ensure that they're paying attention.

The tech asked them who, you know, describe the scenario they just heard randomly also ensuring that they're paying attention. And so -- and then the tech is also looking at the physiological data because, if somebody has arousal, you want them to do too mass (phonetic) or you want their arousal to return to baseline before you would start the next trial.

Q. And was, was all that done for Mr. Sharp?

A. Yes.

Q. Okay. Well, do you have any quality control procedures to make sure that the, the instrument itself is working correctly?

A. Yes. Well, we have lots of room quality control procedures.

So we control the humidity and the temperature. We go through each item on the checklist to make sure that everything is being administered the exact same standard way. Everyone who works in the lab is certified and trained. The lab itself is credentialed.

We have a protocol in place for, for, for everything, from the ordering the gauges, to, to make sure that everything is standardized. Prior to administering a PPG, the gauge has to be calibrated as I just mentioned.

Yeah. So, so I mean I, I really take steps, pains to make sure that everything is being done the exact same standardized way.

Q. Can the -- we started to talk about this a little bit before but can the test be manipulated?

A. By the person --

Q. Yes.

A. -- being given the test?

Q. By the subject of, of the test.

A. Yes.

Q. How is that done?

A. So, there are a variety of things that people can do to try to manipulate the results of the test. And so we try to account for that and we use what's called countermeasures.

So, one thing that the person might do is they might try to flex and like create arousal or movement or -- to something they're not aroused by. For example, consenting adults.

So they're sitting on a pad that's measuring their movement. That's also really helpful for when I'm interpreting the results, because if somebody like had a violent sneeze, that might move the penile gauge and I can look at all that movement data and the penile gauge data to see okay, this is not arousal, this is movement, and I

can see that from the movement pad.

They're also wearing a respiration strap. So I'm looking at their breathing. I can tell if they're holding their breath, if their breathing is really rapid or shallow, and that may be something that somebody's trying to -- they, they realize that they're becoming aroused and they might try to stop it by holding their breath. So we can see that on the physiological data.

So, you can also mentally suppress. And so you could do that by like thinking about baseball and not actually listening to the scenarios that are being presented to you. Something that we try or something that we use to try to get around that is asking them to press on a keypad every time the trial becomes sexual or violent. We have them randomly describe the scenario that they just heard.

And so all of that is trying to, you know, ensure that, that it's valid and they're paying attention.

Q. Are they, are they required at, at any point to stimulate themselves?

I, I know there's some old case law about -- on masturbation.

Explain how that, you know, you're able to detect and avoid outside arousal, arousal.

A. So we -- you're not allowed to touch yourself. Like once you have the gauge on, like you're not -- you should

not be touching your penis. You should not be touching the gauge.

So they're not instructed to stimulate themselves. That would spoil the test. It would make the test invalid. I could see if they were doing that based on the key gauge and the movement.

So, the, the movement's center's really sensitive. So I can see little tiny movements and then like if somebody masturbated to organism, like the test would be over. Like there's no -- they're not allowed to stimulate themselves. We don't ask them to do that. That would make the test invalid.

Q. So, I think you started to allude to this.

So who, who's in the room with the subject?

A. When they are taking the test, nobody is in the room with them. They're in the room by themselves.

Q. Does the subject or the respondent in this case have to do anything other than put the gauge on their, on their penis?

A. They have to watch the instructional video. They have to sign the consent form. They have to measure themselves. They have to try to sit still during the two and a half minute trials. Each trial, they're also trying to remain still. They have to rate the -- they do a self-rating, so how aroused or how disgusted they felt,

and they have to indicate on the key pad when it became sexual or violence.

Q. Now, is -- the PPG, is it used for sexually violent predator treatment?

A. Yes.

Q. What states currently use it?

A. So I know a number of the states that purchased the Limestone system specifically. I don't know all states that use -- there's, there's other manufacturers of PPG.

But, for Limestone, Minnesota SVP programs uses it. Missouri, Illinois, South Carolina has a PPG that they have used at least in the past for treatment. But I don't know if they currently use it for treatment. California uses PPG in their SVP program. So many -- New York. Many states' SVP programs use PPG for treatment.

Q. So it's not isolated just to South Carolina?

A. No.

Q. Is the test used in other countries?

A. Yes.

Q. Where is it used?

A. We published a paper in Behavioral Sciences and the Law where we compared the, the acceptance of the Courts in the use of PPG in the courts in the U.K. and Canada and the U.S. There are a lot of researchers in like Czech Republic that use it. So -- but I don't know about their

courts and I don't know -- I know there's a lot of research previously that was coming out of Russia looking at PPG as well. But I don't know if those courts accept it. But it's used widely in the U.K. and Canada.

Q. You know, we talked a little bit about false positives and, and I understand that you re -- you use a, a conservative number.

But how do you, how do you interpret a false positive?

A. I'm, I'm not sure what the --.

Q. Well, I mean if, hypothetically, if, if somebody is squirming in the chair and, and has an unusual number, I mean how are you able to interpret that you've got a reliable result?

A. Well, that is the reason that we use the countermeasures to see if they're squirming in the chair. So, if somebody has like a huge millimeter of change, and I seen all this movement data, that's not physiological arousal. That's movement.

Q. On -- did you have the opportunity to, to review the results of Mr. Sharp's PPG?

A. Yes, I did the interpretation.

Q. Okay. And did he squirm in the chair or try to create a false positive?

A. I did note that he had -- I, I don't know if it was

movement and breathing irregularities. But there was some evidence that he may have been trying to dissimulate or purposely manipulate the results of the test.

Q. Doctor Gottfried, do you use polygraphs?

A. I don't.

Q. Why not?

A. So before I became the director of the sexual behaviors clinic and lab at MUSC, that lab was using polygraph. Some evaluators used polygraphs. Sometimes they use it for treatment.

I have a lot of issues using polygraph especially for an SVP case. So, under -- they're many reasons. But the -- I, I guess one of the legal ones is there's no unique physiological indicator of deception.

So, you know, on a polygraph, they're looking at your breathing. They're looking at your heart rate. They're looking at like your skin conductives. But none of those are only saying that somebody's being deceptive.

And so I think the literature suggests, for a polygraph, we don't actually know what we're measuring. Like are we measuring that someone's lying or we're measuring that somebody is fearful. You would have very similar physiological reactions.

And so, because there's no independent, unique indicator of deception, I, I don't think that the

polygraph is useful.
Q. Okay. What is ATSA, A-T-S-A?
A. ATSA is this -- the Association for the Treatment and Prevention of Sexual Abuse. It's like the national, scientific, professional organization for individuals who do this kind of work.
Q. And are you a member?
A. I am.
Q. Do you hold any titles within?
A. I was elected to their board of directors. I think I'm on my second year of a three year term right now. So, I serve as the chair of the research committee and I'm a voting member on the board of directors for that organization.
Q. And what is ATSA's mission?
A. We're actually recreating our mission statement as we speak. But it's essentially like to create a world with no sexual harm, something in that vain.
Q. Can anybody join?
A. No.
Q. What does it take to join ATSA?
A. So, they have different like levels. So you could be a student. You could be -- they just added an affiliated category for like probation officers or attorneys. But if you are a clinical member, at least when I joined, I had

to get reference letters from other ATSA members. I had to submit the number of hours I had spent conducting sexual behavior evaluations for treatment. I had to submit all my licensing information. I had to attest that I wasn't, you know, under investigation by my licensing board or had been charged with a crime.

So they kind of verify all of that information, which is more extensive than some of the other professional organizations.

Q. So you don't just pay some dues and get in?

A. Correct.

Q. I'm showing you what's -- I think we're up to 10, judge?

THE COURT: Yes, sir.

(WHEREUPON, the ATSA practice guidelines was marked as State's Exhibit No. 10 for identification purposes only at this time.)

Q. What I've now marked as State's Exhibit 10.

Do you recognize that?

A. Yes.

Q. How do you recognize that?

A. So, the Association for the Treatment and Prevention of Sexual Abuse or ATSA publishes a number of practice guidelines. The one you handed me is a photocopy of the ATSA practice guidelines for the assessment, treatment,

and management of male, of male, adult sexual abusers. This was published in 2014.

The revision is being finalized and probably will come out late this year or early 2024. But this is the most recent published ATSA guidelines. So, they're, they're best practices.

Q. Thank you.

So, are you part of the group that has developed the best practices?

A. I am not part of the group who developed it. But as one of my duties as a board member, I review it and suggest -- I -- it's -- suggest extra research that they cite. I have to vote to approve the final draft. That's part of my duties as a voting member on the board.

Q. What does the best practices manual say about the PPG?

A. So, they describe different kind of tests that you could use in sexual behavior evaluations. They support the responsible use of PPG in the treatment and assessment of men who have sexual offenses. They describe, you know, ethical ways of administering and interpreting a PPG.

They caution that PPG should never be used as the sole data points for any decision but they kind of list each decision that it should not be used for. They note that it can be helpful in risk assessments. It could be

helpful for diagnosis, be helpful for planning treatment targets. So, they support the responsible use of penile plethysmography.

Q. And has the -- there been additional research on the PPG since 2019 in the meta study?

A. Yes, there's, there's been research on the PPG that comes out. I'd say at least a few times a month I get iCloud alerts and Google alert or some scholar telling me whenever a new article is published.

Q. And today, as a matter of fact, you presented me with a few articles.

Can you take a look at these articles and explain for the judge what they are?

A. Yes.

So these are the latest peer-reviewed publications using PPG. So, not necessarily about men convicted of sexual offenses but using it for -- across the spectrum of sexual behaviors. So, I think I gave you one -- six. I believe most of them were published in 2024. One or two may have been published at the end of 2023. But these look like the earlier articles.

Q. So, the PPG is, is actually being investigated, continuing to be investigated, even in the last couple of months?

A. Correct.

Q. And has it been consistently held to be reliable?
A. Yes. Not every article is specifically looking at reliability because it's been around for a long time. The reliability has been established. So, some of these articles are looking at something novel related to sexual arousal and they're using PPG as the gold standard to measure that.

MR. FISHER: I think we're up to 11, judge?

THE COURT: Yes, sir.

(WHEREUPON, the PPG articles reference page was marked as State's Exhibit No. 11 for identification purposes only at this time.)

MR. FISHER: And I would just ask that these be received as, as a composite so that -- thank you.

Based -- in your opinion, based on your knowledge, experience, and expertise in this field, is the PPG reliable?

A. Yes.
Q. How did you reach that conclusion?
A. I, I do my own research on the PPG and read all of the research that comes out on it. I consult with other people who do this work. I -- we believe in olvers (phonetic) in risk factors and what makes somebody more likely than not or at high risk to commit a new sexual offense and I know that being aroused by something other

than a consenting adult human is a risk factor for risk of recidivism for somebody who is already offended.

And so the PPG, to me, is the only way to validly assess what somebody's aroused by in an individual who's not going to be totally forthcoming about what they're actually aroused by.

Q. Is -- the PPG, is it generally accepted in the mental health community?

A. Yes.

Q. Within both precommitment and treatment of sex offenders?

A. I, I believe so. I mean it's, it's accepted insofar that it's regularly used in sexual medicine. SVP programs across the country use it as part of their treatment. People use it in evaluations. But the breakdown, I don't know that it's -- I'm not sure that it's been studied about, you know, the reviews versus the initial.

Q. Is the PPG generally accepted within the wider medical community?

A. Yes.

Q. In this case, was the PPG used on Mr. Sharp?

A. He was administered a PPG examination, yes.

Q. And did he sign the consent forms that we talked about before?

A. He did.

Q. And do you remember when Mr. Sharp's PPG examination was?
A. Based on my report, it's -- it was on March 6th of 2023.
Q. And did you get interpretable results?
A. Yes.
Q. What were those results?
A. He showed goodly significant sexual arousal to I believe two trials featuring consenting adult women, one trial featuring prepubescent children, and one trial featuring pubescent or adolescence (sic) girls. But there also was some evidence that he may have been trying to purposely manipulate the test results. But despite that, he still had those trials as being clinically significant.
Q. Now, you -- what was your ultimate diagnosis with Mr. Sharp?
A. Ultimately I diagnosed him with pedophilic disorder, exhibitionistic disorder, and an alcohol use disorder.
Q. Was the PPG the sole purpose, the sole tool used to diagnose him?
A. No.
Q. Was the PPG just one of several data points?
A. Yes, I would never diagnose somebody with anything based on the PPG alone.
Q. Why not?

A. Because you need a lot more context and also, in order to meet the criteria, they have to have acted on it or it hasn't, you know, caused harm to another person. So we, we know that there are people who have these disorders who have never acted on it.

And so I would never give someone a diagnosis based on one test that was administered on one day in my lab. So when I, when I work with attorneys, when I work with DSS, and I make sure that it's really clear that they know there's no test, there's nothing that's gonna tell us if this person ever committed this crime, if they ever would commit it, if they would ever do it again. It's just telling us about what they were aroused by on the day in the lab. So, it's just one, one data point.

So, for Mr. Sharp, I'm also looking at the officially reported offense behaviors and, you know, asking him about his sexual arousal history. I'm looking to see what victims say. I'm looking at medical records. I'm putting all of that together and not just looking at one test on one day.

Q. Well, in this case, in regard to Mr. Sharp, was, was the test helpful or a data point that you found helped reached the diagnosis?

A. It, it was helpful because it shows us what he was aroused by on that day and, on that day, it also included

prepubescent children, which was the stenth (phonetic) the da -- his history.

MR. FISHER: Judge, at this time I would move into evidence State's Exhibit 2 through 11 I believe is what it is.

THE COURT: It is.

MR. FISHER: And I have already offered the witness as an expert in PPG examinations and as a sexual violent predator precommitment evaluations.

THE COURT: All right. Any objection to the exhibits?

MR. WILSON: No, sir.

THE COURT: All right.

(WHEREUPON, State's Exhibit Nos. 2 through 11 were received into evidence at this time.)

THE COURT: All right. Let's do this. Let's take about a 10 minute afternoon break and we'll back, back and let you have the opportunity to cross-examine her.

MR. WILSON: Thank you, Your Honor.

THE COURT: Oh, yes, sir.

(WHEREUPON, a short recess was taken at this time.)

THE COURT: Yes, sir.

MR. WILSON: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WILSON:

Q. Now, doctor, let's try to get one thing clear from the outset here.

There is no question there are no universal standards for performing these PPG tests, are there?

A. Clinically universal standards?

Q. Universal meaning -- what's, what's -- let's not, let's not even do that.

In South Carolina, is there any universal standard for performing PPG tests?

A. There are the Limestone Administration Guidelines. I would say that those are standardized. Though somebody follows them, that would be standard.

Q. If, if, if they followed them, and we don't know that they do or don't, right, because you don't have any control over that, right, of what other doctors in this state do or psychiatrists do in this state about the PPG -- PPG test and how they perform that test?

You have no control over that, do you?

A. That would be correct.

Q. All right.

A. I don't.

Q. And there are absolutely no written -- I don't want to say guidelines cause that's, that's too general. There are no -- well, let me put it that way.

There are no guidelines that are universally accepted

by the, the doctors or psychiatrists or psychologists in -- even in South Carolina, correct?
A. Guidelines for --?
Q. For administering the PPG test.
A. I'm not sure. So, not every -- I mean I guess you'd have to back up and first says there's no---
Q. Were you---
A. ---standards or guidelines for doing sexual behavior evaluations in South Carolina.
Q. Right.
Is it?
A. There are none.
Q. No.
And, and so we start out with the premise that there is no universally accepted method of performing these tests, right?
A. Correct.
Q. All right. So we've established that.
Now, let's talk about the reliability of what you are doing.
Now, you would agree with me, would you not, that sexual arousal is a mental issue or a factor, right?
At least in part, right?
A. I'm, I'm not sure what you mean.
Q. What I'm asking you is, when you're trying to

determine if a male is, is sexually aroused, that could be something mental from him, right?

Something he is thinking or seeing that would cause him to be aroused, right?

A. Yeah, I, I think if you go back to like the seminal text by Masters and Johnson from the '60s, they have a quote, "the best thing to tell like what a man is aroused by or what's going on with a man is to see what his penis is doing."

Q. Well, the penis shows the result but it doesn't show what caused the, the, the reaction, right?

Because -- let, let me help you with that.

You show some pictures to an individual, right, who you're doing the PPG test with?

And I say you, one or your assistants or whoever shows that person some pictures, right, and they look at those pictures, right?

And then you, judging or trying or at least attempted to judge their reaction to what you think they're looking at, which is the pictures that you put in front of them, right?

A. No, it -- the audio. It's what they're listening to.

Q. Well, I say audio --

A. Yes.

Q. -- right?

But what you don't know and what you can't test is what's going on in their head and what they're actually thinking, can you?
A. There is no test that would help you---
Q. That's right?
A. ---with what somebody's thinking.
Q. That's right. There is no test that can do that.
So, if you show me a picture, you show me a picture of a man but I'm thinking about some beautiful woman that I was with a week ago, then I'm (sic) might get aroused even though you're showing me a picture of a man, right?
That's possible, right?
A. Well, I'm not showing you -- it's -- I'm not looking at your arousal to pictures.
Q. No.
A. I'm giving you multiple trials. So, if you'd only shown arousal to that man and nothing else, that might suggest that you're aroused by that man.
Q. My point is simply this.
You can't tell us -- you can not tell us that, when I look at that picture, that I'm not thinking about something else which causes me to be aroused, can you?
A. Well, we try to mitigate that by having the person describe what they're hearing, having them press the button when it becomes sexual or violence. So that's

we're ensuring -- trying to ensure that they're paying attention. Those are the reasons for that.

Q. I'm gonna ask the question again.

Can you tell me, within that degree of medical certainty or psychiatric certainty or whatever the, the field is that you claim that we're dealing with here, that, that what I'm thinking about is what you just showed me?

A. Well, I, I, I guess not. I'm not---

Q. No.

A. I'm not sure.

Q. Cause you can't determine what I'm thinking. You can determine what you show me and you can measure what's going on with me is what you're saying. But you can't tell what it is that I'm thinking.

So, how do you know -- how can you -- how can we be certain that the measurement that you come up with is not a false result?

A. Well, that's one of the reasons that you would never use PPG data in isolation. You're gonna use it with the context of the offense characteristics. You're going to use it with the -- examine witness statements. But, no, I, I can't read your brain. So it wouldn't --

Q. Right?

A. -- wouldn't be able to do that.

Q. Right. That's exactly right and, and, and let's talk now about the, the, the, the, the test itself.

Okay. I think when the attorney general was asking you some questions he was asking you whether or not -- and I think your statement was oh, no, the test is not invasive and -- but it is, isn't it?

Isn't this test invasive, personally invasive, with whoever you're using the test with?

A. I personally don't think it's invasive.

Q. All right. You don't think it's invasive to be sitting nude in a room being videotaped with something wrapped around your genitals so somebody else can monitor you and you're say -- would, would that be invasive to you if, if that was ordered for you?

A. None of that is happening during a PPG.

Q. Did not you tell the attorney general on direct examination that what you do is a person is put in a room. The person has to sit in a chair. Once they sit in the chair, then that some thing is wrapped around their private parts, and once it's wrapped around their private parts, you -- there's a video going on where you see part of what's going on?

Is that not what you said?

A. So they're not sitting naked. Nothing is wrapped around their penis.

Q. Well, the penis has to be exposed in order for you to wrap or him or whoever it is to wrap something around it, right?
A. It -- nothing is wrapped around. It's a gauge. So, it's a stretchy gauge that's placed over it by the examinee.
Q. Okay. So---
A. They are covered up. Typically they're wearing their jumpsuit.
Q. So, we're saying placed over it as opposed to wrapped around it?
So that's the, that's the -- the difference is that it's placed over it. It's not wrapped around it.
A. Right. Nothing is wrapped around.
Q. All right.
A. You're not sitting nude.
Q. Well, let's talk about that.
A. Only their face is being monitored by a video camera.
Q. How, how in the world, if it's only laying across it, can you measure the circumference of it when it's only laying across it if it's not wrapped around it because the whole idea of circumference is a circle, right?
A. Right. So it's---
Q. And you---
A. It's a stretchy gauge. So, it's not wrapped around.

It's placed over kind of like a hairband. So it would just go over it just like that.
Q. Okay. Well -- and now I'm confused because my understanding is that you're trying to measure the circumference of the penis to measure the blood flow that comes through so that you could determine whether or not it increases or decreases or stays the same.
Right?
A. Yes.
Q. And you gonna put -- and you say a hairband.
Well, a hairband normally are round, right?
A. Well, that -- that's what I'm demonstrating.
Q. Yeah.
A. So it's not wrapped around it. It's placed around the penis.
Q. Well, we're arguing semantics now because we're not---
THE COURT: I've got, I've got the semantics of it.
MR. WILSON: Right.
You're, you're, you're -- the, the bottom line is it goes around a penis and the, the idea is for it to measure the blood flow, right?
A. Correct. It's taking continuous---
Q. Yeah.
A. ---measurements.

Q. Yeah.
And, and it's gonna take measurements of the blood flow.
Now, there's another problem that we've got and that is -- and you testified earlier that, as I understand it, some, some countries, I think you said Canada, they use 1-millimeter, right?
A. Some labs.
Q. Some labs, right.
And then you use 5-millimeters I think you said?
A. That's correct.
Q. All right. And then does other people use 10-millimeters, right?
A. I doubt it.
Q. Okay. Eight?
A. Five is the most conservative that I've heard.
Q. Five is the most conservative.
All right. And, if so, if the test is accurate, why not use one?
A. It has nothing to do with accuracy.
So, if you think about a test that would be positive or negative---
Q. Yeah.
A. ---you're talking about sensitivity and specificity.
And so that is determining how accurate the test is.

What you say is a positive or a negative result depends on where you cut a test. The same with an HIV test. The same with a blood pressure cuff. All tests have specificity and sensitivity.

Q. Okay. But my point is this.

A. Okay.

Q. My point is if the test -- if you're using five, Canada's using one, and if all of you are accurate, that is -- if, if one is the same as five, why not use one or why not use three?

Why use five?

A. One is not the same as five or three.

Q. Well, I understand that. I agree with you. It's not and that's my whole point.

There's that inconsistency in one person -- one of you are saying okay, well, if it shows one, then we got him and, and that person must be a pedophile or at least he is in that category. You're saying well, no, you got to get to five before I think that you're considered a pedophile.

All right. So, if there's an inconsistency in the profession about---

MR. FISHER: Judge, I've got to object. This is a compound question and it's a narrative.

MR. WILSON: It is but she's an expert.

THE COURT: Remember you're not talking to the jury. You're talking to me and I know you're, you're trying to make a record. But let's keep, let's keep the questions short and sweet.

Q. All right. So, what's your answer to that?

A. I'm not sure I know which question.

Q. Okay. All right. Thank you, ma'am.

Let's see. Let's move on.

And let, let me ask you, ma'am, my understanding is, is that you said that you'd ordered 100 of these PPG tests.

Over what period of time would, would that have been?

A. I'd say it's 2015 or 2016.

Q. Okay.

A. Eleven years.

Q. Ten a year cause you said nine years. So, that'd be ten a year thereabouts.

A. No, I, I do much more sexual behavior evaluations in the last I'd say three or four years than nine years ago.

Q. Well, I'm saying, on average, it's, it's been 10 a year.

But you've done more in the last few years than you did earlier is what you're saying?

A. Yes.

Q. Okay. And, and, and -- now, you said I think that

the attorney general asked you something about whether or not there are any states that actually allows the PPG for treatment purposes. I think that was his question.

If I'm incorrect, you can correct me.

A. Well, I, I don't think it's up to -- my understanding that would be up to a state if they allow PPGs to be used for treatment. I don't -- I think -- guess it would depend if it was like an agency that the state had oversight of.

Q. Okay. And, and so -- so, this PPG test -- and, and you said -- I think you said California, Illinois, Missouri I think were the states that you named, right?

A. I think you're -- it was two different questions. One was about the number of SVP programs that I knew of in the country that used PPG and then we also were discussing Missouri and Illinois and Minnesota that they have the same PPG hardware and software that we use.

Q. Okay.

A. But I think the most --.

Q. So, you're, you're not talking about courts. You're talking about doctors or hospitals or, or psychiatric units that -- is that what you're talking about?

A. That was specifically about sexually violent predator treatment programs---

Q. Okay.

A. ---across the 19 U.S. states plus defense (phonetic), plus Washington D.C. that have some iteration of a sexually violent predator act.
Q. Okay. Do you know of any state supreme court in any state, any of the 50 states, that have allowed PPG to be administered or to be testified to in court and I said specifically any Supreme Court of any state in the United States?
Any one?
A. Well, I'm, I'm not an attorney but I do read the case law.
Q. Okay.
A. I'd have to look at an article that we published in 2019 --
Q. Okay.
A. -- cause I think that there is -- in Washington State there are a lot of PPG cases. But I'm, I'm not a lawyer and I don't want to testify that---
Q. All right.
A. ---that happened in Washington. So, maybe I'll say, I'll say no, I'm not aware---
Q. Okay.
A. ---of Supreme Courts.
Q. All right. Now, you also said that you were working on a committee or on a -- I forgot what you called it.

But you were working with some group and y'all were trying to get standards for PPG, right?

You're trying to -- you were -- said that you were on the board of some commission or committee that was studying this?

A. So, I think you're talking about the international standardization group. But then the board I am talking about is ATSA.

Q. Okay.

A. So, the probably standardization group we don't have a board.

Q. Okay.

A. I'm on the board of ATSA.

Q. So with ATSA.

Is that the one that you -- that -- that's the group that's trying to standardize?

A. No, that's the international PPG standardization group.

Q. Okay. All right. So -- but you have not yet been able to do that?

A. We've had a number of meetings. We had an international meeting. We've been working on it. But we haven't -- yeah, we -- it's not done. We're still working on it.

Q. Okay. All right. Now, let me think -- get back to,

to -- to the issue about the invasiveness of, of this process.

My understanding is, is that, when -- and, and I'll specifically use this, this young man.

When he was sent there, he was sent by Court order, right, to you by an order from a Court?

A. I get a letter from the AG's office. I know they file something that they are exercising their ability to hire an independent expert. But I don't have an order from the Court telling me---

Q. Okay.

A. ---to do the evaluation.

Q. All right. So you, you weren't aware that there's a Court order allowing you to do this, right?

A. I know that there's an order for the initial evaluation.

Q. Okay.

A. I'm not aware that the Court then does a separate order from my -- for them specifically to get another evaluation.

Q. Well, you're aware of how the process works that if, if DMH determines that you're not a pedophile, and that then the State, if, if it's in favor of the defendant, then the State has the option, if they want to, to exercise to get a second opinion and that that's---

A. It's my understanding that either side has that right.
Q. Right. That's right.
And you were their choice for a second opinion under that same order?
A. Yeah.
Q. You understand that, right?
A. I believe so. I, I know---
Q. Sure.
A. ---that they got a second opinion.
Q. Okay. And -- well, you've been doing this for a long time now.
How many -- you've said you've been doing this for at least nine years.
So you're familiar with the process that we're going through here, right?
A. I believe so.
Q. Okay. And you've testified in other cases just as you're testifying here, right?
A. Yes.
Q. Yeah.
So, so, my point was the committee or the group or the organization, whatever it was, that you are a part of who was trying to come up with some standards for, for administering the PPG is -- has not yet been able to

conclude that.

Fair?

A. I wouldn't say that we haven't been able to. It's that we haven't finished them.

Q. All right. Well, you haven't finished them.

So it's a work in progress?

A. Correct.

Q. All right. And we don't have any idea as to when that work will end and that progress will be completed?

A. There's a lot of people on the standardization. I don't know the exact timeline. We are -- we have been working on it.

Q. And there in lies a part of the problem, right?

They're a lot of people on there they have different ideas and all this information has to be processed through all these people who are part of this decision making process in order to try to reach some standardization, right?

A. To do with the international guidelines --

Q. Okay.

A. -- and, yes, there would need to be a consensus.

Q. Now, let me go back cause I, I, I started down this and, and, and then I got sidetracked and I apologize. I was asking you about the invasiveness of the process, and, as I understand it, the, the, the respondent was sent to

you by Court order.

All right. Is that fair?

A. Well---

Q. He didn't come there voluntarily?

A. He did not come -- he did not decide to come.

Q. No question about that.

And once he was there, you had him sign some kind of a form or consent form, right?

A. Every examinee goes through the consent form. It takes 45 minutes to an hour for a sender there to go over the consent form with them.

Q. Why -- what is the purpose of the consent form if he is Court ordered to come to you in the first instance?

A. Well, I don't have the Court order. Like if I had one, then that would be okay in my ethics to, you know, not require informed consent. But it's ethical for me to inform an examinee of all the different tests and procedures and give him an opportunity to speak with his attorney if he wants to.

And then -- I mean even if it is Court ordered, I think if it weren't Court ordered, I mean I, I tell all the examinees you can say you don't want to do this. I'm not gonna hold you down and make you do this test. I am going to let the AG's office know or -- and they'll let the Court know.

But if somebody says they don't want to do something, and they don't consent to it, I -- I'm not going to hold them down and make them do it.

Q. Sure. Fair enough.

So tell me what this consent form says.

What does this consent form that you have them sign, what does it say, and, and you can just summarize it. I don't need you to go into every word or detail. But --.

A. So, it's a six to seven page document. It tells them the type of evaluation, the purpose of the evaluation, who will receive the evaluation, the limits to confidentiality.

It informs them about HIPAA not applying. It informs them that they won't receive any treatment while they're here. It goes through the Abel Assessments, which I don't give, but it's still on the consent form. It goes through questionnaires, clinical interviews, PPG, photo vaginal plethysmography, the Abel Assessment.

It talks about how there's security cameras in the room. It talks about how MUSC is a training, educational facility so that trainees or students might observe parts of their evaluation. It goes through how they have the right to, even if they've signed a consent form, prior to the completion of any given assessment or test, they can withdraw their consent for that test or assessment for the

entire evaluation. It talks about bathroom breaks. It, it -- yeah, it's, it's a very long---
Q. Okay.
A. ---cause it goes through---
Q. And, and, and---
A. ---different scenarios.
Q. And this is all done prior to administering the -- actually the test itself?
A. So the -- that consent form is administered the morning of the first evaluation date and then every subsequent appointment. So they usually come for three days.

Every subsequent date they're given that consent form again, given an opportunity to review the entire thing. Then they are given our complication evaluation consent form, the rereading form, where they're again consenting to that.
Q. So, you tell them upfront and have them sign a consent agreement that they're gonna be videotaped, right?
A. Yes.
Q. While they're undergoing this test --
A. It -- I don't think it's---
Q. -- or being administered?
A. ---specific to that test because they -- we have a security camera in every single room.

Q. Yeah, I understand.

But not -- in every single room you don't have the person exposing their private parts. So -- and you're saying that not only do you get a chance to look at it if you want to, the person who's administering gets a chance to look at it.

And if they're students involved, then they get a chance to look at it too or could possibly---

A. Look---

Q. ---get a chance---

A. Look at---

Q. ---to look at it---

A. Look at what?

Q. ---as well, right?

A. What are you referring to?

Q. I'm talking about the administration of a test with the video cameras that you say are placed in every room.

A. Right.

So every, every office, every testing room at MUSC at forensic psychiatrist has cameras. For -- so there's any consent form that -- any place they're going to be they are going to be on camera.

For the PPG, on the examination checklist, the -- there's instructions. So the tech has a cover for the camera. The, the tech covers the camera while they're

measuring themselves. Then the person calls the tech back in over the intercom.

So, I mean we have things around that -- it isn't like they're standing naked in front of the camera.

Q. Okay. Is there, is there any -- is there any clinical significance -- let's say if you administered your test and it says four instead of 5-millimeters, would that be clinically significant?

A. That trial that did not exceed 5-millimeters of change would not be clinically significant.

Q. All right. So, anything from five below, meaning five to back to one, would be -- would not be clinically -- well, four back to one would not be clinically significant?

A. 4.99 and below would not be clinically significant.

Q. And, and who makes the -- who makes the decision?

Who makes the judgment call as to whether or not the standard should be four or five or one?

Who makes that decision?

A. I, I make---

Q. You.

A. ---that decision.

Q. All right.

A. That's how we do it---

Q. All right.

A. ---in my lab because the literature suggests that anything less than 10 percent of a full erection wouldn't be clinically significant. That's two and a half. Because of the nature of the evaluations that I do, I use five. Double that.
Q. Well, you, you said something earlier about BlueCross and BlueShield using or allowing or agreeing to pay for these kind of tests, right?
A. I, I, I think what I said is that form like referred the person who was insured back to their coverage for impotence treatments.
Q. Yeah. And, and, and let's be fair here.
That whole idea that BlueCross is using was for people who were impotent. Men who were impotent were using that in order to try to get insurance coverage so that they could get Viagra or whatever else they were trying to get for some kind of medical treatment.
This was not to determine if that they were a pedophile, right?
A. So, a PPG's not gonna determine if somebody has pedophilic disorder, first of all. Insurance companies don't pay for forensic evaluations. And so -- and typically we're not gonna use a PPG for Viagra prescriptions.
But if somebody was being considered for an implant,

that, that might be a reason or if somebody -- if they really can't determine the ideology for the impotence, that would be a good reason for -- to administer a PPG while --.

Q. Yeah.

Well, my point was -- is simply this. The, the, the purpose of BlueCross wasn't to, to pay for PPG tests so that it could be determined whether or not some person may or may not be a pedophile.

That, that was not the purpose, right?

A. I don't think they pay for it that often. I think it was just that they recognized it as a medical device.

Q. Okay. All right. You were asked if a person could manipulate the test.

That is, if the defendant or respondent or the person taking the test could manipulate the test and, and that is possible, right?

A. Most tests -- you can dissimulate on most tests.

Q. And, and we talked about this earlier.

You can do it mentally, right, to get around what you're tying to do?

A. We do know that people will try to get -- engage in mental---

Q. Yeah.

A. ---suppression, which is why we use those cognitive

tests.
Q. Okay. You -- in, in your conversations with the solicitor, you made a distinction between your use of, of PPG and, and the polygraph exam. Is that -- so, let's explore that for a minute.
Now, the polygraph exam also measures audible reactions, let me put it that way, right?
It measure your heart rate, your pulse, your sweat, that kind of thing, right?
A. That's my understanding.
Q. Okay. And, and your, your test measures blood flow?
A. It measures an erection.
Q. Well -- and that's from blood flow, right?
What else happens -- what else happens, physiologic -- physiologically to a man other than blood flows and it gets stronger and, and more intense?
It's from the blood flow, right?
A. What else happens when someone is aroused?
Q. No. No.
What I'm asking you is it's the blood flow that causes the erection, right?
The arousal -- whatever the stimuli might be. I'm -- I -- I'm not even interested in that.
My point is simply that blood flow is what causes the penis to swell. Let me put it that way to be bold.

A. Yeah.
So, an erection is when the, the penis becomes too massive --
Q. Right.
A. -- and that is because of increased blood flow.
Q. Okay. So, like the polygraph, it's measuring some bodily function, right?
A. Well, no. So I mean it, it measures your breathing like the polygraph does. But it's not saying that breathing is related to arousal.
Q. No, I'm---
A. Blood flow to the penis, an erection, is related to arousal.
Q. I see.
A. Sweating doesn't necessarily mean you're lying.
Q. I understand that.
And, and, and being aroused doesn't necessarily mean that you're aroused by whatever it is you're showing the person?
A. Being aroused -- I'm, I'm not sure I'm following your question.
Q. Well, I'll try to help you if I can.
Okay. And we had this conversation earlier.
If you show me a picture of some gorgeous woman and nothing happens, and then I -- you show me a picture of a

man and I get to your 5-millimeters, so now you're saying is -- your theory then is that I must be interested in men, right?

A. No. My theory would be that you demonstrated clinically significant sexual arousal to one trial.

Q. To one trial?

A. Right.

Q. So now let's talk about in you -- in this case.

You did four trials, right?

A. Oh no.

Q. On the PPG?

A. He had two sets that had multiple trials. Lots of trials.

Q. Okay. Four sets.

A. Lots of trials.

Q. All right. He had two sets of four trials, right?

A. No, he had maybe 25 trials, 15 trials.

Q. Well, I thought you said that there were four -- if I remember correctly, you said that there were four. Two were of -- two of the trials -- two of the sets were of adult females, right?

Is that fair?

A. No.

So he -- it was probably more like 10 consenting adult women. What I said was he showed clinically

significant sexual arousal to four of the trials.
Q. Okay. And two of those were adult women?
A. Correct.
Q. All right. And, and one was for a prepubescent female?
A. Correct.
Q. All right. And, and what was the other?
A. Pubescent girl.
Q. All right. So, one for pre and one for pubescent?
A. Correct.
Q. Okay. And two for adult females?
A. Consenting adult women, yes.
Q. Consenting adult women.
All right. All right. So -- and, and the distinction that you're making is, is that so it's okay to be interested in the female, the adult females, right?
But then their issue would be if you show any interest in the, the prepubescent and the pubescent females?
A. Right.
So, I think some examinees think that if they don't show any results at all that's a good PPG. The best PPG is when -- a healthy PPG is one where someone shows clinically significant sexual arousal with consenting adults and nothing else.

So it could be adult men. It could be adult women but consenting adults.

So, I diagnosed Mr. Sharp with pedophilic disorder nonexclusive type because he is also appropriately sexually aroused and attracted to, to adults as well. Not just exclusively to children.

Q. Okay. So, he's adult -- he's attracted, in your opinion, then to any female, adult or young?

A. No, I think specifically prepubescent children, female children, as, as well as the -- as adult women.

Q. Well, well, well, I'm confused.

Then, then why is that when, in fact, you say that the -- his score was -- what was his score on, on the adult females?

A. I don't give a score. He shows clinically significant sexual arousal in two trials.

Q. Just hold on one sec. Let me find it for you.

Your cut score for him -- and I said score and I apologize.

Your cut score was 5 -- .5-millimeters, right?

A. No, the, the clinically significant cut score for all PPGs at MUSC is 5-millimeters.

Q. Five milli -- 5-millimeters.

Okay. And, and so now, Doctor Burke, is that the person that created the test that you're using now?

A. Doctor Burke, along with another person, made the Real Child Voices stimuli set.
Q. Okay. So, what was his, what was his cut score that he used?
A. He didn't do a PPG in this case.
Q. No, not in this case.
I'm asking you what was his standard cut score that he used in these kinds of cases?
A. I have not done a case with him. I believe that he uses 4.7 millimeters of change. But I -- I've not done a -- we don't do cases together. We refer each other cases. But not like this -- the same case.
Q. Okay. All right. Now, in interpreting, in interpreting when you get -- let's say you get a .5-millimeter or I'm sorry. I keep saying .5-millimeter.
Five millimeter cut score, who interprets what that means?
You?
Is that right?
A. What do you mean who interprets what that means?
Q. Who, who makes the determination as to what that 5-millimeter cut score represents?
A. In my lab, five is what we have identified as the cut score.
Q. Okay. But you could of just as easily done four,

right?
A. I, I wouldn't do four.
Q. No, I'm not saying you wouldn't but you could.
You could of set your standard at four if you had decided to do that, right?
The---
A. I really---
Q. My point simply is, doctor, is it's subjective, right?
It's subjective. What the score is set is is subjective based on your understanding, your knowledge, and your experience.
A. So, the cut score but not the score itself. So, the score itself is produced by the computer. Anywhere you go, regardless of what the cut score is, his level of arousal is not going to change.
Q. Well, we've talked about that and I agree with you. The, the level of arousal though is totally dependent on or at least what would -- what -- what's causing the arousal, what stimuli is causing the arousal, and, and as to how they get to five.
But my point that is the, the setting of the, of the cut score, whether it's five, four, nine, three, whatever, is totally subjective.
It's totally up to the psychiatrist or the doctor to

come up with a number that he or she is comfortable with?
A. Yeah, I mean that could be based on your training and your education and your understanding of human sexuality. But yeah. Based on your expertise that would be appropriate---
Q. Okay.
A. ---to set---
Q. Right.
A. ---that score for, for most tests.
Q. Right.
You, you also said to the solicitor -- to the attorney general, that you would never use the PPG alone, right?
A. Correct.
Q. And what is your basis for that?
Why, why would you not use it?
If it's accurate and reliable, why not use it every single time?
A. I use it every single time. I would never do any test in isolation.
Q. Yeah.
But I'm -- my point is if it's, if it's as reliable as you want us to believe, why not use it and use it only?
Just hook them up to the machine, wrap it around, and whatever the number is, then you got it, right?

Why not?

If it's that reliable, why not do that?

A. Because I use the PPG to help me formulate diagnoses. That doesn't tell me anything about the person's likelihood to go on to reoffend not directly. So, if it was just based on that one number, first of all, that would be unethical. But, second of all, it would never just be based on -- no one's asking me just about the PPG score.

Q. Actually -- I, I just got a couple more questions.

Let me ask you is there any published research, research studies showing the real child or I guess you call it the RCV, the, the Real Child Voices, is reliable and valid stimulus set for the PPG?

A. Yes.

Q. All right. Tell me about it.

A. So---

Q. And if you, if you -- let me -- before you go -- explain to you -- I didn't ask you if there were any articles.

What I asked you -- my question is are there any published research studies?

A. Well, what's the difference between research and a published article?

Q. Well, articles can be anything. I can write an

article sitting here at my desk. That's not, that's not research. I mean and I can write anything or I can put it -- you know, write it on a piece of paper and say oh, yeah, I talked about this, that at such and such a place. That's not what I'm asking you.

What I'm asking you is to tell me any published studies that were done which would use different groups?

A. Right.

So just to be clear though, when I talk about articles---

Q. Yes.

A. ---I'm talking about scholarly, researched publications that have been peer-reviewed. Like we're talking about the same thing. I say an article not -- whether you say an article --

Q. Okay.

A. -- but journal---

Q. So, so---

A. ---scholarly articles.

Q. So, tell me about -- tell me about the published research studies that, that, that you have that shows Real Child Voices is reliable and valid.

A. I think I have a sheet of those references.

While I'm looking for that, so conference presentations are also peer-reviewed, scientifically

peer-reviewed. They're not---
Q. Well, comfortable---
A. ---under---
Q. Hold on.
THE COURT: Let her answer.
Keep going.
A. There have been multiple conference presentations at scientific conferences by my group, by groups in Canada, by groups in the U.K. looking at the reliability of the Real Child Voices. But I want to find my -- hold on one second. I have to find my list of --.
(Pause.)
A. The, the Real Child Voice is one.
There was -- okay. There was an article in 2021 in the Journal of Sex Offenders Identification Risk Assessment, Treatment, and Legal Issues where they described some of the RCV studies. They described the analysis for interpreting PPG data using the Real Child Voices and using Z scores or standardized scores as well as creating index scores where you're comparing to arousal.
In a journal called International Review of Psychiatry that was published in 2019, they described how the RCV stimuli were developed and how to use it to measure problematic sexual interests.

In Current Psychiatry Reports in 2015, there was an article looking specifically at Limestone Technologies and the Real Child Voices sets and how that was developed and like standardized when they created it.

And then, for the conference presentations, most often it's comparing Canada's image -- they call it the sexual behavior clinic standard set. So those are the images of the nude children and they find that the RCV is as reliable or more reliable than using the posed pictures.

Q. You're finished?

A. Yes.

Q. Okay. Now I will ask my question again, and when I say research, what that means is -- research studies are studies that are done and then published in major publications like the American Psychiatric Journal or the Harvard Medical Journal or anything like that.

Okay. But what you're telling is that you went to some conferences and somebody at a conference wrote an article and they submitted it and nobody said anything about it. So, therefore, it becomes -- that's a peer-reviewed?

Is that your point?

A. No, like I didn't say any of that.

Q. I'm sorry.

A. So, I, I read you all the titles of those journals.
Q. Okay.
A. They would be comparable to ones that you just asked about.
Q. How many, how many individuals, in, in, in, in, in the articles that you're talking about, how many individuals were participants in the study that you did -- that you're saying was done?
How many?
A. Across the various studies?
I mean---
Q. Pick anyone you want.
If---
A. It, it ranges. A couple hundred to -- I might say a hundred to a couple hundred across the studies.
Q. Okay. And the -- and you conducted the PPG on each of those individuals, right?
A. Not personally, no.
Q. You didn't?
A. Well, I didn't write most of those articles that I'm referring to.
Q. Well---
A. These are the ones---
Q. ---let's, let's---
A. ---that appear in journals.

Q. Let's talk about the ones that you wrote.

Okay. How many different groups did you use in your studies in order to try and improve the reliability of your tests?

Did you use, for instance, men who are known sexual offenders, men who are -- have no criminal history of being sex offenders, and then I want you to answer -- well, let me stop there for a minute because I have another question after that. But -- so let's just talk about that first.

A. So, on PPG studies that I conduct when I'm using my own data, I only use clinical data. So there are data that were collected through the clinical or forensic evaluations that they signed consent form to have their data used for future research.

Q. And so what you're telling me is that you did not conduct a live study where you used individuals -- both individuals who were -- have known criminal histories say for being violent offenders, sexually violent offenders, and then people who have zero criminal record and no indication that they're -- have any violent predatory tendencies?

You didn't do a study like that to determine whether or not the test works on both sets or just on people who are accused of having sexual violent tendencies?

A. Personally I have not conducted that study. I don't have funds to pay somebody to take a PPG that are pay research participants.
Q. Okay.
A. When they were standardizing Real Child Voices, they did do that. They had a super normal group. There are a lot of PPG studies like the big meta-analysis from Ian McPhail in 2019 where he had really large groups of men that offended against children, offended against no one, offended against adults only to look at the discriminative ability, ability of PPG.
Q. And when was that?
A. That meta-analysis was published in I believe 2019.
Q. And now -- so explain to me then what the McPhail meta-analysis is.
What is that?
What is it?
A. What is a meta-analysis?
Q. What is the -- isn't it Mc -- the McPhail meta-analysis?
A. Well, Ian McPhail---
Q. He's the creator, right?
A. He's the lead author. They're multiple people---
Q. All right.
A. ---on this. He's a researcher in Canada --

Q. Okay.
A. -- and he conducted a meta-analysis --
Q. All right.
A. -- of all the PPG studies relevant to discriminate -- discrimination, sexual interests in children.
Q. Did any of them real -- use this same measure that we're talking about, which is the RCV?
A. They don't list the -- what sets or which trials they did in the method section. It only describes what it means by there is a child group, an adult group, pedo-hebephilia group, which was when they just use the word child and not prepubescent. But it doesn't talk about the specific stimuli.

So, there are various sets. Some of them could have or likely were the Real Child Voices. But he doesn't go through and list what each study used to test that.

MR. WILSON: All right. And, and, and then I'm just -- I'm about there, judge. I apologize. I know it's -- let me ask you, you, you said that when the person is in the chair and they're -- and, and the test is being administered, they're being videotaped, but they can't touch themselves, and they can't move, right, or at least can't sneeze?

They can't move because that might affect the, the, the validity of the test?

A. Well, we can't prevent someone from sneezing. We tell them to try to last for two and a half minutes, try to remain -- like, you know, if, if the tech sees them squirming in the chair, it's like hey, remember kind of try to be still. But like I don't think you can prevent someone in the seat from moving.
Q. Well, let me, let me ask you this too cause this is one of those questions that -- and, and this is just dumb me asking.
A lot of times, with men especially, if you got to go to the bathroom, you got to urinate, you will get kind of a semi-erection.
A. Uh-huh. (Affirmative).
Q. Does that figure into what you do?
A. Well, they use the restroom beforehand. They are instructed -- I mean if they need to go to the restroom, they can use the restroom.
No, it doesn't figure in. I mean we're -- if somebody has any erection or two messings (phonetic), before the next trial can start, there has to be D two messings (phonetic).
Q. Well, how do you---
A. But if it wouldn't go down, then I guess the tech could ask them to go to the restroom.
Q. How do you know?

How do you know that the person doesn't have to go to the restroom or that he's not getting to that point where he may have to go prior to having the, the, the blood flow more into his, his, his penis?

I hate using these words and I --.

A. I, I have no idea.

Q. -- that I'm uncomfortable with.

All right.

A. I have no idea, if he doesn't say he has to go to the restroom --

Q. Okay.

A. -- don't know.

Q. All right. Doctor, thank you so very much. Appreciate it.

REDIRECT EXAMINATION

BY MR. FISHER:

Q. Doctor---

THE COURT: Remember you're talk -- you're talking to me and not to a jury and I'm letting you know I've got it.

MR. FISHER: Okay.

THE COURT: Put what you want on the record but I've got it.

Q. Doctor Gottfried, is there any way to manipulate the raw data?

Once, once the Limestone Technology measures the

increase in the circumference of, of a penis, is it a -- is it the -- consistent over tests -- over multiple tests?
A. Yeah, I mean it spits out the number. I get it -- I print it on Excel sheets. I mean I guess you could cross it out and that would manipulate. But the computer is just telling you what the gauge is reading.
Q. And it -- and the gauge is giving you a number?
A. Correct.
Q. And you're trained by Limestone to interpret that number?
A. Correct. The set -- a set of numbers.
Q. How many times have you testified as an expert on the PPG in courts in the State of South Carolina?
A. Maybe 25 times. That's, that's a guess.
Q. Just to be clear, the PPG diagnoses what?
A. It doesn't -- I mean it doesn't diagnose anything.
Q. Correct.
It just -- it, it, it gives you a data point?
A. Correct.
Q. Is anybody videotaping a subject who's in the chair their private parts?
A. No.
Q. Is there a neutral stimulus?
A. Yes.
Q. What is it typically?

What is a neutral stimulus?
A. So there are multiple neutral ones nonsexual. So there's one describing a man buying a chair. There's one like he's going to a record store. I think there's another one like about going on a trip. So, that -- nothing sexual in those.
Q. Are you able to test and retest?
A. You could give somebody a PPG again, yes.
Q. And again --
A. Sure.
Q. -- and again and, ultimately, does that raw data keep changing?
A. Yeah, it -- it's going to change. It would be like if I measured your blood pressures now and tomorrow, right. So, if you run high, you're gonna run high. But if I give you where you get medication to lower your blood pressure, we're hoping we're gonna see that on the test. It's the same thing with why we would give multiple PPGs after treatment.
Q. Has the PPG been, been used to a reasonable degree of certainty in sexual violent predator cases?
Has the PPG been---
A. I don't---
Q. ---PPG been used as a data point to diagnose people with a sexual violent predator statute?

A. You had me up until the SVP. So, I just use it as a data point looking at a diagnosis because I know that those diagnoses are risk factors for recidivism which can make you an SVP.
Q. Right.
A. But yes.
Q. Yeah.
Thank you. That's all I have.
THE COURT: All right.
All right. Are there other motions that we need to take up before -- you may be excused -- before tomorrow morning?
MR. FISHER: Judge, the State has three motions in limine.
The first one, during the trial tomorrow, we would ask that there would be no discussion, it's not relevant, as to how long or where Mr. Sharp may or may not be confined. It's designed solely to invoke the sympathy of the jury saying that Mr., Mr. Sharp would be confined anywhere or for how long.
So, we'd ask that there be no mention whatsoever of where or how long Mr. Sharp would be confined.
THE COURT: You don't plan to bring that up, do you, Mr. Wilson?
MR. WILSON: Well, yes, sir.

THE COURT: I---

MR. WILSON: If, if, if he testifies, Your Honor, no. If he does not testify, no. But if the -- if he decides to testify, then I can't see how that's not relevant, you know, especially in light of the fact that I made a motion before this Court earlier, whether the Court denies it or don't deny it, arguing that, that the State has violated it's duty under the statute to get him to trial in the appropriate time.

I think that's very relevant.

THE COURT: All right. One, I didn't rule on that one just so the record's straight.

Two, I akin and I liken that to kind of talking about the sentencing range in a criminal case, same as in a civil case. So, whether he testifies or not, I will -- I'll hold it in abeyance to see what he's going to do and take it under advisement. But there's a 90 percent chance I'm gonna keep it out.

MR. WILSON: Yes, sir.

THE COURT: Just know that going into it.

MR. WILSON: I understand. Thank you.

THE COURT: All right. Thank you.

Sir.

MR. FISHER: The second motion in limine we have is in regard to treatment. It's not an issue before the

Court what type of treatment Mr. Sharp may or may not be entitled to or subject to. No talk about treatment.

Again, it's designed for the sole purpose of invoking the sympathy of, of the jury, which has no place in this case.

The issue is, one, does Mr. Sharp have a, a qualifying offense and, two, is he likely to reoffend. Those are the issues before this jury such that he must be confined, confined for long term care, control, and treatment.

So, we'd ask that there be no speaking of treat -- of his treatment.

THE COURT: Yes, sir.

MR. WILSON: Your Honor, in, in regards to the treatment, I don't have a problem with treatment after the Court makes a ruling after sentencing him or, not sentencing him, but sending him -- finding that he's in need of treatment. I have no problems with that part.

What I do have a problem with is one of the things is he did receive treatment while he was in jail here at the detention center over an extended period of time. And, and I think that he's entitled to, to say, to say that, that he --.

MR. FISHER: Yeah. No.

THE COURT: You are. He's just talking about saying

that he would be sent off for treatment.

MR. WILSON: I agree with that.

THE COURT: All right. We're on the same page.

MR. WILSON: I have no issue about that.

THE COURT: Thank you, sir.

MR. FISHER: The, the third one, I've got a note here for -- that it says confinement and we've already talked about that.

Bear with me a second---

THE COURT: Correct.

MR. FISHER: ---here please.

(Pause.)

MR. FISHER: Oh, the last one has to do with how long Mr. Sharp has already been incarcerated or been detained in this case subject to this act.

The total number of days that he since spent, spent in prison, the total numbers of days that he's been in, in confinement, I think I kind of covered that. But based on the Court's ruling, ruling, I think that the Court found that there is no prejudice.

So, we don't want to talk about confinement both now and in the past.

THE COURT: All right.

MR. WILSON: Your Honor, the, the only issue I have with that is, in him talking about the treatment that he

received, he's clearly incarcerated at the detention center, which is where he receives treatment.

THE COURT: I got no problem---

MR. WILSON: So---

THE COURT: ---with y'all talking about that. He's just talking about what sentence he received and how long he's been in prison.

MR. WILSON: I agree with that.

THE COURT: So, I think we're on the same page.

MR. WILSON: I agree.

THE COURT: Obviously, can't really talk about it. But what would be the point of having him wear regular clothes. We just bring him out in the other clothes I mean if that were the case.

So -- all right.

MR. WILSON: Yes, sir.

THE COURT: All right. Y'all have a good evening. See you tomorrow morning at 9:30.

MR. WILSON: Thank you, Your Honor.

MR. FISHER: I apologize.

Are you the -- taking the admissibility of the PPG under advisement?

THE COURT: Yeah. But you'll have my answer at 9:31.

MR. FISHER: Okay. Thank you.

MR. WILSON: Thank you.

(WHEREUPON, Court was in recess for the evening.)

Tuesday, February 27th, 2024

THE COURT: All right. Thank you very much. Please be seated.

You ready?

THE DIGITAL REPORTER: Uh-huh. (Affirmative).

THE COURT: All right. All right. All right. After thinking about it overnight, I believe that the State has met its burden as to the doctor's ability to testify as to the PPG and I will allow it.

Anything else before we get started?

MR. WILSON: Yes, sir.

THE COURT: All right.

MR. WILSON: I just like to put in the record, Your Honor, that -- take exception to the Court's ruling. I also ask the Court to make a ruling with regard to whether or not the test itself is invasive under the Fourth Amendment for the record.

THE COURT: All right. Under the Fourth Amendment, I find that the test is, is not invasive.

All right. Anything else before we get started?

MR. FISHER: No, Your Honor.

MR. WILSON: Nothing further.

THE COURT: Bring them out.

THE BAILIFF: All right.

MR. WILSON: Your Honor, before, before they come out, just so that I don't have to keep sanding up and objecting to the information about the PPG, I ask the Court to allow my objection to any information or testimony regarding the PPG be a continuing objection so that I don't have to stand up and object every time the word PPG is mentioned as the State goes through its process.

THE COURT: I'll allow it. Noted for the record.

MR. WILSON: Thank you.

(WHEREUPON, the following takes place within the presence of the jury.)

THE COURT: All right. Well, I hope y'all had a wonderful rest of your afternoon and evening. We stayed and got everything that we needed to be done done.

So, we're ready to proceed with the trial. I apologize for the slight tardiness. I put my keycard for here in my phone and it was in my hotel room. So I got here, couldn't get in the building, had to drive all the way back, get my phone, come all the way back. So the, the delay's on me. So, I apologize about that.

At this time, as I indicated before, I'm gonna allow the parties to give what they call an opening statement. It is simply just a statement as to what they believe the evidence is gonna show throughout this trial.

It's not to be considered evidence by you whatsoever. All the evidence will come through the witness stand.

All right. Yes, sir.

MR. FISHER: Thank you.

May it please the Court?

THE COURT: Yes, sir.

MR. FISHER: Good morning.

My name's Jim Fisher and I got with me Edward Collup both with the Attorney General's Office and it's our privilege to present this case to you.

There is a number of dates that are gonna be really important and we'll get to them. But I just want to write down some of those dates and maybe some key information. There's a total of six pages.

Now, the State has the burden of proof beyond a reasonable doubt that Mr. Sharp is a violent sexual predator -- sexual violent predator. I'm not sure I like the, the name of the law. But that's the name of the law.

Well, we have to show that Mr. Sharp has been convicted of a sexually violent crime and I've got the certified copies of the convictions still.

The second thing that the State has to prove is that Mr. Sharp suffers from a mental abnormality or a personality disorder that makes him likely to engage in acts of sexual violence if not confined in a secure

facility, facility for long term care and treatment.

So, the first date, we'll call this number one, this was May 29th and it was an eight year old girl. Mr. Sharp pled to a different crime but he was original (sic) charged with criminal sexual conduct in the third degree.

What I think the evidence is gonna show is that Mr. Sharp was living with the mother of an eight year old -- and I'm not gonna use anyone's name. I'm gonna use initials. There's no reason to get our sense (phonetic) up here. So, I'm gonna -- her name was K.M, eight year old girl, and K.M. would come over to her mother's house for the weekend and Mr. Sharp was living with K.M.'s mother.

One night Mr. Sharp got up, early morning, 2:00, 3:00 in the morning, went into K.M.'s bedroom, removed her pajamas, and molested her digitally. He molested K.M. well digital -- digitally.

We're gonna call this case number two. Mr. Sharp was subsequently arrested. This happened in Kershaw County.

He was subsequently in Kershaw County Jail, and while in jail, he solicited an inmate to kill K.M. This happened on June 20th and 21st, 2012, and he solicited another inmate to kill K.M., eight year old girl, and her mother. We'll call her A.S.

He was arrested for it. He -- the solicitor went to the Grand Jury and got a true bill and he was facing those charges. We're gonna call this number three.

Now, Mr. Sharp eventually pled guilty to assault in this first case right here. He eventually pled guilty to assault and battery of a high and aggravated nature. He was sentenced by the Court. He was sentenced to prison pending successful completion of probation.

So he got probation with special condition that he do sex offender treatment and I think you're gonna hear evidence that he successfully completed sex offender treatment. Terminated his probation.

But while still on probation for that offense, on 10/15/2017, Mr. Sharp is now living in Johnsonville, South Carolina. He has moved from Kershaw and he is now in, in Johnsonville and I think you're gonna hear evidence that he was living with his parents on Trinity Road, East Trinity Road.

And, on October 15th, 2017, he attempted to abduct an 11 year old girl. I think you're gonna hear evidence that Mr. Sharp left Johnsonville, went to Florence County, Florence, went to a location known as [redacted] Banbury Circle. He approached S.B. and asked if he -- if she had seen his puppy. He was driving a black Chevy Tahoe registered to his brother, I believe Randy, Junior, and the little girl

saw Mr. Sharp masturbate in the car as he reached for S.B. The little girl, girl ran. She ran up one block through yards, neighbors. She ended on a completely different block. She -- but she did success -- successfully get home and she told her father what had happened.

Her father went to confront Mr. Sharp at about 95 miles an hour. I think you're gonna hear evidence that there was gunshots. S.B.'s father chased Mr. Sharp all over this neighborhood and finally Mr. Sharp blew a red light while, lucky he didn't get t-boned, blew a red light at a -- 95 and a hundred miles an hour, gunshots, and he took off and the father lost sight of him.

But you got to understand the father was chasing Mr. Sharp through multiple neighborhoods. We'll call it number four.

On November 7th -- you're gonna hear evidence that being shot at and chased at by an angry father wasn't enough to stop Mr. Sharp. And, on November 7th, Mr. Sharp went back into a new neighborhood, the same area, the same thing, Florence, he was masturbating again and he at -- attempted to abduct E.B. E.B. is 10 years old.

Again, Mr. Sharp was living at [redacted], [redacted] Trinity Road driving his brother's truck. At least it's registered to his brother. I believe it's his brother, Randy, Junior,

in the same Chevy Tahoe, and the little girl, E.B., again same subterfuge, same trickery, and would you like to see a picture of my puppy, golden retriever. Little girl sees him masturbating and runs. Mr. Sharp is charged with attempted kidnapping and solicitation of a minor.

He pled guilty to solicitation of a minor and I've got certified copies of convictions. Case number five.

On November 13th, Mr. Sharp confronted not one but two girls, age seven and nine. You're seeing a pattern here. It's all girls. It's all little girls. You've got one who's seven and one who's nine.

The seven year old is L.L. and the nine year old is A.L. Same subterfuge. Would you like to see a picture of my, of my puppy, of my dog, have you seen my puppy. The girls see him masturbating in the car. They run. I got certified copies of convictions.

Mr. Sharp pled guilty to attempted, I'm sorry, solicitation of a minor and indecent exposure. When it comes time I will enter these certified copies of convictions into the record and you'll see that, as part of a plea negotiation, Mr. Sharp pled guilty to solicitation of a minor and indecent exposure. The attempted kidnappings were dropped, dismissed, in lieu of his plea agreement.

Now, I plan on putting on Doctor Emily Gottfried,

Medical University of South Carolina. She is a sexual behavioral expert. The State has to prove that Mr. Sharp has a propensity to commit these offenses.

So, based on Doctor Gottfried's testimony and expert opinion, she is of the opinion that Mr. Sharp is a sexual violent predator. He was on probation when he committed the next offense. He was in custody when he solicited the inmate for murder. He was on probation when he approached E.B. after being shot at by S.V.'s father and chased at high rates of speeds. He was going back to yet another neighborhood on November 13th, 2017, to solicit yet another young girl ages seven and nine.

Doctor Emily Gottfried, I think, is going to tell you that Mr. Sharp has a paraphilic disorder.

Now, before I came to the Attorney General's Office I didn't know what that was. But what it is is it's a mental disease or defect.

See, Mr. Sharp can't help himself. That's what it's about and the State has the burden of proof that Mr. Sharp can't help himself such that he needs to be confined for long term care, treatment, and control. This -- and the State's got to prove this case beyond a reasonable doubt.

But what is it gonna take to get Mr. Sharp to stop, stop?

Being shot at didn't work. Going through a high

rates of speed didn't work through neighborhoods. Being on probation didn't work. Sex offender treatment didn't work. And when Mr. Sharp was done with his prison sentence, the, the Attorney General's Office issued a petition asking the community of Florence to confine him for long term care and control and treatment.

That's why we're here. Mr. Sharp has a propensity for little girls.

Now, some of this may be really alarming and I apologize. I'm not doing saying this -- I'm not saying the things I'm saying for salacious reasons. I'm saying them simply because that's what we got to prove.

Doctor Emily Gottfried is gonna say that Mr. Sharp has a pedophilic disorder, nonexclusive, sexually attracted to girls underage, prepubescent girls, and also he's sexually aroused by consenting women.

But this is his history. This is his history in, in a world that I don't think anybody should have to worry about their child going out into the neighborhood on their bike, some stranger coming up, and asking guys, do you want to see a picture of my puppy. Next thing you know they're -- he's trying to abduct her and these girls all ran.

What lawyers say is not evidence. So, I'm not gonna drawn on any longer but let me just ask you this.

As you listen to the evidence of all five of those cases, Doctor Gottfried, how far do these, do these girls have to run?

Thank you.

THE COURT: Yes, sir.

MR. WILSON: Madam Forelady, and ladies and gentlemen, I understand that we are here to make a decision about long term care for Robert Sharp. The question is -- really is how did we get here.

How did we get here to this point?

Of course let me say to you this. The attorney general put all of these things on that board and he said he's a sexually violent predator.

No person did he ever physically touch. Not one. Robert never laid a hand on one single person in any of these instances.

Another thing. In this process, the State has the burden of proof and it's not like a normal civil trial cause this is considered a civil trial. I don't know why but it is and, in civil trials, normally, if everything's equal and one person tilts the scale just ever so slightly, that person wins in a civil trial. That's not true in this case. Tilting doesn't matter.

So, if they tilt it even so slightly, they lose cause that's the law because that's not beyond a reasonable

doubt and I'm gonna give you a reasonable doubt to start with.

To start with, the State's own doctor, who is paid by the State of South Carolina, will come in here and tell you that the things that they're saying are not true, that he does not have a mental illness or a mental abnormality, that he is not a pedophile, and that they wrote a report to that effect and gave it to the Attorney General's Office.

So they knew that but what did they do because they didn't like the report that their own doctors created?

So what do they do?

Say well, we'll find somebody else who will give us what we want.

That's why we're here today and I tell you right now, you look hard enough and long enough, you'll find somebody to say anything you want them to say if you got enough money to pay them. That's why we're here.

For every one of these cases, you heard the attorney general, he pled guilty. He was sentenced and did whatever time they gave him. Nobody's disputing that. Even the attorney general doesn't dispute that.

So then you ask yourself why are we here. We're here because the Attorney General's Office didn't like the report that their own doctor gave them and what you will

find, what you will find, with one exception in the reports that the doctor -- the State's doctor gave and Doctor Gottfried gave, the only difference is gonna be one test that was done. One test. And we'll talk about that a lot during the course of this case.

But, for right now, their results were primarily the same. That is the results from Doctor Gottfried and the State's doctor were almost identical except for this one test that this new doctor that they went out and found came back with and we're gonna talk about that test as we go through this process.

See, the system ought to be fair to everybody. It's called justice. It's called due process. He's entitled to that. Just like me. Just like you.

We've all been taught over the years that we must pay for our crimes. We should.

Lastly, what I ask you to do, folks, is this. Just pay attention and I know you will. Listen to the evidence and the testimony as it unfolds from this witness stand so that when you are asked to make a decision, you're gonna be in a position to do that and that decision must be unanimous. That mean (sic) all 12 of you must agree to that decision and that decision has to be beyond a reasonable doubt.

That's all I ask of you. Give us your attention for

however long this process takes. And one of the things I learned a long time ago is there's usually two sides to every story. Here's the State. They deserve that. They deserve to be heard. But the defendant deserves to be heard as well. That's all we care about. That's all we ask.

Thank you.

THE COURT: Yes, sir.

MR. FISHER: Judge, at this time I would like to move into evidence the certified copies of convictions, convictions. They do bear the insignia of the Clerk of Court for Florence.

MR. WILSON: Without objection, Your Honor.

THE COURT: Without objection.

MR. FISHER: And are we up to 12 or 13?

THE COURT: Twelve.

(Whereupon, the certified copies of convictions were marked as State's Exhibits No. 12 and received into evidence at this time.)

MR. FISHER: And, with that, the State would call Doctor Emily Gottfried.

THE CLERK: Place your left-hand on the Bible and raise your right-hand.

EMILY GOTTFRIED, being first duly sworn, testified as follows:

THE CLERK: Please be seated and then state your name for the record.

THE COURT: Would you mind moving the easel so she'll be able to see the witness please?

MR. WILSON: Your Honor, may we approach for a second before --?

THE COURT: Sure.

(WHEREUPON, a bench conference was held out of the hearing of the jury at this time.)

THE WITNESS: My name is Doctor Emily Gottfried. G-O-T-T-F-R-I-E-D.

DIRECT EXAMINATION

BY MR. FISHER:

Q. Good morning, Doctor Gottfried.

A. Good morning.

Q. Doctor Gottfried, are you employed?

A. Yes.

Q. Where do you work?

A. I work at the Medical University of South Carolina in Charleston.

Q. And what do you do there?

A. Currently I'm an associate professor of psychiatry and behavioral science and I serve as the director of our sexual behaviors clinic as well.

Q. What is this -- what is that laboratory about?

How -- what do you, what do you do over there?
A. The sexual behaviors clinic and lab is a, is a clinical office. So, we do primarily forensic evaluations for people who have been charged with or convicted of sexual offenses. We provide treatment for the same and then we also conduct research and do consultation.
MR. FISHER: Is it okay?
MR. WILSON: Yeah, that's fine.
Q. Okay. I was just moving the podium so that Mr. Wilson can see you.
And how long have you been in that position?
A. I've been at MUSC since 2015. So about nine years. And I've been the director of the lab at least 2018 or 2019.
Q. And what did you do before that?
A. Prior to starting at MUSC, I did a post-doctoral fellowship in forensic psychology at the Medical College of Georgia in Augusta.
Q. And what are your current duties as the director of the sexual behavioral lab?
A. So I oversee all of the operations --
Q. Uh-huh. (Affirmative).
A. -- day-to-day of the clinic or lab. So, I select the test and measures that we use. I do all the ordering for supplies and procurements. I oversee staff and faculty

who work in the lab. I conduct forensic sexual behavior violations. I provide treatment. I conduct research. I teach students apart from USC on sexual behaviors as well.

Q. What is a sexual behavior evaluation?

A. So, it can vary but most typically it will be a -- an attorney, so they have a client who's been charged with a sexual offense or I have a contract with probation, United States Probation. So, somebody who's getting out of federal prison for a sexual offense. So they generally want an evaluation kind of to see what's going on with the person and, ultimately, how risky are they.

So do they have a sexual behavior disorder that is in need of treatment that will reduce their risk, what risk factors do they have that makes them dangerous or likely to reoffend in the future, and kind of what's gonna make them successful in not reoffending.

Q. And what a -- what training do you offer to students at, at your lab?

A. So, I have a variety of duties related to students and supervision and training. So, I teach medical students about paraphilic disorders. So those are the psychiatric disorder where sexual arousal to something other than a human consenting adult.

I also teach medical students about sexual dysfunction. So that could be things like erectile

dysfunction or organism dis -- disorder. I teach physician and assist students on the same. I supervise psychiatrists and psychologists who are specializing in forensics.

So, I provide them all year on sexual behavior and then I provide national trainings and lectures on sexual behavior disorders around the country as well.

Q. Have you ever published peer-reviewed articles?

A. I have.

Q. Would you detail some of those for the, for the jury?

A. Sure.

I believe I have 33 peer-reviewed scholarly researched publications in professional journals. I have seven book chapters in scholarly texts.

And so, kind of overall, my research is related to accurately assessing sexual violence risks, paraphilic disorders, and kind of assessment or testing, psychological testing, in general.

Q. What is the peer-review process?

What goes into it?

A. So, when you submit a manuscript describing your research to a professional scientific journal, it goes to the editor of the journal. So they take a look at it and they can just flat out reject it at that point. But if they think that the paper might have merit and is

appropriate for that scientific journal, they will send it out to a team of what's called peer-reviewers.

So those are experts in the field. Typically for journals it goes to three reviewers. Some journals send it to more. But it's generally three.

So those three experts will read the study, look at the methods, the analyses, and make a lot of comments, and then usually the best case scenario is you'll get what's called a revise and resubmit. So, they'll send you all of their comments, ask for you to revise it in light of those comments, and then it may go through that process multiple times before it's ultimately accepted for publication as being scholarly for the match (phonetic) or not.

Q. And how many times have you testified as an expert in courts in the State of South Carolina?

A. I've been qualified as an expert 46 times in South Carolina and then also in Georgia.

Q. Are you licensed in South Carolina?

A. I am.

Q. And anywhere else?

A. I'm also licensed as a psychologist in Georgia as well.

Q. And who issues that, that license?

A. In South Carolina, it's the, the LLR, Licensing, Labor, Regulation.

Q. And are you in good standing with your license?
A. Yes.
Q. How many precommitments, which is what we're here for, how many precommitment evaluations have you done?
A. I'm trying to be accurate. Hold on.
For a precommitment, I have been referred 56 precommitments.
MR. FISHER: At this time I'd off Doctor Gottfried as an expert in precommitment sexual violent predator cases.
THE COURT: Any objection?
MR. WILSON: Subject to my previous objections.
THE COURT: All right. Ladies and gentlemen, I will qualify her as an expert.
What that means is lay witnesses can not testify as to their opinion, but experts can, and I'll charge you on the law later on. But, at this point in time, she's allowed to give her opinion.
Okay.
Q. Doctor Gottfried, are you compensated for being here?
A. Yeah.
Q. Explain what the contract is and how it works.
A. Sure.
So MUSC has a contract with the State Attorney General's Office where, if they want a second opinion, they might choose to send it to MUSC. Per the contract,

it's -- they pay $5,600 for the evaluations. That includes the three days of the evaluations, and one day of testimony, writing the report and, and all of that.

Q. Do you have any personal interest in this case?

A. No, I mean the money, the money doesn't come to me. It goes to MUSC. I'm sure it's used to pay my salary but I, I don't get a check for it.

Q. Let's change the subject a little bit. Let's talk about the PPG.

What is that?

A. So PPG stands for penile plethysmography. That is a physiological test for measure of male sexual arousal. It's an objective measure looking at what a man is aroused by in the lab.

Q. And explain how the PPG operates.

A. So, kind of really simply, you have a man sit in the lab by himself. He is instructed on how to place a gauge over his penis. He's then presented with a variety of sexual and nonsexual stimuli.

So, depending on where you are, that could just be audios of sound. It could be pictures. It could be video. And you are looking at their sexual arousal to the different stimuli presented.

For these kinds of or for all the sexual behavioral evaluations that I do, we tailor the stimuli to like the

age and gender of the victims that they've had. So, we're looking at their arousal, for example, to prepubescent children, children not in puberty, compared to their arousal to consenting adults, and then also looking at arousal to nonsexual stimuli.

Q. Is this a standard test that you use, the PPG?

A. Yes, I administer PPG or penile plethysmography for every adult man referred for a sexual behavior evaluation.

Q. But why do you use it?

A. So, for a couple of different reasons.

Based on a lot of research, we know that somebody who has committed a sexual offense and has sexual arousal, paraphilic sexual arousal, so that's arousal to something other than a human consenting adult, we know that the presence of that paraphilic arousal is a risk factor for reoffending. So, it's really important to look and see what somebody's aroused by.

As you can imagine in cases like this, people are not necessarily going to be completely honest or forthcoming about what they're aroused by and that makes a lot of sense. If, if somebody was evaluating me, I don't think that I would be totally honest about something that could make me look bad.

And so, because we know that people are not necessarily gonna come in and say yes, I committed this

offense because I'm sexually aroused by really young children, we need an objective way to measure it in the lab.

Q. And are you trained to administer this PPG?

A. Yes.

Q. Explain to the jury what kind of training you've had.

A. So, in 2018, I was certified by Limestone Technologies as a clinical analyst. That means that I have the training and education and certification to both administer as well as interpret the PPG data.

Q. And are you certified in -- to use the PPG?

A. Yes.

Q. Okay. Who is Limestone?

A. Limestone is the company that manufactures the hardware and the software for the PPG. That's where we purchased it from. I think recently they changed their name or they sold a part of it. But Limestone, historically, was the company that, that made it.

Q. And do you rely solely on the PPG?

A. No, it's, it's one data point in a multi-method, comprehensive evaluation that I use for a lot of different tests for.

Q. So, the PPG is not gonna diagnose anybody?

A. Right. It's just a, a data point. You're looking for data that kind of line up or converge. So that's just

one piece of data that you're looking at in the context of all of the case information that we know, your interview, and the results of other testing as well.

Q. How long has the PPG been around?

A. Since the 1950s.

Q. Okay. And can you explain to the jury some of the ways that you use the PPG?

A. So, the PPG is most commonly used for treatment and assessment. So because we know that this paraphilic or deviant sexual arousal is a major risk factor, that's why it's important to use it in evaluation. But it's also widely used in treatment.

So, if you are treating somebody for a paraphilic disorder, you're giving them strategies and techniques for how they can minimize and even get rid of that arousal. Really the best way to test to make sure that treatment is working is to bring them into the lab, give them another PPG, and kind of do things -- come over the intercom and have them, you know, if you can see the physiological data that they're becoming sexually aroused, you can kind of coach them through the intercom. It's really the best way to make sure that that treatment is working.

Q. And how many times have you administered the PPG, PPG test?

A. Well, I have a technician who administers it. So,

I've ordered about a hundred PPGs be administered.
Q. And why specifically do you order the PPG?
A. Why do I order it?
Q. Well, let---
A. Okay.
Q. ---let, let me rephrase the question.
Have you found it to be reliable?
A. Oh, yes. I mean I, I use the PPG because it is the gold standard objective measure of looking at sexual arousal. If I have somebody come in and, and they say I offended against a child because I'm really sexually aroused by this child and am still sexually aroused by this child, a PPG probably isn't necessary. I have the data that I need. But people generally are not going to do that.
So, because it's my opinion that it's very well studied, it's, you know, been around for, I'm not gonna do math, since the 1950s. I, I -- it's an important component of an evaluation.
MR. FISHER: At this time I'd also ask that Doctor Gottfried be certified as an expert in the use of the PPG.
THE COURT: All right. Over the objection.
Q. Let's change the subject a little bit, doctor.
Did you use -- what type of evaluation did you perform on Mr. Sharp?

A. So this is called a precommitment sexually violent predator evaluation assessment.
Q. And what did -- what are some of the things that you considered?
A. So, I get the whole case file. So, I get all of the police and sheriff's department's discovery documents related to the sexual offenses. I get records from the prison. I get any victim or witness statements. If a child, number one, had a forensic interview where they met with a specialized mental health person to kind of detail what happened to them, the offenses, I review all of that.

I schedule the examinee to come to MUSC on three different dates. On the first date they're -- they go over a consent form. They're made aware of all the various parts of the evaluation. Then they're administered a battery of psychological tests on the computer.

And then, on the second day, they come in and they have their PPG. And then, on the third day, I meet with them and I do a clinical interview where I cover pretty much their whole life history, talk to them about their offenses, kind of get their perception of why these offenses happened, how likely they are to happen again. I go over their test results with them. And then I put all of that information together and write a report on my

findings or my opinions.
Q. Does, does the fee change at all based on your opinion?
A. No.
Q. Now, did you perform a precommitment evaluation on Mr. Sharp?
A. I did.
Q. And would you explain to the jury briefly what those steps were?
A. So, the Attorney General's Office would contact my office and ask -- request the evaluation. They would then send all of the discovery documents, file information. Since I review all that, see if it looks like anything is missing. If it's missing, then I would request that information.

Once I have all of the case information, then I let the Attorney General's Office know three dates that we're going to see the examinee. The examinee is then transported to MUSC and then they do the testing, PPG, and then their clinical interview.
Q. Was Mr. Sharp told what -- the extent of, of the evaluation you were gonna perform?
A. Yes.
Q. And did he sign a consent form to perform the evaluation?

A. Yes.

So, on the first day of the appointment, we go over -- it's like six or seven page consent form where it describes, you know, the purpose of the evaluation, the nonconfidential nature of it, who's going to re -- to receive copies of the evaluation report, all the various possible tests that he could be administered.

It has information about clinical interviews. It has information that they're security cameras, that because MUSC is a teaching university, there might be students observing. It goes over, you know, bathroom breaks and like that they're allowed to withdraw their consent at any time.

So, he would go over that consent form, have an opportunity to ask questions, and then if he consents to the evaluation, then proceed and then, on each subsequent day that he comes to MUSC, we go back over the consent form and then he signs another rereading of that consent form on each date.

Q. And the person you -- who signed the consent form, who you interviewed, is he in the courtroom today?

A. Yes.

Q. Okay. Could you point him out and identify an article of cloth -- clothing that he's wearing?

A. Type of clothing, yes.

Q. Yes.
A. He's wearing a navy blazer sitting next to his attorney.
MR. FISHER: Let the record reflect the in-court, in-court identification of the respondent.
THE COURT: It'll so reflect.
Q. Now, the, the records that you got from the Sheriff's Office, prison, all the records, did you rely on those records?
A. Yeah.
Q. Let's talk a little bit about Mr. Sharp's relationships.
Did Mr. Sharp indicate -- why are relationships with other people important in -- as you develop your diagnosis?
A. Well, a lot of historical information's important because, you know, we're only seeing this person for a couple hours over a three day period. And in order to have enough data to see if there is a diagnosis present, you need to kind of look at their whole history.
So, having a history of poor relationships or conflict in relationships might be the result of someone having a personality disorder. It could be a risk factor later on.
So, it's, it's important to kind of assess the nature

and quality of relationships including looking at like future relationships for social support, social network for when they get out of incarceration.

Q. Do you know Mr. Sharp's date of birth?

A. I do. I believe it's [redacted], 1986.

Q. I'm sorry.

[redacted] what?

A. [redacted] -- yes, [redacted], 1986.

Q. Now, did you review with Mr. Sharp the first incident of May 29th, 2012?

A. Yes.

Q. Explain to the jury what you discussed about that incident with K.M.

A. So, I kind of -- I start out pretty open ended for I -- so I have them just kind of describe what happened at the time of the offense and then I'll ask questions if it's different from what's in the discovery documents.

Mr. Sharp reported that this happened on one occasion, that he was curious about what a girl's, girl's vagina looked like and that he had kind of had these thoughts or was thinking about it for approximately a month before he acted on it.

He said that he went into her room and he kind of touched her vagina to essentially open it to look to see what it looks like after I believe like pulling down her

pajamas or removing her pajamas. And then he said that she woke up and was startled and he asked her if she was okay. And then he said he left the room.

Q. Pursuant to the police reports and the records, what happened next?

A. Well, so that was his report and then he said nothing else happened. But the discovery information indicated that he came into her room a second time, that she hid underneath the covers, and he was whispering her name or calling her name, and that she yelled out for her mom, and that's what stopped it.

Q. Okay. Now, who was the mom?

Who was A.X.?

I'm sorry.

Who was, who was the mother of the first victim, K.M.?

A. That was Mr. Sharp's girlfriend at the time. They were living together.

Q. Is living together, you know, add -- adults in a consenting relationship, is that important to you?

A. It, it can be.

Q. But pursuant to the police reports, what else did you discover about their relationship?

A. It seemed like they had a stormy relationship. So, prior to this offense, I believe that his girlfriend had

called the police about a physical altercation that they had. I think ultimately the police responded. But I, I don't think she wanted medical attention or really to pursue it.

And then following this incident, his girlfriend called the police a number of times and reported that Mr. Sharp was calling her a lot, I think over a hundred times, calling her work, approaching her in public places. Essentially that she was gonna ruin his life with these charges and was maybe trying to intimidate her or at first or maybe recant the allegation.

Q. Now, as part of the -- your investigation, did you subsequently find that, that Mr. Sharp had been arrested for solicitation to commit murder?

A. Yes.

Q. Explain what that was about.

A. So, according to the incident reports, an inmate at the detention center asked to speak with detectives and their staff and said that Mr. Sharp was giving him a lot of personal information about where the victim's mother worked and lived, I believe what kind of car she drove, that he thought that if something happened to her, then I think the charges would go away, and gave the inmate a lot of information and requested that he -- I believe it was -- the quote was like take care of them or kill them.

He -- the -- that inmate subsequently met with a couple people at the detention center and provided the statement accounts.

Q. Why is that important to you to, to know that?

A. Well, it's important to know all of their criminal history because we use that to score a -- risk assessment measures. It helps us predict the severity of future offenses. That's concerning. So it's not a sexual offense. But that is a data point and concerning if true.

Q. Okay. What did Mr. Sharp say about his relationships?

Did he have long term relationships?

What, what did he say?

A. Romantically he was never married. He had three relationships that he identified as being, you know, significance, important relationships in his life. One before this victim's mother and then one after.

He reported having a really good relationship with his mom both during his youth and as an adult. He said that he and his father kind of had a strained relationship when he was a kid. He said that they didn't really see eye to eye. But that, as an adult, at least when I interviewed him, he identified his father as being like his best friend.

Q. Did Mr. Sharp indicate that he dated a lot or, or

that he met a lot of girls?

What did --?

A. I don't think that he said he dated a lot. I know that he said he had had sex with maybe 50 different women, about 30 of them being like really casual, or one night stands. But I don't think that he reported that he dated a lot outside of the significant relationships that he had had.

Q. A question I forgot. Let me backtrack just a little bit.

When Mr. Sharp said he was curious about seeing K.M.'s private, ex -- explain what that would mean to you.

A. Well, I know that he told the previous evaluator who did the evaluations in the Department of Mental Health that he wanted to see if an eight year old's vagina looked like her mom's vagina, which was his girlfriend's. So I asked him about this during my evaluation and he said something like he wanted to know what an eight year's old vagina looked like.

And I asked him like this eight year old or any eight year old. And, and it sounded to me like he was saying any eight year old and, and didn't really endorse that he was looking at it to see if it resembled her mother's vagina.

It's not unusual for when you talk to an individual

who has pedophilic disorder, which is sexual arousal to prepubescent girls or children, it's not unusual for them to kind of characterize their arousal in terms of interest or curiosity. That's something that we see.

So, instead of just saying I am sexually aroused by this, they'll often say I'm interested in children, I'm very curious about children. And so I noted that, that he used the word curious a couple times.

Q. And, and you found that to be a data point?

A. Yeah.

Q. Okay. We talked about sexual partners.

How many sexual partners did Mr. Sharp say he had?

A. I believe he estimated that he had approximately 50.

Q. And how many one night stands?

A. Let me double-check my report. I believe he estimated having 50 consensual sexual partners and he said "a lot, probably about 30 hetero relationships or one night stands."

Q. Okay. Did he indicate that he had any sexually transmitted diseases?

A. I think he had a history of contracting one sexually transmitted infection that's curable and notifying his partners.

Q. Okay. Let's, let's move on.

Oh, subsequently, Mr. Sharp was convicted of assault

and battery, correct?
A. Yes.
Q. Of a high and aggravated nature first degree.
A. First degree, yes.
Q. It -- it's in the certified copies as well.
A. Yes.
Q. And he was placed on probation, correct?
A. Yes.
Q. When is the next time Mr. Sharp was sexually offending?
A. So, he was arrested in November of 2017 and I believe he reported a -- it was October, November of 2017. It was made a note of that.
Q. Okay. And let's take them -- not just the convictions. But let's talk about Mr. Sharp's self-reporting.
What did he tell you he was doing when he was in Florence and masturbating?
A. So he reported that in 2017 he would ride around masturbating in his car and eventually stopped and asked women and female children for directions or asked them a question.
So, he said that this has been going on. He was doing it every few days to every couple weeks. I believe that he said that it happened approximately six times. I

think there's other information maybe that he told the other evaluator that he had stopped about 10 women, both -- somewhere between six and ten women that he approached while covertly masturbating.

So, covert would be like trying to hide. And then he approached, I think, four different female children and he said that he was arrested and charged for every child he approached but not for any of the adult women that he approached.

Q. Let's go back to May 29th, 2012. I'm sorry to backtracks (sic) and, and K.M.

Did Mr. Sharp self-report to you that, when he wanted to look at K.M.'s privates, that he did it for a sexual reason?

A. He talked about being curious. I know that he told the other evaluator that -- like he started saying well, it wasn't sexual and then he said well, I guess it was sexual. He -- my memory, he never actually said like I did this because I was really aroused by it. He more put it in terms of that he was curious about it.

Q. So, so, he told the other evaluator that he did it for sexual reasons -- I guess sexual reasons but he didn't tell you that.

A. Well, that's not necessarily I think with what that meant in the report. I think, when she asked him about

the sexual offense, he started saying like it wasn't actually sexual and then corrected himself like okay, well, I touched her vagina. So I guess it was sexual.

Q. Now, when going through them, I think there's about six where Mr. Sharp self-reported that he was masturbating while driving in Florence.

What was the first incident?

A. Let's see. So, I know the one that he reported to me was an adult woman.

Do, do you want me to talk about the ones that he wasn't arrested for or---

Q. Correct.

A. Okay.

Q. Just --.

A. Let's see.

So I had him kind of detail what was going on with him at this time. So, kind of lay out exactly who he was exposing himself to and, and what was happening. So, let me find it in my report.

Okay. So he said that the first incident occurred with a woman who was running and he stopped her and asked her for directions to Wal-Mart and he said that she gave him full directions to Wal-Mart and that the entire time he was masturbating.

Q. And did he eventually ejaculate?

A. He said that he spoke to the woman for maybe two minutes and then drove off and was masturbating while driving thinking about what had just happened. He ejaculated in his car and then he went home.
Q. Okay. The second time he self-reported, what was -- what did Mr. Sharp tell you with that?
A. He said that it happened a couple weeks later and that he was in his car and there was a girl who he estimated to be somewhere in her twenties walking her dog. And so he stopped her and asked her if she had seen his dog and then they started talking about her dog.

He said that he was masturbating through like the weekends fosters (phonetic) at that time. When I asked him like did she know that you were masturbating, he said that he didn't know. He said he didn't know whether or not she knew. He said that they talked for maybe five to six minutes and he ejaculated while talking to her, but he didn't think that she knew, and then he drove off.
Q. Now, the next one, the third one. It's the -- I think a runner.

Explain to the jury about this situation.
A. So, that one Mr. Sharp indicated that he actually had his penis like out of the fly of the pants that he was wearing at that time. He stopped the woman and asked her directions and he said that this woman saw his penis and

actually grabbed it and said something like do you need help with that. He said that he was really shocked by this and that it scared him because he was worried that she was going for him or do something to him. So, I think he drove off when that happened.
Q. What does the fact that he was scared or, or showed some fear about this woman grabbing him, is that clinically significant to you?
A. It's the data point I considered.
Q. Why?
A. Well, one of the reasons that I think it's significant is that he continued to engage in this behavior. So even though he had this experience that he said shocked him, freaked him out, like it didn't deter him to stop doing it.
Q. Let -- when he started approaching these ladies, was he still on probation?
A. Yes.
Q. And was he ordered to successfully complete sex offender treatment?
A. Yes.
Q. Explain why that would be a data point to you.
A. Because the information suggests that he successfully completed sexual behavior treatment, that he re -- fulfilled all the requirements. I believe that was in

2015.

And so, despite going through that treatment, and successfully completing it, he still reoffended and he's on probation. He got a relatively light sentence for a, a, a serious offense in 2012.

So he, you know, was threatened with serious punishment, kind of avoided that. He's on probation but he's still engaging in this behavior and that could suggest that he can't control that behavior.

Q. So that takes care of the first three.

The next one, the fourth one that we're gonna talk about, was that the one with K.M.?

A. I believe that's the next one that you told me about.

Q. And what did Mr. Sharp tell you about his contact with K.M.?

I'm, I'm sorry. Strike that.

Now, S.V. I apologize.

A. He said that he was riding through a neighborhood and that he saw a girl riding her bike. He said he couldn't tell her age and that he later came to find, find out that she was 12 or 13 years old. I believe that she was 11 if I'm not mistaken. She was 11.

She approached her and asked if she had seen his dog. She said that she had not seen his dog and he said that he doesn't know like if it was because of the arm was moving

or because like the way she was on her bike, she could see over the door, but he said that she saw his penis.

And so, however, he knew that she'd seen his penis. That made him drive off. He said he was trying to get out of the neighborhood. But he didn't realize that he was close to her house.

And so, when she went home and told her parents, he reported that her father chased him in his own vehicle, that he was driving like a hundred miles an hour, and he said that her father fired a gun at him or there were gunshots and that he ended up losing him and I think he went home after that.

Q. Did he continue to ejaculate as he's running from the father?

A. I believe so. Yes, I, I believe that he ejaculated while fleeing.

Q. Is that a data point for you?

A. Yes.

Q. What is -- what does that situation tell you?

A. Well, the ejaculation suggests that he was sexually aroused by it. The fact that he reported that somebody was shooting at him, so I did not note that in the police report, but that's at least his perception that he was being shot at, but then he continued to engage in that behavior, which, again, suggests that you, you have a very

hard time controlling that behavior if you're, you know, facing such serious consequences and someone's shooting a gun at you.

Q. So, being shot at, high rate of speed through residential neighborhoods, and he continued to engage in that activity?

A. Yes.

Q. When is the next time that Mr. Sharp engaged in this driving through neighborhoods masturbating?

A. I mean he said that it happened every couple days to a week, a week and a half. But the next time it was reported to police was November 7th of 2017.

Q. What happened on November 7th?

A. That was when he approached a 10 year old girl and I believe showed her a picture of a dog and asked her if she had seen the dog. That's the one that she told police that he had a sexual conversation with her. The police warrants indicated something about like asking her about hot dog, if she liked hot dogs.

So I asked her -- when I asked her -- Mr. Sharp, during my evaluation, he acknowledged that that had happened. He said that he asked her do you like hot dogs and she said yes. And then he asked her do you like dick and then I think she ran away at that point. And when I asked him why he engaged in that sexual conversation, he

said he did not know.
Q. Now, so far we've got an eight year old. We got an 11 year old. We got a 10 year old.
Are any of them pubescent?
A. I mean it's possible that an 11 year old has started puberty. It -- that's possible. An eight year old, the -- she underwent a medical and a forensic interview and the doctor noted that she was totally prepubescent.
A 10 year old could be prepubescent, could be starting puberty. But when you see a 10 year old child on the streets, it, it would be hard to tell whether or not they were in puberty. They would certainly not look like a 14 year old or a 15 year old with developed breasts.
Q. So, do you have any evidence that they were pubescent?
A. I don't have evidence that they were pubescent.
Q. But we know the eight year old was prepubescent?
A. Yes.
Q. And we know that the, the next two, November 13th, seven year old and a nine year old, is it possible that they're pubescent?
A. It's possible that -- yeah, I mean sometimes children develop early. It -- it's possible that they had started puberty. They certainly weren't pubescent where they had secondary sex characteristics, things like breasts, and,

and pubic hair and things like that.
Q. So, I ask the question was it possible that they were pubescent.
Is it reasonable that they were pubescent -- pre pu -- strike that.
Is it reasonable that they were pubescent at seven and nine?
A. I don't really think it's reasonable. I think that, if you saw them on the street, they would look like a, a child.
Q. And on, on November 13th when he approached the, the two girls, explain what -- how Mr. Sharp explained what happened at that event.
A. He said that he wasn't masturbating at that time. He actually said that he approached three children, that it was two boys and a girl. He didn't really remember or report what, what was in the police report. And he said I believe that he asked them again about his dog. And when I asked him the purpose of that, he kind of said I don't know and didn't really have any reasons.
Q. Did you ask Mr. Sharp why he was doing all this?
A. Yes.
Q. And what did he say?
A. He said it was a dark time in his life and that he -- that's kind of what he attributed it to and then, in

talking about why he was masturbating, he said he was aroused by or he was doing it kind of the -- that he was masturbating and they didn't know about it. Like that's what he would do outside.

Q. When it comes to S.B., the -- October 15th, looking at, at the police reports now, did he actually attempt to, to grab her?

A. I, I believe that, that the police report indicated that he attempted to grab at her or grab her.

Q. But he was unsuccessful cause she ran away?

A. Yes.

Q. Do the police reports indicate on -- that on November 7th that he attempt to grab E.B.?

A. I'm not sure. The information I have is that he pulled over and called her over to his vehicle. He asked her her name and asked her if she'd seen his golden retriever, showed her a picture of his dog, talked to her about hot dogs, asked the question about liking dick, and then she ran in her house and like she came off what happened.

Q. So S.B. and E.B. ran.

What about November 13th with L.L. and A.L.?

Did he attempt to, to grab or abduct those two?

A. The only information that I have on that is that they were riding their bikes. Mr. Sharp approached them in his

vehicle. He asked them if they had seen his dog. They said no and they rode away on their bikes.

Q. Now, was Mr. Sharp subsequently located?

A. Yes.

Q. Did you read the re -- were you able to review the police reports on, on how they caught him?

A. Yes.

Q. Explain to the jury how they caught Mr., Mr. Sharp.

A. I, I believe it's from his tag number, like his license plate number. I know they, they went -- they had like the car registration and they went to the house where the car was registered and I believe they asked his girlfriend or somebody if he use to have a beard. But I think he had shaved his face.

I, I believe that's how he was caught based on security or someone's like Ringer door -- doorbell camera, something like that at the -- after what happened to the two girls on the bikes.

Q. So, somehow somebody had a Ring doorbell, video, was able to identify the vehicle, and then, from there, were able to get the license plate and find out where it's registered?

A. Yes.

Q. Was, was Mr. Sharp subsequently arrested for all of these incidents?

A. Yeah.
Q. And what was he arrested for?
A. So initially he was charged with -- so, in November of 2017, he was charged with indecent exposure, two counts of criminal solicitation of a minor, and three counts of kidnapping.
Q. From -- do you know what the ultimate disposition of the case was?
A. Yes, in 2019 he pleaded guilty to two counts of criminal solicitation of a minor and indecent exposure. And so, when he took that plea, the other charges were dismissed.
MR. FISHER: Your Honor, at this time may I publish the certified copies to the jury?
THE COURT: Yes, ma'am. Yes, sir.
Just hold off on that because they'll, they'll have it in the back. But if you want to take a look at it during a break cause, if not, it will take forever for everybody to go down the, the line.
Q. But the kidnapping counts were dismissed in lieu of the plea, correct?
A. Yes.
Q. What was Mr. Sharp sentenced to?
A. He was sentenced to 10 years on the criminal solicitation of a minor charges and three years for the

indecent exposure charge.

MR. FISHER: Okay. If I may have a moment, Your Honor?

THE COURT: Take your time.

(Pause.)

THE JUROR: Your Honor?

THE COURT: Yes, ma'am.

THE JUROR: May I go use the restroom?

THE COURT: Yes, ma'am.

All right.

THE JUROR: Thank you, your Honor.

THE COURT: We're gonna go ahead -- nope. Give me one second.

We're gonna go ahead and take our midmorning break. Give you about 10 or 15 minutes to stretch your legs, use the restroom, and we'll bring you right back in.

(WHEREUPON, the following takes place outside the presence of the jury.)

THE COURT: You can bring them out.

THE BAILIFF: Judge, we got one in the bathroom.

(WHEREUPON, the following takes place within the presence of the jury panel.)

THE COURT: All right. Sorry about that. I thought we could go for a couple more minutes but that is perfectly fine. If anybody needs a break, just raise your

hand. Be happy to give you break.

All right. Fair enough.

CONTINUED DIRECT EXAMINATION

BY MR. FISHER:

Q. Doctor Gottfried, did you ask Mr. Sharp why he wanted to see K.M.'s private parts?

A. Yes.

Q. What did he say?

A. I think he just said he was curious. But I mean, ultimately, he said he didn't know.

Q. Did he say -- did he knowledge it should never have happened?

A. Yes.

Q. Now, when you were reviewing the police reports and the -- Mr. Sharp's version of the facts, did you ask him why their -- the versions were so different?

A. I pointed out to him that they were different. He said he had, he had read that Mr. Elvin (phonetic) and they were different. He didn't know why they were different. But that he was telling me what had actually happened.

Q. Okay. Let's move on to the various tests that you used with Mr. Sharp.

Did you, did you use tests of some sort to get a gauge on his mental capacity and his ability to understand

and so on?
A. Yes, I administered a standard battery to everyone that I do this type of evaluation with.
Q. Did you do the Minnesota Multiphasic Personality Inventory?
A. Version 3, yes.
Q. And that's affectionally called the MMPI?
A. The MMPI-3, correct.
Q. MMPI?
A. Yeah.
Q. What are some of the other tests that you performed on Mr. Sharp?
A. I did the SASSI, which is a substance abuse scale. I did the Personality Assessment Inventory. I did the MIDSA that -- I can't remember what --.
Q. Well let's stop there.
What was the SASSI?
That' S-A-S-I?
A. It's two s's. S-A-S-S-I Version 4.
Q. Okay. And Version 4.
And what did that reveal to you?
A. So that is the Substance Abuse Self-Screening Inventory Version 4. And so it's looking at the probability that someone has or has had a problem with drugs or alcohol.

And that indicated that his response was suggestive that there was a high probability that he has had problems with substances or alcohol use. And when I presented the results to him, excuse me, he said that he agreed with that, that he essentially said that, during his twenties, he was clubbing a lot and drank a lot of alcohol.

Q. After the SASSI, what was the next one?

A. The Personality Assessment Inventory or the PAI.

Q. What is that test?

A. So, that is looking at psychopathology. So, symptoms of a mental health disorder. It's also looking at personality (indiscernible) characteristics.

Q. And what did the PI -- PAI reveal to you?

A. His results suggested that he probably has little self-confidence. He might have some specific worries and fears. He might have a traumatic event in his life that he still thinks about.

But there was no indication that he was reporting depression, thought disorder, major mental illnesses. His response is suggestive that he was reporting having difficulty with his angers, stable relationships, having social support.

It also looks at like how motivated somebody likely is for mental health treatment. And so that's not specifically sexual behavior treatment. It's general

mental health treatments and his responses suggest that he likely acknowledges having major difficulty dysfunctioning and perceiving that he really needs treatment.

But I went over his results with him during the follow-up interview. He said that he didn't have any traumatic life experience but that, otherwise, he generally agreed with the results.

He said that he wanted like a therapist or individual counseling to help him kind of adjust after prison but not that he needed sexual behavior treatment. It was more related to kind of experiences that he had in prison and how to reintegrate back into society.

Q. When Mr. Sharp went for treatment as part of probation, was that in -- was he confined or was he out?

A. It's my understanding it's while he was on probation while he was out.

Q. And based on the fact that he reoffended, did the treatment -- was it successful?

A. That would, that would make it not successful because both one of the primary goals of treatment is to prevent reoffending.

Q. Did you perform the Multi-Dimensional Inventory of Development, Sex, and Aggression, MIDSA?

A. Yes.

Q. Explain what that is to the jury.

A. So, this is a self-report instrument used with people who have been sexually violent or sexually coercive. It's looking at like their general sexual histories, what they're reporting about their arousal, their, their sexual experiences. It's a questionnaire based completed on the computer.
Q. And, and you gave that test that -- to Mr. Sharp?
A. Yes.
Q. What was the, the results?
A. You get a lot of results from that and kind of looking to see if they're consistent with what people mean about a sexual history during the interview. I noted that he reported a lot of like anxiousness, nervousness around women and potential sex partners, that he found it difficult to talk to women, that he had trouble finding a sex partner, and, otherwise, I think it was pretty consistent with what he told me during his clinical interview.
Q. What did the -- that MIDSA tell you about Mr. Sharp's sexual preoccupation?
A. There was some evidence of sexual preoccupation but that's noted if somebody reports either having greater than 14 sexual partners or regularly cheating on a partner. And because he told me that he had around 50 sexual partners, that would suggest sexual gratification

on the MIDSA.
Q. What are the Sexual Inadequacy Scales?
A. So that is looking at like anxiousness, nervousness about approaching a woman. It could be related to being embarrassed or anxious when talking about sex, difficulty finding a sex partner, feeling inadequate in your sexual relationships.
Q. And based on your examination, did all of that apply to Mr. Sharp?
A. That's what he was self-reporting.
Q. Let's talk about the PPG. We already talked about what it is.
Did you use the PPG on Mr. Sharp?
A. Yes.
Q. Explain how you performed that examination on Mr. Sharp.
A. So, he came in on the PPG day and he met with the technician. He re -- signed the consent forms. The technician explained the PPG process to him, answered any questions.
He would then watch an instructional video about like how to place the gauge on his own penis, that he should try to remain like as still in his chair as possible during each of the trials of the PPG.
So, then he was administered the PPG. He was given

two different what's call stimuli sets.

So, one of them was called the Real Child Voices set and that has some sound effects in it. So he'll listen to the audio and he was presented with different trials describing an adult man having sex with prepubescent and pubescent female children, consenting adult women, and nonsexual mutual trials.

And then he also was administered what's called the Marshall Set and that is also audio. But it's more of a monotone male voice kind of describing in second person the sexual scenarios and he was given these sets that feature prepubescent and pubescent female victims and then consenting adult women and then nonsexual mutual child as well.

Q. And was that on the Limestone equipment that we talked about before?

A. Yes.

Q. And at the time you administered it, you were certified to administer that test to him?

A. I did not administer it. I have a technician who actually does the administration. But I do the interpretation.

Q. And you've already been qualified as an expert to interpret the data on the PPG?

A. Yes.

Q. What were the, what were the results of the PPG?
A. So, he had an interpretable PPG. That means that it was valid.
So he showed clinically significant sexual arousal to four of the trials on the PPG. So he showed clinically significant sexual arousal to two trials featuring consenting adult women. So that would be like a normal PPG reaction result. And then he also showed clinically significant arousal to one child featuring a prepubescent child and then one trial featuring a pubescent or if you're an adolescent female.
Q. Explain to the jury how, how you interpret this data.
A. So, you're looking at their maximum arousal from where they started at baseline of the trial to where they exhibited the largest circumference change. So, erection, increased blood flow to the penis. So you are looking at that.
Anything over 5-millimeters of change from where they started at baseline is considered clinically significant sexual arousal. And so we only interpret those trials that reach or exceed 5-millimeters of change.
Q. Why 5 min -- 5-millimeters?
A. So I use 5-millimeters because it's a very conservative score.
So, when you have any kind of test, not just for a

PPG but for any test that you could have, you have to determine what the cut score should be and where you should cut that test to say okay, this is a positive result or this is a negative result.

There are zero tests in the world that are perfect and you have to kind of balance would you rather have more false negatives or false positives.

So, if you have a test that has high false positives, in like this example, you're looking at somebody being aroused to children, a high false -- I don't know if I said -- we'll say false positive to start. So, that would be somebody who is not sexually aroused by children but the PPG shows that they are sexually aroused by children.

On the other hand, if you have a test that has high false negatives, that would mean that somebody is aroused by children but the test is not showing arousal. So, because no test is perfect, you have to decide which direction would I prefer my error to go.

And so because the PPG is just one data point that I use in my comprehensive evaluation, I would rather miss somebody on a PPG and say that they don't have the arousal then they actually do then say that somebody has an arousal when they actually don't. And so 5-millimeters of change is a very conservative test score in order to minimize the risk of having any false positives.

Q. Now, based on the, the PPG, did Mr. Sharp attempt to manipulate the machine or explain how he responded?
A. I, I -- there was some data that he may have been trying to purposely manipulate the test results. And so there's a couple things that we do to try to make sure that the test is valid.

So, when they're giving a PPG, on the chair that they're sitting on, there's a pad that's recording their movement. And so we can see if somebody starts squirming a lot during a particular trial. Sometimes people will try to like flex and have arousal or an erection to something they're not actually aroused by. And so we can see all of that physiological data of them moving.

They also are wearing a respiration strap. So I can see if they are holding their breath, if their breathing changes, and all those could be purposeful attempts to kind of prevent them from being aroused.

And so, for Mr. Sharp, there were multiple trials where he was moving a lot, holding his breath, and that could be an attempt to try to prevent him from being aroused.
Q. And what is the next test that you used?
A. Those were all of the tests that I administered and then I scored him on a couple clinician administered tests. So, I scored him on the Hare Psychopathy Checklist

Revised or the PCL-R.
Q. Okay. And what did that reveal?
A. So that is looking to see if like how many or the extent of characteristics a person has with psychopathy or being a psychopath. And it was my opinion, based on his results, that he doesn't have psychopathy.
Q. So the MMPI was a data point?
A. Yes.
Q. The SASSI's a data point?
A. Yes.
Q. The PAI is a data point?
A. Yes.
Q. MIDSA?
A. Yes.
Q. PPG?
A. Yes.
Q. And then you score on the matter?
A. Yes.
Q. And you also have -- well, you interview him?
A. Yes.
Q. You read the police reports?
A. Yes.
Q. You see the background of the offenses?
A. Yes.
Q. Okay. Let's change the subjects a little bit. I'm

not trying to ask this questions.

So, based on your testing, were you able to identify whether or not Mr. Sharp had a paraphilic disorder?

A. Yes.

Q. And what was your diagnosis?

A. Ultimately I diagnosed him pedophilic disorder and exhibitionist disorder.

Q. And as to alcohol?

A. Yes. He also has an alcoholic's disorder.

Q. What are some of the risk factors that you take into account when eval -- evaluating somebody as a risk if they're in the community?

A. So, there is a, a, a very good knowledge of what differentiates these being people who sexually offended and go on to reoffend from those who do not. And so there have been very large research studies following people, usually for about five years, over a period of years to see what are some factors or risk factors or characteristics that make some -- that like separate those two groups of people who reoffend versus those who don't.

And so I assess all of the known risk factors when doing my evaluation.

Q. And are some of those risk factors static risk factors?

A. Yes.

Q. What are static risk factors?
A. So, static risk factors are things that are not changeable. So, for example, your, you know, your age. You're, you're always gonna get older. But there's no treatment that I can give you that's gonna make you younger. So your age is not treatable, not changeable.

We know that the presence of a male victim differentiates between those two groups. And so I can give you treatment so that you never have another male victim. But there's no treatment that I can give you that's gonna take that male victim out of your past.

So, static risk factors are things that you can't change. They're always gonna be there in your history.
Q. Now, as a static risk factor, was age at the time of the release from the indexed sexual offense reported to you?
A. Yes.
Q. Explain to the jury why that was important.
A. So, your risk goes down the older that you get. When I evaluated Mr. Sharp, he was 36. He's 37 now.

So, it's kind of a mutual. You can get a zero on the risk measure for that. But if he was like over 40 or over the age of 60, that could be what's called a protective factor. And so, while this isn't increasing his risk, it's also not decreasing his risk.

Q. What about nonsexual violent offense convictions prior to the indexed sexual offense?
A. Yes.
Q. Why was that important to you?
A. The assault and battery from 2012 is a violence offense. So, it's categorized on the risk assessment measure as a -- both a, a sexual offense because we know the underlying details. But also a nonsexual violent offense. And so the presence of somebody having a history of convictions for violent offenses could increase their risk and that's a known risk factor.
Q. You, you talked about the relationship between Mr. Sharp and A.S.'s -- I, I don't know if you called it bumpy or -- but, to your knowledge, was there a domestic violence injunction issue?
A. Is, is an injunction like a protective order?
Q. Yeah.
A. I believe so. There was a hearing and I believe that she got the permanent restraining order against him.
Q. So would that be a, a prior conviction nonviolent or would that be violent?
A. Well, it wouldn't necessarily be considered a conviction because, for this risk assessment measure, we're looking at criminal charges. And so, to my knowledge, I don't think he was convicted of domestic

violence against her and I think that would be civil.
So, for the purposes of that measure, we wouldn't factor that in because it wasn't like he was arrested for criminal domestic violence and was convicted of it.
Q. And did you consider prior sexual offenses?
A. Yes.
Q. Explain to the jury why that was important to you.
A. Well, so, we know that one of the best predictors of future behavior is past behavior. So, the presence of being charged with and convicted of sexual offenses in the past, that's a risk factor for reoffending because a person has already reoffended.
Q. And did you -- let, let me see if I got that right.
Did you say that the best indicator of future conduct is past conduct?
A. Yeah. One of the best predictors of future behavior is looking at what somebody's done in the past.
Q. And as far as static risk factors, did, did you consider prior sentencing dates excluding the indexed sexual offense?
A. I did.
Q. And explain why that's important to you.
A. Well then, for Mr. Sharp, that was scored a zero on his risk assessment measure because the, the magic number I guess from the literature that separates people is if

you have four or more prior sentencing dates for anything that differentiated between people who reoffended from those who didn't as one of the risk factors.

So -- but I also noted that all of his offenses that he's been arrested for prior to the sexual offenses were like very minor traffic stuff, speeding, maybe not returning your license after it was suspended, things like that, and a lot of them were dismissed. So pretty much his entire criminal history was -- were the sexual offenses.

Q. How about convictions for noncontact sexual offense?

A. Yeah.

Q. Did you consider that?

A. I did.

Q. Well, why, why did you consider that?

A. So, noncontact sexual offenses are ones that are kind of -- they're called hands-off. So, exposing yourself in public or looking at pornography as an example, those would be hands-off or noncontact offenses. We know that a lot of noncontact offenses have high reoffending rates. And so that is another risk factor that's separated people who reoffended from those who didn't.

Q. Now, at -- did Mr. Sharp admit that he was hands-on with K.M. --

A. Yes.

Q. -- the, the first -- the first lady, young lady?
How about unrelated to the victims?
A. Yes.
Q. Explain why that's important.
A. So, people who offend against family members have re-offense rates that are lower than people who offend against victims who are unrelated to them. So, all of Mr. Sharp's victims were not related to him like blood or---
Q. Okay.
A. ---family.
Q. And what about a stranger to the victim?
A. Yes.
So, we -- offending against strangers, then you're known for less than 24 hours is a risk factor that separates people who reoffend from those who don't. All of the victims from 2017 were strangers to Mr. Sharp.
Q. And based on those static risk factors, were you able to reach a, a conclusion?
A. Yes.
Q. And explain to the jury how you score it and what those numbers mean.
A. So, all of this is referring to a measure called the Static-99R. And so this is a risk assessment measure that is looking at the known static risk factors based on the

research studies of what separates men who reoffend from those who do not sexually. And this is what's called like a mechanical or ancillary technique of looking at risk assessment.

And so what that means, and then use an example, if you think about like when you apply for life insurance, the life insurance company is gonna want to get a lot of information from you to look and see if you have risk factors that are associated with early death. So, they're gonna want to know, you know, do you smoke, do you get a lot of speeding tickets, are you a race car driver, are you a man or a woman cause we know that, on average, women live about five years longer than men.

They're going to, you know, send you for a physical, get your blood pressure, and all of that. And so they're gonna put it together and decide like how they're gonna charge your premium.

So, the life insurance company has no idea when you are gonna die or if you are going to die early. But they're gonna look to see how many of those risk factors that are known or associated with early death, how many you have.

And so, in a similar way, the Static-99 can't tell you anything about the person that you're assessing. It's only looking at these known risk factors to see how

similar or dissimilar person is that you're evaluating.
Q. And based on those static risk factors, were you able to reach a conclusion as to what Mr. Sharp's score would be?
A. Yes.
Q. What was that score?
A. So, he scored a five on the Static-99. So the scores range from negative three to 12 and a five is in the above average risk range for being charged with or convicted of a sexual offense.
Q. So, based on the test and the interview and everything that you did, static risk factors led you to believe he's a -- above average or well above average?
A. He is above average risk on the Static-99.
Q. What are the dynamic risk factors?
A. So, dynamic risk factors are risk factors like I mentioned but these are ones that you could treat. They might be really difficult to treat but they're treatable.
So this is gonna be things like using drugs or alcohol, like a problem with drugs or alcohol, having paraphilic sexual arousal. So we know that that's really hard to treat, just like drugs or alcohol, really hard to treat but they are treatable.
So, these are things that you can identify as being treatment needs or targets. And so we separate them from

the static factors, which are not changeable, and these are the dynamic risk factors.

Q. Now, did you consider his sexual offending cycle?

A. I did.

Q. And explain to the jury why you would consider that effective.

A. So, for Mr. Sharp, the frequency of his sexual acts, so he offended in 2012 and then multiple times in 2017, the victim pool. So, if I mean against -- his girlfriend's daughter and then people who are complete strangers to him. He self-reported offending against adult women by exposing to them. He wasn't arrested for that.

So, that victim pool of, you know, prepubescent children to adult women, all of that suggests a risk factor for him.

Q. And what about treatment compliance?

Did you, did you consider that a factor?

A. I did.

Q. And tell us about that and why you considered it.

A. So, completing sexual behavior treatment can be a protected factor. We know that it can prevent reoffending.

For Mr. Sharp, he successfully completed treatment literally at the end of 2015. But he was arrested for new

sexual offenses in 2017 after he had already successfully completed that treatment. So, that means that the treatment wasn't successful. It didn't work.

Q. What about deviant sexual preference?

Did you consider that?

A. I did.

Q. Explain to the jury why you -- what this is and why you considered it.

A. As I mentioned, if somebody is sexually offending because they're sexually aroused by that behavior, that is a risk factor.

So, I diagnosed Mr. Sharp with pedophilic disorder, which is sexual arousal to prepubescent children. That's a paraphilic disorder. I also diagnosed him with exhibitionistic disorder. That is sexual arousal to exposing your genitals to unsuspecting people and that is also a paraphilic disorder and we know that, if you're offending because you like it, you're aroused by it, that increases your risk.

Q. What about sexual compulsivity?

Did you consider that factor?

A. Yes.

Q. Why did you consider that?

Well, first of all, what is it?

A. That's looking at sexual preoccupation. So having a

much higher or a higher number of sexual partners to be using sex as coping. You're feeling bad about yourself. Also a known risk factor for sexual reoffending and, and he, based on his history and his descriptions of the sexual behavior, there's some evidence of sexual preoccupation.

Q. And what, what are intimacy deficits?

A. That can be problems in your relationships, problems romantically finding a partner, having stable relationships.

Q. Did Mr. Sharp indicate that he had stable relationships?

A. At least the, the one with the victim's mother did not seem very stable. Police had been called to the home before and just kind of a lack of really like intimate relationships with appropriate aged adults.

Q. How many total relationships with adult consenting women did Mr. Sharp say that he had?

A. Relationships or sexual relationships?

Q. No. Relationships. Not, not just sexual.

A. He reported having three significant romantic partners.

Q. And how old is he?

A. He's 37.

Q. Did Mr. -- did you consider compliance with community

super -- supervision?
A. Yes.
Q. And why -- what, what is that and why did you consider that?
A. So, an inability to follow like the rules and regulations is a risk factor. For that risk factor, Mr. Sharp was on probation and he offended while on probation, which also violated his probation.
So, I believe that they -- I don't, I don't know if they violated or if he was investigated for a violation of probation not only because he didn't notify his officer that he'd been arrested for new offenses but also I think that like not paying or not calling up to his officer. So, he demonstrated some problems following these rules and regulations.
Q. But the offenses against S.V., E.B., L.L., and A.L., he was on probation when he committed those offenses of which he was ultimately convicted?
A. Correct.
Q. Did you consider insight?
A. Yes.
Q. What is that?
A. So, insight is your understanding of what's going on within yourself and having a lack of insight can be a rise factor for future offenses. I don't think that Mr. Sharp

has very good insight into his risk for reoffending for reasons he offended and reoffended in the fist place.

His sexual arousal, I don't think he has good insight into how he can prevent another sexual offense. He described some techniques of just like kind of suppressing his sexuality and we know that like avoidance and suppressing are not sufficient to avoid these kinds of behaviors.

While he has insight and he, you know, reported feeling bad about what happened in 2012, like that insight wasn't enough to prevent the 2017 offenses. I also think that he lacks insight if he really truly believes that he offended in 2012 cause he was curious about the victim.

Q. Did you ask him why, why were you curious about this victim?

A. Yeah, he said he didn't know.

Q. During the course of your interview, did Mr. Sharp indicate that he had knowledge of what he was doing and, and did it anyway?

A. Yeah, I mean I, I know that he said that he felt bad about it. I know that he said, in the prior evaluation, that like he didn't like the victim being at the house because he was trying to avoid doing this or avoid evil thoughts. But, yeah, he, he, he acted on it despite that.

Q. And did you consider cognitive distortions?

A. Yes.
Q. What is that and explain to the jury what -- why you considered it?
A. Cognitive distortions essentially are what we tell ourselves to make something okay. So, we might -- an example I give in treatment is I might decide I'm gonna go to the gym every day after work. And then there's gonna be days where I'm gonna like, you know, give my permission. But in -- instead of just giving myself permission, I'm gonna say you know what?

I worked really hard this week. So, I deserve to take a day off or I am gonna do twice tomorrow.

So, it's what you tell yourself to make something okay even when you didn't want to do it or you promised yourself that you would do something.

And so, for Mr. Sharp, I think the -- that he was curious about these prepubescent girls. Like they said that's a cognitive distortion of him kind of not wanting to admit to himself that he's sexually aroused by this and that's why he was doing this.

Q. Sort of denial?
A. I mean it can be related to denial. It's more of like making it okay to yourself.
Q. And the last is -- of, of the dynamics risks is substance abuse.

Did you consider that?
A. Yes.
Q. What is it about substance abuse that's important to know as you value risk assessment?
A. So, we know that there's no drug or alcohol that's gonna make somebody do something that they never thought of before. Like, you know, drinking a lot of alcohol is not gonna make you rape somebody if you've not had that thought before.
So, the presence of, excuse me, substances on its own is not a risk factor for committing sexual offenses. But if you've committed a sexual offense, and you have a problem with drugs and alcohol, that can lower your inhibition. It can make you, you know, less in control of yourself.
So, if you have a problem with drugs or alcohol and you've offended, continuing to do that is going to increase your risk for future offenses and, and Mr. Sharp has a history of problems with alcohol.
Q. Okay. And based on all of the dynamic risk factors, did you come up with a score for Mr. Sharp?
A. So, when I look at dynamic risk factors, it isn't a scored measure. It's kind of a guide to thinking about all of the known risk factors and you kind of put those together, and, and based on my evaluation of all the

dynamic risk factors that he has, he was at high risk to reoffend.

Q. Okay. Moving on a little bit.

Did Mr. -- did, did Mr. Sharp indicate to you that he had a plan, a future plan, to stop from reoffending?

A. I discussed his plans with him. I mean he, he said some things that would make me think that he thinks that he has a future plan to, to avoid reoffending. But, to me, it wasn't sufficient.

Q. Do you know if he's got any probation in the future, supervised release, anything?

A. I believe his only requirement will be that he has to register on the Sex Offender Registry. But he'll have no supervision.

Q. Now, doctor, based on the risk factors that we've talked about and, and your complete analysis and diagnosis of Mr. Sharp, did you reach a conclusion?

A. I did.

Q. And what is that conclusion?

A. My ultimate --

Q. Yes.

A. -- conclusion?

So, putting it all together -- so not only did I score the Static-99 but we also have a measure called the Static-2002R that looks at both static offending and in

addition to works in the report over here and that also put him at above -- well above average risk to reoffend.

So, compared to other men who have been charged with or convicted of sexual offenses, he is at above to well above average risk to reoffend. He has a number of risk factors including paraphilic sexual arousal to prepubescent young girls. I don't think that he has good insight into why he offended, these disorders, the treatment that he needs to keep other people safe.

I think that it's really concerning that he successfully completed treatment, got this probation sentence, but continued to offend while he was on probation and after being successful according to the treatment provider on this treatment.

So, it's my opinion that he's likely to sexually reoffend if he doesn't get the, the treatment.

Q. Okay. And did you draw all your conclusions to a reasonable degree of psychological certainty?

A. Yes.

MR. FISHER: I think that may be it, Your Honor, but if I may have just a moment?

THE COURT: All right.

(Pause.)

Q. I do have a question.

Do you believe that Mr. Sharp has a propensity to

engage in sexually violent acts in the future?
A. Yes.
Q. Do you believe that he poses a menace to the health and safety of others if not committed to long term treatment, care, and control?
A. It is my opinion that he needs treatment in order to control his behaviors and, without it, that -- without it, he would reoffend.
MR. FISHER: Okay. That's all I have at this time, Your Honor.
THE COURT: All right. All right. Yes, sir.

CROSS-EXAMINATION

BY MR. WILSON:

Q. Doctor, let's start with, with this.
In -- in your report -- and your report, as I understand it, was done in what, '23?
Is that correct?
A. Correct.
Q. All right. And, and, as I understand it, it was done at your facility and that -- is that in Charleston?
A. Correct.
Q. All right. And also, as I understand it, Mr. Sharp came to your facility or was brought to your facility?
A. That's right.
Q. All right.

A. He was transported on three occasions.
Q. All right. And was that voluntarily or involuntarily or do you know?
A. Well, he didn't -- like he did not request the evaluation.
Q. Okay. He didn't request it.
But I understood you to say that, once he got there, that you had him sign some kind of a consent form, right, in order to undergo whatever test you were going to have him undergo, right?
A. He signed a consent form for the entire evaluation.
Q. Okay. And did he sign it?
A. Yes.
Q. All right. Were you present when he signed it?
A. Yes. And, and it gets witnessed as well.
Q. Okay. And, and just so I'm clear, did he give you any difficulty?
During this evaluation that you did, did he give you any difficulty whatsoever in either refusing to answer your questions or refusing to cooperate with you in anything you asked him to do?
A. I would say that he was cooperative. He was overall polite. I think that him saying I don't know to a large number of questions was less than cooperative. But he was polite and, and attempted to answer every question I had.

Q. Well, let's talk about that for a second.
You said that he answered some questions and said I don't know?
A. Yeah.
Q. So, if he doesn't know, how is he suppose to tell you something that he doesn't know?
A. Well, if, if you genuinely don't know, then I don't know would be an appropriate response. But some of these questions -- he, he answered I don't know to a large number --
Q. Uh-huh. (Affirmative).
A. -- specifically about his offenses or how he could successfully prevent to reoffend. So, it wasn't like, you know, being tired of every question I asked him and said I don't know to.
Q. So---
A. We had those two areas.
Q. Did he deny to you any of the offenses for which he pled guilty?
Did he deny any of them?
Did he say I didn't do it?
A. Not the offenses. It was more of like the differences of what was in the officially reported documents and what he said he did. But I mean he said he, he did something to each of the victims.

Q. Right.
And now the details that we're here talking about, the details that you read which you say were in the warrant or in the charging documents, were somewhat different than what he said?
A. Yes.
Q. Is that what you're talking about?
A. That would be where the inconsistencies would---
Q. Okay.
A. ---of been. But he, he did say that, that he did something to each of the victims that he was convicted of.
Q. But you've being doing this a long time.
How long did you say you've been doing it?
A. I mean I've been at MUSC for nine years and then I've, I've done similar work as a trainee for years before that.
Q. Okay. So, a lot of years.
But the bottom line is you know that he didn't write those police reports or those incident reports that you were reading, right?
A. He did not.
Q. All right. And he would of had no input in what's in there, right?
A. I would imagine he would have no input.
Q. Right.

Okay. Now -- but let's talk for a minute about these battery of tests that you gave. We're gonna talk about that. But, but even before we get to that, let's talk about how you got involved in this case.

You got involved in this case when you got a letter from the Attorney General's Office, right?

A. Yes.

Q. And that letter asked you to give an opinion on this particular individual. That is Mr. Sharp.

A. Correct.

Q. All right. No question about that?

A. No questions.

Q. And no question about the fact that you got paid for that or is getting paid for that or however that works?

Fifty-six hundred dollars I think is what you told the attorney general?

A. Yes.

Q. Right?

A. MUSC receives $5,600 for it.

Q. And you said that -- how many of these you done, 46?

A. Well, that was -- that's just for precommitments.

Q. Well, that's what I'm talking about.

That's what we're here on, the pre, right, a precommitment --

A. Correct.

Q. -- evaluation?
And you said you've done 46 of those---
A. Fifty---
Q. ---for---
A. Fifty-six.
Q. How many?
A. Fifty-six.
Q. Fifty-six.
All right. So you've done 56 of them and are you the only doctor in the state that does these pre-evaluations when they've been denied by the Department of Mental Health?
Are you the only one?
A. I -- that I don't know.
Q. Well, you're the only one at MUSC, right?
A. Oh, I'm the only one at MUSC---
Q. Right.
A. ---that does---
Q. Nobody else does it?
A. No.
Q. Do you know of any other doctor in South Carolina who does these second evaluations other than you?
A. Yes.
Q. Who?
A. I believe Jeff McKee has done one or two. I, I, I

know there have been cases that I have not done and that they had somebody else do it.
Q. And how many, how many times has that happened then that you know of?
A. That I don't. I don't think it happens that often. But I don't know, I don't know the number.
Q. All right. Maybe twice.
And, and how many years you're talking?
A. I've been doing these maybe where they've used August (phonetic) maybe since 2017---
Q. Okay.
A. ---'16.
Q. All right. And you knew, you knew in this case, when you got this case, when it was sent to you for the evaluation, that another doctor had already done an evaluation, right?
A. Yes. Whenever I get asked to do an independent evaluation, it's always because somebody else has already seen this person. The Department of Mental Health does all of the initial.
Q. And you know that if you -- if it was sent to you, that they're looking for a different opinion than what they got before because otherwise there'd be no reason to send it to you, right?
A. I don't know if they're looking for a different

opinion. They're looking for a second opinion and, and I do them for both sides. I've done them for the respondent's attorneys in addition to the Attorney General's Office.

Q. Well, right now we're just talking about the attorney general. We'll come to that in just a minute.

You knew when you got the report, when you got the request, that you were expected to do a report and that -- and, and, and let me ask you this. You also got a copy of the report that was done by the other doctor.

Is there any question about that?

A. Oh, no. Yeah. I---

Q. Right.

A. ---review that report as well and go over it.

Q. So, you had the advantage of reading the other doctor's report and then doing your report?

A. I don't know if it's an advantage. But, yes, I, I review all the materials that I receive before I do the---

Q. Yeah.

A. ---evaluation.

Q. And so even before you started doing your report, you knew that another doctor in the State of South Carolina who works for the State of South Carolina had already made a determination that he was not, was not a pedophile or pedophilic, right?

You knew that.
A. I -- yes, I read the opinions of the Department of Mental Health evaluator.
Q. My question was did you know when you read the report that that report said that he was not pedophilia?
A. I, I know that, that she did not diagnose him with pedophilic disorder.
Q. So is that a yes, you did know?
MR. FISHER: Objection, judge. This is getting argumentative.
THE COURT: Just ask the question.
Q. Did you know, that's my question, when you got your report and you read it, did you know?
A. Did I know what?
Q. Did you know that the other report from the other doctor said that he was not pedo -- pedophilia?
A. I answered the question she did not diagnose him with pedophilic disorder.
Q. Okay. So then the answer is yes, right?
A. That she did not diagnose pedophilic disorder.
Q. Yes.
A. Yes.
Q. Okay. Now -- but you did?
A. I did.
Q. Right.

Also, let me ask you, when you got the report, did you know that that report recommended that he was not in need of treatment and care on a long term basis?
A. Did I know that he wasn't in treatment and care?
Q. Did, when you got the report and you read the report, did you know that the report said that he was not in need of long term -- long term care and treatment?
A. Yes, I know that it was the evaluator's ultimate opinions that he did not have a mental abnormality or personality disorder that made him need a long term treatment and care.
Q. That's right.
And that is just the opposite of what you're saying here today, right?
A. Right. There's two ways you can go. She, she had one opinion. I had the other.
Q. That's the point. It's an opinion.
MR. FISHER: Objection, judge.
Can we approach?
THE COURT: Sure.
(WHEREUPON, a bench conference was held out of the hearing of the jury at this time.)
Q. Repeat my question.
Did you know that---
THE COURT: She's already asked and answered that

one.

Move on.

MR. WILSON: Judge, and, and I apologize---

THE COURT: That's o---

MR. WILSON: ---but I'm trying -- and I'm not -- how---

THE COURT: She gave her opinion.

MR. WILSON: Yes, sir.

THE COURT: All right.

MR. WILSON: But I need to -- I need to make sure that I'm clear on where I'm going with this and I, I need her to be clear about the answers and I understand -- and I'm not---

THE COURT: All right. Just ask the question. Let me see what it -- what, what the question is.

MR. WILSON: All right.

Q. My question is this and I will try to phrase it as clear as I can.

When you got the report, you understood that the Attorney General's Office was asking you for an opinion?

MR. FISHER: Objection. Asked and answered.

THE COURT: Just say yes, no, and then explain.

Doctor, just say yes or no and then explain.

THE WITNESS: I'm, I'm sorry.

Could -- the question is that they were requesting a

second opinion?
Q. Yes.
A. That is what I understand.
Q. Yeah -- yes, sir, that's the question.
That is the question you answered?
A. Yes.
Q. All right. Now, doctor, you also said that -- I think it was -- the other thing that you spent -- you found that he was -- is it an exhibitionist?
Is that what it was?
A. Yeah, he meets diagnostic criteria for exhibitionistic disorder.
Q. Okay. And you also know that the original report that was issued by the state prop -- or the Department of Mental Health for the State of South Carolina says that that's not true either, right?
They disagree with that in that original report, right?
A. She did not diagnose exhibitionistic disorder.
Q. Right.
And is it unusual for a doctor, psychologist, to have disagreements about various things?
A. Sure.
Q. Sure.
And when we have disagreements, it doesn't mean that

I'm right and you're wrong or you're wrong and I'm right. It just means my opinion versus your opinion.

Right?

A. I don't know how to answer that. It's my opinion that he did meet for those disorders.

Q. Right.

That's your opinion --

A. Yes.

Q. -- which you got paid $5,600 to write, right?

A. I didn't get paid 5,600.

Q. And how many cases did you say that they refer to you?

How many, how many do they refer to you?

You said 56, right?

A. Total or, or for precommitment?

Q. Pre. Let's, let's stick with that.

A. Fifty-six.

Q. Fifty-six at five hundred -- five thousand dollars a clip?

A. Well, the -- it changes over the years.

Q. Yeah.

Now -- and did I understand you to say that no other doctor, the only doctor, literally hundreds if not more doctors at MUSC, right?

Do you---

A. We have -- I, I would imagine with you -- with all the specialties, there's probably at least a hundred physicians and doctors that work at MUSC.
Q. Okay. Well, let's make it easy.
They're at least dozens and dozens of doctors at MUSC?
A. Yes.
Q. And MUSC is one of the most respected universities in the State of South Carolina, right --
A. Sure.
Q. -- or medical facility?
And on top of that, you're the only doctor there that does this, these precommitments, for the A.G.'s, right?
In fact -- wait. I'm sorry.
A. Well, I'm the only one qualified to do them. So, in forensic psychiatry, we have four full-time psychologists. But I'm the only one qualified out of that group. A forensic psychiatrist could also be qualified. We have three or four of those and, and none of them specialize in sexual behavior.
So I'm the only doctor at MUSC who does forensics and specializes in sexual behavior.
Q. Okay. All right. Now, let's talk for a minute about this PPG test that you say you did.
All right. Because, in your report, other than --

because you say you did a Static R -- I think you said the Static R99?

Is that what you called it?

A. I did the Static-99R and the Static-2002R.

Q. Okay. But that was also done in the first report by the doctor from DMH or Department of Mental Health, right?

A. She did a Static and a -- 99 and 2002 as well.

Q. As was her results different than yours?

A. No.

Q. And those tests, those tests, the Static R99, that test, those are pretty standard -- standardized test, right, in your profession?

A. All the tests I give are standardized.

Q. All right. And so the results that you got mirror the results she got, right?

A. We scored him on the same measures and we have the same results, yes.

Q. You got the same results on those two tests, right?

A. Yeah.

Q. But what you do is you give him what's called a PPG test, penile test, right?

A. It's -- that's one of the measures in my battery of all the tests I give.

Q. Yeah.

And did -- other than the penile test, was there any

test that you gave him, any standardized test that you gave him, that he was not given by the Department of Mental Health?
A. Oh yes.
Q. What, what was that?
A. The MMPI-3?
Q. Okay.
A. The SASSI-4.
Q. Okay.
A. The PAI, the MIDSA --
Q. Well --.
A. -- the PCL-R, the Sexual Violence Risk Poinengy (phonetic). I, I gave those.
Q. Okay. All right. And when you gave him this -- the Static R99 test, you come up with the same results that the state hospital or DMH has come up with?
A. Well, I don't give the test. That's a clinician administered score -- or scored test where I rate them.
Q. Okay. So -- but you interpret the results, right?
A. Yes.
Q. All right. And so that's kind of your opinion again about what you think it shows, right?
A. I'm not sure I understand the questions.
Q. Well, my question is you didn't give the test, right? You said you didn't give it.

A. It's -- Static is a clinician's scored. So, based on my expertise, I score him on the presence or absence of the risk factors.
Q. I understand.
But my question is you said that you did not give the test yourself. A clinician gave the test.
A. No.
Q. The---
A. So, the Static is -- I score it. He does not have anything to do with that test.
Q. All right. So you---
A. So he---
Q. ---you administered the test and then you scored the test?
A. Well, I, I rated him on that test. So I took the test.
Q. All right. Did you administer the test or not?
A. No.
Q. Who administered the test?
A. The static is not -- you don't administer it. You score them on the test yourself.
Q. All right. Well, somebody has to either read him the questions or ask him the questions or give him the information or show him the video or whatever it is you're gonna do.

Who did that?
A. No one needs -- he does not -- he does not participate in a Static scoring.
Q. So, you do a test without the person participating?
A. Correct.
Q. All right. So, you just what, go in a room and write something down and say this is what I've think?
A. Pretty much, yeah. We score them on the risk measures.
Q. All right. Okay. All right. So, you, you, you, you let -- you give him a test with -- that he's not a part of.
Now, when he came to you, did you do three days of testing with him?
A. I mean we did three days. The third day is the clinical interview.
Q. Three days of testing with him. But I want to talk for a minute about the PPG test because that's the, the one where, as I understand it, and you help me if I -- if I explain it wrong, then you, you stop me.
Where -- y'all have him come into a room. He is seated in a chair and the chair has got some kind of device in it that, if he moves, then you're gonna know about it, right?
A. It's a pad that's measuring your mid (phonetic) --

Q. Okay.
A. -- pressure.
Q. All right. And so he sits in that chair.
Then you have him see a video of how he is to put some kind of a ring around his private parts, right?
A. It's a gauge, yes.
Q. Okay. And so after he sees the video, then he has to put this device or ring on his private parts all of which is being videotaped?
A. No.
Q. Well, didn't you, didn't you say earlier, at least at another occasion, that there is a video, a security video, in the room the entire time and there's a security video in the room -- in every room at MUSC?
A. Yes.
Q. You did not say---
A. In forensic psychiatry, we have security cameras in every room. But part of our administration checklist when somebody is having a PPG, they -- the camera is covered up when they're putting the gauge on themselves. They're in the room by themselves and then, during the testing, they're covered up. But the camera only monitors from like the, the chest up. So, his penis is not on the camera.
Q. Well -- okay. Well then, if that's true, then how in

the world would you know whether he's manipulating himself or not when he is seated in the chair?
A. Because it's -- that doesn't come from the video. It's the movement and the breathing, physiological data.
Q. Oh. So, so, you put him in the chair.
And so now his private parts are out, right?
A. No.
Q. Well, where are they?
If you got a ring around it, where are they?
A. There's a drape. They can drape themselves. They can pull their pants back up. It's just a little band that goes around their penis. It doesn't interfere with them being covered or wearing clothing.
Q. All right. And so -- and how long does this test that you're talking about where you put the ring on, how long does that take?
A. So, it would be, as to two different sets, the RCV set and the Marshall set. There's different trials. The trials are about two and a half minutes each. Typically there's a lunch break in-between. It's an hour and a half, two hours like per sets.
Q. Okay. And what you're trying to test for is blood flow, right, blood flow in the penis and to determine if he is becoming aroused?
A. It measures arousal.

Q. That's right.
It will -- measures the blood flow?
A. It measures the changes in the circumference to the penis.
Q. Okay. And what causes the change in circumference of the penis?
A. An erection.
Q. And an erection is caused by what?
A. Increased blood flow.
Q. Increased blood flow. So we're at -- back to blood flow. So it's, it's the blood flow.
And what happens is, when the blood flow starts or the process starts, then you're saying that this little device that you put around the penis, that's what's gonna determine whether or not he is aroused by whatever it is, the stimuli or whatever it is you're showing him, and the stimuli would be whatever pictures or voices or whatever it is you're showing him, right?
A. Correct.
Q. All right. Now, as I understand it, you said that they're four sets of stimuli, right?
A. Two.
Q. Or two. Two sets of stimuli. But there were four different ones. Two with adult females and two -- one with a prepubescent child and one with a pubescent child?

A. Those -- there were four that he demonstrated clinically significant sexual arousal to.
Q. All right. Two of them being adult females, right?
A. Yes.
Q. And one being a prepubescent child?
A. Yes.
Q. One being a pubescent child?
A. Yeah.
Q. All right. Now, what order did you give this stimuli to him?
A. What, what do you mean?
Q. What I mean is, in each set, which set did you do first?
Did you do the adult females first?
Did you do the prepubescent child first?
Did you do voices first?
What did you do first and in what order?
A. I believe what -- we did the Real Child Voices first. And so that contains prepubescent girls, pubescent girls, adult women, and then did the Marshall, which also has similar stimuli. So, it isn't like you got all of the adults and then all the children. They alternate.
Q. Okay. So, so, you think that you did the prepubescent first?
Is that what you're saying?

A. No. I believe we did the Real Child Voices first and that includes consenting adult women, prepubescent girls, pubescent girls, neutral nonsexual, and then, after the lunch break, he would of gotten the Marshall set, which also includes prepubescent and pubescent girls, consenting adult women, and mutual contact.

Q. Okay. All right. So, so let's talk about that. You show him the adult voices first.

Is what you're saying?

A. No.

Q. All right. Well, explain it to me cause I'm, I'm confused.

A. So the first set that he had was the Real Child Voices.

Q. Real Child Voices.

Explain to us what that is.

A. So that is an audio set where there's sound effects. So there's, for example, one of the childs (sic) describes a situation of a woman getting raped in a bar. So, you would hear like a woman's actors voice. You would hear the man's voice. You would hear glasses clinking. The ones that feature children have child actors and you can hear their voices and everything, the mutual ones.

So he would get all of the trials out of the Real Child Voices set. So, the adults, the children, the

neutral.

Then typically they would take a lunch break. Then he'd come back in the lab and then he would do the Marshall set, which is the monotone male voice describing the sexual situations between consenting adults and women and adult man and prepubescent and pubescent children and then the neutral non-reference child.

Q. Okay. So, and each set you're going to be measuring, correct?

A. It continuously measures throughout the whole test, correct.

Q. So, how long are these, these voices -- let's say the, the, the Real Child Voices.

How long are, are -- audio is that?

A. So we---

Q. Two minutes, three minutes?

A. Each child is about two and a half minutes.

Q. Okay. And, and how many of those sets do you show to him or give to him while he's seated there?

A. How many trials?

Q. Yes.

A. Let's see what I have here.

So because he has no male, male victims, I would have omitted the male victims. So, for the Real Child Voices, he was administered 17 trials.

Q. Seventeen trials?
A. Yes. And that includes the neutral, the consenting adults, the rape of an adult, a woman, and then the prepubescent and the pubescent.
Q. Okay. So, if you give him all of these, how do you know which ones he's reacting to?
A. Well, you're looking at ones that demonstrate clinically significant arousal.
Q. Well, that's my point.
How do you know that?
How do you know it's regarding the adult females or whether it's regarding the prepubescent children or the pubescent children?
How do you know which of these stimuli is causing him to have the blood flow or the erection?
A. Well, so from the data when I'm interpreting a PPG, I'm looking at each trial individually and looking where he started with his circumference of his penis was, where he started for that child at baseline, and then I'm looking at his maximum arousal on that trial. When somebody demonstrates clinically significant arousal, so they can get an erection, the next trial is not started until the penis returns to baseline.
Q. So, tell us how it is that you know what he's thinking about when he becomes aroused.

How do you know that he's not thinking about his girlfriend that he had last year or that he's not thinking about somebody he saw on television yesterday or even you for that matter?

How do you know that?

A. I don't know what he's thinking while he's doing anything.

Q. No, I'm asking you how do you know what's going on in his head so that, even though you're showing him a picture of one thing, that that's what he is reacting to?

A. No, I, I don't know what happens in his head.

Q. Right. You don't.

And there's no way to know in this world what a person is thinking of when you're showing them one thing that they're not thinking about something else?

A. Well, I, I can't read anyone's mind. So I don't know---

Q. Right.

A. ---what he's thinking.

Q. That's right. That's right.

So, the only thing the test really tells us is that he had blood flow and erection at some point in time while he's seated in that chair?

We know that much, right?

A. Correct.

Q. Right.
So, beyond that, the test is really worthless because you can't tell us what he was thinking about when he got erect?
A. I, I would disagree that it's worthless.
Q. But that's one of your data points, right?
A. Yes.
Q. Yeah.
A. I, I think it's worthwhile.
Q. Yeah.
A. That's why it's admitted.
Q. Yeah. It's one of your data points. A lot of psychology is based on your interpretation of what is before you.
Would you agree with that?
A. I'm not sure I understand.
Q. Well, let me help you a little bit.
In trying to make decisions about various things in your report, do you have to make or give your opinion?
Do you have to interpret whatever it is was said or done just like you did with the PPG test?
You interpreted that to mean that he was a pedophile in the sense that he might be interested in children, prepubescent children and pubescent children. That was your determination.

But that was your opinion, right?
A. I would say everything is my opinion.
Q. Right. That's my point.
So, what you're giving us is not any hard and fact -- fast fact. You're giving us your opinion, the benefit of your opinion?
A. Well---
Q. And everybody's got one, right?
A. So, I was asked to give my expert opinion because, ultimately, the ultimate issue was up to the trier of fact, which would be the jury or the judge. So, it would always just be my opinion.
Q. All right. Okay. Now, let, let, let me ask you if, if, during your evaluation process, as I understood it, you said that you tell the individual that look, we don't want -- sign this consent form, and not only will you sign it, but we want -- there may be other people in the room looking, watching, students, other clinicians, or doctors, or whatever, right?
Is that what the consent form makes them agree to?
A. That's one of the items on the consent form.
Q. Yeah.
And so when, when I'm seated in that chair trying to put this device on, there could be other students looking at me, seeing me do this as a part of their training?

A. There could be. When I have people observe, we normally sign this consent form. I entered -- like I ask the person's permission. I say, hey, I have a fourth year medical student working with me today. Would it be okay if they sit in.

So, I notify them of that. But, yes, it's on the consent form that, because we're an educational institution, most of our work is going to be training other people or students learning.

Q. Did you find any arrests or conviction for any offense of Mr. Sharp after 2017?

A. I do not -- I don't believe he was ever arrested after 2017.

Q. Right.

And this is what?

2024?

A. Well, I, I don't think he's had an opportunity to reoffend.

Q. Okay. But my question was is there any record of him reoffending since that date?

A. Well, I don't think he's had an opportunity because I, I don't think he's been in the community to reoffend.

Q. Yeah. And I don't mean to be argumentative. I apologize. But that's not my question. My question was simple.

THE COURT: She's asked and answered the question.

MR. WILSON: Thank you, Your Honor.

Now, as I understand it, you're saying that, that you determined that he is a pedophile, right?

A. I diagnosed him with pedophilic disorder.

Q. And, and that's based on the PPG test and what else?

A. So, the diagnosis is based on him offending against a prepubescent female child that he committed a hands-on offense against. I believe that he targeted prepubescent female children in the community and exposed himself to them. And I believe that the data suggests that he was targeting them and attempting to commit a hands-on offense if he had not -- you know, the child did not run off cause there was a parental intervention.

I am basing that off of his report that he thought about this for a month in advance, that he was curious about it, and that he showed arousal on the PPGs as well.

Q. Is there, is there any record, history of any diagnosis for pedophilia, exhibitionism prior to yours in the history of Mr. Sharp?

Any.

A. Well, I don't think he's ever been evaluated by anyone other than the Department of Mental Health and, and they did not diagnose that for this evaluation.

Q. Is that a no?

A. Right. I have no records that he was previously diagnosed.
Q. Never, as far as you know, right?
A. As far as I know he never had an evaluation---
Q. Okay.
A. ---before that.
Q. All right. Now, let's, let's talk a minute about these Real Child Voices that you get.
Now, are these really children voices that you use or is this something y'all made up with A.I. or is -- I mean what is this?
I mean did -- I mean explain what that is for us.
A. Yeah, they're child actors.
Q. They're child actors.
So they're real children who are actors?
A. Yes.
Q. All right. And the real children who are actors, what are they saying?
A. It depends on the trials. So --.
Q. Well, let's talk about Mr. -- cause -- Mr. Sharp.
What are the children saying?
A. So, the child actors were given different scenarios like if, if they would say like oh, wow, it's so big or is it okay if I touch it. And they didn't know that it's for this or for that. So, their parents did. They signed a

consent form.

They would just say a line and then it was spliced into that scenario. It wasn't like they were acting out abuse or, or know what they were using it for.

So, they would make what could be sexual statements in a different context about, you know, dogs and birthday cakes and, and things like that.

Q. Now -- well, let me ask it.

Are these children actors really nine or ten or eleven or are they adults who just kind of acting like children or trying to pretend they're children or are these real, real children?

A. They're real children.

Q. They're real children?

A. Correct.

Q. And, and so -- and we got them saying stuff like oh, it's big and God knows what else?

You got them saying that?

A. Yes.

Q. Is that not child abuse or something?

A. No.

Q. No.

Court bear with me just one second, Your Honor. I'm trying to make sure I've covered everything.

THE COURT: Take all the time you need.

(Pause.)
Q. It -- and, and I -- let me go back to, to the Real Child Voices.
So, the Real Child Voices are taped recorded and then, when the person is attached to this device, and he or she is listening -- well, I get -- does it work on women too or that's just for men?
A. We photo vaginal photography. Penile plethysmography is just for men.
Q. Okay. So, just for men but there is a -- one for women too?
A. Yes.
Q. A different one?
A. Yes.
Q. Okay. All right. So, so, anyway, the -- when, when these voices are playing, do they come in through the wall?
You put a headset on?
You watch your computer or how does the individual hear these children talking?
A. Through headphones.
Q. Okay. All right. Now, do you get men who have no sexual arrests or convictions and test them at the same time you're testing the person who you say has the convictions --

A. No.
Q. -- to see if that person reacts in some way?
A. I don't, no.
MR. WILSON: Okay. And I don't think I have any other questions, Your Honor.
THE COURT: All right. Anything to follow-up?
MR. FISHER: Yes, Your Honor.
REDIRECT EXAMINATION
BY MR. FISHER:
Q. Let's---
THE COURT: Does anybody need a quick break?
Just all I'm gonna do is let him do a little follow-up and then we're gonna go to lunch.
Does anybody need a break before then?
(WHEREUPON, there was no audible response.)
THE COURT: All right. Go right ahead.
MR. FISHER: Okay.
Let's get this straight. This, this Static-99 and the Static-2002 a test?
A. It's a measure. It's an instrument.
Q. Okay.
A. Some people call it a test.
Q. But it's not really a test. What you're doing is you're taking these, these factors here and seeing if they apply to Mr. Sharp?

A. Correct. Yes.
Q. And we already went through all those factors and you considered those factors as a part of Mr. Sharp?
A. Yes.
Q. Not a test?
A. Right. It's not a test where I'm asking him have you ever had a male victim, yes or no. You're scoring it based on all the records and information that he has about the person.
Q. To your knowledge, does Doctor Bill Burke do evaluations for the, the Attorney General's Office?
A. I, I, I know he does them for S -- for SVP in general. I don't know for which side. But I know he's done them before.
Q. Okay. Does Doctor McKee do SVP evaluations for the Attorney General's Office?
A. It's my understanding that he does, yes.
Q. Are there others that do them?
A. I'm, I'm sure.
Q. You testified that you do evaluations for both sides?
A. Yes.
Q. How many times have, have you -- the Attorney General's Office sent you a person to be evaluated and you said that they did not have a personality disorder or mental abnormality?

A. Fifty-one percent of the time I said yes, they need for SVP and then the other half. So, it's about 50/50 but a little bit more on the, the, the other side.
Q. We talked about S.B. and we talked about E.B. and we talked about L.L. and A.L. and we talked -- Mr., Mr. Sharp went to prison for those?
A. Yes.
Q. I know this is a dumb question.
How many eight year old girls are in prison?
A. Zero.
Q. Ten year old?
A. None.
Q. Eleven year old?
A. No.
Q. Seven or nine year olds?
A. No.
Q. So, since Mr. Sharp went to prison he hasn't reoffended?
A. That's correct.
Q. But is there any doubt whatsoever that he committed those qualifying offenses?
A. No.
Q. Is the PPG the only thing you use to determine whether or not somebody is sexually aroused with children?
A. No.

Q. Those convictions were pretty important, weren't they?
A. Yes.
Q. You did an interview with Mr. Sharp.
Did you believe everything he said?
A. No.
Q. Why not?
A. I mean, as I mentioned, people have understandable reason for not like telling you things that could make them look bad. And I don't believe -- and I didn't think that every word -- every word of what someone says to me. So, no, I didn't believe everything he said to me.
Q. Did you, after talking to Mr. Sharp, did you believe he was minimizing?
A. I think that he was minimizing or he didn't know what a good answer would be. I, I think that's a good way to put it. Like he didn't necessarily want to tell me something that could make him look bad and sometimes people who make stuff up, and I didn't think he was making stuff up, I think he was just saying I don't know because either he didn't know what to make up or he didn't want to make something up.
Q. Who is the head of the MUSC sexual laboratory?
A. I'm the director.
Q. So, you're -- could we go any higher?

A. I mean I have a division director who's over all of forensics. But I'm the director of the sexual behaviors clinic.
Q. And how many doctors do you have working with you?
A. Well, not that many of them do sexual behavior. The ones that do do treatment. So, in the sexual behavior clinical lab, we have -- well, one, two, three, about four other doctors who primarily do sexual behavior treatments with some counselor. But then, in forensic psychiatry, the -- that's where most of the doctors are.
Q. So is there anyone other than you that we could go to?
A. No.
Q. And is your ultimate diagnosis and recommendation based on a real -- reasonable degree of scientific certainty in psychology?
A. Yeah.
Q. And what is that?
A. What is my opinion?
Q. Yes.
A. I believe that Mr. Sharp has pedophilic disorder that predisposes him to future acts of sexual violence. I think that all of the data suggests that he can not control his behavior. He might, he might want to control it. But his actions and lack of insight suggests that he

can't control it, that he lacks control over those behaviors, and I think that he needs treatment in order to get better so that he isn't at risk to other people that he doesn't reoffend again.

Q. So he's not a menace to society?

A. Yes.

MR. FISHER: That's all I have, Your Honor.

THE COURT: All right. You may be excused.

THE WITNESS: Thank you.

THE COURT: All right. Ladies and gentlemen, it's 12:35. Let's try to get back here around 1:44.

Okay?

(Whereupon, Court was in recess for the lunch break.)

THE COURT: All right. Thank you very much.

Anything before we get started?

MR. FISHER: No, Your Honor.

THE COURT: Bring them up.

MR. WILSON: Well, Your Honor, before -- Your Honor, is the State resting at this point or --?

THE COURT: Well, I don't know.

Hold on.

MR. FISHER: Yes.

MR. WILSON: Oh.

THE COURT: All right.

MR. WILSON: Then we do.

THE COURT: Okay. Well then hang tight.

Do you want to rest in front of the jury?

MR. FISHER: That was my anticipation but it -- of course, that---

MR. WILSON: That's fine. That's fine.

MR. FISHER: I hate to see them be brought in---

THE COURT: Yeah.

MR. FISHER: ---and then go back out and---

THE COURT: Well, let's go ahead and do the motions now and you can formally -- you've already rested. You formally rest in front of the jury so we won't have to bring them back out.

MR. FISHER: Fair enough.

THE COURT: All right. Yes, sir, I'll be to happy hear from you.

MR. WILSON: Yes, sir.

Your Honor, I'd -- first, I'd, I'd make a motion for directed verdict based on the lack of, of, and I assume that the standard is proof beyond a reasonable doubt, as to whether or not this -- Mr. Sharp is in need of treatment and care beyond what he's already had. And I base that on the fact that, that there are competing reports, if you will, or, at least, reports that are different and with -- the different conclusions.

But they're, they're at least two reports and which

Doctor Gehle, I'm sorry, Doctor Gottfried admitted to and acknowledged and that she, and that she had read those reports and that she was in receipt of those reports and that her report is different in the outcome of those two reports. And so, based on that, I would move for a directed verdict.

The other thing, Your Honor, before you rule on that is I, I made -- I know we had a Council hearing and the Court decided to allow the testimony regarding the PPG into evidence. I would ask for a mistrial based on that in the sense that I think that that information, that testimony, is, one, unreliable. Two, it is invasive and, three, that it is prejudicial to the defendant in this trial.

So, those are my grounds for, one, the motion for directed verdict and, two, for a mistrial.

THE COURT: All right. What's the State's response?

MR. FISHER: Judge, looking at the evidence most favor -- most favorable to the nonmoving party, the State has clearly proven, by certified copies of convictions, that Mr. Sharp has the qualifying offenses. He -- not only one but two of them and Doctor Gottfried specifically testified that Mr. Sharp has a mental abnormality, specifically paraphilia -- paraphilia disorder, pedophilia nonexclusive to pubescent and prepubescent children.

Looking at the evidence and the ultimate testimony of Doctor Gottfried, I think the State's at least met its burden of proof for a directed verdict.

THE COURT: All right. All right. I agree.

This is a, a, a classic case of competing experts and the weight will be given to and the value with what -- which -- with whatever the jury decides is a factual question for the jury. So, I will deny the motion for a directed verdict and I'm going to deny the motion for a mistrial based on the previous grounds I've already stated.

All right.

MR. WILSON: Thank you, Your Honor.

THE COURT: Yes, sir.

How many witnesses are you gonna call?

MR. WILSON: Three at the most.

THE COURT: Okay. Bring them out.

MR. FISHER: Judge, can we address that as long as we're here?

THE COURT: Sure.

MR. FISHER: The witness list was served on the State by Mr. Sharp's attorney, I'm looking at it, on February 19th. These witness list have to be filed with the Court and served on opposing counsel no later then 10 days before the trial. So, they were late.

I am not going to object to, to Doctor Gehle. I -- there is no surprise. I fully anticipated her calling -- coming.

The next witness, Doctor Gottfried, no surprise.

Phillip Wren, Corbett Stone, and Randy Sharp, I have no earthly idea who -- what these people are gonna say. But they're not gonna be qualified as experts and the -- I, I do not want them coming in and testifying to -- as to hearsay or things that Mr. Sharp had, had said to his father, that type of thing.

I don't have any earthly idea what they're gonna say. However, the witness list was late and, two, these witnesses should not be allowed to come in and testify as to hearsay or things that they heard or that nature.

I would suggest they we -- they go ahead and proffer it.

THE COURT: That's all right. Let me ask this.

Mr. Wilson, who are you gonna call?

MR. WILSON: I'm gonna call Doctor Gehle, the defendant, and his father.

MR. FISHER: Well, cert -- certainly I have no objection to the defendant taking the stand.

What is his -- if his father's gonna come in and say I love my son and I support him, I'll stipulate to that. I, I, I would expect nothing less of his father to do

that. But if a father's gonna come in and testify as to hearsay or things that his son told, that should not be allowed.

THE COURT: All right. Let's do this. We're gonna get through the first two. We'll take a break and we'll -- if we need to proffer, we'll proffer at that time.

MR. FISHER: Thank you.

THE COURT: All right. Bring them out.

THE BAILIFF: Yes, sir.

(WHEREUPON, the following takes place within the presence of the jury.)

THE COURT: I've always been amazed by this and it's only happened -- so I've been a judge since I was 29 years of age. I've been doing this part of this job for about six and a half years.

I can't tell you how many jury trials that I've tried. It's just in the thousands and thousands and thousands and do you know I've only had one jury panel not sit in exact same seats?

Think about it. I didn't tell you to sit in those seats. You just do it and everybody does it.

You're the only person who has to sit there. Everybody else can change around. But every single time, I've only had it one time, isn't that crazy?

Think about how many thousands of people have had to -- who always sit in their exact same seats and it's always in the way in which you were picked.

You just, you just come out first every time, correct?

THE JUROR: Yeah.

THE COURT: You just assume it, right?

THE JUROR: Right.

THE COURT: Just thought it'd be interesting -- something very interesting.

But State call your next witness.

MR. FISHER: And, judge, with that, the State would rest.

THE COURT: All right. Mr. Wilson.

MR. WILSON: Thank you, Your Honor.

THE COURT: Yes, sir.

MR. WILSON: Your Honor, we'd call Doctor Gehle.

THE COURT: Doctor Gehle.

THE CLERK: Please place your left-hand on the Bible and raise your right-hand.

MARIE GEHLE, being first duly sworn, testified as follows:

THE CLERK: Please be seated and then state your name for the record.

THE WITNESS: My name is Marie Gehle. It's spelled

G-E-H-L-E.

DIRECT EXAMINATION

BY MR. WILSON:

Q. Doctor, if you would, tell us where you work.

A. I work at the South Carolina Department of Mental Health in Columbia.

Q. All right. And what do you do there at the Department of Mental Health?

A. I am a forensic psychologist in the forensic evaluation service and my primary duty is to commit sexually violent predator precommitment evaluations and then I also do some training there.

Q. Okay. And how long have you worked for -- well, let me ask you this question.

The Department of Mental Health is run by who?

A. Who it's run --?

Q. Yeah.

Which agency --?

A. The, the Department of Mental Health is run -- I guess it's overseen by a commission and then we have a director. There's a number of people that work there. I'm not, I'm not sure exactly if I'm answering your question. But --.

Q. Yeah.

I'm just asking I guess whether or not the State is

the source of funding for the -- for the Department of Mental Health.

A. Yes, it is a state agency.

Q. Okay. All right. And how long have you worked at the Department of Mental Health?

A. I've worked there since I think 2009.

Q. Okay. And so let's go back and let's talk about your education, your background, your experience prior to coming to the Department of Mental Health.

A. You want me just to summarize that?

Q. Yes, ma'am.

A. Okay.

Q. Yes, ma'am.

A. Okay. I got a Bachelor's Degree in Psychology from Ohio Northern University. I have a Master's Degree, Degree in Clinical Psychology from Xaiver University and a Doctorate in Clinical Psychology from Xavier University.

Prior to completing my degree, after I did my education but before they grant a degree, I did a year long internship in Washington State. Part of that year was at their sexually violent predator program and then part of the year was at their forensic evaluations services, inpatient and outpatient.

After that, I received my degree and then I did a postdoctoral fellowship at Eastern Shore Regional Hospital

in Augusta, Georgia. And that was doing forensic evaluations. Typically pretrial evaluations like competency to stand trial and not guilty by reason of insanity.

At the end of that postdoctoral year I took a job with the Department of Mental Health and I've been there ever since. I'm also, as part of my job at the Department of Mental Health, I am an assistant, assistant professor at the University of South Carolina Medical School. I help train their forensic psychiatry fellows and some medical students.

I'm also involved in the training of forensic psychologist at the Department of Mental Health. We have our postdoctoral fellowship there.

Q. And, doctor, have you ever testified in, in the Courts of the State of South Carolina and/or Georgia?

A. Yes.

Q. And how many times would you say you've testified in either of those states?

A. It's well over a hundred times.

Q. Okay. Have you testified in one of these precommitment hearings in the past?

A. I've testified in many of these precommitment hearings or as in jury trials in the past, yes.

Q. How, how many pretrial commitment hearings would you

think that you've done and how many trials would you have done---
A. Well---
Q. ---at this time?
A. ---I've been qualified in some hearings when cases were dismissed in pretrial or precommitment cases. I have testified in some hearings to determine whether evidence was admissible, things like that, and qualified as an expert in precommitment hearings and then I've testified in over 50 precommitment jury trials.
Q. Okay. So, in over 50 of trials like this one that we're in today?
A. That's correct.
Q. All right. And was that in South Carolina or was that some place else?
A. That was in South Carolina.
Q. Very well.
Now, let me ask you as well if you are a member of any organization which has I guess it's tenor to be over psychiatry, to, to kind of help psychologist and psychiatrist in, in developing standards and rules and guidelines?
A. Well, psychologist and psychiatrists --
Q. Are different.
A. -- we typically are in our own kind of groups.

Q. Okay.
A. So, I am a member of the American Psychology & Law Society. That's a group that primarily is for forensic psychologists, people who do forensic evaluations like this, and then I'm a member of the Sex Offender Civil Commitment Program Network or SOCCPN. That's a group of people who are involved in sexually violent predator evaluations and treatment programs.
Q. Okay. Now, doctor, did you say how long you had been with the Department of Mental Health?
A. I've been there over 14 years now.
Q. Okay. And during that 14 year period, have you issued reports regarding or have you done evaluations, let me put it that way, for pretrial or for, for precommitments?
A. Yes.
Q. I think I'm asking it the right way.
A. Yes.
Q. If I'm not---
A. Yes.
Q. ---restate it for me.
And, and so how many years have you been doing that?
A. I started in the department in 2009, and at the beginning of the first couple years, I did evaluations of people who were committed to the program already. And

then I started doing just precommitment evaluations primarily. And also did some of the pro -- some of the evaluations of people who were in the program. But I started to do the precommitment evaluations full-time I believe in 2011.

Q. Okay.

A. And I've been doing them full-time ever since.

Q. Let me ask you.

Are you the only doctor at the Department of Mental Health who receives these pretrial commitment cases?

A. No.

Q. All right. How many other doctors at the Department of Mental Health receive these same kinds of cases?

A. Well, there are six doctors at the Department of Mental Health who are, who are on the Court ordered could be assigned the case. But it typically goes to three of them. A couple of the other ones have done just maybe one or two precommitment evaluations. The bulk of them go to two of us. But three of us routinely get assigned.

Q. How, how are they assigned to you?

A. Well, the forensic evaluation service gets the order and the files and then the supervisor, who's a clinical psychologist and runs the forensic evaluation service, she assigns the case.

Q. Okay. All right. So, you don't have any, any role

in the assignment of cases?
A. Nope. I just get it in a mailbox that's in our offices and that's how I know that's---
Q. And that's your case to handle---
A. Yes.
Q. ---from that point?
A. That's correct.
Q. Now, during the, the, the 50 times -- you say you've been qualified over a hundred times.
In those qualifications, what were you qualified as an expert in?
A. Typically it would be as a forensic psychologist or an expert in forensic psychology and sexually violent predator evaluations.
MR. WILSON: All right. Your Honor, at this time I would move to have Doctor Gehle admitted as a forensic psychologist and/or a sexually violent predator -- what was the last word?
A. Sexually violent predator -- just an expert in sexually violent---
Q. Yes.
A. ---predator evaluations.
MR. WILSON: An expert in sexually violent predator---
A. Qualified.

MR. FISHER: Without objection.

THE COURT: All right. Ladies and gentlemen, as indicated previously with the other expert, she would be allowed to give her opinion.

Okay.

Q. All right. Now, doctor, at some point in time were you assigned a case for which we're here today and that person's name would be Brian Sharp?

A. Yes, I believe his, his legal name is Robert Brian Sharp.

Q. Right.

A. Yes, I was, I was assigned that --

Q. Okay.

A. -- case.

Q. And when, when did you receive that case?

A. I can tell you when the order was. I wouldn't have recorded exactly when I received a case. But I believe the order, the order for evaluation was dated August 25th, 2022.

Q. Okay. And tell us what the procedure is.

Once you receive a case, what -- and, and let me back up just for a second.

Have you had any contact with Robert Brian Sharp prior to receiving an order to do an evaluation?

A. No.

Q. All right. Did you know anything about his case or his family or anybody else---
A. No.
Q. ---like you would---
A. Not before receiving the order for evaluation.
Q. Okay. So, once you got the order for the evaluation, tell us what you -- what the next steps are and what you did as a result of that.
A. Okay. Well, the order comes to our office with a file full of information. It includes the petition that was filed by the Attorney General's Office and it includes records that the multidisciplinary team used to make their decision about whether to send him for, for, for the consideration.

Automatically my office, a paralegal in my office, asks for health records from the Department of Corrections and she runs, she runs a scan on a database that we have at the Department of Mental Health that shows all contacts that somebody has with the Department of Mental Health. So, those things happen automatically.

I get that information and I will -- I actually request National and Criminal Information Center, criminal history report. I have to fill out an affidavit and have that notarized. I send it over to public safety at the Department of Mental Health and then they will run an

NCIC, which is a -- like a rap sheet of their national criminal history.

So, I receive that, and then, after I get that, I order and that or I schedule them for an interview. They come to my office from whatever facility they're at, whether they're in the Department of Corrections or in a jail at that point. They're transported to my office and we do an interview and then, at the end of that interview, they return with the guards that brought them.

It's always an outpatient interview. We don't bring them into the hospital and admit them. It's just we do it at the forensic evaluation service.

Q. All right. And, and let me ask you, once that person shows up for the evaluation, then you -- do you have standardized tests or procedures that you use in order to make the determination as to whether or not the person's in need of care and treatment?

A. I have a consistent way that I approach these evaluations to come to an opinion. It can vary a little bit depending on certain factors. If the person was a juvenile, if the person was a female, the procedures would change a little bit.

But, typically, how it works is they sit down with me. I explain to them the process, what the purpose is of the evaluation, how the process of the law works. So that

will calm down some of their anxieties because I'm the first person that they're typically talking to about the whole process. And I -- it's been my experience that people are pretty nervous. They don't know what to expect.

So, I explain as much as I can about that process and ask them if they'll agree to be interviewed. I ask them questions all about their lifespan from birth to what they plan to do in the future. It takes, you know, many hours.

During that interview, I'll also make a list of places that I might be able to get other records about them. If they have medical problems, I'll get medical records. I'll get school records, anything like that. But I try to collect as many records as I can that would be relevant to, to the evaluation.

Q. Would, would you also get copies of any criminal history that that person or persons might have?

A. Yes, that comes automatically with the order for evaluation.

Q. All right.

A. So, when I get a case, I already have the incident reports, arrest warrants, indictments, sentence sheets --

Q. Okay.

A. -- victim statements and things like that. If they're -- those items are missing, I'll, I'll request

those. But typically I already have that information.
Q. And, and let me ask you this as well.
Do you also get copies of empty -- any mental health history that the person may have had prior to coming to you?
A. Well, we run that check on the Department of Mental Health databases to see if we have contact with a facility, either inpatient or outpatient facility with the Department of Mental Health, anywhere in the state. And if he has had contact with any place in the state, I'll request those records.
Q. Okay. And did you do that in this case?
A. I don't believe that he had any contact with the Department of Mental Health prior to, prior to this contact.
Q. Okay.
A. So, there was no records to request.
Q. All right. So, after you get all of the documents, the records, criminal history, all those documents together, then what are your steps after that?
A. Well, my purpose is to determine if the person has a mental abnormality or personality disorder that's related to sexually violent offending and then to do a risk assessment to determine, to determine if they're likely to commit acts of sexual violence in the future.

So, I take all that information and that's how I look at it to answer those two questions. I write a report outlining my opinions and the basis for those opinions and then I submit it to the Attorney General's Office.

Q. Okay. All right. And do you have a copy of the report that you submitted?

A. Yes.

Q. All right. Let me show you -- well, let me ask you first.

Did you also do an amended report?

A. I did.

Q. All right. And that amended report was done in June 27th of 2023?

A. It's dated June 26th, 2023.

Q. And your original report was December 28th of 2022?

A. Yes.

Q. Okay. Let me show you these two documents and ask you if these are your reports that you generated.

A. Yes, these are.

MR. WILSON: Your Honor, I'm not offering these as exhibits for the Court. But what I do want to do is place them as Court's Exhibits.

THE COURT: What are they?

MR. WILSON: They're her actual reports from her evaluation.

THE COURT: Do you have any objection to that?
It doesn't really matter.
MR. FISHER: No, if they remain out of evidence, then that's fine.
THE COURT: All right.
MR. FISHER: Court's Exhibits is acceptable.
(WHEREUPON, the reports were marked as Court's Exhibits 1 and 2 for identification purposes only at this time.)
Q. All right. So, doctor, once you, once you start your process, tell us what the first thing you do.
Once you get the individual in and you're going to conduct your evaluation, beyond just speaking to him and saying good morning, what, what, what is the process and why do you use that process?
A. Well, the first thing that I do is I ask them to read a notification form out loud so I can assess their reading abilities and then I explain that form to them. That's telling them the nature, purpose, limits to confidentiality. I'm not gonna keep secrets. They could be prosecuted for unsolved crimes, things like that. It's, it's giving them that, them that information about the parameters of the evaluation.
I'll answer any questions they have about that and then I will explain the different steps in this SVP Act.

So, the screening process that happened and then, you know, what's gonna happen with like after the evaluation. If the opinion was no, this is what can happen. If the opinion is yes, this is what can happen.

Q. So, so help me understand.

What is it that you're trying to determine exactly?

When you're doing your evaluation, what is it that you're looking for and why are you looking for that specific thing or things?

A. Well, what I'm asked to do is determine if the person has a mental abnormality or personality disorder that makes them likely to engage in acts of sexual violence if not confined in a security facility for long term control, care, and treatment. That's the legal question.

Q. Well -- and, and let me stop you there.

What, what would be an abnormality?

What would that be?

A. An abnormality---

Q. Right.

A. ---could be any mental illness. But typically the ones that are related to sexually violent offending are paraphilic disorders. Those are, those are the primary ones. And then a personality disorder would be antisocial personality disorder is the one that's most commonly related to---

Q. Okay.
A. ---sexual offending.
Q. Now, is there a -- in trying to determine if a person has a, a good -- a abnormality, a mental illness if you will for lack of a better word, is there some standard that you must use in order to make it -- make a determination as to whether or not that person fits say as a pedophile or as an exhibitionist?
Are there standards that you must comply with in order to make that determination?
A. Yes, there's a book of all the standards in it.
Q. Okay.
A. The definitions of different disorders and what the standards are, the criteria are, that they have to meet to be diagnosed with that disorder.
Q. Okay. And, and so tell us -- let's, let's start, first of all, did -- well, let, let me ask you this.
Did you perform any tests or evaluation that would help you decide whether or not Mr. Sharp had an abnormality or suffered from a personality disorder?
A. That was the interview.
Q. That was the---
A. The inter---
Q. ---interview?
A. The interview is how I determine that.

Q. Okay.
A. And then if I can't determine that from the interview, then I will do specific psychological testing.
Q. Okay. Now, in your -- after you completed your testing with him, did you make a determination that he was not a pedophile or came under the disorder of pedophilia?
A. Yes, I considered whether he had pedophilic disorder and, and it was my determination that there was insufficient evidence to draw that conclusion.
Q. All right. And tell us -- explain that to us.
You, you decided that, based on everything you knew at that time, that that was not an appropriate diagnosis.
So why?
A. Well, it comes down to there was a lack of evidence of a six month pattern of sexual arousal to prepubescent children. So, pedophilic disorder is all about your sexual interests in prepubescent children. Prepubescent meaning no evidence of secondary sexual characteristics. So no breast development, no pubic hair development.
With one of the victims, the first one, she had undergone a medical examination and we saw evidence from that medical doctor. They documented her level of sexual development when they examined her and---
Q. Now that, that would be K.M.?
A. Yes, that's correct.

Q. Okay.
A. And she was prepubescent. So they, they documented that she was Tanner Stage 1, which is a scale that's used by medical doctors to determine the level of sexual development. So, anything under two -- you know, Tanner Stage 1 is prepubescent. Two is pubescent. Three is pubescent. Four is pubescent. Five is full sexual development.

For the other victims, there was no medical examination. And so I had to use age to determine their likely level of sexual development and that's where I could not make that determination.

So it -- when you use age, you, you can rely on research that pediatricians do to talk about what's the common ages for puberty development because it does vary.

So, that's what I did. I looked at that research to determine if these victims were likely pubescent or prepubescent --

Q. Okay.
A. -- and I determined that, that I, I couldn't say with certainty that they were prepubescent.
Q. All right. And, and you couldn't say that why?
A. I couldn't say that because their ages and people of those ages are more likely in puberty than not in puberty.
Q. Okay. And, and, and K.M. was eight years old?

A. That's correct.
Q. And she, and she was prepubescent?
A. That's correct.
Q. And you were able to make that determination?
A. Well, that was documented. That's a fact.
Q. Okay. And then S.B. was a -- 11 years and four months old?
A. That's correct.
Q. And you're saying that she is not prepubescent.
She would be considered pubescent?
A. Well, I'm saying, based on her age, that is my best estimate because I don't know for a fact. Nobody did a medical examination on her.
Q. Okay.
A. But I know that puberty for white girls -- she was a white girl and the race matters. When we're talking about puberty, there are racial differences and when people begin puberty and there's gender differences.
So, girls, girls start puberty before boys do. But the studies show that it's, you know, sometime at nine years old people typically are starting puberty.
Q. Okay.
A. Girls -- white girls are starting puberty.
Q. All right. And this one was 11 years and four months?

A. Correct.
Q. All right. And what about E.B.?
A. E.B. was 10 years, nine months. So, again, it's likely that she was starting -- that she was already pubescent.
Q. Okay. Did you find any medical records from any of these victims that was inconsistent with your finding?
A. No, I had no medical records for anyone other than E.B., the eight year old.
Q. Okay. Now, let me ask you if -- there was A.L.
What -- explain to me what your diagnosis or your reasoning was, I guess is a better way to put it, what was your reasoning about A.L.?
A. Well, A.L. was nine years, nine months, and he was charged with attempted kidnapping. He was not convicted of an offense involving her. That was a very brief incident. It -- it's unclear if there was any sexual behavior. He wasn't charged with a sexual offense involving that victim.
Q. Okay. So, with A.L., he was not convicted of any offense?
A. Right. He was charged with attempted kidnapping and that was the only, only charge involving that victim and he was not convicted of it.
Q. Okay. And what about L.L.?

A. He was not charged with any offense involving L.L.
Q. Okay. So explain to us then how all of these factors together help you come to the conclusion that pedophilia was not an appropriate disorder.
A. Well, it comes down to a lack of information and a lack of that six month pattern of deviate sexual interests. So, I think that the first incident involving K.M., who was prepubescent, that's evidence of pedophilic disorder.
But I need, I need a second data point to show that he has pedophilic disorder and it has to be at least six months later. You have to have that six month pattern. That's what the criteria is.
Q. Where are you -- where do you -- where are you getting that from?
A. The six month pattern?
Q. Yes.
A. From, from this book.
Q. Would you read that to us?
A. Yes.
Q. And that book that you're holding in your hand, that is kind of like the Bible for psychologists and psychiatrists?
A. Yes, it's called the Diagnostic and Statistical Manual of Mental Disorders. It's a Fifth Edition Text

Revision.
Q. All right. And read to us what the requirements are to be determined to be a pedophile or a pedophilia?
A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges or behaviors involving sexual activity with a prepubescent child or children, and then, in parentheses, generally age 13 years or younger.
Criteria B is the individual has acted on these sexual urges or the sexual urges or fantasies caused market distress or inner-personal difficulty.
Criterion C. The individual is at least age 16 years and at least five years older than the child or children in Criterion A. And then there are some specifiers that it -- there's a note that says do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12 or 13 year old and specify whether it is exclusive type, whether the person is attracted only to children, or it's a nonexclusive type. Specify if they're sexually attracted to males, sexually attracted to females, sexually attracted to both, and then specify if it's limited to incest.
Q. Okay. Now, the general gist of that then is that you would need two events which occurred within a six month period in order to qualify as pedophilia---

A. Well---
Q. ---and that would be with prepubescent children?
A. Prepubescent -- they have -- not within but over---
Q. Over at least.
A. ---at least six months. So at least six months.
Q. Okay. All right. And, and your finding was is that there was not that six, six month period?
A. That's correct.
Q. All right. Now, did you make a finding of exhibitionism?
A. I considered that disorder and found that there was insufficient evidence to diagnose that.
Q. Okay. Tell us why you came to that conclusion.
A. So there was evidence that he exposed his genitals to one unsuspecting person. But then he described covertly masturbating but not exposing his genitals to other unsuspected persons. And that is not what exhibitionistic disorder is. It is exposing your genitals to unsuspecting persons.
Q. So, if you would find that for us and read to us what that is, what exhibitionism is, and how it's determined.
A. Over a period of at least six months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person as manifested by fantasies, urges, or behaviors.

Criterion B is the individual has acted on these sexual urges with a non-consenting person or the sexual urges or fantasies caused clinically significant distress or impairment in social, occupational, or other important areas of functioning. And then you specify whether it's sexually aroused by exposing genitals to prepubertal children, sexually aroused by exposing genitals to physically mature individuals, sexually aroused by exposing genitals to prepubertal children and to physically mature individuals, and then you specify if they're in a controlled environment, and this applies to individuals who are living in an institution or other settings where opportunities to expose their genitals are restricted.

And then the last part is whether it's specified if it's in full remission, individual has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning for at least five years while in an uncontrolled environment.

Q. Okay. Now, what I need you to do is break that down to me so all of us we'll -- I can understand what that means.

If you -- just in lay words try to explain it to me so I can understand exactly what you've just read.

A. Well, the, the first part of diagnosing a paraphilic disorder in identifying whether the person has a paraphilic interest.

So, you can have a paraphilic interest that's not going to be a disorder if it's less than six months, and, in this case, when we're talking about exhibitionistic disorder, it is very clear that there has to be at least six months of sexual arousal that's recurrent and intense from the exposure of their genitals to an unsuspecting person.

Q. Okay.

A. It has to be the exposure.

Q. All right. All right. And, and so if, if there's no exposure, then that doesn't count?

A. That's correct.

Q. Okay. And, and what you're saying is you didn't find that exposure in, in, in what you were doing in your evaluation?

A. We had evidence that he exposed his genitals to one person and then he reported that he had covertly masturbated without exposing himself to other people.

Q. Covertly meaning that they didn't see it?

A. That's correct. And even, even if all of those people had seen him, it was still -- all that stuff happened within a month. So, it wouldn't be evidence of a

six month pattern that's necessary to diagnose the disorder.

Q. All right. So, because it happened within a month, it didn't continue it for say six months, then would that have been sufficient?

A. If it had continued with six months and he was exposing his genitals --

Q. Yes.

A. -- then, yes, it would be---

Q. So it'd have to be both things, continuing for six months and exposure for six months?

A. Yes.

Q. Each time or at least---

A. Yes.

Q. ---one---

A. You have to have a six month pattern of exposing your genitals --

Q. Okay.

A. -- or having intense recurrent fantasies and urges to do that, which he did not report having.

Q. Okay. All right. So, let, let me ask you now about another subject.

This PPG test, the penile -- and I can't even pronounce the second word.

What is it?

A. Plethysmography.
Q. Plethysmography.
Tell us about that.
What is---
MR. FISHER: Objection, Your Honor. This witness is not qualified as an expert in the PPG.
THE COURT: I agree.
If you want to try to attempt to qualify her as an expert in PPG, I have no problem with you proffering the witness.
MR. WILSON: Your Honor---
THE COURT: Well, let's do this.
Ladies and gentlemen of the jury, let's take -- certain matter of law outside the presence of the jury for a moment. So, if you'll excuse us. I'll bring you right back in.
Okay?
(WHEREUPON, the following takes place outside the presence of the jury.)
MR. WILSON: Your Honor, I know she's been qualified as an ex -- forensic expert in psychology and this is just one test that they do. It is not exclusive to MUSC and she -- well, I'm not saying she performed the test and I'm not asking her questions about performing the test.
What I was going to ask her was why did she not use

this test.

THE COURT: Okay. Do you -- in your course of treatment, do you regularly use the PPG?

THE WITNESS: I do not.

THE COURT: Are you trained in how to utilize it?

THE WITNESS: No, I'm not.

THE COURT: Would you know how to do it?

THE WITNESS: Would I know how to do it?

(WHEREUPON, there was no audible response.)

THE WITNESS: No, I've not underwent that training on how to do a PPG.

THE COURT: Well then you can't ask her that then. She -- she's, she's gonna have to answer because I've never been trained to know how to do it I mean and that's the true answer.

THE WITNESS: I've never been trained how to do it. But I've done like a lot of reading about the PPG --

THE COURT: Okay.

THE WITNESS: -- and I've testified about it. But I've not administered the -- those tests.

THE COURT: All right. I'm not gonna strike the question but I'm not gonna allow her to answer it.

All right. I don't think she's qualified.

All right. Let's take a five minute break.

(WHEREUPON, a short recess was taken at this time.)

THE COURT: All right. We're waiting on everybody.
(Pause.)
MR. WILSON: Okay. Your Honor, before you do --
THE COURT: Yes, sir.
MR. WILSON: -- I, I, I understand the Court's ruling and, you know, obviously I take exception to the Court's ruling respectfully.
THE COURT: That's no problem.
MR. WILSON: And, and, Your Honor, let me also make sure I'm clear on what it is that I can and can't ask.
As I understand your ruling, I can not ask her or maybe I can.
Can I ask her why she doesn't use the PPG?
Can I ask that question?
THE COURT: Why do you not use the PPG?
THE WITNESS: I don't use it because there's a lot of problems with the research basis of it and we certainly, in these kinds of evaluations, just the general problems that have been associated with it.
THE COURT: What's your position?
MR. FISHER: Judge, it's clear that Doctor Gehle has no expertise in the PPG. What she just said before we took a break was that she's read stuff about it.
Well, what she's reading isn't necessarily correct because the Court's prior ruling is that it is reliable

and it has been found to be reliable over and over and over again. Doctor Gehle should not be asked any questions about the PPG whatsoever. She is not an expert.

THE COURT: All right. I agree.

Let's just move on past the PPG because, again, she's not qualified whatsoever to testify about anything. She's not trained in it. She's already said that. She said any, any literature that she may of read would just simply be, again, her opinion that it's not reliable and, you know, we just have competing things.

So, she's not gonna be able to testify unless she's an expert in the PPG. That would be completely different obviously if she was cause you'd have two competing experts.

MR. WILSON: Judge, she -- and, and, again, I, I understand your ruling and I don't like to, to -- but let me say this.

I, I take exception and, Your Honor, the reason that, that I take exception is she is an expert. She is a forensic psychologist. She has testified that she has read the literature in the area. She does not use the test for her own reasons and the, and the Court is saying that she can't say to, to this jury why she doesn't use the test when she is a doctor in psychology who has studied and, and, and has been -- testified for over 50

times in courts just like this in these kinds of hearings.

I, I can't---

THE COURT: I understand that. But she can testify all she wants about what she is capable of testifying about. She has no knowledge whatsoever about the PPG. She's never been trained. She just admitted that. She's never done a procedure. She admitted that.

She has nothing -- she, she knows nothing about anything about the result of the test other than what's in the literature that she read about the PPG and she doesn't want to utilize it as being reliable.

So you can put what you want on the record. But my job is to make sure that the correct information and law and evidence is admissible. I've made a ruling. She's not gonna talk about the PPG.

MR. WILSON: I understand.

THE COURT: All right.

MR. WILSON: Thank you.

THE COURT: Bring them out.

(WHEREUPON, the following takes place within the presence of the jury.)

MR. WILSON: May we approach the bench for one second?

(WHEREUPON, a bench conference was held out of the hearing of the jury at this time.)

CONTINUED DIRECT EXAMINATION

BY MR. WILSON:

Q. Doctor, now I want to go back. You did an amended report in June of -- on June 27th of '23.

Is that correct?

A. Right.

Q. All right. And explain to us what, if any, differences there are in the two reports, in the original report of which was December, and then the -- December 28th of '22 and then your amended report in June of -- 27 of '23?

A. Okay. The -- there was an act passed in South Carolina on May 16th, 2023, that changed some aspects of the SVP Act. One of them being the definition of likely to engage in acts of sexual violence change.

And so I was advised by my supervisor to update all of the cases that I had already submitted a report prior to the law changing that had not been disposed of as far as we knew. And I was asked to submit an update regarding that new standard of likely to engage in acts of sexual violence.

Q. Okay.

A. So, I -- my opinion did not change. I just addressed that and answered it to the new standard.

Q. Okay. And so what was your original opinion and what

is your opinion today?
A. The, the opinion fundamentally did not change. My opinion is that he doesn't -- that Mr. Sharp doesn't have a mental abnormality or personality disorder that makes him likely to commit acts of sexual violence if he's released into the community.
Q. Okay. And is that your opinion based on your scientific understanding as a psychologist who had worked in this field for many, many years?
A. Yes.
Q. All right. And, as of today, has that changed in any way whatsoever?
A. No.
MR. WILSON: All right. I don't have any other questions.
Thank you, ma'am.
THE COURT: Thank you.

CROSS-EXAMINATION

BY MR. FISHER:

Q. Good afternoon, Doctor Gehle.
I'm looking at the statute. You said that you amended your report. It says likely to engage in acts of sexual violence means that a person is predisposed to engage in acts of sexual violence and more probably than not will engage in acts of sexual violence to such a

degree as to pose a menace to the health and safety of others.

Would you agree that's the statute?

A. Yes.

Q. Okay. I'm referring to your report specifically. Page 15, the Static-200R risk factors.

A. The Static-2002R.

Q. Yeah.

What did I say?

Four -- 2002, correct.

And after doing the static risk factors, you agree that Mr. Sharp is well above average in his risk to reoffend, correct?

A. Yes, that's the category that his score placed him in, correct.

Q. You also, on Page 15 of your report, said Mr. Sharp lacks emotional, intimate relationships.

Is that true?

A. Yes, he has a lack of emotionally intimate relationships with adults.

Q. Has poor problem solving?

A. Yes.

Q. And he has life-style impulsiveness, correct?

A. Yes.

Q. K.M. was eight years old, correct?

A. Yes.
Q. The -- S.B. was 11 years old?
A. Yes.
Q. You're not saying that they were not prepubescent?
What you're saying is that you just assumed, based on their age, that they were not prepubescent?
A. I have no evidence for sure to say what that, what that victim's level of sexual development was. So, I went to the research on puberty to see what was likely.
Q. But it's also entirely possible that she was prepubescent, right?
A. That's correct.
Q. Now, calling your attention to E.B., who was 10 years old.
Based on the literature, you made the assumption again that she was not prepub -- prepubescent, correct?
A. Yes, I believe that was, most likely, she was in the early stages of puberty. But, again, she could of been prepubescent. I didn't have evidence either way.
Q. In the case of A.L., who was nine years old, you said you didn't consider the sexual offense because the case was ultimately dismissed.
A. Well, he was not charged with a sexual offense involving that child. He was charged with attempted kidnapping and that -- and the interaction appeared very

brief.
Q. But it's clear from the police reports he was masturbating in the car, correct?
A. I don't know if that is clear from the police report.
Q. If -- he attempted to kidnap that child, that nine year old child, A.B. We know that because he was charged with it.
A. Well, he was not convicted of it.
Q. That's not the question because, even in the DSM, it doesn't talk about convictions.
It talks about offenses, does it not?
A. An offense would be something that happened, yes.
Q. Okay. Thank you.
And then as far as L.L. goes, she was only seven years old?
A. That's correct.
Q. And you're assuming that she was not prepubescent or pubescent because it didn't never -- because he wasn't charged with trying to abduct her?
A. He was charged with a crime involving L.L.
Q. Now, isn't it true that the kidnapping and the attempt -- attempted kidnapping were all dismissed as part of a plea negotiation?
A. Yes, it was dismissed.
Q. Now, isn't it true that Mr. Sharp admitted to

fondling the genitals of K.M.?
A. Yes.
Q. Isn't it true that he said he wanted to see what her vagina looked like?
A. Yes.
Q. Isn't it true he admitted to you that it was sexual in nature?
A. Yes, he -- I think he initially said that it wasn't but then corrected himself and said well, it must of been. Why else would I have done that.
Q. Isn't it true that Mr., Mr. Sharp went to treatment?
A. Yes.
Q. And he successfully completed it?
A. That's correct.
Q. And then he reoffended after treatment?
A. That's correct.
Q. Isn't it true that he said to one of these young girls do you like dick?
He admitted saying that to you, didn't he?
A. I don't know that he admitted it. I know that that was definitely reported by the victim.
Q. Isn't it true that Mr. Sharp said that he plans on living with his parents if he's released?
A. Yes.
Q. Where was he living when he reoffended?

A. I believe that he was living with his parents at the time or possibly a -- I think, I think around that time he was living with a girlfriend and they broke up and then he was living with his parents. That's my understanding.
Q. So, when he got into the truck, the black Tahoe, went up to Florence and was masturbating, driving around neighborhoods, residential neighborhoods, he was actually living with his parents?
A. I can't say that with, with absolute certainty.
Q. Well, what was his address at the time?
A. I'll see if I can find it.
(Pause.)
A. It's (sic) looks like for one -- in one incident report his address was noted to be [redacted] Northgate Drive, Camden. In another one it was [redacted] Trinity Road, Johnsonville.
Q. Who lives there?
A. I don't know.
Q. So, was he or was he not living with his parents?
A. I, I don't know.
Q. Would the best indicator of that be certified copies of convictions of where he was living?
A. I, I mean I actually don't know what his parent's address is.
Q. You did no other testing other than to interview

Mr. Sharp, correct?
A. I completed two actuarial risk assessment measures.
Q. And those are the ones we talked about, right?
A. The 2002R and the Static-99R, yes.
Q. And in that, and in that risk factor, you said he was well above average to reoffend?
A. In that risk assessment, yes.
MR. FISHER: If I may have just a moment, Your Honor?
(Pause.)
Q. How many sexual partners did Mr. Sharp tell you that he had?
A. I think he estimated it was around 30.
MR. FISHER: I don't think I've got much else, judge. If I could just have a moment please?
THE COURT: Take your time.
(Pause.)
Q. In your report, isn't it true that you concluded, and I'm gonna read from Page 16 of your report, second paragraph, while he offended against minors, his sexually violent offenses involved individuals who were likely pubescent.
You're not suggesting that Mr. Sharp could drive around and, and violate people, girls, just because they may or may not look eleven, ten, nine, and so on?
A. I'm not suggesting that at all. All of that stuff is

against the law.
Q. Correct.
A. But that doesn't mean that it, it indicates or it's evidence of a mental abnormality.
MR. FISHER: I think that's all I have at this time, Your Honor.
THE COURT: All right.
MR. WILSON: We have---
THE COURT: Any follow-up?
MR. WILSON: ---nothing further. Nothing further.
THE COURT: Thank you very much.
You need some time?
MR. WILSON: Five minutes.
THE COURT: All right. All right. Ladies and gentlemen, if you'll just give us five minutes. Just stretch your legs real quick. Bring you right back in.
Okay?
(whereupon, the following takes place outside the presence of the jury.)
MR. WILSON: Your Honor?
THE COURT: This is a very unique situation, Mr. Sharp, because, in a criminal case, this would be the time whenever, whenever I would charge you on the law indicating that you have a Fifth Amendment right to remain silent. But this is a civil case and -- but I do want to

express to you the decision to testify on your own behalf is only your decision.

Okay. Only you can make it. Nobody can make it for you.

Okay. So, in doing so, I want to give you all the time in the world to think about your decision to testify. You can talk to your lawyer. You can talk to your mom. You can talk to anybody you want. But, at the end of the day, it's gonna be your decision.

You understand?

MR. SHARP: Yes, sir.

THE COURT: All right. You wants (sic) a couple minutes with him?

MR. WILSON: Yes, sir.

THE COURT: Take your time.

MR. WILSON: And, Your Honor, before we break, do you want to do the father now before you break just so that we don't have to stop again?

THE COURT: Well, why don't you just -- why don't we do this?

What are you gonna proffer from the father?

What are you, what are you trying to elicit I guess---

MR. WILSON: Well---

THE COURT: ---is my question.

MR. WILSON: ---essentially what he's gonna testify to is that he is a minister, that he is a, a police, he'd been a police officer many years, and that he is a chaplain, and has been a minister for many years, and that he has seen changes in his son and that, that he thinks that his son is on the right path. That's essentially what he's going to say.

THE COURT: All right.

MR. FISHER: I don't see how it's relevant.

We're here to -- we're here to discuss whether there's a qualifying offense and whether or not Mr. Sharp -- I want to read the statute. But bear with me, judge.

(Pause.)

MR. FISHER: The issue before the Court is whether there's a qualifying offense and whether the defendant, in this case respondent, suffers from a mental, mental abnormality, a person disout (phonetic) -- disorder that makes him likely to engage in acts of sexual violence if not confined in a secure facility for long term control, care, and treatment.

What his father wants to say is opinion. He's (sic) can't be qualified as an expert and I just don't see how it's relevant. And I will stipulate that Mr. Sharp, Senior loves his son and he supports him and I would think

nothing less of Mr. Sharp. But to say that he's seen changes goes to his opinion.

MR. WILSON: Judge, we---

THE COURT: Mr. Wilson, the only concern I have is, is that it is his opinion and I mean, at a sentencing hearing, obviously he'll be able to tell you all the things they wanted to mitigate the damages. But this isn't a sentencing hearing and he can't testify under oath as to his opinion.

How we gon' get around that?

MR. WILSON: Well, Your Honor, this is really character evidence more than anything else about his son and about what he thinks his son is and how he is now versus how he was in the past and there's nobody who would know that better than him, someone who's had contact with him consistently over the last seven years while he's been incarcerated.

There's nobody who would know better than that than his father who will testify that he's talked to him every single day since he's been locked up.

MR. FISHER: And, judge, I appreciate all that. Unfortunately, it's just not relevant for this, this proceeding.

MR. WILSON: I, I disagree. I disagree vehemently.

In every case when a person is on trial for anything,

to say that they can't have a character witness?

I have never heard of that.

MR. FISHER: At sentencing that may be true.

THE COURT: Yeah, it is true.

MR. FISHER: But not during a trial.

THE COURT: I'm wondering then if we have to call the father first. In, in fact, I'm gonna find that's relevant enough to allow him to testify to put his character into evidence. So, when he testifies, you get to attack his character.

Y'all think about that for five minutes. I'll be right back.

MR. WILSON: All right, sir.

THE COURT: Cause it could get -- it could get ugly.

(WHEREUPON, a short recess was taken at this time.)

THE COURT: All right. Mr. Sharp, did you have another -- opportunity to speak to your attorney or anyone else that you'd like to speak to?

MR. SHARP: I have. I have.

THE COURT: Do you need any more time?

MR. SHARP: Do you want to?

MR. WILSON: I can you -- he's asking you if you need more time.

THE COURT: Oh, I'm sorry.

Do you need more time?

MR. SHARP: Can we get five more minutes?
THE COURT: Sure. I'm just gonna sit here though.
MR. SHARP: Okay.
THE COURT: Okay.
MR. SHARP: That's fine.
(WHEREUPON, a short recess was taken at this time.)
MR. WILSON: Decision on the father?
THE COURT: He can testify. But I -- if he is, if he is gonna testify, I want him to go now.
MR. WILSON: Yes, sir, we'll put him up first.
THE COURT: All right. But let's also try to keep it to what he has done meaning what he's done on a daily basis and what he has personally experienced.
MR. WILSON: Yes, sir.
THE COURT: Let's try not -- to keep a lot of the opinion stuff out.
(WHEREUPON, the following takes place within the presence of the jury.)
THE COURT: All right. Call your next witness.
MR. WILSON: Thank you, Your Honor.
THE COURT: Uh-huh. (Affirmative).
MR. WILSON: Mr. Sharp.
THE CLERK: Please place your left-hand on the Bible and raise your right-hand.
RANDALL BROOKS SHARP, SENIOR, being

first duly sworn, testified as follows:

THE CLERK: Please be seated.

THE WITNESS: Thank you.

THE CLERK: And then state your name for the record.

THE WITNESS: All right. My name's Randall Brooks Sharp, Senior.

DIRECT EXAMINATION

BY MR. WILSON:

Q. And, Mr. Sharp, what is your relationship to Robert Brian Sharp?

A. I'm his father.

Q. And how many kids do you have?

A. Two.

Q. And where does he fit in that category?

A. He's, he's the youngest.

Q. He's the youngest of, of the two children?

A. Correct.

Q. All right. Now, let me ask you -- let's talk for a minute about your son and his development over the last several years and, and just tell us how it is, if at all, that your son has changed from when he was last living with you and when did he last live with you?

A. In 2017.

Q. Okay. Tell us how he has changed since then.

A. I've seen a dramatic change in his demeanor. Before

he was seclusive and very evasive when you talk to him about questions and stuff and secretive.

Q. Hold on.

A. Well now he's open.

Q. Hold on. And before -- and I apologize.

A. Oh, I'm sorry.

Q. I, I should of asked you a couple other things first.

A. Okay.

Q. But let me ask you what kind of work do you do?

A. I'm the chaplain at the Kershaw County Detention Center in Camden. Before the -- and I'm pastor for 32 years and I -- before that I was in law enforcement. I was a lieutenant at the Kershaw County Sheriff's Department.

Q. All right. Y'all lived in Kershaw for a while?

A. Yes, sir.

Q. All right. And where do you live now?

A. Kershaw County. Camden.

Q. Okay. Now let's go back.

So tell me what changes you've seen in your son since 2017 and how do you know that these changes are real or if you do?

A. As I've sat and talked with him, I've seen his life change because of his -- even what he told me the other day was that he said I was a self-centered jerk before I

met Jesus. And I see him reaching out to other people. Before, I didn't see that. It was all about him instead of about other people and I've seen remorse in his life of, of the things he's done before he met Christ six and a half years ago.

So, I've seen him change because -- well, to me personally, I just believe that God can change people.

Q. All right. Is there anything else that you want to tell us specifically about what changes you've seen in your son?

A. Well, I -- in listening to his conversation, not telling me that he's read the Bible through so many times, and I kind of counted them as I talked to him. He's read it through quite a few times since six and a half years ago.

Probably, probably read the Bible more than some of my church members and I, I don't really see him pursuing a different avenue and the transformation is almost as different as Paul in the Bible from being a christian killer to being the greatest evangelist that ever -- that's how much transformation I've seen.

Q. All right. And, and that's your son. You love him.

A. I love him and I -- but I'm -- I been in law enforcement for 11 years back here. I know, I know both sides of everything and I don't -- before COVID, I'd go to

the prison and preach to inmates, 400 on a Sunday night, for nine years and I've seen -- I've been around offenders and I've seen changes and I recognize change.

Q. All right. Thank you. Ask -- answer any questions the attorney general might have for you.

CROSS-EXAMINATION

BY MR. FISHER:

Q. So, let me see if I got this straight.

Your son has been in the Department of Corrections, correct?

A. He has.

Q. How many eight year old girls are in the Department of Corrections?

A. There's not none that I know of.

Q. How about seven year old?

A. None.

Q. How about nine year old girls?

A. None.

Q. How many 10 year old girls are in---

A. None.

Q. ---prison and the last, last.

How many 11 year old girls?

A. None.

Q. So he's had no opportunity to reoffend, correct?

A. Well, not offend, no. But --.

Q. But the, the question is has he had an opportunity to reoffend against young girls in prison?
A. I didn't know if we was gon' talk about being -- him being in prison.
Q. Well, I understand that.
A. I mean he's already, he's already paid his dues. So --.
Q. Well -- and I tend to agree with that too. The problem is when he -- when your son --
A. Uh-huh. (Affirmative).
Q. -- reoffended --
A. Right.
Q. -- was driving around residential neighborhoods in, in Florence---
A. Right.
Q. ---masturbating to little girls --
A. Right.
Q. -- and tried to kidnap one---
A. I don't know.
Q. ---and another, he was reoffending after -- well, that's when he met---
A. He actually told me---
Q. ---the little girl, K.M.---
A. ---he cried.
Q. ---correct?

A. We all, we all have sinned and come short of the Lord God.
Q. Well, I could not agree more.
A. Okay.
Q. I could not agree more.
We're all God's children, aren't we?
A. Ones that are saved, yeah.
Q. Well, as -- so it's only a select few?
A. It's the one's who've been washed by the blood.
Q. How long have you, you known your son?
A. Thirty-eight years.
Q. He was reoffending when he was living with you, wasn't he?
A. He did. Like I said, all that's pre -- all that's pre-Christ.
Q. Well, it doesn't really matter if he's now gonna be let loose with little girls in, in residential neighborhoods, correct?
A. We got a lawyer in this county shot seven police officers---
Q. We're not talking about lawyers.
A. ---and the sheriff---
Q. No, don't speak about that.
A. Well---
THE COURT: Hold on. Hold on.

THE WITNESS: Okay.
THE COURT: He asked you a question.
THE WITNESS: Okay. I'm sorry. I'm sorry.
THE COURT: That's all right. The one question he asked you.
THE WITNESS: Okay. I'm sorry.
Would you rephrase it so I could answer the question?
Q. There's no controls on, on your son when he is let loose, if you were to be, to be let loose, on the residential neighborhoods of Florence?
What controls would there be?
A. What controls would anybody have?
Preachers mess up too.
Q. Well, I, I agree. I agree. I think all of us can, can, can mess up.
A. Yeah.
Q. The problem is, is that your son has no supervision and you can't live with him.
You, you can't, you can't be with him 24 hours, seven days a week, right?
A. That's right.
Q. So it's up to him?
A. Right.
Q. And you're saying---
A. That's why---

Q. ---that---
A. ---he's made those changes.
Q. Well -- and those changes are what, self-serving?
A. Well, I don't know about that.
Q. Well -- but let's -- you love your son?
A. Yeah.
Q. Can you see him---
A. I've been a christian for 45 years. So I, I -- it might be self-serving with me too but --.
Q. I've been a christian---
A. I found out a long time ago that's the best way to go.
Q. I could not agree more. I've been a christian 65 years.
I am with you and I think I proved that to you, didn't I?
A. You gave me a coin.
Is that what you're talking about?
Q. Absolutely.
A. Okay.
Q. You were a sheriff in Kershaw County when he molested those little girls -- I'm sorry. A lieutenant. Not a sheriff.
A lieutenant in Kershaw County when he molested that girl in Kershaw County?

A. No, sir.
Q. Well, how long were you a sheriff or sheriff's deputy or a lieutenant?
A. That's right. I left Kershaw County Sheriff's Department in 1993. I've been pastoring 32 years.
Q. Well, I'm, I'm very happy for you but you're not on trial, are you?
A. No. No, what I'm saying, I'm qualifying the fact that he was not -- I was not a deputy when he did that.
Q. But you're not on trial, are you?
A. No, sir. No, sir.
Q. Now, we had an expert come in and talking about alcohol disorder.
Were you aware of your son's drinking?
A. Yes, sir.
Q. And what controls are gonna be on, be on, on him as far as using alcohol if he were to be released?
A. What controls?
Q. Yes.
A. The commitment that you make to Christ I guess.
Q. But we know beyond all doubt that if he's committed, civilly committed for long term control, care, and treatment, he will not reoffend?
We know that, right?
A. I guess so. But there's no control over anybody.

You can go out here today or I can go out here today and do anything I want to do. I just don't want to do it.
Q. I don't either.
But that's the differences between somebody with volitional control and somebody without it?
A. Can people change?
Q. I'm sorry, Mr., Mr. Sharp. I'm not on trial here.
A. I understand.
Q. I get to ask the questions --
A. Oh.
Q. -- and you get to answer them.
A. Okay.
Q. And I understand you want to twist this around---
A. No, no, no, no, no.
Q. ---but it's not about that. It's about what's best for the community---
A. Right.
Q. ---and whether your son is a menace---
A. I understand.
Q. ---to the community.
That's all I have, Your Honor.
A. Okay.
THE COURT: Anything in follow-up?
MR. WILSON: Nothing further, Your Honor.
THE COURT: Step down, Mr. Sharp.

THE WITNESS: Thank you.
THE COURT: All right. Call your next witness.
MR. WILSON: Brian Sharp.
THE CLERK: Please place your left on the Bible and raise your right-hand.

BRIAN SHARP, being first duly sworn, testified as follows:

THE CLERK: Please be seated. State your name for the record.
THE WITNESS: My name is Robert Brian Sharp.

DIRECT EXAMINATION

BY MR. WILSON:

Q. How old are you, Brian?
A. Thirty-seven.
Q. All right. And the gentleman who testified earlier, what's his relationship to you?
A. That's my father.
Q. That's your father.

All right. And did you live with him off and on up until 2017?

A. Right.
Q. And your mother is also here in the courtroom?
A. Yes.
Q. All right. And that's the lady seated next to him on the bench back there?

A. Correct.
Q. Now, I need you to speak into this microphone.
A. Okay.
Q. I know you -- kind of -- your voice is kind of soft. So, I need everybody to hear what you have to say.
A. Yes, sir.
Q. Okay. Now, what I want you to do is let's talk about, first of all, all of the allegate (phonetic) charges that have been brought against you over the last what, five, six, seven, how many years before 2017 -- up until 2017.

You've not had any charges since then, right?

A. That's correct.
Q. The ones that you pled guilty to, you've admitted to those?
A. Yes.
Q. You've did those crimes?
A. Yes.
Q. All right. And now -- and there's, and there's no question about that. You're not denying that you did those crimes.
A. That's right.
Q. All right. Tell us then you did those crimes. You paid your dues for those crimes.

So, why, why should we believe now that you're

changed, that you're a different person?

Explain to us what it is about you that has changed since 2017 that will make you different now.

A. 2017, I was incarcerated at the Florence County Detention Center and, in that timeframe, I was very bitter. Very. And I, I, I said I wasn't gonna get emotional.

I was a very bitter and -- person. I didn't care about nobody but himself. I did all these things that been spoken about today and I can't erase those things. I can't change those things and the people that I -- I'm looking at right now that I hurt that are sitting here, I can't change those things. If I could rewind the tape I would.

2017, when I got incarcerated, I was at the end of my rope with life. I was very angry at the world, very angry at life. I was very depressed.

I got on the phone one night and I called my family and I never forget it. My mom said you've tried everything in life. Tried a lot of things. She said try Jesus. She said how about try Jesus.

My roommate ended up leaving and went to court. I was in the room by myself that night and me and God had a talk. I been raised my entire life -- excuse me.

I been raised my entire life in Christianity. But I

had run from it. I ran from it all my life. Knew I had a call on my life to preach. Been running from it.

That night me and God had a talk. I knelt down and prayed and I said God, if you're real, show yourself to me. That night the Lord came in that room. His presence was so prevalent. If that's been the love, I discovered some love for me.

I accepted Jesus Christ as my Lord and savior in a puddle of tears about this big. Began to read my Bible and began to realize that the stories were true that Jesus had died for me.

I went on to my incarceration from there from Effingham and went on to -- I took the plea that was offered and I went on from there to prison.

Well, in those two, say two years there at Effingham, I studied and read the word of God and I -- and it, it was like every book that I picked up, I wanted every christian book that they had there at the jail. That's all I read.

I was reading John Grisham or I didn't read James Patterson. I didn't read anything else but the word of God. I was hungry for what God had for me.

I went to prison and the chaplain there -- and I was trying to get him -- we were trying to get him to testify and he could testify to all these things that I'm getting ready to tell you. I get there to that yard and it's one

of the worst yards -- prison yards there is in Ridgeland Correctional. It's near Georgia right off of 90 -- 95.

There was stabbings taking place. A lot of things going on there that was -- it was a tough environment to live in. I pulled myself into the chapel there and I, and I got with the chaplain and I, I, I spoke with him, went in his office for the first time, sat down with him, and begin to talk, which I stayed in that office with him for an hour and a half as I begin to express to him the change that God had made in my life not knowing that I was encouraging the chaplain there on that yard.

We had 20 people there in that chapel. People were coming -- just 20 people. It ended up growing to the place when -- I was over the music program there. I ended up looking -- over the music program. I seen -- sang all my life and I plugged myself into that chapel and I said God, this is, this is where you sent me. Please help me to do the work you want me to do here.

So, as I begin to plug myself in, I begin to go over -- I, I came over -- I, I formed a band. We got together. We started working on some things. Started to get some things together there. Got instruments. We got some singers and we began to minister in that chapel.

What ended up happening there was awesome. I wish we had a television that we could show it. It went from 20

people till, when I left there, over 200 men were coming off of that yard. Had nothing to do with me. It was him listening to me.

I would begin to minister there in those, in those services and I'd walk back and forth, back and forth. I just begin to minister to the guys and these guys are just hard up guys, you know, tough men. But that's how I began to minister to them. Tears running down their faces.

Q. And let me ask you this.

When you say that you were the minister to them, what does that mean?

A. I would be singing, singing in ministry, ministry sone -- by song. Ministering things that God was showing me and I would share it with them. Basically preaching I guess you could say.

Q. Okay.

A. And tears be running down these guy's faces and -- well, one day there was a guy that's under that ministry. One of the worst guys on the yard. Bringing in drugs. Bringing in all kind of things on that yard.

He got saved under that ministry there. He always come in and sit on the front row. Be excited about being at church. He came to me. He said Brian, he said you don't even know who you're ministering to. I said what do you mean. I said I know these guys.

He said no, you don't even know who you're ministering to. He said you got the leaders of the Crips over here. You got the leaders of the Bloods. You got the leaders of all these different gangs he said and they got tears running down their faces when you speak.

It wasn't me. Like I said, it was him ministering to me. The change that God made in my life is what I'm testifying to today. It's him and, um, he has saved me. He will save all of us.

Q. So, tell me this Brian.

If you, if you were released, and you went back home, tell us about how that would look.

Explain to us how that would look.

A. I want to start a ministry, prison ministry. Go back into the prisons and jails and minister. I want to change lives.

The change that has taken place in me, I want everybody to feel this change. The Lord has saved me, changed me mentally, spiritually, and I believe that he's gonna set me free from this.

Q. Do you have any questions about reoffending?

A. (WHEREUPON, there was no audible response.)

Q. Well, I ask for why not?

A. Well, the change that's taking place in my life, I don't believe I'm, I'm going back to those places, those

dark places. There's nothing to return back to. The peace that I feel, I want to keep that.
Q. And, and how long are these changes that we're talking about been going on with you?
Since when?
A. Since 2017 God's been molding me, shaping me.
Q. And you would -- were you doing prison ministry when you were at Effingham?
A. I was.
Q. And then you continued to do it when you went to Ridgeland?
A. Yes.
Q. And where are you now?
A. Effingham and it has been handled. I minister there best I can.
Q. Is there anything else that you want to say?
A. I think that's it.
Q. Let me ask you this.
Why do you believe that you don't need long term care -- treatment and care?
A. Because of the change that has taken place in my life.
Q. Do you believe that the change that has taken place in your life is a permanent change?
A. It's permanent.

Q. Do you have any doubt about that?
A. No doubts.
Q. Answer any questions the attorney general might have for you.

CROSS-EXAMINATION

BY MR. FISHER:

Q. Mr. Sharp, do you know what a foxhole conversion is?
A. No.
Q. You understand you could be released at anytime once the doctors say you're, you're good to go?
You understand you hold the keys to the hospital?
You understand that?
A. Talking about --?
Q. If, if you were to go into the treatment facility, you won't -- you understand that you hold the keys, correct?
A. If I was a minister there?
Q. No.
If, if you went into long term control, care, and treatment, you understand you can be released at anytime?
At anytime you can petition and say I'm better and the doctors will be able to testify on your behalf and let you go?
A. I don't believe -- I don't think that's true. That's not true. If that were the case we wouldn't be here.

Q. But we're here because you -- this is what you wanted, right?
You could have voluntarily gone into the hospital?
A. Well, that's correct.
Q. But you're saying that there is -- that you can not petition for release?
A. There's an annual -- one year every -- annual review that comes up every year. I, I know about what's, what's getting ready to take place if I'm sentenced there. I understand that.
Q. But you can petition at anytime for release. You don't have to wait a year. You, you have the ability to draft up a position -- a petition and ask to be released?
A. That's not true.
Q. Okay.
A. Not from what I've read.
MR. FISHER: Well, if I may, judge?
THE COURT: Take your time.
(Pause.)
Q. Mr. Sharp, I'm gonna call your attention to 44-48-120. We're here under Section 44-48-90, which is your right to a trial.
Do you understand that?
A. Yes, sir.
Q. Petition for release. If the director of the

Department of Mental Health determines that the resident's mental abnormality or person -- personality disorder has so changed that the defendant -- resident, not defendant, the resident is safe to be at large, if released, is not likely to commit acts of sexual violence, the director must certify such a determination in writing with a specific basis thereof authorizing the resident to petition the Court for release.

A. But that's not a guarantee.

Q. There are no guarantees in life.

There was no guarantee when you molested K.M., right?

A. (WHEREUPON, there was no audible response.)

Q. You went into that little girl's room in 2012 and molested that child, correct?

A. And I live with that every --.

Q. And you should, shouldn't you?

A. Oh absolutely.

Q. Isn't it justice?

What do you, what do you believe you did to that little girl?

What do you believe you did to K.M.?

A. (WHEREUPON, there was no response.)

Q. The question stands. She lives with that.

So, it's only justice that you live with it too, correct?

A. Well, I served the time.
Q. Well, I understand that but she's serving the rest of her life, isn't she?
A. So am I.
Q. It doesn't matter. You committed the crime. She didn't. She was just a little---
A. I understand.
Q. ---eight year old girl.
A. I understand.
Q. And you did that to her.
You scared her, didn't you?
A. (WHEREUPON, there was no response.)
Q. She is still to this day traumatized by what you did to her and you think you should be let out early because she's living a life sentence or because you are?
A. (WHEREUPON, there was no response.)
Q. The question stands, Mr. Sharp.
A. (WHEREUPON, there was no response.)
Q. I'm waiting for an answer, Mr. Sharp.
A. Things in my past I can not change.
Q. Well, I understand that. But you understand I just read the statute to you and it is, it is up to you.
You have the ability to petition the Court for release, correct?
A. Yes.

Q. And it's done by the director of mental health. So, you don't have to prove anything to anybody except the director of mental health and you can petition for release.

So, who holds the keys to the hospital?

A. (WHEREUPON, there was no response.)

Q. You said you didn't think it was true.

Is it true?

I read you the statute.

A. It's true but it's not a guarantee.

Q. Well, what is guaranteed, Mr., Mr. Sharp?

A. The litigation could go on for, for years.

Q. And why would it go on for years?

A. (WHEREUPON, there was no response.)

Q. Why would it go on for years if you're so changed?

A. (WHEREUPON, there was no response.)

Q. The question stands, Mr. Sharp.

A. Well, just like today, we have two doctors. They have their opinions.

Q. That's right.

And who is the only witness that got to listen to all of the testimony?

Got to listen to all of it.

Who is that person?

A. Who got to listen to all of it?

Q. Yeah, you.
You've chosen to become a witness in this case, correct?
A. That's right.
Q. Let's talk about K.M. Brian came into my room and woke me up.
Is that true?
A. It is.
Q. He started touching on my privates.
Is that true?
A. It is.
Q. He pulled my PJ's pants down, pants.
Is that true?
A. It is.
Q. You said do you want to touch my weaner.
Is that true?
A. No, sir.
Q. You acted like you, you were going to kiss her private parts but she covered herself up.
A. None of that---
Q. Is that true?
A. None of that's true.
Q. Well, the only person that was there is you and her, correct?
A. Right.

Q. Do you know what a foxhole conversion is now?
A. (WHEREUPON, there was no response.)
Q. You kissed her on the mouth, correct?
A. I did not.
Q. You took your weaner out and asked if I wanted to touch -- if she wanted to touch it?
A. None of that's true.
Q. Mr. Sharp, did you take notes on what you did to that little girl?
A. (WHEREUPON, there was no response.)
Q. Did you take notes on what you did to that little girl?
A. I don't understand the question.
Q. Pardon me?
A. I don't understand the question.
Q. Did you take notes cause I'm reading from her notes?
This is K. -- K.M.'s notes. I'm reading directly from them. They're dated May 31st, 2012.
Did you take notes?
A. No.
Q. She did. She remembered it. I mean you can sit up there and deny it. Maybe we ought to bring K.M. in and let her revisit all of the things -- what, what you did to her.
Let's move on to the next incident, S.B.

Do you remember trying to abduct her?
A. I didn't abduct anybody.
Q. Well, I understand you didn't get away with it.
A. I didn't try to.
Q. Well, do you remember masturbating in front of her?
A. I did.
Q. Well, a little 11 year old girl, correct?
A. Yes.
Q. And she was traumatized, correct?
A. Yes.
Q. She ran home and you ran after her.
How far was she suppose to run, Mr. Sharp?
A. I didn't run after her.
Q. Why were you running after her?
A. When she left I left.
Q. But you could of gone---
A. I just happened to be in the same part of her neighborhood.
Q. You could of kept going straight but you didn't.
You turned left when she went left, didn't you?
A. (WHEREUPON, there was no response.)
Q. You could of gone straight. You didn't. You didn't leave the neighborhood.
You turned left, didn't you?
A. I turned through the neighborhood and went back in.

Q. And you could of gone out and never to be found again?
A. Yes.
Q. You, you chased after that girl and she made it home, didn't she?
A. (WHEREUPON, there was no response.)
Q. She made it home, didn't she?
A. She did.
Q. And then her father came out, right, and he chased after you?
A. Yes.
Q. What were the speeds you were going through this residential neighborhood?
A. It was actually a highway.
Q. What speeds were you going?
A. Too fast for conditions.
Q. In your own---
A. I mean it's not funny.
Q. No, no.
A. No.
Q. I do find the fact that you laughed at that funny.
But you were going in excess of 95 miles an hour, weren't you?
Those are your statements. That's what you told both doctors.

A. Yes, sir.
Q. And there were gunshots, correct?
A. Yes, I heard gunshots.
Q. And then you went back and you did it again, didn't you?
A. (WHEREUPON, there was no response.)
Q. Mr. Sharp, is there anything on this board that is not accurate?
On May 29th you molested K.M. On June 2nd -- June 20th, 2012, you were arrested for solicitation to commit murder on A.S., K.M.'s mother, and K.M., correct?
A. That was never --.
Q. But you were arrested for it, weren't you?
A. Somebody in my cell wanted to get time for that. That's all that was.
Q. I, I understand that's your excuse today but it's not what they---
A. It's not an excuse. It's true.
Q. It's not what happened, is it?
You got arrested for it, didn't you?
A. I got charged with it.
Q. That's right.
And then, on October 15th, 2017, you attempted, at the very least, you masturbated in front of S.B. and petrified her so much that she ran away, correct?

A. Yes.
Q. On November 7th, you masturbated in front of E.B., correct?
A. Yes.
Q. In a residential neighborhood?
A. Yes, sir.
Q. Petrified her and she ran away and then you came back again on November 13th.
Isn't that true?
A. Yes, sir.
Q. And you were masturbating in front of L.L., little girl?
A. No, I wasn't masturbating.
Q. And you were masturbating in front of the nine year old?
A. Neither one of them.
Q. Mr. Sharp, are you able to tell the age of a child from a distance?
A. (WHEREUPON, there was no response.)
Q. Are you able to tell that she's nine, but she's seven, she's 12, she's six?
Are you able to do that?
A. From a distance it didn't, it didn't look like a child.
Q. But it was, wasn't it?

A. It was, yes.
Q. And you know that you tested positive for prepubescent pedophilia?
You know that, right?
A. Yes.
Q. You've had some substance abuse issues and alcohol, correct?
A. Yes.
Q. Who's the last person know they're an -- an alcoholic?
A. The last person who?
Q. Yeah.
A. The---
Q. It's the alcoholic himself, isn't it?
A. That's right.
Q. So, you've got these, these paraphilia and now you want to believe a -- believe -- this jury to believe that you're good to go, correct?
A. No, I'm just saying that the change has taken place in my life. I'm not that same -- I'm not that individual.
Q. Well, and, again, you're gonna petition the Court to -- for release if that's the case, right?
You're in and out. You're gone. You're a ghost. That's up to you.
If this change is real, don't you agree that you can

petition the Court to get out?
A. I do. I do.
Q. But who---
A. I believe they would seek it.
Q. So, the answer is you can petition the Court at anytime to get a release -- to be released. But you're gonna have to prove that change, not to me, but to a Court when you're (indiscernible).
So you hold the keys to that hospital, correct?
A. I guess, sir.
Q. Isn't it true that you still have poor problem solving?
A. Oh, yeah.
Q. That you lack emotionally intimate relationships, correct?
A. I don't know about that. Not anymore.
Q. Well, this report is dated June 27th, 2023. I think you had us all that saying you changed in 2017.
So, is this not right six years later?
A. Is that Gottfried's?
Whose report is it?
Q. Mr. Sharp, I'm just asking, asking the questions. This is Doctor Gehle's report.
A. Uh-huh. (Affirmative).
Q. The question stands.

A. I care for people more than I used to. I'll say that.
Q. That's not the question and I understand that you want to -- I understand a foxhole conversion. I get it. But the answer -- the question is do you lack emotionally intimate relationships with adults. Doctor Gehle just said you did.
Is she wrong?
A. That's her opinion.
Q. Is she wrong?
A. I believe so.
Q. What else is she wrong about?
We can go through this whole report and see what, what you agree with and what you don't.
A. Well, we could do the same with Gottfried's.
Q. Well, we probably could.
But are you a professional?
Are you a psycho -- licensed psychologist in this state?
A. I'm not.
Q. Are you a licensed psych -- psychiatrist?
A. No, sir.
Q. What clinical training do you have in mental health abnormalities?
A. Zero.

Q. So, should be -- I think we should try -- trust the experts.

And you also have lifetime impulsiveness, correct?

A. I am not even sure what that means.

Q. Well, when you're go -- after you go to treatment, and you reoffend, that's impulsive, isn't it, meaning you'd have to know that what you were doing was wrong?

A. Right.

Q. Okay. Couldn't control yourself?

A. (WHEREUPON, there was no response.)

Q. Correct?

A. Then.

Q. There was the eight year old girl. There was the 11 year old girl. There was a seven year old girl. There was a nine year old girl. There was a 10 year old girl and you couldn't control yourself after treatment and after being shot at.

A. (WHEREUPON, there was no response.)

Q. The question stands, Mr. Sharp.

A. Like I said, I looked at life differently then.

Q. Well, I understand that you, you, you now want us to believe that you've somehow changed and you're not gonna do this.

But didn't you learn that in treatment you can't do it?

A. I didn't have a made up mind then. Now I do.
Q. I get it.
Foxhole, foxhole conversion, right?
Nothing stops you from ministering to other inmates, does it?
I mean if you're at the hospital getting control, care, and treatment, nothing stops you from continuing a ministry, does it?
A. No, sir.
Q. Mr. Sharp, where is the place we know beyond all doubt that you will not reoffend?
We, we know you will not reoffend against little girls.
Where is the one place we know you will not reoffend?
A. Where you're trying to put me.
Q. The hospital, correct?
A. (WHEREUPON, there was no response.)
Q. What you're saying is believe me this time, right?
A. A change has taken place.
Q. How many times have you been convicted of a felony or a misdemeanor involving dishonesty of course -- false statement?
A. Never.
Q. You, you were not convicted of criminal solicitation of a minor?

A. Yes.
Q. Okay. So that's one.
How many times were you convicted of criminal solicitation of a minor?
A. I believe it was two.
Q. How many times have you been convicted of aggravated battery and assault in the first degree no less?
A. Once.
Q. So, how many times have you been convicted of a felony or a misdemeanor involving dishonesty or false statement?
A. I don't understand the question.
Q. The question, the question that -- I just want an answer.
A. How can I give you an answer if I don't understand the question?
Q. Okay. How many times have you been convicted of a felony---
A. Okay.
Q. ---or a misdemeanor involving dishonesty or false statement?
How many times?
A. Dishonesty and false statement -- I don't, I don't understand that question.
Q. The -- I'm just asking the question.

How many times have you been convicted---
MR. WILSON: Your Honor, he's asking a---
A. Never. Never.
Q. You've never been convicted of a felony?
A. I have.
MR. WILSON: Your Honor, he's asking---
A. But not of dishonesty.
THE COURT: Hold on.
MR. WILSON: He's asked the question 15 times. He's told him the answer.
THE COURT: All right. All right. Let's move on.
Q. Okay. So you've been convicted of three felonies?
A. Correct.
Q. Your credibility is not exactly elevated at this point, is it?
A. Well, no.
Q. Would you agree with this statement?
There is no greater incentive to color testimony than to have an incentive in the outcome of the case.
A. Explain.
Q. Well, will people say some certain things when they take the stand if they have an interest in the outcome of the case?
A. Oh, absolutely.
Q. Would you agree that the best indicator of future

conduct is past conduct?
A. No.
Q. Well, you heard two experts say that it was.
You heard Doctor Gehle say it and you heard Doctor Gottfried say it, correct?
A. Well, they both had a different opinion about me.
Q. Well, they both said the same thing that you were well above average to reoffend. That was the Static-2002. You're well above average to reoffend.
A. I believe the quote was average.
Q. Okay. Let's -- where is my report?
You see the amended report.
Would you take a look at -- I don't mean to insult you. I really don't. Not trying to be rude.
You can read and write, can't you?
A. Correct.
Q. Okay. Would you read that right there, the Static-2002R?
A. It says 2000R. Mr. Sharp scored -- status is -- status in 20 -- 22R7 place with in the lower six well above average risk.
Q. So, Doctor Gottfried and Doctor Gehle both agreed that you're above -- well above average to reoffend?
A. What's the highest average?
Q. Sorry, Mr., Mr. Sharp. I get to ask the questions

and you get to answer them.

What was Doctor Gottfried's risk to reoffend?

A. I'm not sure.

Q. Was hers was well above average as well?

A. No, sir.

Q. Reading Doctor Gottfried's report, would you read that paragraph for the jury?

A. Five, which is the Risk Level 5, at above average risk.

Q. To reoffend, correct?

A. Correct.

Q. So, both doctors say you are well above rev -- average to, to reoffend, correct?

A. Correct.

MR. FISHER: Judge, I think I've -- that's all I have at this time.

MR. WILSON: I just have a couple of questions.

REDIRECT EXAMINATION

BY MR. WILSON:

Q. The attorney general asked you -- I think his question was if you're out -- if your abnormality changes, you can petition DMH for release.

A. Yes, sir.

Q. In fact, DMH is the one who recommended that you be released?

A. Correct.
Q. And we're here because the Attorney General's Office decided to get another opinion?
A. Right.
MR. WILSON: I don't have any other questions.
THE COURT: Mr. Sharp, you may step down.
THE WITNESS: Thank you.
THE COURT: Mr. Wilson, call your next --.
MR. WILSON: That would be the respondent's case, Your Honor.
THE COURT: All right.
All right. Ladies and gentlemen, the defense has rested as well. And so let me talk scheduling with them just real quickly so I can get you an accurate assessment allowing us to move forward.
So, give me about five minutes. I'll bring you right back in.
Okay?
(WHEREUPON, the following takes place outside the presence of the jury.)
THE COURT: So, will y'all agree that y'all probably don't want to argue and charge tonight?
MR. FISHER: No, probably first thing in the morning.
MR. WILSON: Yes, Your Honor.
(Pause.)

THE COURT: What time y'all -- how long you think that will take?

How much do you need for your closing?

MR. FISHER: I don't know what the Court's preference is. But typically my close is gonna be about a half an hour, twenty minutes on close, and then 10 minutes on a rebuttable.

THE COURT: All right.

Yes, sir.

MR. WILSON: Twenty to thirty.

THE COURT: Well, let's do this. It only takes me three minutes to read that.

Let's start again at 9:30. Y'all be here at 10:30 and I'll send them back.

(Pause.)

THE COURT: Y'all okay with that?

MR. FISHER: Yes, sir.

THE COURT: Y'all agree with that?

MR. WILSON: Yes, sir.

THE COURT: Yeah, we'll get everybody done.

All right. Will you bring them back out real quick so I can tell them?

(WHEREUPON, the following takes place within the presence of the jury.)

THE COURT: All right. As I indicated in the

beginning, it's my job to rule on all the admissible evidence. It's also my job to kind of balance, you know, your time and everybody else's in here time. And we just kind of reached the cusp where we're not gonna be able to complete the entire trial today cause I don't want to keep you here.

As I indicated, you got lives, you know, after five o'clock. You have children and other things you need to tend to.

So what we're going to do is we are going to adjourn for the day and, tomorrow morning at 9:30, we're going to reconvene. At that time I'm gonna allow the attorneys to give what's called a closing, a closing argument.

As I indicated at the beginning of the case when I let them have -- do opening statements, it's simply argument as to what they believe the evidence has shown.

Okay. That will take about 45 minutes, you know, to an hour, just depending, and I'm gonna charge you on the law, which will take a whopping six minutes and then I'll allow you to begin your deliberations.

Okay. Just for planning purposes, that's kind of what we're looking at for tomorrow.

All right. And I'll try to be on time. I won't leave my phone in my room. So, we'll start directly at 9:30.

All right. Again, as I indicated, please don't discuss or Google or do anything about the case. We will give you the opportunity to discuss it amongst yourselves and deliberate tomorrow. Hope y'all have a wonderful happy hour and, again, nobody knows where you are.

(WHEREUPON, the following takes place outside the presence of the jury.)

THE COURT: Deputies, if you don't mind, or bailiffs, if you don't mind, if y'all just have the courtroom open at nine o'clock so they can get all set up.

So, if y'all can just be here. Just get it all set up cause I don't know if y'all got PowerPoints or whatever y'all gonna want to do. But I'll make sure that it's open at nine o'clock so y'all can be here ready to roll.

MR. WILSON: Your Honor?

MR. FISHER: Thank you.

MR. WILSON: Do you want to do motion for directed verdict now or do you prefer---

THE COURT: We'll do it in the morning. But let me just go over this real quickly with you too.

This is the jury charge. I know that you -- you've had a chance to take a look at it.

MR. WILSON: Yes, sir.

THE COURT: I modified it a little bit. Nothing crazy. Took out I mean obviously Madam Forelady, certain

things like that.

So we have an introduction that discusses what Mr. Sharp has been charged with. I then charge duties of judge and jury. I put in my own direct and circumstantial evidence and this explains it a little bit further. But it does end with the law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence nor is a greater degree of certainty required of circumstantial evidence that direct evidence.

It also has the part that the State wanted about it doesn't matter which one that you rely on. But the combination of the two is adequate.

Credibility of witnesses. I've put in burden of proof. I utilized the State's. Then I utilized my reasonable doubt as Mr. Sharp did, expert witnesses, and what a sexually violent predator charge is.

Anything else that we need in there?

MR. FISHER: Nothing I can think of.

THE COURT: All right. The verdict form is going to say as -- did the State prove beyond a reasonable doubt that the respondent is a sexually violent predator. Yes. No.

Think about it overnight. If you got any problems with it, we'll be happy to change it and we'll talk about

it.

MR. WILSON: Yes, sir.

THE COURT: All right. Anything else before we adjourn?

(WHEREUPON, there was no response.)

THE COURT: Y'all have a wonderful rest of your evening.

(WHEREUPON, Court was in recess for the evening.)

Wednesday, February 28th, 2024

THE COURT: All right. Mr. Wilson, you wanted a motion heard. I'll be happy to hear from you.

MR. WILSON: Yes, sir.

Your Honor, I, I would again -- I know I moved at the end of the State's case for a directed verdict. I, I would renew that motion at this time on the same grounds that I stated during my initial motion at the end of the State's case.

But, but I also -- Your Honor, I would add to that that -- not so much on the, the motion for a directed verdict. But I'd also make a motion, Your Honor, for a mistrial and my grounds for that are, are twofold.

One, I, I believe that it was error for the Court to refuse to allow Doctor Gehle to testify regarding her reasons for not using the PPG test let alone being -- also I think the Court said that she could not talk about the, the PPG test.

And, and so, on both those issues, I think that that was error on the Court's part and I understood the Court's ruling. So I did not go any further with that line of questioning with her. But I, I think that's certainly prejudicial to the defendant or to the respondent in the sense that she had done a report and this is a witness who

has testified, by her own testimony, and been qualified as a forensic psychologist over a hundred times and that she had done more of these precommitment hearings than -- certainly than Doctor Gottfried has ever done, almost twice as many, and had been qualified as an expert in each of those cases.

I think that, when you combine that and look at the prejudice to the defendant or to the respondent in, in regards to that, not being able to explain why she didn't use that test to this jury, I think that that's certainly prejudicial to this defendant and, and I would ask the Court to grant the mistrial for that.

And, lastly, I -- the other reasoning that I have is the, the primary difference, even though I know Doctor Gottfried said she did some intelligence tests or whatever she said she did, the primary difference between the two tests, between the two evaluations that were conducted by Doctor Gottfried and by Doctor Gehle is that -- this PPG test and, and what it purports to, to indicate, you know, in regards to this defendant's exhibitionism or exhibitionism or his pedophilia and, and who are the -- those are the two basic things.

Almost everything else between these two doctors were primarily the same and, and how they reached their conclusions were primarily the same except that, that she

used this test and, as a result of this test, and I understand that, during the course of her argument, she said well, you know, yeah, but that's just one of my data points.

Well, the problem is it is a data point and, and, and which makes it significant in, in her findings. It's a, it's a big part of her findings. That is Doctor Gottfried's findings because it is a data point according to her and we were not allowed to say why it should not have been a data point with a doctor who is an expert who has testified.

So, I, I would ask the Court, one, and so that I can separate it and the Court can make its ruling, one, I would ask the Court to, to grant me a directed verdict on the, on the grounds that I made at the end of the State's, at the end of the State's presentation of its evidence. And then I would also, secondly, then ask the Court make a ruling as to, one, the intrusiveness and the Court has already ruled on that and I understand that. And I'm reraising that and I'm doing this out of an abundance of precaution, Your Honor, because I don't know.

The Supreme Court always tells us, you know, you, you need to keep saying it. You can't just not say it one time and then think that it's the rule cause you may have waived it.

So, I apologize if I seem like I'm being repetitive. But I, I -- I've taught -- I've been taught that we, we have to keep making these things over and over again regardless of what the Court says. So, I need to, to just put those things in the record.

So, I'm asking really for a ruling on three separate things.

One, a motion to -- for directed verdict.

Two, for a motion to determine that, that this -- that the test itself, that is the PPG test itself, is an intrusive test and it violates the Fourth Amendment. And then, thirdly, I'm asking the Court to make a, a ruling as to a mistrial for refusing to allow Doctor, Doctor Gottfried to testify regarding the PPG test or why she did not use that particular test.

THE COURT: All right. Well, as to the directed verdict and to the intrusiveness, I've already made my rulings on those. Those will be noted for the record that those have been reargued.

As to the not allowing the doctor testify as to the PPG, you just indicated -- and I think the last thing that you said is spot on. You indicated the respondent didn't have opportunity to get a doctor or an expert with the PPG to indicate why, in fact, that they would not have utilized the test or why it would of not been useful in

their diagnoses or anything along those lines and I completely disagree.

You could of simply gone and got an expert that is trained, is an expert in the PPG, and got an expert opinion as to why it should not have been used or why it wasn't used. And if it wasn't used, what was the benefit and why the diagnoses would of been different if, in fact, it wasn't.

So, that's my position on it.

Again, from the State?

MR. FISHER: Nothing further, Your Honor.

THE COURT: All right. Anything before we get started?

MR. FISHER: No, Your Honor.

THE COURT: Bring them out.

THE BAILIFF: Yes, sir.

(WHEREUPON, the following takes place within the presence of the jury.)

THE COURT: All right. Ladies and gentlemen of the jury, thank you so much for being on time. As I indicated, we'll be ready to go.

And so, as I indicated yesterday, I'm gonna allow the State to give a closing argument as we've stated before. It is not to be utilized as evidence. To you, it's simply just an argument as to what they believe the evidence has

now shown.

I'll allow the defense to do the same and then I'll give the plaintiff -- I mean not plaintiff. I'll give the State a brief rebuttable.

All right. After that I will charge you on the law. And, Madam Forelady -- Madam Forelady, I will instruct you as to your roles and responsibility as the forelady. And then I will allow y'all to return to your jury room to begin your deliberations.

Fair enough?

MR. FISHER: Thank you.

If it please the Court.

Thank you for your attention the last two days.

A lot of the things we talked about are, are not easy. They're just not easy things to talk about.

But there seems to be this question that was raised why is the Attorney General's Office asks us for a second opinion and we do it in almost every case.

The attorney general is not charged with filling the jails, filling the prisons, or putting people like Mr. Sharp into a hospital for care and control and treatment.

We are here to protect the victim. We're here to protect the community from sexually violent predators such as Mr. Sharp. We're here to protect the victims and its

families.

Now, Doctor Gehle testified that she didn't have enough information. She didn't testify he's not a pedophile. She said I don't have enough information because I don't know the ages of his victims and well, that's not too hard to do.

Why didn't you run some tests?

Her entire analysis and evaluation with Mr. Sharp was based on an interview and reading some reports. Woefully insufficient. And what Doctor Gehle needed to do was begin to connect the dots because she was looking at something but she couldn't reach a conclusion. She didn't know what she was looking at.

Well, it's not that hard.

Why don't you connect the dot?

Why don't you connect another dot?

Why don't you do some testing?

The MMPI, that's the Minnesota Personality Inventory. The SASSI, which was the substance abuse.

We know that, ultimately, alcohol was found to be a problem for Mr. Sharp.

Is there any control -- is there any guardrails on Mr. Sharp when he -- if he were to be released?

So what you have to do is you have to begin to connect the dots. The image isn't clear until you do all

of the evaluation -- evaluations, until you have not one, as we heard from Doctor Gehle, but three interviews.

Why not do the PAR or the MIDSA?

Why not do it?

It's just a lot more work. But it's guaranteed that you will have a much better picture of what, what are you looking at.

Now, Doctor Gehle said that she didn't do any of these tests. But there's no evidence in front of you that she couldn't do them.

She chose not to and why?

Well, the Attorney General's Office is not going to allow a person to be released unless we are certain that they're not gonna reoffend.

So, what are you looking at?

Ultimately, what are you looking at?

And as you continue to do more tests and you meet, meet more requirements, make a full, thorough, robust evaluation, you begin to see what you're looking at and the image becomes a little more clear.

Now, as the image became clear to Doctor Gottfried, she made a diagnosis and part of that diagnosis, and I followed it because I think the testimony was very clear, the PPG is a data point. It doesn't say he's a pedophile. His criminal history says he's a pedophile. The PPG

simply is a data point.

Do we know what we're looking at now?

Mr. Sharp showed an increased medically diagnosed, objective increase, in sexual arousal to prepubescent girls and pubescent girls. It's a data point.

Doctor Gehle read this -- read from this book. We talked about the DSM-5-TR. She read directly from the book. So, I'm gonna read from the book.

This was her testimony. When it comes to pedophilic disorders, over a period of at least six months, so we have our indexed offense against K.M. in May 29th, 2012. That's our index offense and then we have 2017.

We know that Mr. Sharp was arrested for trying to hire somebody to kill K.M. and her mother A.S. But here's our follow-up. S.B.

So, that's a period of greater than six months. Recurrent. We have offenses in October, October 15th, November 7th, and November 13th, and we, of course, know that Mr. Sharp was on probation where he was going into neighborhoods. Mr. Sharp admitted to Doctor Gottfried not one, two, or three but six times he went into neighborhoods masturbating.

We also know that he said to Doctor Gehle he did it 10 times. Let's not forget, let's not forget all of the other times that Mr. Sharp masturbated.

Remember the adult runner. Well, he's sexually aroused by adult females. Makes sense.

But when, when Doctor Gottfried testified that he -- that she reached into the car and tried to grab him and he became startled and ran away. Sexual urges, indecent exposure, masturbating, criminal sexual conduct with a minor, trying to solicit this minor, these, these little girls, that's my qualifying offenses, or behaviors involving sexual activity with prepubescent children or children, this is the key, generally aged 13 years of age or younger.

I didn't say it. Doctor Gehle said it. Thirteen. We got an eight year old. We got a ten year old, 11 year old. We got a 10 year old and we've got a seven year old and a nine year old.

Doctor Gehle would have you believe that he wasn't charged with abducting -- attempting to abduct or soliciting A.L. He was there with -- I'm sorry. With L.L. He was there with A.L. trying to abduct her.

Why the State brings charges -- why the State dismisses charges is beyond me. But here's the certified copies of convictions and it says, cover page, nolle prossed. The defendant pled to other warrants and indictments and tend to -- 2019, he pled to other charges.

I suggest that it's entirely reasonable to believe

that the State did not want to put those little girls on the stand. We're gonna re-victimize the victim by putting them on the stand and the State, the solicitor, chose not to do that. All those girls were under the age of 18 and that comes directly from this book.

Doctor Gehle assumed those, not my words, those are her words, assumed that the girls were pubescent. We don't know that. She didn't even bother to try to investigate it. She just made an assumption oh, so he's not a pedophile.

Well, I suggest to you how difficult would it have been to interview the victim's parents?

Pick up the phone. They'll tell you. She didn't do it. She didn't do it. I wonder why.

I said yesterday there can be no greater incentive to color testimony than to have an interest in the outcome of the case and Mr. Sharp didn't want to answer the question. One of the questions you're gonna ask is you're gonna have to evaluate the testimony of the witnesses and one of those is was the witness honest and straightforward in answering the, the attorney's questions.

How many times did I say to Mr. Sharp yesterday the question stands, the question stands?

I couldn't get an answer to the question. He just sat there.

I think it's really interesting God blessed me with four children. My oldest son is on spectrum. I've never had a case where theology, religion, Christianity became an issue in my entire career until yesterday. And I'm here to tell you I can't pray my son well. I can't love him enough. I can't appreciate him enough. All I can do is be there for him. I can be scared for him. I can worry about him.

You know, last night I thought this was so, so interesting to me in my world. On my Bible app last night it said this. It was about hypocrisy. Matthew 23:1-12. It said this.

The scribes and pharoses sit on Moses' seat. Therefore, do whatever they teach you and follow it. But do not do as they do for they do not practice what they preach.

I thought that was really relevant because Mr. Sharp yesterday took the stand and told you he's well now. He's okay now because he found Jesus.

Well, if that's true, I'm very, very happy for him. If that gives him peace, I'm very happy for him.

But as I said yesterday, he holds the kell -- the keys to the, to the hospital. I read this yesterday.

44-48-120 and 44-48-130, nothing in this chapter prohibits a resident from filing a petition for release

pursuant to this chapter. He -- if, if he is truly a changed person, if he's not gonna go out and solicit little girls anymore, if he's not a pedophile anymore, then he holds the keys to the, to the hospital. It's up to him.

I also talked about a -- foxhole conversions. There are no atheists in a foxhole. There are no atheists in a foxhole.

You know, the other side is the opposing party, the opposing party is, is, is advancing on your position. They're no atheists in a foxhole. Found it, religion, when this happened.

Is the best indicator of future conduct, Doctor Gehle and Doctor Gottfried both said it is, but, most importantly, both Doctor Gehle and Doctor Gottfried said Mr. Sharp is well above average to, to reoffend. There is no testimony that rebuts that. There is no testimony contrary to it. Both of them agree.

The only thing they don't agree on is whether or not Mr. Sharp has a -- is a pedophile. He -- Doctor Gottfried did -- performed all these tests. He showed increased arousal to prepubescent children. Doctor Gottfried or Doctor Gehle refused, for whatever reason, to further their investigation. She saw only what she wanted to see. She signed a report and submitted it and we're done.

Well, I don't care if Doctor Gehle said he was good -- if he was -- needed to be committed. We owe an obligation, as the, the Office of the Attorney General, to the community of Florence.

I asked Mr. Sharp yesterday and he wouldn't answer the question, in fact, I had an objection and then I moved on, how many times have you been convicted of a felony or a misdemeanor involving dishonesty or false statement. The purpose of that question was to attack the credibility of Mr. Sharp.

See, if he's willing to violate the laws that we all share in not one, not two, but three felonies, if he's willing to do that, what makes us believe that he's not gonna violate the oath to tell the truth?

Mr. Sharp's credibility is shot and there is nobody who can rehabilitate him.

Doctor Gottfried said that, that Mr. Sharp minimizes and didn't -- you know, I, I was starting to read notes from, from K.M.'s report. Well, that happened, that didn't happen. He started out by saying it's all true. He said it's all true. Took the stand and said it's all true.

But then, when he got into the nitty gritty of it, he started saying well, that's not true. That's not true. So he impeached himself.

But Doctor Gottfried said he minimizes and most people aren't gonna come in and say yes, I'm sexually attracted to children.

How hard is that for a father to say?

How, how hard is it to say my son's a pedophile?

No father wants to admit that.

I believe that Mr. Sharp, Senior is a good man. He loves his son. He supports his son. I get that. I would think of -- I would think of nothing else he should say.

The judge is gonna give you an instruction on reasonable doubt. I like to think of what reasonable doubt is not in my mind.

Reasonable -- reasonable doubt is not a speculative doubt, imaginary doubt, or force -- false doubt. It's not a forced doubt. Such doubt should not influence your verdict if you have a firm conviction that Mr. Sharp is a sexually violent predator. If you're forcing yourself to find doubt, the State has met its burden.

Mr. Sharp was on probation. He violated it. Mr. Sharp had treatment for sex offending -- sex offender treatment. He violated it. Mr. Sharp was shot at and he went back.

Mr. Sharp can not help himself and that's called impulsivity, compulsivity. He can't help himself. Doctor Gottfried said that yesterday. Mr. Sharp can not help

himself.

There's no brakes on the bus. So now he's found God and he's all good to go.

Well, I suggest the best place for Mr. Sharp to ensure that he doesn't reoffend, cause if he does he's just going back to prison, and I can tell you I don't want that part. But the best place for him is in a secure facility where he will get the treatment that he needs to control his impulses, his compulsivity, and he'll get treatment he needs to get well.

Let's get Mr. Sharp the treatment he needs. Thank you.

I'm sorry. Let me get that out of your way.

MR. WILSON: That's all right.

If there is a part of a trial that is probably worthless, it's probably this part where the lawyers get a chance to tell you what you heard.

You've been sitting there for two days and you've heard and now I'm going to tell you what you heard just as the attorney general had just told you what you heard as if though you're not capable of knowing what you heard.

Let me tell you how we got here cause this is where we started out two days ago.

Mr. Sharp was convicted of several crimes. Not one time have you heard that he had a jury trial. Not one.

Pled guilty. Nobody's denied that. He can't change that. That's the facts.

We can't change the fact that he did those crimes. He was convicted or pled guilty to those crimes and he served his time. That's not the issue here. That is not why we're here. We're not here to determine if he did these things. He's already pled guilty to them, been punished for them.

The question, the question that we're here for is to decide really which of these reports are correct, the one that Doctor Gehle gave or the one that Doctor Gottfried gave because they're very different. And remember His Honor told you that you're gonna have to make a decision and the standard of or the burden of proof is on the State and they must prove beyond a reasonable doubt.

Remember I told you at the outset that, in most civil trials and this is a civil trial, we start out with everything being equal and whoever tilts the scale wins.

So, if this were a wreck case, and one side put up just a tiny bit more evidence than the other, then that side wins. That's not how it works here because the burden of proof is different. The burden of proof here is beyond a reasonable doubt. Not clear and convincing evidence. Not by a preponderance of the evidence. It's beyond a reasonable doubt.

So, you must be left firmly convinced that one report is right and the other's totally wrong. I would submit to you that that is not correct.

Doctor -- think about this for one second. Doctor Gehle is employed by the same state in just another agency within the State of South Carolina just like the Attorney General's Office. Paid by the same people. Their job is to do these evaluations.

What possible motive would Doctor Gehle have to come in here and tell you a lie just to make up something to get -- to help somebody who's been charged with these crimes?

Why in the world would she do that?

It makes no sense.

But they didn't like it. They didn't like the fact that she said look. It doesn't meet the standards. He is not a pedophile according to the book that he's just been reading from. According to that book, she says he is not a pedophile because the book requires standards, things that they must prove in order to qualify him as one, and the book says no and she said no because that's the way the law is suppose to work.

But what happened is that they didn't like it. So, they said well, we don't like that. You know the book says that. Well, we don't care. We gon' go find us

somebody and we'll pay them $5,600 to give us a different opinion, one that we feel more comfortable with, one we like and I tell you this.

If you got enough money and enough time, you can find somebody to say whatever you want them to say. That's just the way the system works. I'm not saying it's right. I'm just telling you that's how it is.

The attorney general would have you believe that there is no such thing as changing, that you are who you are, and that you're the same today as you were 25 years ago, and you're gonna be the same five years from now and 10 years from now and 25 years from now and that ain't true either.

People do change. Things do happen. And, yeah, I'm a christian. I teach Sunday school every Sunday and have for years and years. I'm a trustee in my church and I believe people can change. I do. Not everybody. But, yeah, people can change and I tell you this.

None of us, none of us can predict what's gonna happen to someone next week or next year. None of us. I don't care who you are. You don't have a crystal ball. Only God knows that. We don't know.

And they come up with these tests to try to determine the likelihood is what they call it of whether or not people are gonna reoffend. But they don't know. It's a

guess. It's a best guess. I don't know and the attorney general doesn't know either.

None of us like these crimes. None of us. I have four kids of my own. Two of them are lawyers. The other one's in law school. I don't know what they're gonna do tomorrow. I don't know because we're all human.

And when you start talking about the Bible, some of the worst people in the Bible, Paul for instance, who was any worse than Paul in the Bible?

Turned out to be what?

One of the best.

Peter in the Bible.

Denied Jesus how many times?

Turned out to be one of the best.

So, no, people do change. People do change. They do and they have throughout history.

You're gonna have to decide, you're gonna have to decide because, again, people are (indiscernible) because if you accept the report that was issued by Doctor Gehle, who is the state's own doctor -- and you know what the amazing thing is?

She is their doctor.

She works for the Department of Mental Health and you know where they're trying to send him back to?

The Department of Mental Health who's the ones who

said he don't need to be here.

What sense does that make?

She said that.

You know, I wish that I could look into the future and I could tell you with some degree of certainty what's gonna happen next month, next year, five years from now, 10 years from now. I wish I could. I can't. But I can tell you that people do change.

You got the chance to hear directly from Mr. Sharp for yourselves and you're gonna have to judge because you're the judges of the facts. You're gonna have to judge. You're gonna have to decide if you believe him and you believe Doctor Gehle or if you just want to disregard that and believe Doctor Gottfried.

Let's talk about Doctor Gottfried for a minute. I want to talk to you about the PPG test because that's really the only real thing that she did different than Doctor, Doctor Gehle, and, folks, if they ain't junk science I don't know what is.

If that ain't junk science, there is no such thing cause ain't no way that you can wrap something around my private part and then tell what I'm thinking or what I'm thinking about. There ain't no way because you can't look in my head and know what my thoughts are and that's what you'd have to be able to do to know what the results are

and whether those results reflect what you showed me or what I'm thinking about.

There ain't no way. They haven't invented something that can look inside your brain yet. It may happen. But, so far, they have not invented anything that can look in your brain and tell you what somebody's thinking. It can't be done.

That test is a junk science test. It ain't worth the time it takes to do it except it gives them justification, gives them justification for coming in here telling something different than another doctor has said. That's it because their, their ain't two cents worth of difference between those two reports other than that test. Nothing.

But they got to have some way of distinguishing what they're saying versus what Doctor Gehle said. So, you got to come up with something.

So, it's oh, well, we'll look at the penile test and you will take that there and show them okay, he had point -- well, I think she said 5-millimeters. It wasn't show -- and I don't even know what 5-millimeters looks like. But I know it's a lot less than an inch. But I have no idea what 5-millimeters is. But it's a real small, small, small tiny amount.

Let me say this to you. Doctor Gottfried -- and,

and, and the attorney general's right. When you want to look at the outcome of something, ask yourself what interest, what vested interest, if any, does the person have in the outcome.

Well, Doctor Gehle has more vested interest than any -- I mean Doctor Gottfried had more of a vested interest than anybody. Doctor Gehle ain't gonna get another dime. She works for the State. She gets a check every two weeks. It ain't gon' go up or down no matter what happens. She's been doing it for 14 years. She's testified in court over a hundred times and qualified as an expert every single time.

Doctor Gottfried, on the other hand, gets paid by the state and she said, according to her, 56 times they have sent her these cases. Fifty-six at five thousand dollars and six hundred a clip. I should be so lucky.

A vested interest, of course, cause if she stops giving them the answers that they want, are they gon' use her anymore?

No. They'll go to somebody else because, when they disagree with their own doctor, they got to find somebody who's willing to say what they want them to say in order to get here to where we are today. Otherwise, they can't get here.

Lastly, I'm not going to insult you by standing here

telling you what you heard. I'm not and I'm not gonna draw a bunch of stuff on the board like you're third graders and try to explain it to you. You know what you heard. You know what your heart's telling you and you know what your mind's telling you.

The main thing about jury duty is you bring the same good common sense into this courtroom that you use in your everyday's lifes (sic). You know when people are lying to you. Those of you who have kids like I do, you know exactly when they're telling you something that ain't true.

You don't even have to ask them about it. As soon as they say it, and they're finished with it, you know whether they told you the truth or not. You just know. That's just a part of our nature as parents. We know.

Well, you use that same kind of judgment here. You know in your hearts when somebody is feeding you a line and when they're not, when they're being sincere, when they're being just and fair.

And the attorney general said oh, well, you know, my job is to protect the victims and protect the community. Well, that's (sic) is a part of his job. But it's also to be fair to defendants. Fair. He left that part out cause that counts too.

You see, as a defense lawyer, my sole job is to do

what?

Represent my client.

That is not his job. He doesn't have a client. His job is to do justice for all the people and that includes defendants.

I was solicitors -- the elected solicitor in Horry County for eight years and a chief deputy solicitor for four years before that. That's always been my job when I was doing it.

Right is right. Wrong is wrong. Fair is fair.

The only thing we ask of you is to do justice. You have no friends to reward. You have no enemies to punish. There is, folks, no evidence in this case, based on these two competing reports, would show that this defendant is in need of treatment because, one, Doctor Gehle made that determination early on and then, what, eight, nine, ten months later, they get Doctor Gottfried who says well, you know, I disagree with that and I do my PPG test and that says you're a pedophile.

No.

The other thing about that PPG test, it's got to be the most humiliating thing I've ever heard. I, I, I can't imagine you go into a room. They're cameras in the room. There are students watching through some glass at you, and you got to pull out your private part. You got to put a

ring on it and sit there for hours while they played voices for you. And I asked Doctor Gottfried about that. She said well, yeah, we got one for women too. I can't imagine how that works.

And, and, folks, I, I don't want you to get hung up on whether or not he did these crimes because that's not why we're here. He did these crimes. He just did his best (phonetic) for those crimes. That's not why we're here.

I simply ask you to look at the evidence. There is no reason that Doctor Gehle to have lied to you or misled you in any way whatsoever. There is just absolutely no reason and they haven't given you a justification for why she would of lied to you. Ask them that.

Why in the world would Doctor Gehle, who works for the State of South Carolina, come into here and lie to you and make up something who's been doing it for 14 years for the State, testified over a hundred times?

Why, why would she do that?

I thank you for your patience. I know that you have paid very close attention throughout this process.

This is Mr. Sharp's day in court. He's entitled to that by the same statute and the laws that the attorney general's been referring to that brought us here in the first place.

I simply ask you to do justice. Nothing more. Nothing less.

Thank you very much.

MR. FISHER: Let's be real clear. I never said nor insinuated that Doctor Gehle lied. I'm gonna tell that she didn't lie. I never said it. Never insinuated it. But I did say that she failed to do a thorough report because she only interviewed Mr. Sharp about his version of the facts and read some reports.

Well, there's got to be more to it and Doctor Gottfried, from that witness stand, said that she agrees with the office about 50 percent of the time. So, when we go to her for a second evaluation, half the time she comes back and confirms what DMH said.

Change?

People can change. Of course they can change.

But what evidence do we have of any change?

There's none. There's just self-serving statements of Mr. Sharp and his father.

But where's the empirical evidence?

Where's the scientific evidence that he's truly changed because we know that the PPG showed that he was sexually aroused to prepubescent girls.

So, where's the change?

And I see that Mr. Sharp was sentenced to prison.

There's no little girls in prison. He couldn't reoffend.

It is arousal. Well, it has to be because all right, when he goes for the PPG, it comes right back.

Where's the change?

There isn't any.

But I submit, if we can give him the treatment that he needs, he can change. He can learn tools. He can, he can do things to stay away from prepubescent girls.

One of the testimony that Doctor, Doctor Gottfried gave to us yesterday was that he -- Mr. Sharp admitted to her that he was trying to get away from the eight year old because he was, he was having these fantasies of looking at this young lady before he molested her, the eight year old, K.M.

The PPG, this test -- this, this entire case is not about PPG. That's just one data point. It's not the entire case.

But I'd submit to you, from that witness stand, we had one witness testify to its reliability and no witness to testify that it was not reliable. Certainly if there was evidence that it was not reliable, Mr. Sharp could have presented that witness.

The, the only evidence we have is from Doctor Gottfried and she said it's reliable and it's an objective measure.

My client is the State of South Carolina and it's the entire state. Justice Marshall, our first Supreme Court justice, said that it's the State's job to use harsh gloves. But they must always be fair and I submit to you I have been nothing but fair to Mr. Sharp.

So, let me -- in closing, let me ask you this. I drew an airplane from a couple pieces and the image became clearer and clearer and clearer image as it was shot. Look at what you're doing here and I do. Although, I know how hard it is, I think you were able to see what I was drawing here.

So, telling people -- I know I'm not getting on, on that airplane if it's well above average to crash.

Thank you.

THE COURT: Mr. Fisher, will you move the podium so everybody can see me or can you help him out please?

MR. FISHER: I'm sorry, judge?

THE BAILIFF: You want me to move this?

THE COURT: Yeah, just so everybody can see.

MR. FISHER: Oh, absolutely.

THE COURT: Yes, sir.

MR. FISHER: Thank you.

THE COURT: All right. At this time it's my role and responsibility to charge you on the law in this case. It is -- it's not overly lengthy. But don't be overly

concerned because I'm gonna allow you to have this in the back. And the reason is is because I indicated in the beginning of this trial is that I'm the sole jury -- trier of the law in this case and you are the sole trier of the facts. So, you need the law to match the two together to make your decision.

Okay. So, I'm gonna read it to you. But you will have it in the back. So, don't worry about it if you miss a piece.

Okay?

Madam Foreladies (sic), and ladies and gentlemen of the jury, it is now my duty, as the trial judge, under the Constitution of this state, to charge and instruct you on the law applicable to this case. It is your duty, as jurors, to accept and apply the law as I will now state it to you.

The State has brought this case under the sexually violent predator law of South Carolina. The State seeks the civil commitment of Robert Brian Sharp, the respondent, for long term control, care, and treatment in a secure facility administered by the South Carolina Department of Mental Health. This is not a criminal proceeding seeking incarceration but rather it is a proceeding seeking civil commitment.

The State of South Carolina alleges that the

respondent, Brian -- Robert Brian Sharp, is a sexually violent predator under the law. Respondent denies that he is a sexually violent predator and the burden of proof is, therefore, on the State to true -- to prove, by evidence sufficient to satisfy each of you beyond a reasonable doubt, that Mr. Sharp is a sexually predator. If the State is unable to meet that burden of proof as to one or more of the elements of this claim, the respondent is entitled to a finding that he is not a sexually violent predator.

Ladies and gentlemen, I want to make sure that you understand that Mr. Sharp is not accused of committing a crime in this proceeding. As you heard from the testimony, he did have previous charges for which he was convicted and sentenced by the Court.

The respondent has now completed his sentence for those charges and the State is alleging that Mr. Sharp is a sexually violent predator as defined by the predator act. The State has the burden of proof in this case and must prove its case beyond a reasonable doubt.

If you find that the State has not met this burden, respondent will be released to the community. If you find that the State has met its burden of proof, and find that the respondent is a sexually violent predator, he will not be released but rather will be civilly committed and

transferred to a secured treatment facility in Columbia.

Now, during this trial, you and I have had separate duties to perform. As the trial judge, it is my responsibility to preside over this trial and I also have the duty to rule upon the admissibility of the evidence offered during the process of the trial.

In that regard, you are to consider only the competent evidence before you and you are to disregard any testimony ordered stricken from the record of this case during the progress of the trial if there was any at all. You are to consider only the testimony which has been presented from this witness stand, together with any exhibits admitted into the record of this case, and any stipulation of counsel made into the record.

Furthermore, I have the additional duty to charge you on the applicable law of this case, and, in that regard, I am the sole judge of the law of this case. It is your duty to accept and apply the law as I now state it to you. If you have any preconceived ideas as to what the law is or what the law ought to be, and those ideas do not agree with what I tell you the law is, you are obligated, under your oath, to abandon these preconceptions because you are sworn to accept the law precisely as I now state it to you.

In this trial, you are the sole and exclusive judges

of the facts and I am the judge of the law. Do not infer that I have any opinion about the facts in this case for any -- from anything I have said during the course of this trial in ruling upon admissibility of evidence or otherwise or from anything that I now say during the course of this charge to you. In this regard, the law simply does not permit me to have an opinion about the case whatsoever.

As jurors, it is your duty alone to determine the effect, value, weight, and accuracy of the evidence presented during the course of this trial.

In this trial, they're two types of evidence generally presented, direct evidence and circumstantial evidence.

Direct evidence directly proves the existence of a fact and does not require deduction. Direct evidence is the testimony of a person who claims to have actual knowledge of a fact such as an eye witness. It is evidence which immediately establishes the main fact to be proven.

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is evidence which immediately establishes collateral facts from which the main fact can be inferred.

Circumstantial evidence is based on inference and not

on personal knowledge or observation. It is proof that does not actually establish the fact in question but that a search or describe something else from which you may either reasonably infer the truth of the fact or at least reasonably infer an increase in the probability that the fact is true.

For circumstantial evidence to be sufficient to warrant the finding of a fact, the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The existence of a fact can not be based on speculation, surmise, or conjecture.

The law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence nor is a greater degree of certainty required of circumstantial evidence than that of direct evidence.

As to every witness who has testified in this trial, you must determine the credibility of the witness. Credibility simply means believability. It becomes your duty, as jurors, to analyze and to evaluate the evidence and determine which evidence convinces you of its truth.

In determining the believability of witnesses who have testified in this case, you may believe one witness over several or several witnesses over one. You may

believe a part of the testimony of a witness and reject the remaining part of the testimony of that exact same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether any witness has exhibited to you any interest, bias, prejudice, or other motive in this case. You may also consider the appearance and manner of a witness while they testify on the witness stand.

Ladies and gentlemen, in most civil cases tried in the court of -- court of burden proving claims is Common Pleas. The preponderance -- it's called the preponderance of the evidence, which has been described and explained to you previously in this trial, or the greater weight of the evidence. However, in this type of case under this particular statute, the State's burden is greater than that. Here the standard of proof is beyond a reasonable doubt.

As I already stated to you, the State has the burden of proof. Under the law of this state, according to the sexually violent predator statute, the State must prove its case to you beyond a reasonable doubt. If the State fails to meet this burden, then you must find Mr. Sharp is not a sexually violent predator.

What is reasonable doubt in the law?

Proof beyond a reasonable doubt is proof that leaves you firmly convinced that the respondent is a sexually violent predator.

Ladies and gentlemen, there are very few things in this world that we know with absolute certainty and the law does not require proof that overcomes every possible doubt. If, based on your consideration of the evidence, you are firmly convinced that Mr. Sharp is a sexually violent predator, then you must return a verdict for the State. If, on the other hand, you think there's a real possibility that he is not a sexually violent predator, you must give him the benefit of the doubt and return a verdict for the respondent.

Reasonable doubt may arise from evidence that is in this case or from the lack of evidence in this case. It is up to you, the jury, to determine whether or not a reasonable doubt exists in this case.

As I explained to you throughout the trial, the rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses.

A witness, who by education, experience, has become an, an expert in some art, science, profession, or calling may state an opinion as to relevant material matter in which the witness claims to be an expert and may also

state the reasons for their opinion. You should consider any expert opinion received in evidence in this case, and like any other evidence, give it the weight you think it deserves. If you decide that the opinion of an expert witness is not based on sufficient education and experience or you conclude that the reasons given in support of the opinion are not sound or that opinion is outweighed by other evidence, you may disregard the opinion in, in -- entirely.

An expert witness testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert. Further, you are not required to accept an expert's opinion even if it's not contradicted.

Sexual -- sexually violent predator act states that the State must prove, beyond a reasonable doubt, one, that the respondent has been convicted of at least one sexually violent offense, two, and two, that the respondent suffers from a mental abnormality and/or personality disorder that makes him likely to engage in acts of sexual violence if not confined in a secure facility for long term control, care, and treatment.

Ryan -- Brian Sharp has been convicted of two counts of criminal solicitation of a minor. The criminal solicitation charges are sexually violent offenses and the State has met its burden as to this first element.

Inherent in the second element is that the State must prove that the respondent's mental abnormality or personality disorder causes him serious difficulty in controlling his behavior. In other words, the State must prove, beyond a reasonable doubt, that the individual it seeks to commit suffers from a mental illness which he could not sufficiently control without the structure and care provided by a mental health facility and that that illness renders him likely to commit another sexually violent offense.

In order for you to better understand the elements of the State's cause of action, I'm going to define for you some of the terms that I just used.

One, mental abnormality means a mental condition affecting a person's emotional or volitional capacity that predisposes the person to commit sexually violent offenses. This mental abnormality or personality disorder must cause Mr. Sharp serious difficulty in controlling his behavior.

Two, likely to engage in acts of sexual violence. This means that a person is predisposed to engage in acts of sexual violence and more probably than not will engage in acts of sexual violence to such a degree as to pose a menace to the health and safety of others so that he is dangerous to the public.

Again, I remind you that the burden of proof is on the State to prove beyond a reasonable -- beyond a reasonable doubt satisfaction that, that, that to your doubt a res -- respondent has been convicted of a sexually violence offense as that my -- as I have instructed you and that he also suffers from a mental abnormality or personality disorder that makes him likely to engage in acts of sexual violence if not confined in a secure facility for long term control, care, and treatment.

If the State carries its burden of proof and convinces you beyond a reasonable doubt as to each of the two elements of the cause of action, it is entitled to find that Mr. Sharp is a sexually violent predator. If the State does not meet that burden of proof as to one or both of these elements, the respondent's entitled to a finding that he is not a sexually violent predator.

All right. Madam Forelady, I will instruct you on your role and responsibility now. So, in just a couple moments I'm gonna ask that y'all retire to the jury deliberation room and don't begin deliberating because we still got to go through all the evidence that was presented and so we make sure we have everything. I will have the bailiff bring it back to you and ask you to go ahead and begin your deliberations.

All right. That's number one.

Number two, while doing so, and in -- and in your deliberations, Madam Forelady, I would ask that you ensure that everyone has the opportunity to participate and the reason is it has to be unanimous.

All right. All 12 have to agree.

Okay. And what I mean by that is, is that just give them the opportunity. Some people may wish to participate a ton and some may participate very little. That's just by human nature. But it's just your role and responsibility to ensure that everybody has a fair shake at being able to participate in the deliberations.

Also, if an emergency comes up, somebody needs the phone, needs to go to the restroom, stop the deliberation because it has to be unanimous and everybody has to participate together.

All right. Fair enough.

Any questions that may arise, it is your role and responsibility to write that question down, date it, sign it, bring it to me, and I will address whatever concerns that y'all may have. But as I have indicated on several different occasions, I am the sole judge of the law. You are the sole judge of the facts.

So I tell every juror I will answer every single question that you ask. But, remember, you may not like my answer because I can only -- there's only certain things

that we can discuss.

Fair enough?

All right. So, at this time -- oh, I'm sorry.

As to the verdict, in the matter in the care of treatment of Robert Brian Sharp, the -- it's simply did the State prove, beyond a reasonable doubt, that the respondent's a sexually violent predator. The answer is either yes or no. I certify this decision was the unanimous decision of the jury.

You would sign it, Madam Forelady, and date it for today's date. Knock on the door. The bailiff will come and get me and I will bring you back out and render the verdict.

Okay. If you have any questions, do the same. Knock on door. Hand the, the question to the bailiff. He'll bring it to me. I'll bring you out and I'll answer the same.

All right. Retire to the jury room. Give us a couple minutes. We'll get all the evidence back to you and we'll allow you to begin your deliberations.

(WHEREUPON, the following takes place outside the presence of the jury.)

THE COURT: Anything further from the State?

MR. FISHER: No objection, objection to the reading of the jury instructions or the verdict. Nothing further.

MR. WILSON: Your Honor, I, I, I do have an objection in regards to the, to the Court's charge that there are two things that the, that the jury has to find.

One, that he's been found guilty of a sexual offense which qualifies and then, two, the -- that they must find an abnormality. But I think that there's a third one that they must find, which is the -- that he is likely to commit an offense.

So, I would ask the Court -- I think that they're three, three things that they must consider. Not just the two. Even though the Court did, in reading -- to be fair, the Court, in reading the, the description of sexually violent predator, did actually talk about the fact that it's -- that the person is likely to commit another offense. I don't think that, when the Court did the charge, it said that the jury had to only find two things and I think they're three.

THE COURT: It's just a double pronged -- and it's really just a double pronged charge as to number two. It says likely to engage in acts of sexual violence means that a person is predisposed to engage in acts of sexual violence and, more probably than not, will -- willing to engage in acts of sexual violence to such a degree as to pose a menace to the health and safety of others so that he is dangerous to the public.

So, I think it's sufficient.

MR. WILSON: Yes, sir.

THE COURT: All right.

MR. WILSON: Thank you, Your Honor.

THE COURT: Yes, sir.

All right. Come see what all we got to get. This is the verdict form and here is all of the exhibits. Make sure that everything's there and we will send it back.

(WHEREUPON, the jury charge was marked as State's Exhibit No. 13 and received into evidence at this time.)

THE COURT: Oh, are all those exhibits to go back as well---

MR. FISHER: Not---

THE COURT: ---cause some are utilized in the -- in just the in camera hearing with the doctor?

MR. FISHER: The answer is no. Probably the only thing of real value is the certified copies.

THE COURT: Oh, okay. All right.

MR. FISHER: The rest of it is for the --.

THE COURT: Take that and everything else and send it back. Just leave all those to Court's Exhibits.

(WHEREUPON, the jury began deliberations at 10:39AM and returned with a verdict at 11:50AM.)

THE COURT: All right. We got everybody that we need on your side?

All right. Mr. Wilson.
MR. WILSON: Yes, sir, there we go.
THE COURT: We can go get them.
MR. WILSON: Sorry.
(WHEREUPON, the following takes place within the presence of the jury.)
THE COURT: Madam Forelady, it's my understanding that you have a verdict.
THE FORELADY: Yes, we do.
THE COURT: All right. Will you pass it to the deputy or to bailiff please?
(WHEREUPON, the forelady complies._
THE COURT: All right, Mr. Sharp. If you'll please stand.
(WHEREUPON, the respondent complies.)
THE COURT: All right. The verdict rendered by the jury is did the State prove, beyond a reasonable doubt, that the respondent is a sexually violent predator.
Yes. I certify this decision was the unanimous discussion of the jury. Signed Madam Forelady, Debbie -- and your last name?
Tanner?
(WHEREUPON, there was no audible response.)
THE COURT: All right. Ms. Tanner, is this verdict a unanimous verdict?

THE FORELADY: Yes.
THE COURT: All right. Any further polling of the jury?
MR. WILSON: No, sir.
MR. FISHER: None from the State.
THE COURT: All right. All right. Ladies and gentlemen of the jury, I can not thank you enough for your attentiveness. I know that y'all were paying attention and I want to thank you for that.
Mr. Sharp, you'll be committed to the Department of Mental Health until you can be restored.
Good luck to you.
Thank y'all so very much. You may be excused and have a wonderful rest of your day.
(WHEREUPON, the following takes place outside the presence of the jury.)
THE COURT: All right. Anything further from the State?
MR. FISHER: Nothing further, Your Honor.
THE COURT: All right. From the defense?
MR. WILSON: Yes, sir.
Your Honor, again, and not to belabor any of this, I renew all the motions that are made at the end of the State's case and the end, and the end of defense's case, case.

I would also submit to the Court, Your Honor, that the evidence in this case is insufficient to sustain the verdict that the jury has rendered and I, I would, therefore, assume that this verdict is based on some kind of passion or caprice or bias that the jury may or may, may of had in regards to the facts of this particular case.

And, again, lastly -- so I would ask the Court to set aside the jury verdict and, and order that the defendant be released and allowed to not have to go into long term treatment.

THE COURT: All right. Anything?

MR. FISHER: Not to that, Your Honor. I do have a proposed order but I have to go back outside and get it.

THE COURT: Not a problem. You can pass it up through the Clerk's Office or through the deputies.

All right. It's noted for the record. Thank you so very much. I appreciate y'all's working hard to get this case tried and your diligence getting it done.

And so, at this time, I'm gonna deny that motion. But, however, obviously you know you have 10 days from today's date to file any motions that you seek---

MR. WILSON: Yes, sir.

THE COURT: ---see fit.

Good luck to you.

MR. WILSON: Thank you, Your Honor.

* * *END OF REQUESTED TRANSCRIPT OF RECORD* * *

BlueCross BlueShield of Texas

PLETHYSMOGRAPHY
MED202.018
POSTED DATE: 6/11/2003
EFFECTIVE DATE: 8/15/2003

COVERAGE:

Plethysmography modalities considered **medically necessary:**

Thoracic Electrical Bioimpedance (a type of plethysmography) is considered medically necessary for in-patient or out-patient hospital or office places of service as this technique replaces more invasive methods (i.e. thermodilution) when used to:

- establish a baseline status on a patient with heart failure (CHF), or
- monitoring patients with congestive heart failure.

Plethysmography Modalities **considered NOT medically necessary:**

While **Plethysmography** has been used to aid in the diagnosis of peripheral vascular disease, doppler/duplex ultrasound scan has become the method of choice and gives a more accurate and definitive diagnosis. Therefore, any of the following types of plethysmography are **considered NOT medically necessary:**

- Segmental Plethysmography;
- Electrical Impedance Plethysmography (other than Thoracic Bioimpedance - see above); and
- Venous occlusion plethysmography performed with a Strain Gauge.

Plethysmography Modalities considered **experimental or investigational:**

- Inductance plethysmography
- Capacitance plethysmography
- Mechanical oscillometry
- Photoelectric plethysmography
- Bionic plethysmography.

Total Body plethysmography is **considered NOT medically necessary. Examples of non-covered indications include:**

- residual volume, functional residual capacity and total lung capacity as more accurate methods such as pulmonary function tests are available;
- body water and/or fat composition or lean body mass using Bioelectric Impedance, Bod Pod or Tanita methods.

DESCRIPTION:

EXHIBIT
tabbies
2

BlueCross BlueShield of Texas

PLETHYSMOGRAPHY
MED202.018
POSTED DATE: 6/11/2003
EFFECTIVE DATE: 8/15/2003

Plethysmography is the measurement and recording (by one of several methods) of variations in the size of an organ, body part, or limb reflecting the circulation of blood to that body area.

Plethysmography techniques include:

- **Segmental** - Included under this procedure are services performed with a regional plethysmograph, differential plethysmograph, recording oscillometer (measures changes in the volume of the arteries accompanying the heart beat), and a pulse volume recorder.

- **Dynamic venous** - the measurement of changes in limb circumference in response to exercise or passive compression of the limb.

- **Electrical Impedance** - a technique for detecting blood volume changes in a body part by measuring changes in electrical resistance. It is used in the diagnosis of deep venous thrombosis. Electrodes are placed around the calf and a pneumatic cuff around the thigh is inflated just enough to cause venous occlusion and then rapidly deflated. The drop in voltage is recorded (it is smaller in a leg with deep venous thrombosis than in a normal leg).

- **Thoracic Electrical Bioimpedance** - this is a non-invasive alternative for measuring cardiac output. Bioimpedance is defined as the electrical resistance of tissue to the flow of current. For example, when small electrical signals are transmitted through the thorax, the current travels along the blood filled aorta which is the most conductive area. Changes in bioimpedance, resulting from the pulsatile changes in volume and velocity of blood in the aorta, are inversely proportional to the stroke volume (cardiac output equals the stroke volume times heart rate). Bioimpedance relies on the same technology as plethysmography and only provides a regional measure of the thorax. Other non-invasive methods for measuring cardiac output are echocardiography, transesophageal echocardiography (TEE), and doppler ultrasound. The BioZ is a device approved by the U.S. Food and Drug Administration (FDA) that measures thoracic bioimpedance.

- **Venous occlusion** - (the oldest form of plethysmography) is time consuming, cumbersome, and requires considerable training to give useful, reproducible results. With this method a *strain gauge* is used in the evaluation of deep venous thrombosis and chronic venous insufficiency. The strain gauge is used to record changes in limb circumference employing a rubber tube filled with a conductive fluid. As the tube expands and contracts the resistance in the fluid changes in proportion to the circumference of the limb. The

instrument consists of a chart recorder, an automatic cuff inflation and deflation system, and a recording manometer.

- **Oculoplethysmography** – is a noninvasive cerebrovascular test that indirectly measures blood flow in the ophthalmic artery and reflects the adequacy of cerebrovascular blood flow.

- **Penile Plethysmography** - a non-invasive test for measuring the variation in the volume of the penis and in the amount of the blood present or passing through it. Refer to the Medical Policy on Evaluation of Impotence for coverage information.

- **Total Body plethysmography** - The following list is made up of different types of body plethysmography that are used for:

  1. measuring residual volume, functional residual capacity and total lung capacity. The patient sits inside an airtight box, inhales or exhales to a particular volume (usually functional residual capacity {FRC}), and then a shutter drops across their breathing tube. The subject makes respiratory effort against the closed shutter causing their chest volume to expand and decompressing the air in their lungs. The increase in chest volume slightly reduces the box volume (the non-person volume of the box) and thus slightly increases the pressure in the box. A calculation is made to determine the original volume of gas present in the lungs when the shutter was closed. Body plethysmography may be appropriate for patients who have air spaces within the lungs that do not communicate with the bronchial tree. In these individuals, gas dilution methods of measurement would give an erroneously low volume reading;

  2. body composition analysis (i.e., BOD POD Body Composition System) that measures whole body mass and volume, which are then used to estimate whole body density. The patient sits in a fiberglass cabin while computerized pressure sensors determine the amount of air displaced by their bodies. Once whole body density is measured, the relative proportions of body fat and lean body mass can be calculated using population specific equations which relate body density to body fat and lean tissue masses.

  3. in vivo (in the living body, referring to a process or reaction occurring therein) prediction of total body water, extracellular water and intracellular water using the bioelectrical impedance system.

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NOTE: Another test frequently billed as total body plethysmography is Body Composition Analyzer/Scales (Tanita). A person's height, age, and gender are entered and the patient steps on the scales. Within seconds, weight, body mass index and body fat percentages are displayed. If more in-depth results are desired such as hydration levels, fat free mass, basal metabolism rate, a separate software package is available. This type of analysis is not true plethysmography.

- **Photoelectric Plethysmography** - involves the measurement and recording of changes in the size of a body part by the circulation of blood to that body part to determine whether or not a pulse is present.

RATIONALE:

A variety of small case series have reported inconsistent results regarding the relationship between measurements of cardiac output (CO) determined by thoracic bioelectric impedance and thermodilution techniques. For example, Belardinelli and colleagues compared the use of thoracic bioimpedance, thermodilution, and the Fick method to estimate cardiac output in 25 patients with documented coronary artery disease and a previous myocardial infarction. There was a high degree of correlation between cardiac output as measured by thoracic bioimpedance and other invasive measures. Shoemaker and colleagues reported on a multicenter trial of thoracic bioimpedance compared to thermodilution in 68 critically ill patients. Again, the changes in cardiac output as measured by thoracic bioimpedance closely tracked those measured by thermodilution. In contrast, Sageman and colleagues did not recommend the use of bioimpedance as a postoperative monitoring technique for patients who have undergone coronary artery bypass surgery. In this study of 50 patients, there was only a poor correlation between thermodilution and bioimpedance, due primarily to the postoperative distortion of the patient's anatomy and the presence of endotracheal, mediastinal and chest tubes. In a study of 34 patients undergoing cardiac surgery, Doering and colleagues also found that there was poor agreement between thoracic bioimpedance and thermodilution in the immediate postoperative period. The largest case series (the cost study) has been published in abstract form only. In this case series, estimations of cardiac output using thermodilution methods and thoracic bioimpedance were performed in 191 patients who underwent right heart catheterization for a variety of clinical indications. Linear regression analysis revealed an overall correlation of r=0.73. The authors concluded that cardiac output can be reliably measured with either thermodilution or thoracic

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bioimpedance, and that bioimpedance has the additional value of being noninvasive.

Inductance, Capacitance, Mechanical Oscillometry and Photoelectric plethysmography have not yet reached a level of development such as to allow their routine use in the evaluation of peripheral artery disease.

Color flow Doppler/Duplex ultrasound scans are newer and preferable methods of detecting a venous thrombus with an accuracy near that of venography. Doppler ultrasound has become the method of choice when scanning for venous occlusive disease. Plethysmography cannot detect deep calf venous thrombus.

Plethysmographic methods need to be validated in randomized, controlled, clinical studies that include long term outcome measures to evaluate the clinical effectiveness in the diagnosis of venous and arterial diseases.

PRICING:

None

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DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member's contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.
HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.

510(k) SUMMARY

Applicant's Name, Address, Phone, Fax, Contact Person, Email, Date Prepared

Limestone Technologies Inc.
Jamie Brown, President
556 O'Connor Drive
Kingston, Ontario K7P 1N3
Canada
Phone: [redacted]
Fax:
Email:

APR 26 2006

Date Prepared: September 29, 2005

Device Name, Common/Generic Name and Classification Name

Proprietary Name:	PrefTest Professional Suite™
Common/Usual Name:	Penile Plethysmograph
Classification Name:	Monitor, Penile Tumescence

Predicate Device

Device Name:	MONARCH 21 Penile Plethysmograph (K033126)

Description of the Device

Limestone Technologies Penile Plethysmograph is based on a circumference measurement using a strain gauge transducer which measure penile tumescence in millimeters. PrefTest Professional Suite™ computer software is used to store, tabulate, display and print out the acquired data from a personal computer or lap top.

Intended Use of the Device

The PrefTest Professional Suite™ is used to measure penile tumescence in response to visual and auditory stimuli. Penile tumescence data can later be combined with other standardized psychological testing procedures to assist clinicians with their assessment and treatment of sexual offenders.

Technological Summary between PrefTest Professional Suite and its predicate device

PrefTest Professional Suite™ has the same intended use and function as its' predicate device.

Performance Test Results

Testing for the PrefTest Professional Suite™ software included software validation. A risk analysis performed according to ISO 14971: 2000 was conducted.

Clinical Test Results

Testimonials and published literature supports the safety and effectiveness of this technology.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Food and Drug Administration
9200 Corporate Blvd.
Rockville MD 20850

APR 26 2006

Limestone Technologies, Inc.
% Ms. Nancy Ruth
Associate Director, Regulatory Services
CanReg, Inc.
4 Innovation Drive
Dundas, L9H 7P3
CANADA

Re: K052929
Trade/Device Name: PrefTest Professional Suite™
Regulation Number: None
Regulatory Class: Unclassified
Product Code: LIL
Dated: March 31, 2006
Received: April 3, 2006

Dear Ms. Ruth:

We have reviewed your Section 510(k) premarket notification of intent to market the device referenced above and have determined the device is substantially equivalent (for the indications for use stated in the enclosure) to legally marketed predicate devices marketed in interstate commerce prior to May 28, 1976, the enactment date of the Medical Device Amendments, or to devices that have been reclassified in accordance with the provisions of the Federal Food, Drug, and Cosmetic Act (Act) that do not require approval of a premarket approval application (PMA). You may, therefore, market the device, subject to the general controls provisions of the Act. The general controls provisions of the Act include requirements for annual registration, listing of devices, good manufacturing practice, labeling, and prohibitions against misbranding and adulteration.

If your device is classified (see above) into either class II (Special Controls) or class III (Premarket Approval), it may be subject to such additional controls. Existing major regulations affecting your device can be found in the Code of Federal Regulations, Title 21, Parts 800 to 898. In addition, FDA may publish further announcements concerning your device in the Federal Register.

EXHIBIT
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Please be advised that FDA's issuance of a substantial equivalence determination does not mean that FDA has made a determination that your device complies with other requirements of the Act or any Federal statutes and regulations administered by other Federal agencies. You must comply with all the Act's requirements, including, but not limited to registration and listing (21 CFR Part 807); labeling (21 CFR Part 801); good manufacturing practice requirements as set forth in the quality systems (QS) regulation (21 CFR Part 820); and if applicable, the electronic product radiation control provisions (Sections 531-542 of the Act); 21 CFR 1000-1050.

This letter will allow you to begin marketing your device as described in your Section 510(k) premarket notification. The FDA finding of substantial equivalence of your device to a legally marketed predicate device results in a classification for your device and thus, permits your device to proceed to the market.

If you desire specific advice for your device on our labeling regulation (21 CFR Part 801), please contact the Office of Compliance at one of the following numbers, based on the regulation number at the top of this letter:

21 CFR 876.xxxx	(Gastroenterology/Renal/Urology)	240-276-0115
21 CFR 884.xxxx	(Obstetrics/Gynecology)	240-276-0115
21 CFR 892.xxxx	(Radiology)	240-276-0120
Other		240-276-0100

Also, please note the regulation entitled, "Misbranding by reference to premarket notification" (21 CFR 807.97). You may obtain other general information on your responsibilities under the Act from the Division of Small Manufacturers, International and Consumer Assistance at its toll-free number (800) 638-2041 or (301) 443-6597 or at its Internet address
http://www.fda.gov/cdrh/industry/support/index.html

Sincerely yours,

Nancy C. Brogdon

Nancy C. Brogdon
Director, Division of Reproductive,
Abdominal, and Radiological Devices
Office of Device Evaluation
Center for Devices and Radiological Health

Enclosure

Indications for Use

510(k) Number (if known): K052929

Device Name: PrefTest Professional Suite™

Indications For Use: The PrefTest Professional Suite™ is used to measure penile tumescence in response to visual and auditory stimuli. Penile Tumescence data can later be combined with other standardized psychological testing procedures to assist clinicians with their assessment and treatment of sexual offenders.

Prescription Use __X_____ AND/OR Over-The-Counter Use _____
(Part 21 CFR 801 Subpart D) (21 CFR 807 Subpart C)

(PLEASE DO NOT WRITE BELOW THIS LINE-CONTINUE ON ANOTHER PAGE IF NEEDED)

Concurrence of CDRH, Office of Device Evaluation (ODE)

Page 1 of _____

(Division Sign-Off)
Division of Reproductive, Abdominal,
and Radiological Devices
510(k) Number K052929

PPG:

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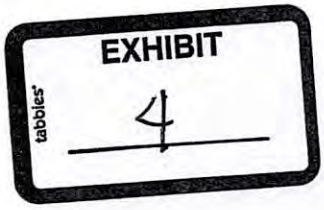

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Penile Plethysmograph (PPG) Administration Instructions

1. Ensure that the examinee is at least the minimum age for a Penile Plethysmograph (PPG) examination.

2. Verify that the consent form has been signed by the appropriate person(s).

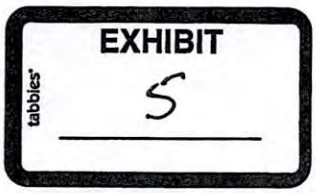
3. Use the PPG Examination Checklist to prepare the examination room:
   a. Inflate the Stingray counter-measures pad, if needed.
   b. Ensure unused paper is covering the examination chair.
   c. Place unused disposable covers on the examinee's headphones.
   d. Place an unused disposable cover over the numeric keypad.
   e. Place an unused disposable medical gown on the exam chair.
   f. Prepare two unused disposable Galvanic Skin sensors.
   g. Turn-on the power for the examination room video monitor.
   h. Check and log the examination room temperature.
   i. Check and log the examination room humidity.
   j. Adjust the room lighting.

4. Prepare the PPG software:
   a. Enter examinee data.
   b. Select stimuli set and record it on the check sheet.
   c. Log the examination room temperature.
   d. Select the "start recording video during instructions" box.

5. Activate the video monitoring system:
   a. Power on the control room monitor.
   b. Power on the examination room camera.
   c. Verify the camera is properly focused.

6. Have the examinee sit in the examination chair and adjust the angle for his comfort and viewing of the monitor.

7. Provide the examinee with an unused circumference ruler and an ink pen, explain how to use the ruler including how to mark it, and advise him to announce when he is finished.



8. Cover both video cameras; point out to the examinee that the cameras are covered and will not record video of him or provide a means to observe him while he uses the circumference ruler.

9. Leave the examination room and close the door while the examinee uses the circumference ruler.

10. Return to the control room and put on a pair of disposable medical gloves.

11. After the examinee announces he is finished measuring, return to the examination room, retrieve the circumference ruler and verify the ruler has been marked.

12. Log the measurement on the PPG Examination Checklist after confirming the mark with the examinee.

13. Retrieve the proper size strain gauge and show the examinee the strain gauge still sealed in its original plastic packaging.

14. Return to the control room with the strain gauge.

15. Activate the Instructional Video Presentation if it is being used for this examination and if not available, advise the examinee to remain seated in the lab and await your return after calibrating the strain gauge.

16. Calibrate the strain gauge as follows:
    a. Connect the strain gauge to the PPG DataPac at the ports labeled "P Gauge."Complete the on-screen questions for the calibration; use 10mm increments.
    b. Place the strain gauge on the calibration cone according to the on-screen instructions and follow the calibration instructions.
    c. Move the strain gauge down the cone in according to the on-screen instructions (10mm increments) using a pointed, but not sharp tool (4.5 mm knitting needle), ensuring the gauge does not roll up on itself or twist as it could break.
    d. Log each increment change using the PPG software.
    e. Ensure the PPG software accepts the entry and proceed to the next increment (10mm larger) until you have recorded five increments.
    f. Review the calibration data.
    g. Return the gauge to the measurement level that matches the gauge size and ensure that the measurement is within acceptable limits; if yes, proceed to 18.h., if no, pull the gauge from the cone by no more than ½ inch and release; if the measurement is still not accurate, repeat the calibration process starting at 18.a.; if two attempts fail, then replace the gauge and calibrate the new gauge.
    h. Remove the gauge from the calibration cone using a pointed, but not sharp tool (4.5 mm knitting needle).

[The calibration instructions continue to the next page.]

i. After advising the examinee via the intercom system, pass the strain gauge from the control room to the examination room through the access door, closing and securing the door after doing so.
j. Select "rate" from the PPG software desktop toolbar.

17. Verify the video display is visible on the desktop. Advise the examinee via the intercom system that the audio/video recording has been activated and that although the camera is currently covered and therefore the video is blocked from recording the room, the audio is able to record.

18. Return to the examination room and secure the strain gauge sensor lead to the examination chair using a Velcro strap Velcro straps are positioned on both sides of the examination chair beneath the armrest trays).

19. If the Instructional Video Presentation was not used, then provide to the examinee the following instructions verbally:
    a. Take the gauge and carefully make the opening just large enough to slip onto your penis.
    b. Make sure the gauge does not roll up on itself or twist as it could break.
    c. Carefully place the gauge around the mid-shaft of your penis.
    d. Take the disposable gown and put it on or cover your lap with it - whichever way you feel most comfortable.
    e. If you attempt to beat the exam by moving, tensing your muscles, not paying attention, holding your breath, or breathing rapidly, the person conducting the exam will be able to detect your attempts because of the following countermeasures in use during the examination:
        i. Video Recording: the entire exam will be digitally recorded to ensure that all exam protocols have been followed as well as to record if the examinee attempts to beat or fool the exam.
        ii. Countermeasure Cushion: detects even the slightest movement made by the examinee to include tensing muscle groups associated with response interference; it is best to stay as still as possible during each stimulus story; you will be given the opportunity to rest and move a bit between stories.
        iii. Galvanic Skin Response Sensors: two sensors will be placed on one of your hands to measure electrical impulses that indicate muscle tension; if you strain your abdomen, groin, leg, or other muscle in an attempt to fool the exam, the person conducting the exam will detect your attempts.
        iv. Respiration Belt: you will be given assistance to place the respiration belt around your chest; the respiration belt measures the rate and depth of your breathing; if you hold your breath or breathe rapidly in an attempt to beat or fool the exam, the person conducting the exam will be able to detect your attempts; it is best to breathe normally throughout the exam

20. Offer to answer questions the examinee may have and show the Instructional Video Presentation again, if it was used, or repeat the verbal instructions, if necessary.

21. Provide the examinee with a disposable medical gown and advise that he may wear it or use it to drape across his lap to cover his genitalia.

22. Give the examinee the strain gauge, advise him to place it on his penis after you leave the room and close the door, remind him how to place the strain gauge, advise him to announce to you when he has put the gauge on and covered his genitalia, and then leave the room closing the door behind you.

23. After the examinee announces that he has placed the strain gauge on his penis and covered his genitalia with the gown, put on a pair of disposable medical gloves, and return to the examination room.

24. Uncover the cameras; ensure the examinee understands where the camera is aimed.

25. State the date (month, date & year) and examinee's name for the camera and have the examinee verify the information.

26. Remind and have the examinee confirm for the camera that he (have him look at the recording camera while answering):
    a. Is aware that the examination audio-video recording system has already been activated and obtain his acknowledgement of each for the audio/video recording.
    b. Has signed the consent form.
    c. Has heard a description of the PPG examination.
    d. Has been given the opportunity to ask questions about the exam process.
    e. Has measured himself for the strain gauge size (hold the strain gauge with the marked measurement facing the recording camera).
    f. Has been shown the strain gauge selected for his exam while it was still in a sealed package.
    g. Has placed the strain gauge on himself as instructed or be assisted in placing it (if assisted, then list names and relevant license credentials of person(s) assisting and witnessing assistance, why assistance was provided, and that the examinee provided consent for assistance).

27. Dispose of the used circumference ruler in a trash receptacle in the examination room.

28. Position the Respiration Belt on the examinee with it centered on his chest.

29. Attach two galvanic Skin Sensors to the examinee's non-dominate hand using unused disposable adhesive sensor pads.

30. Ensure the numeric keypad is on the tray attached to the examination chair on the examinee's dominant hand side and that he can comfortably reach all the keys.

31. Give the examinee the headphones and ensure that he places them correctly over his ears assisting him as needed.

32. Explain to the examinee that he will be requested to pull the strain gauge away from his penis by no more than ¼ inch using the sensor lead side; ensure his understanding of the task and the importance of not overreaching the distance or pulling from an incorrect location.

33. Answer the examinee's questions.

34. Make sure the door is unlocked, leave the room, close the door, and return to the control room; dispose of the used medical gloves.

35. Test the examinee's headphones and the intercom system by briefly conversing with the examinee using the microphone-headphone system and the intercom system.

36. Adjust the recording camera monitoring window so it is visible, but not obscuring the sensor traces.

37. Check the senor traces on the computer monitor to ensure each is visible on the monitor and not overlapping each other.

38. Direct the examinee to pull the strain gauge away from his penis no more than ¼ inch by grasping the gauge at the point of connection of the sensor lead and then releasing the gauge; verify a change on the p-gauge tracing.

39. Place on the on-screen cursor on the instruction/stimuli display monitor and verify that the examinee can see the cursor on the screen in the examination room.

40. Begin the examination:
    a. Remind the examinee to:
        i. Relax.
        ii. Listen carefully to each story.
        iii. Pretend to be the person telling the stories.
        iv. Press "OK" on the numeric keypad whenever the story begins to be sexual or violent in nature.
        v. Be ready to describe the previous story if asked or to use the following scale to rate the level of arousal to the previous story if asked/directed do so by pressing the corresponding button on the numeric keypad and viewing the selected number on the video monitor and then pressing the key labeled "OK"
            1 – highly disgusted
            2 – moderately disgusted
            3 – neither disgusted nor sexually aroused
            4 = moderately sexually aroused
            5 = highly sexually aroused
        vi. Be ready for the examination to begin momentarily
    b. Click "start" on the PPG software desktop screen.
    c. Check the scenario audio to ensure it is playing through the computer and PPG systems.

d. Adjust the traces to keep them visible and separate from each other on the computer monitor during the examination.
e. At the end of each scenario remind the examinee to rate the level of arousal he experienced using the numeric keypad (if he does not respond to the visual prompt on the video monitor) and/or ask him to briefly describe the last scenario.
f. Ensure adequate detumescence (if tumescence occurred) before proceeding to the next scenario.
g. Advise the examinee that the next scenario is about to begin.
h. Continue the examination following steps 36.b. through 36.g. until the conclusion of the examination stimulus set.
i. If during the examination, the examinee wants to use the restroom, advise the examinee that you will enter the examination room and cover the cameras so that he can redress and exit the examination room to go to the restroom.
    i. Put on a pair of disposable medical gloves.
    ii. Knock and enter the examination room and cover the cameras.
    iii. Take the headphones from the examinee and place them out of his way.
    iv. Place an unused paper towel on the tray attached to the side of the examination table where the examinee will place the strain gauge; show the examinee where to place the strain gauge after he removes it.
    v. Remove the respiration belt and galvanic skin sensors from the examinee.
    vi. Leave the examination room and allow the examinee to dress and leave the examination room (with an appropriate escort if required).
    vii. Upon the examinee's return from the restroom, give him the headphones and ensure that he places them correctly over his ears.
    viii. Verbally remind him how to place the strain gauge on his penis and depart the examination room to allow him to place the strain gauge on his penis; return to step #23.
j. Log the time of the end of the trials on the PPG Examination Checklist.
k. At the conclusion of the examination, advise that examinee that the examination is complete and that you will enter the examination room and cover the cameras so that the examinee can remove the strain gauge and redress.

41. Put on a pair of disposable medical gloves.

42. Knock and enter the examination room.

43. Take the headphones from the examinee and place them out of his way; dispose of the disposable headphones covers in a trash receptacle.

44. Place the strain gauge package on the tray attached to the side of the examination table where the examinee will place the strain gauge.

45. Show and describe to the examinee how to place the strain gauge into the strain gauge package after removing the gauge.

46. Remove the Respiration Belt from the examinee and place it on the exam chair arm tray.

47. Remove the disposable Galvanic Skin sensors from the examinee and dispose of them in a trash receptacle.

48. Cover the cameras.

49. Exit the room so that the examinee can remove the strain gauge and get dressed; advise him to announce when he has removed the strain gauge and gotten dressed.

50. After the examinee announces that he has removed the strain gauge and gotten dressed, return to the examination room.

51. Uncover the cameras.

52. Answer the examinee's questions and then escort him from the examination room back to the waiting room.

53. Log the time the examinee leaves the examination room and other required post-examination data on the PPG Examination Checklist; ensure the Checklist is complete and sign and date it.

54. Save the examination data using the PPG software.

55. Put on a pair of disposable medical gloves and return to the exam room.

56. Using a trash receptacle, dispose of the paper gown, numeric keypad cover, used examination chair paper, and strain gauge, if it is disposable or follow cleaning instructions if it is re-usable.

57. Clean the examination chair using an appropriate cleaning material.

58. Dispose of the used medical gloves in a trash receptacle.

59. Deflate the Stingray counter-measures pad, if inflated.

60. Power off the:
    a. Examination room video monitor.
    b. Audio/video recording system.
    c. Intercom system.
    d. Video monitoring system (monitor and camera) and power cord.

61. Print and conduct an analysis of the examination results now or at a later time.

62. Log out of the PPG software when finished.

Sexual Behaviors Clinic and Lab
Penile Plethysmograph (PPG) Verbal Instructions/ Commands

Read the following Instructions to the Examinee:

If you attempt to beat the exam by moving, tensing your muscles, not paying attention, holding your breath, or breathing rapidly, the person conducting the exam will be able to detect your attempts because of the following countermeasures in use during the examination:

- *Video Recording: the entire exam will be digitally recorded to ensure that all exam protocols have been followed as well as to record if the examinee attempts to beat or fool the exam.*
- *Countermeasure Cushion: detects even the slightest movement made by the examinee to include tensing muscle groups associated with response interference; it is best to stay as still as possible during each stimulus story; you will be given the opportunity to rest and move a bit between stories.*
- *Galvanic Skin Response Sensors: two sensors will be placed on one of your hands to measure electrical impulses that indicate muscle tension; if you strain your abdomen, groin, leg, or other muscle in an attempt to fool the exam, the person conducting the exam will detect your attempts.*
- *Respiration Belt: you will be given assistance to place the respiration belt around your chest; the respiration belt measures the rate and depth of your breathing; if you hold your breath or breathe rapidly in an attempt to beat or fool the exam, the person conducting the exam will be able to detect your attempts; it is best to breathe normally throughout the exam*

*Offer to answer questions the examinee may have and show the Instructional Video Presentation again, if it was used, or repeat the verbal instructions, if necessary.

State the date (month, date & year) and examinee's name for the camera and have the examinee verify the information. Remind and have the examinee confirm for the camera that he (have him look at the recording camera while answering):

- ✓ Is aware that the examination audio-video recording system has already been activated and obtain his acknowledgement of each for the audio/video recording.
- ✓ Has signed the consent form.
- ✓ Has heard a description of the PPG examination.
- ✓ Has been given the opportunity to ask questions about the exam process.
- ✓ Has measured himself for the strain gauge size (hold the strain gauge with the marked measurement facing the recording camera).
- ✓ Has been shown the strain gauge selected for his exam while it was still in a sealed package.
- ✓ Has placed the strain gauge on himself as instructed or be assisted in placing it (if assisted, then list names and relevant license credentials of person(s) assisting and witnessing assistance, why assistance was provided, and that the examinee provided consent for assistance).

Just before starting the exam - Remind the examinee to:

- Relax.
- Listen carefully to each story.
- Pretend to be the person-telling the stories.
- Press "OK" on the numeric keypad whenever the story begins to be sexual or violent in nature.
- Be ready to describe the previous story if asked to
- Use the following scale to rate the level of arousal to the previous story if asked/directed do so by pressing the corresponding button on the numeric keypad and viewing the selected number on the video monitor and then pressing the key labeled "OK"
  - 1 = highly disgusted
  - 2 = moderately disgusted
  - 3 = neither disgusted nor sexually aroused
  - 4 = moderately sexually aroused
  - 5 = highly sexually aroused

"Be ready for the examination to begin momentarily"

William T. O'Donohue · Daniel S. Bromberg
Editors

Sexually Violent Predators: A Clinical Science Handbook

Springer

The Use of Penile Plethysmography in SVP Assessment and Treatment Decision-Making

15

Joseph J. Plaud

The use of clinical tools in the evaluation and treatment of sexual offenders take on special analytical and ethical scrutiny when the target population concerns those who are involved in sexually violent predator (SVP) legal proceedings. Put bluntly, each and every clinical decision in an SVP case ultimately entails the liberty interests of the sexual offender being evaluated or treated, as day-to-life civil commitment decisions involve the ongoing secure custody of that person after the expiration of the sexual offender's criminal sentence. Even before the advent of SVP laws in 20 American states, the District of Columbia, and within the federal judicial system, penile plethysmography (PPG) was no stranger to controversy as a research instrument, as an evaluation tool, and as an adjunct to cognitive-behavioral sexual offender treatment (Gaither, Rosenkranz, & Plaud, 1998; Plaud & Blackstone, 2014). SVP laws have only broadened the questions and concerns about the ethical, reliable, and valid use of PPG in assessment and treatment decision-making, as well as the manners in which PPG data influences decision-makers in this process. It is to this peculiar area concerning the use of PPG in SVP cases that we now turn our attention.

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Before analyzing the use of PPG in SVP cases, a short introduction to the instrument itself is in order. As detailed by Plaud and Blackstone (2014), the PPG was developed as a tool to measure physiological patterns of male sexual arousal and by implication sexual deviance. The PPG was introduced by Freund (1963), who described an instrument which recorded changes in penile volume as a function of being exposed to varied sexual stimuli. These changes in volumetric pressure or penile volume were termed phallometry. In an early study, Freund demonstrated that he could correctly classify his subjects according to their stated sexual preferences by the use of phallometry. Freund's research was followed up by numerous other empirical studies over the ensuing decades demonstrating that the PPG could be used to identify both normative and deviant patterns of sexual arousal using volumetric measures as well as other types of penile circumference measurement gauges (Plaud & Blackstone, 2014). As noted by Plaud and Blackstone (2014), generally speaking circumferential measures are the most commonly used devices in PPG evaluations. The basic PPG apparatus is visually depicted in Fig. 15.1.

The PPG device itself, which is called in circumferential measures a penile strain gauge, looks like a rubber band, more appropriately described as a small rubber-like ring, generally made of silicone, which contains a column of mercury within. The person being

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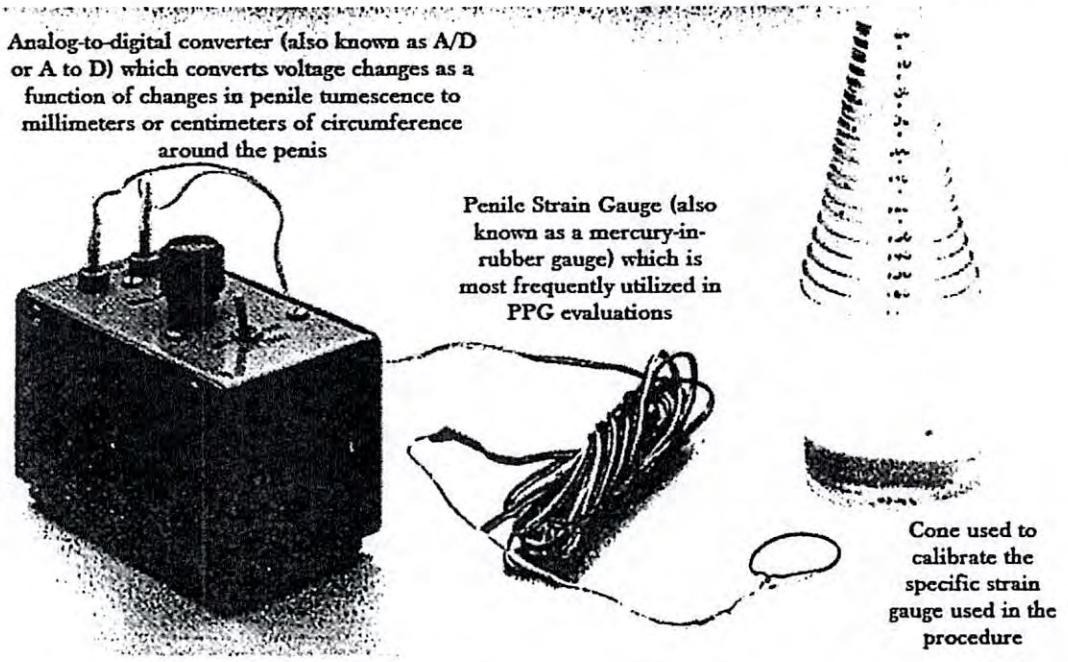

Fig. 15.1 A visual depiction of the basic PPG apparatus

evaluated via PPG places this rubber-like ring on his penis in privacy. The strain gauge is first calibrated according standardized protocols, and the essential measurement being recorded during the procedure involves changes in voltage which are then converted to changes in millimeter or centimeter of penile circumference. As noted by Plaud and Blackstone (2014), the PPG procedure is specifically designed to be private and as non-intrusive as possible.

There have been multiple attempts to measure human sexual arousal via physiological assessment techniques. Such approaches have included skin conductance, heart rate, blood pressure, pupillary responses, and temperature measurements. Almost half a century ago, Zuckerman (1971) argued that measure of penile tumescence was the most sensitive and valid measures of sexual arousal developed. This is not to say that the legitimacy of PPG has not been questioned since its inception. It has been both debated and its legitimacy challenged, sometimes vociferously. As detailed by Plaud and Blackstone (2014):

> PPG was developed to measure sexual arousal in the most direct manner: by recording changes in the erectile tissue surrounding the penis as it becomes filled with blood. This is the most basic overt physiological manifestation of sexual arousal in the human male. Despite this basic physiology, it remains the case that controversy surrounds the use of PPG as a tool of basic sexual research as well as clinical applications with sexual offenders (O'Donohue & Plaud, 1994; Gaither & Plaud, 1998). This is not to say that basic behavioral research on patterns of sexual arousal has not been conducted; it has, especially in the principles of basic conditioning and habituation of sexual arousal in respondent or classical conditioning (Plaud & Martini, 1999; Rachman, 1966; Rachman & Hodgson, 1968), operant conditioning (Cliffe & Parry, 1980; Rosen, Shapiro, & Schwartz, 1975), and habituation and spontaneous recovery (Koukounas & Over, 1993; Meuwissen & Over, 1990; O'Donohue & Plaud, 1991; Plaud, Gaither, Amato-Henderson, & Devitt, 1997). In most of the scientific studies of the conditioning, habituation and predictive utility of sexual arousal research, the penile plethysmograph (PPG), has been the essential tool of measurement. And yet the apparatus and the procedure are seemingly plagued by controversy (pp. 73–74).

It is also important in PPG evaluations to differentiate between primary and secondary

sexual stimulus characteristics (Gaither & Plaud, 1998). Primary stimulus characteristics refer to the categorical nature of the stimuli themselves; for example, whether or not the stimuli depict normative versus deviant sexual activities. Penile responding to primary stimulus characteristics most clearly correspond with an individual's stated sexual preferences. Secondary stimulus characteristics are those which may vary both within and between categories but lack the salience of primary stimulus characteristics. The results of PPG assessments are normally considered to be due to the manipulation of primary characteristics; yet, if they are not controlled, some secondary stimulus characteristics may confound those results. Mode of sexual stimulus presentation is an example of a secondary stimulus characteristic.

Indeed, an oftentimes overlooked element of conducting PPG evaluations concerns the mode or modes in which the sexual stimuli are presented during the assessment. Modes of PPG stimulus delivery include visual depictions, via slide or video presentation, audio descriptions (spoken text in the first or third person), written text, and fantasy inducement (Julien & Over, 1988). Stimulus combinations can also be conducted. Research has demonstrated that video elicited greater levels of sexual arousal than slides, spoken text, and written text, and fantasy elicited significantly less arousal than the other four modes (Julien & Over, 1988).

The purpose of this chapter is not to provide for a detailed analysis of the reliability and validity of the PPG as an assessment instrument per se. The reader should refer to Plaud and Blackstone (2014) for a more detailed analysis and exposition of these issues concerning both adolescent and adult sexual offenders. As pointed out by these authors, the following potential sources of variability should always be considered when employing or inspecting the results of PPG evaluations:

1. The type of strain gauge used and the proper placement of the strain gauge
2. The type of sexual stimuli used (audio, video, both)
3. Specific sexual scenes depicted by the sexual stimuli used
4. Duration of both stimulus and detumescence (quiet) periods
5. The instructions given to the client
6. The type of specific PPG technology employed, including type of recording instrumentation
7. The data sampling rate and type of data interpretation used of PPG results
8. Whether or not probes for dissimulation (faking) were employed during the procedure
9. The setting of the assessment facility (e.g., prison vs. outpatient setting)

Penile Plethysmography in SVP Decision-Making

Beyond the ongoing debate over the psychometric properties of the PPG itself, there are three immediate implications to SVP evaluations that follow from the development and use of PPG: (1) patterns of male sexual arousal can be objectively measured; (2) deviant sexual arousal can therefore also be identified on an individual level; and (3) measured changes in patterns of deviant sexual arousal can also be demonstrated as a function of cognitive-behavioral sexual offender treatment strategies developed to modify deviant patterns of sexual arousal. Why do any of these potential uses of PPG matter in SVP civil commitment cases? Before answering this question, we first need to explore the role of sexual arousal itself in the prediction of future sexual recidivism, a significant issue that SVP statutes are designed to address, namely, reducing sexual offense recidivism by civilly detaining, from a day-to-life, those sexual offenders identified as being the most risky to reoffend.

Since SVP laws were first enacted, professionals involved in the decision-making processes have advanced any number of methodologies designed to weigh and combine sexual offense risk factors in order to predict the likelihood of future sexual offenses. It has been demonstrated many times in the past two decades that mental health professionals employ a clinical

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decision methodology, that is, making risk predictions based on idiosyncratic weighing of risk factors, that in fact *decreases* the accuracy of prediction by causing clinicians to overpredict risk. Because the use of clinical judgment most probably produces misleading results that would not accurately identify those offenders who are most likely to reoffend, such analyses generally do not meet the test for scientific acceptance. Despite many efforts to predict sexual recidivism using such clinical judgment, there has been no evidence showing any valid link between such clinical judgments and actual future offenses. And there has been abundant evidence that shows that such predictions are generally no more valid than tossing a coin. The reality is that clinicians' evaluations based on a clinical, or even structured clinical, approach have virtually no predictive utility whatsoever despite their clear beliefs to the contrary (Hanson, 1998):

> [M]any of he frequently used risk assessment procedures have questionable validity ... *[T]he accuracy of [clinical] risk assessments has been unimpressive ... The clinical prediction of sexual offender recidivism is no exception.* Across 10 studies (N = 1453) that examined the predictive accuracy of clinical judgments concerning sexual offender recidivism risk, the average correlation was only 0.10 ... Evaluators assessing the long-term risk for recidivism can be reasonably sure that a factor should not be considered when the average correlation is near 0 ... Included among the unrelated factors are measures of general psychological adjustment ... (average $r = -0.01$). (pp. 52–57)

Even though the validity of making future sexual recidivism risk predictions via any methodology or combination of methodologies has been debated since the first such laws were enacted (cf., Harcourt, 2005), PPG may have an objective, scientifically based role to play in that psycho-legal process.

Penile Plethysmography and SVP Sexual Offense Risk Assessment

Why is PPG important in both the evaluation and treatment of sexual offenders who are being considered for SVP status? The most straightforward answer to this question is because the identification of deviant sexual arousal has been found by several researchers to be a significant predictor of sexual offense recidivism. Further, publication of these research findings occurred at the very moment in time when many jurisdictions had recently adopted, or were considering adopting, SVP statutes. The most notable example of this type of publication was the oft-relied-upon meta-analysis conducted by Hanson and Bussière (1998). These researchers found that deviant sexual arousal to prepubescent children, measured specifically by the PPG, was the single greatest predictor of sexual offense recidivism, individually accounting for approximately 10% of the experimental variance.

This empirical finding has held up in subsequent studies as well, although the strength of the statistical association between sexual offense recidivism and deviant sexual preferences measured via PPG has not been as strong as in the original Hanson and Bussière meta-analysis (e.g., Hanson & Morton-Bourgon, 2005; Mann, Hanson, & Thornton, 2010). Taken as a whole, and this is important, a survey of the research indicates that there is in fact empirical support for the finding that deviant sexual arousal is a dynamic risk factor for predicting sexual offense recidivism. From a more theoretical perspective, this research finds support in positing that there is a relationship between being sexually aroused by something and acting behaviorally on that arousal (Plaud and Blackstone, 2014). This finding is generally referred to as the "sexual preference hypothesis."

According to the sexual preference hypothesis, sexual offenders, especially those considered for SVP status, are more physiologically aroused by deviant sexual stimuli depicting illegal, coercive sexual activities than by stimuli depicting consenting, legal sexual activity with adults. The sexual preference hypothesis posits that such individuals are more likely to engage in deviant sexual behavior if they have underlying deviant sexual arousal in that domain. From an empirical perspective, PPG research has provided some support for the legitimacy of the sexual preference hypothesis, mostly with sexual offenders

who have prepubescent victims outside of their families, in contrast to incest offenders and adult rapists (Leitenberg & Henning, 1995).

If the measurement of sexual deviance becomes relevant to SVP proceedings, how can the PPG be utilized to assist evaluators in making professional determinations of risk? There are at least two answers to this question, involving the PPG's potential role in both psychodiagnostic and treatment decisions.

The Relevance of Penile Plethysmography to Psychodiagnosis

Part of the legal criteria utilized to find an adjudicated sexual offender to be SVP involves the use of statutory terms such as "mental abnormality" and "personality disorder" and legal constructs which are defined as congenital or acquired conditions of the person that affect that person's volitional capacity or control over his or her sexual behavior (although it should be noted that those deemed SVP are almost universally male). What follows from this central tenet in current SVP laws is that the person being considered for such legal status has an underlying mental condition which motivates or propels that person to commit further acts of sexual violence if not further confined to a secure facility after the expiration of his or her criminal sentence. In other words, such legal SVP definitions implicitly endorse the conclusion that not only is the sexual preference hypothesis legitimate but also that a subset of the clinical population of sexual offenders has significant or serious difficulty in controlling these underlying deviant sexual interests. Therefore, the prevailing notion goes that societal safety demands that such persons identified as sexually, volitionally compromised should remain institutionalized past the expiration of their criminal sentences. This is an essential element of all modern SVP laws that an underlying condition or conditions make a sexual offender likely or more likely than not to engage in further acts of sexual predation if not further confined to a secure facility as SVP.

Consider the statutory definition of a sexually dangerous person (SDP; a variant of the term sexually violent predator in other jurisdictions) in the Commonwealth of Massachusetts under General Laws (G.L.) Chapter 123A, § 1:

> ...any person who has been (i) convicted of or adjudicated as a delinquent juvenile or youthful offender by reason of a sexual offense and *who suffers from a mental abnormality or personality disorder* which makes the person likely to engage in sexual offenses if not confined to a secure facility [emphasis added].

Further, G.L. Chapter 123A, § 1 defines mental abnormality in the Commonwealth of Massachusetts as:

> *A congenital or acquired condition of a person that affects the emotional or volitional capacity of the person in a manner that predisposes that person to the commission of criminal sexual acts to a degree that makes the person a menace to the health and safety of other persons.*

Additionally, the Massachusetts SDP statute defines a personality disorder as:

> *A congenital or acquired physical or mental condition that results in the general lack of power to control sexual impulses.*

The federal government of the United States in 18 United States Code § 4248 uses the following similar legal language in this domain, specifically whether the person suffers "from a serious mental illness, abnormality or disorder." All other SVP/SDP statutes contain variations on this basic requirement for a positive finding of sexual dangerousness.

A further implication of this psycho-legal conceptualization of "mental abnormality" or "mental illness" as a component in SVP statutes is that psychodiagnosis is a central element in the SVP legal process. Enter the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* or *DSM-5* (American Psychiatric Association, 2013). The paraphilias defined in the *DSM-5* include voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, fetishistic disorder, transvestic disorder, and "catch-all" diagnostic categories referred to unspecified and other

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specified paraphilic disorders. According to the *DSM-5*, "a paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention" (page 686). In the *DSM-5*, "Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (i.e., distress, impairment, or harm to others)" (page 686). As the *DSM-5* specifically notes: "In keeping with the distinction between paraphilias and paraphilic disorders, the term *diagnosis* should be reserved for individuals who meet both Criteria A and B." In other words, it is clinically possible to have a paraphilia, but not a paraphilic disorder using the diagnostic criteria of the *DSM-5*.

Can the PPG aid in psychodiagnosis of paraphilic disorders in SVP evaluations? *DSM-5* is equivocal in addressing this question:

> Psychophysiological measures of sexual interest may sometimes be useful when an individual's history suggests the possible presence of pedophilic disorder but the individual denies strong or preferential attraction to children. The most thoroughly researched and longest used of such measures is penile plethysmography, although the sensitivity and specificity of diagnosis may vary from one site to another. (p. 699)

A recent meta-analysis of PPG found that several phallometric testing procedures did provide for valid indicators of what the authors termed "pedohebephilic interest," a term discussed in greater detail below (McPhail et al., in press). At the very least, it is clear that a fair number of clinicians do utilize PPG as at least an adjunct assessment tool in order to make paraphilia diagnoses. McGrath, Cumming, Burchard, Zeoli, and Ellerby (2010) found, for example, that in community samples, 27.9% utilized PPG in their evaluations of adult sexual offenders and in 9.5% of adolescent sexual offenders. With adults, that number climbed to 36.5% in residential programs. So while a clinical diagnosis of say, pedophilic disorder, should not be made solely or even primarily on a PPG administration, it is the case that PPG data can and oftentimes is used as a part of the diagnostic process concerning diagnosing clinical paraphilias.

While the PPG may assist an SVP evaluator in the clinical diagnosis of one of more paraphilias, there is also room for its misuse, most notably using the PPG in order to assist in the creation of paraphilias not generally accepted in the scientific community. One example of this potential misuse of PPG is attempting to expand what the *DSM* terms "other specified paraphilia," a broad diagnostic area historically reserved for low-frequency examples of sexual deviance that don't have their own specific diagnostic criteria. Perhaps the most frequent attempt to create a new sexually deviant diagnostic category in SVP proceedings is the term "hebephilia," which has been used in civil commitment proceedings to describe sexual offenders who evidence sexual arousal to postpubescent males or females who have not yet attained legal status to consent to sexual activities. However, as Rind and Yuill (2012) concluded: "The broad-based scientific evidence indicates that hebephilia is not a dysfunction, and therefore cannot justifiably be declared a mental disorder in the *DSM*" (p. 823). Despite this finding, it is all too common for some clinicians in SVP cases to label the sexual behavior of those who have engaged in sexual activities with pubescents/postpubescents as being within the realm of paraphilic or deviant sexual behavior. Plaud (2009) criticized the use of PPG by Blanchard et al. (2009) to support their conclusion that hebephilia should be considered a paraphilic mental disorder, focusing on improper PPG analysis:

> There does not appear to be any homogeneity of groupings along the axes of sexual interest groups. If there are 'hebephiles' among us, then this sexual interest/arousal pattern appears to be a very heterogeneous one. If it is heterogeneous, how can it have diagnostic specificity as Blanchard et al. state it has in their conclusion? Look at Fig. 3. In the pedophile groups (especially Pedo 2), there was significant overlap between physiological arousal to both pre-pubescent and pubescent girls. As a matter of fact, in their Pedo 2 group, there was more arousal to pubescent girls than to pre-pubescent girls. And this relation does not seem to hold for homosexual males (even though Blanchard et al. state that the hetero/homo groups were remarkably similar). How is that a diagnostic indicator of pedophilia?...

> In the final analysis, rather than establish the validity of a bona fide diagnostic category such as hebephilia for inclusion in the *DSM-5*, these data show that Blanchard et al. labeled Hebe groups tend to be more Pedo "light" groups than a separate class of sexual deviates, at least with the heterosexual subjects. (p. 327)

Suffice it to say that the use of professionally dubious paraphilia terms such as "hebephilia" is prevalent in SVP proceedings (Singy, 2015). SVP evaluators should be cautious in the use of pseudo-diagnostic terms when there is no accepted empirical validation utilizing the PPG. Another example of this troubling trend concerns what was advanced by certain clinicians involved in SVP proceedings as "paraphilia NOS – nonconsent," or more recently in *DSM-5*, "other specified paraphilia – nonconsent." As with "hebephilia," these terms do not represent formal, accepted clinical diagnoses, and the "nonconsent" label has not achieved acceptance in the professional community of psychologists and psychiatrists. The *DSM-5* does have a specific category of clinical diagnosis related to rape-related paraphilia; it is entitled sexual sadism, and PPG should be used to present objective data on both normative and deviant patterns of sexual arousal, not to advance agendas to increase the range of paraphilia diagnoses beyond what the *DSM-5* has validated in order to make more diagnoses available to clinicians in context of SVP proceedings. Remember, because all modern SVP laws rely upon the identification of an underlying condition or conditions which affects the emotional, cognitive, or volitional capacity of the sexual offender being considered for civil commitment, there is an ongoing possibility that psychodiagnosis can be misused and misapplied in this psycho-legal context.

The Relevance of Penile Plethysmography to Treatment Decisions

Perhaps the main strength of PPG evaluations in SVP contexts concerns its use as an adjunct to cognitive-behavioral sexual offender treatment. As Gaither et al. (1998) pointed out, many of the most commonly employed techniques are based upon the principles of learning and conditioning. As such, it becomes important to have precise measurements of sexual arousal for two primary reasons: (1) measuring change in sexual arousal patterns over time as a result of treatment participation and (2) targeting deviant arousal directly in order to administer behaviorally based interventions such as the administration of punishing stimuli (e.g., use of ammonia inhalants) or covert sensitization techniques (Alford, Plaud, & McNair, 1995; O'Donohue & Plaud, 1994).

How can PPG be employed as an adjunct to behavioral treatment of sexual offenders committed under SVP statutes? Although the *DSM-5* specifies a number of topographically divergent paraphilias, ranging from noncontact (e.g., exhibitionistic disorder) to contact (e.g., pedophilic disorder) paraphilias, behavior analytic approaches focus upon stimulus control and conditioning approaches to sexual arousal, as well as the relationship of sexual arousal to sexual behavior (Barbaree & Marshall, 1991; O'Donohue & Plaud, 1994; Gray & Plaud, 2005). Behavior analytic approaches to paraphilias have as their bases the relationships among habituation, respondent (or classical) and operant conditioning, and overt sexual expression (Plaud, 2005). Given the wide applicability of conditioning principles (Plaud & Vogeltanz, 1993), a common theoretical assumption is that sexual responses are learned (O'Donohue & Plaud, 1994). Learning-based accounts of sexual behavior focus on the importance of both conditioning and habituation of sexual arousal; however, there are differences in the extent to which different behavioral theories emphasize the role of conditioning-related factors (O'Donohue & Plaud, 1994).

Further, understanding the etiology of the sexual paraphilias to a large extent rely on the assumption that at least to some extent sexual behavior and arousal are learned. For example, theories derived from anthropology and sociology have also claimed that human beings learn the range of sexual behavior through a variety of societal and cultural mechanisms (Davenport, 1987; DeLamater, 1987). In applied behavioral contexts, the shaping, maintenance, and modification of paraphilias have been explained by theories of learning (Barbaree & Marshall, 1991; Laws & Marshall, 1991; LoPiccolo & Stock, 1986; Masters & Johnson, 1970). For example, paraphilias have been hypothesized to

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develop due to early conditioning experiences and to be maintained by their association with orgasm from masturbation to deviant fantasies or through other mechanisms of the principles of reinforcement (Laws, Myer & Holmes, 1978; O'Donohue & Plaud, 1994). Many behavior therapy regimens used to treat sexual disorders also rely on learning principles in the modification of sexually deviant behavior (Kelly, 1982). The PPG is designed to measure potential changes in the patterns of sexual arousal as a function of cognitive and behavioral intervention/treatment strategies designed to target deviant sexual arousal.

The use of PPG in the treatment of an adjudicated sexual offender was described in a case study conducted by Plaud and Gaither (1997) in which a procedure known as assisted covert sensitization was evaluated through PPG monitoring. Covert sensitization as a behavioral intervention involves a combination of respondent and operant conditioning (Plaud, 2002). In the early stages of treatment, the therapist and client come up with an aversive image or verbal script/narrative, later used to pair with situations involving the lead up to deviant sexual responding. The aversive image may be conceptualized as an unconditioned stimulus (US). The images of the events/situations leading to deviant sexual arousal are then paired with the US and according to the principles of respondent conditioning become the conditioned stimulus (CS). The unconditioned response (UR) to the US, and the conditioned response (CR) to the CS consist of negative reactions along both emotional and cognitive/behavioral domains; for example, feeling fearful or anxious and becoming nauseous or physically ill. According to the principles of learning and behavior, the therapeutic technique is for the sexual offender to avoid or escape the situations associated with the deviant sexual behavior due to the aversive consequences of that behavior. As the therapeutic procedure unfolds, sexual arousal is measured via PPG monitoring. Employing this therapeutic methodology, Plaud and Gaither (1997) demonstrated decreased deviant arousal to sexually inappropriate stimuli, coupled with decrement self-report of deviant sexual arousal as one of the findings in their case study reported in the literature. The PPG was the required measurement tool to demonstrate clinical efficacy in this study.

There are many other behaviorally based sexual offender treatment techniques employed in SVP facilities in which PPG can be used as an adjunct to treatment. Such techniques can include olfactory aversion or olfactory aversive therapy. Similar to covert sensitization as described above, olfactory aversion is based closely on learning principles; however in this case, the punishing stimulus is in the form of a noxious odor. The behavioral theory underlying olfactory aversion also involves principles involving both respondent and operant conditioning (Gaither et al. 1998). In contrast to covert or assisted covert sensitization described above in which an aversive (or punishing) stimulus is based upon the use of imagery and verbal scripts/narratives, the punishing stimulus is the use of ammonia, valeric acid, or other noxious odors which generally are self-administered by the treatment participant himself. Sometimes a small atomizer, which is designed to spray a small amount of a noxious vapor into the treatment participant's nostrils, is also employed. Again, the treatment participant's sexual arousal is being monitored via PPG.

PPG evaluations, conducted periodically while individuals deemed SVP continue to participate in sexual offender treatment, can also be used to assess whether or not the individual is demonstrating changes in deviant sexual arousal as he advances through the treatment program, whether or not he is engaging directly in behavioral treatment as described above. PPGs can also assist in the assessment of behavioral treatment strategies aimed at decreasing deviant sexual arousal, such as masturbatory satiation. In brief, masturbatory satiation involves the treatment participant masturbate while engaging in deviant fantasies for a much longer time than is pleasurable, usually 1–2 hours at a time). In masturbatory extinction, the goal of treatment is to increase sexual arousal to nondeviant fantasies while he masturbates while engaging in nondeviant fantasies until he ejaculates (Alford, Morin, Atkins, & Schoen, 1987).

As a final example of behavioral treatment interventions which can be monitored through PPG assessment, orgasmic reconditioning is a technique in which the therapeutic goal is to increase appropriate sexual responding, while decreasing deviant arousal. Sexual arousal to nondeviant stimuli is increased, while simultaneously sexual responding to deviant stimuli is decreased, as reported by several researchers (Foote & Laws, 1981; Keller & Goldstein, 1978; Kremsdorf, Holmen, & Laws, 1980; Laws, 1985). The basic procedure is to have the client engage in deviant fantasies, but before ejaculation occurs, he is instructed to switch to a nondeviant fantasy, which then becomes paired with the reinforcing orgasm.

Cognitive-behavioral treatment of sexual offenders adjudicated as SVP obviously involve multiple strategies and techniques beyond the application of direct learning principles to sexual responding, monitored via PPG (e.g., social skills training, assertiveness training, other behavioral skills training, relaxation training, and systematic desensitization). However, data gathered over time from PPG evaluations while SVP clients are undergoing treatment participation can help to pinpoint changes in sexual arousal, which can be considered to be a critical index of the success of sexual offender treatment targeted at reductions in deviant arousal and/or increased level of normative sexual responding.

Penile Plethysmography and SVP Decision-Making in the Courtroom

When an individual is being considered for SVP status, how do PPG results enter into the legal process of civil commitment? There are three scenarios in which PPG results can become incorporated into SVP proceedings. The first scenario involves historic PPG evaluations conducted prior to the civil commitment petition. These types of PPG evaluations take place when the sexual offender was still serving a criminal sentence, as part of an earlier evaluation or participation in treatment. The second possibility involves PPG evaluations conducted by one or more government or defense experts in context of the current SVP petition, incorporated in their clinical findings and psychodiagnoses provided to the court. The third scenario relates to SVP release cases, involving one or more PPG evaluations conducted as part of post-commitment treatment participation.

In many cases admission of PPG results directly in court proceedings has not been allowed, whether under the Frye or Daubert standards, depending upon the jurisdiction in which the SVP petition is filed. The older of the two evidentiary standards in court, Frye, deals with whether the methodology in question is "generally accepted" by relevant experts in the field in which it belongs (Frye v. United States, 293 F. 1013 (D.C. Cir.), 1923). Under the Daubert standard, a methodology is evaluated on the following factors, one of which incorporates Frye: (1) whether the theory or technique in question can be and has been tested; (2) whether it has been subjected to peer review and publication; (3) its known or potential error rate; (4) the existence and maintenance of standards controlling its operation; and (5) whether it has attracted widespread acceptance within a relevant scientific community (Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 1993).

A main reason for the exclusion of PPG results in SVP trials is that the procedure did not meet either the Frye or Daubert standard which controls the admitting of evidence in that case. As noted above, it is the fact that there is ongoing debate among professionals concerning the reliability and validity of the PPG, as discussed in greater detail by Plaud and Blackstone (2014). For example, in United States v. Powers, 59 F.3d 1460 (4th Circuit, 1995), PPG was excluded because the court found that it did not qualify under the scientific validity prong of Daubert. This is not to say that PPG are automatically discredited or discarded in SVP proceedings. There are cases in which PPG results do enter into the court record; and even if PPG results per se do not make it into the record, PPG data can still enter the civil commitment proceeding in court through testifying expert witnesses. In such cases the expert's psychodiagnostic or risk conclusions in part may be derived from PPG results, even

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though the results themselves do not become directly incorporated into the evidentiary record. Therefore, PPG results have the possibility of entering into SVP cases either directly as evidence, or indirectly through its influencing expert opinion, which ultimately translates into court testimony.

It is also true that individual jurisdictions can take specific positions on the use of PPG in SVP proceedings as a matter of statute. The first state to create what can be called the "second wave" of SVP laws is the State of Washington, which enacted its sexual offender civil commitment statute in 1990. A dozen years later, in 2012, the state legislature amended Washington's SVP law and specifically permitted the court to compel PPG evaluations in SVP cases. In the Revised Code of Washington 71.09.050(1), it states that:

> Within forty-five days after the completion of any hearing held pursuant to RCW 71.09.040, the court shall conduct a trial to determine whether the person is a sexually violent predator...The prosecuting agency shall have a right to a current evaluation of the person by experts chosen by the state. The judge may require the person to complete any or all of the following procedures or tests if requested by the evaluator... (c) plethysmograph testing [emphasis added].

The constitutionality of compelling the use of the PPG in Washington SVP proceedings has recently been held up on appeal (State of Washington v. Donald Herrick, App. No. 69818-4-1, 2017). In other jurisdictions outside of Washington, sexual offenders facing civil commitment can also be court-mandated to participate in PPG evaluations (Garrison, 2015), although generally speaking PPG results face an uphill battle for admissibility in court, even when such results lead to sexual offender treatment recommendations within an SVP institution.

Conclusion: PPG Evaluations in SVP Proceedings

When SVP proceedings are initiated against adjudicated sexual offenders whose criminal sentences are about to expire, or when those already deemed SVP initiate proceedings to end that legal status, PPG data are not oftentimes considered central or even relevant in the ultimate decision processes involved in civil commitment. Yet as we have seen, PPG has the potential to have applicability to all elements of the SVP process, from psychodiagnosis to measuring sexual offender treatment progress. Further, the manner in which PPG results influence SVP proceedings can vary significantly, and very often PPG data has a more indirect role to play in the sexual offender civil commitment process.

The PPG was designed over half a century ago in order to measure patterns of male sexual arousal objectively and scientifically. As we have seen, the proper identification of deviant patterns of sexual arousal may have relevance to SVP proceedings given the established empirical relationship between deviant sexual arousal and the prediction of sexual offense recidivism, as analyzed in our exploration of the sexual preference hypothesis. Further, the PPG can and is being utilized in SVP sexual offender treatment programs in order to measure changes in patterns of deviant sexual arousal as a function of treatment participation. It is also true that there is ongoing controversy concerning the psychometric properties of the PPG in the evaluation and treatment of sexual offenders, and even at this time there is no "standardized" assessment protocol when it comes to PPG administrations. However, there is little doubt that when a civil commitment law is based in large part upon statutory definitions that invoke underlying mental conditions as requisite for the finding that an adjudicated sexual offender is SVP, there needs to be a way to measure sexual deviance in an objective manner.

This chapter has been focused on the many ways in which PPG can and does play a role in SVP civil commitment of sexual offenders. It should also be noted that SVP programs should address the potential community reintegration of those adjudicated SVP because lifetime institutional commitment is not the goal of these statutes. Rehabilitation and community reintegration are the ultimate goals of all SVP statutes currently enacted in the United States. Once a sexual offender is no longer considered SVP, whether through demonstration that the person has made satisfactory progress in a sexual offender treat-

ment program or other nontreatment-related reasons, that person should be placed in some type of transition program that will serve as the first step to community reintegration and aftercare of the person. It has been found that for sexual offenders in general, the first 2 years after release from an inpatient treatment program or correctional facility are the most critical in terms of sexual recidivism (Gaither et al. 1998). Oftentimes PPG evaluations conducted institutionally can provide for more specific recommendations for tailoring sexual offender treatment in outpatient settings after an SVP is released back into the community.

In the final analysis, the PPG as both a research and clinical tool is here to stay. Like any tool or assessment procedure, the PPG has its pluses and minuses, its accomplishments and controversies. PPG data should always be used as one piece of information in making clinical (and legal) decisions in SVP proceedings. Civil commitment of sexual offenders should never be based upon PPG findings in any context. The PPG is a useful tool in attempting to understand the specific patterns of sexual arousal for individuals involved in the SVP process; and it can also be useful as an adjunct to cognitive-behavioral treatment programs. When utilized validly and ethically, the PPG can have a significant role to play in the civil commitment of sexual offenders.

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Genetic and physiological. Since pedophilia is a necessary condition for pedophilic disorder, any factor that increases the probability of pedophilia also increases the risk of pedophilic disorder. There is some evidence that neurodevelopmental perturbation in utero increases the probability of development of a pedophilic interest.

Sex- and Gender-Related Diagnostic Issues

Laboratory measures of sexual interest, in terms of psychophysiological responses to sexual stimuli depicting children, which are sometimes useful in diagnosing pedophilic disorder in men, are not necessarily useful in diagnosing this disorder in women because there has been very limited research on the assessment of pedophilic sexual interest in women.

Diagnostic Markers

Psychophysiological measures of sexual interest may sometimes be useful when an individual's history suggests the possible presence of pedophilic disorder but the individual denies strong or preferential attraction to children. The most thoroughly researched and longest used of such measures is *penile plethysmography*, although the sensitivity and specificity of diagnosis may vary across sites, which frequently use different stimuli, procedures, and scoring. *Viewing time*, using photographs of nude or minimally clothed persons as visual stimuli, is also used to diagnose pedophilic disorder, especially in combination with self-report measures. U.S. clinicians, however, should be aware that possession of visual sexual stimuli depicting children, even for diagnostic purposes, may violate American law regarding possession of child pornography and leave the clinician susceptible to criminal prosecution. The option exists to use audio stimuli describing sexual interactions in penile plethysmography. Across psychophysiological methods, the diagnostic marker is relative sexual response to stimuli depicting children compared with stimuli depicting adults, rather than absolute response to child stimuli.

Differential Diagnosis

Pedophilia. Individuals with pedophilia experience recurrent, intense, sexually arousing fantasies or sexual urges involving sexual activity with a prepubescent child or children. Unless the individual has acted on these sexual urges with a prepubescent child or unless the sexual urges or fantasies cause marked distress or interpersonal difficulty, a diagnosis of pedophilic disorder is not warranted.

Other paraphilic disorders. Sometimes individuals present with a different paraphilic disorder but are referred for an evaluation regarding possible pedophilic disorder (e.g., when an individual with a diagnosis of exhibitionistic disorder exposes himself to children as well as adults). In some cases, both diagnoses may apply, whereas in others, it may be the case that one paraphilic disorder diagnosis is sufficient. For example, an individual who exposes himself exclusively to prepubescent children may have both exhibitionistic disorder and pedophilic disorder, whereas another individual who exposes himself to victims, irrespective of the victims' age, may be considered to have only exhibitionistic disorder.

Antisocial personality disorder. Some individuals with antisocial personality disorder sexually abuse children, reflecting the fact that the presence of antisocial personality disorder increases the likelihood that an individual who is primarily attracted to mature persons will approach a child sexually, on the basis of relative access to the child. An additional diagnosis of pedophilic disorder should only be considered if there is evidence that over a period of at least 6 months, the individual has also had recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child.

Limestone:

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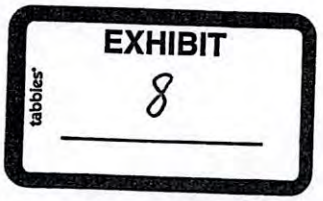

Our lab: _____

Murphy, L., Ranger, R., Stewart, H. *et al.* Assessment of Problematic Sexual Interests With the Penile Plethysmograph: an Overview of Assessment Laboratories. *Curr Psychiatry Rep* **17**, 29 (2015). https://doi.org/10.1007/s11920-015-0567-z

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Association for the Treatment of Sexual Abusers

ATSA

Practice Guidelines

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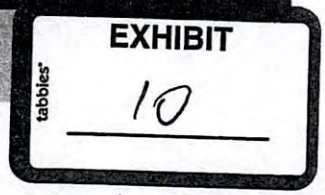

Appendix B: Phallometry, Viewing Time, and Polygraphy

Phallometry

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, members 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.

Phallometric testing using penile plethysmography involves measuring changes in penile circumference or volume in response to sexual and non-sexual 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 appendix.

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

Phallometric test results are not used as the sole criterion for determining atypical 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 (such as, 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 or has not committed a specific sexual crime. As well, there are limited data available regarding the use of the plethysmograph with clients who have developmental disabilities and clients with an acute major mental illness. Therefore, members need to exercise caution in using phallometry with these populations and in interpreting and reporting phallometric results.

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.

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.

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 abuse and control subjects than less explicit stimuli. It is important to ensure that the stimuli are good quality and avoid any distracting elements.

Members 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, pre-pubertal 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 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.

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

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 testing, and a summary and description of the client's profile of responses. Client efforts to fake or other potential problems for the validity of the data or the interpretation of results are also reported.

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.

Deviance indices can be calculated by subtracting the mean peak response to non-deviant 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.

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

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.

Viewing Time Measures

Viewing time measures are a specialized form of assessment used with individuals who have engaged in sexually abusive behaviors. Using the results of viewing time measures responsibly requires members 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, members should be familiar with current literature and obtain appropriate training before using or interpreting viewing time testing results.

Currently, unobtrusively measured viewing time is primarily used to identify sexual interest in children. For instance, to test 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. The relative amount of time clients spend looking at pictures of children (who

are clothed, semi-clothed or nude, depending on the jurisdiction,) is compared to the time that the same adult spends looking at pictures of adults. Research suggests that, as a group, individuals who have engaged in sexually abusive behaviors 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 non-sexually abusive subjects. Little is known, however, about the value of retesting using viewing time as a measure of treatment progress.

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. Note that there is limited information specific to the use of viewing time with clients who have developmental disabilities. Currently 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.

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 for the validity of the data or the interpretation of results are also included.

As noted in the main body of this document, 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, and pattern of masturbation) and are never to be used to make inferences about whether an individual has or has not committed a specific sexual crime.

Polygraphy

Polygraph testing involves a structured interview during which a trained examiner records several physiological responses of the examinee. Following this interview, the examiner reviews the charted record and forms opinions about whether the examinee was non-deceptive or attempting deception when answering each of the relevant questions. Many regions and jurisdictions do not utilize polygraphy for a variety of reasons, including empirical questions about its reliability and validity, yet in many other jurisdictions it is a widespread practice.

Post-conviction sex offender polygraph testing is a specialized form of general polygraph testing. 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 members to have at least a rudimentary understanding of how the polygraph works, its advantages and limitations, and special considerations related to its integration into work with individuals who have engaged in sexually abusive behaviors. As with any instrument or procedure, members should be familiar with current literature and obtain appropriate training before using or interpreting polygraph results.

Post-conviction sex offender testing is intended to serve the following objectives:

1. Facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors (generally disclosed in the interview portion of the examination);

2. Eliciting from the client clarifying information regarding the instant/index offense

3. Exploring potential changes, progress and/or compliance relative to treatment and other case management goals and objectives (through yes/no questions about adherence to specific treatment and other case management expectations); and/or

4. Making collaborative case management decisions about a client with other partners and stakeholders based on the information gleaned from the examination interview.

Some research indicates that the polygraph examination can lead to clients providing increased information regarding their sexually abusive behaviors; however, as has been mentioned, test validity and reliability often vary widely across studies. Examiner and examinee characteristics, treatment milieu, instrumentation, procedures, examination type, base rates of attempted deception in the population being tested, and other idiosyncratic factors can also affect reliability and validity. 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 third objective of post-conviction sex offender testing –to gauge enhanced supervision and treatment compliance – has received only limited empirical attention.

Members' primary purpose for collecting sexual history information is to further inform, as a complement to other assessment data, clinical interventions and other management strategies. The usefulness of post-conviction sex offender polygraph testing as a "clinical" tool is based on its potential to elicit historical information, thus arguably allowing psychosexual behavioral patterns to be more fully revealed, better understood, and therefore more effectively managed and changed.

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

Four types of post-conviction polygraph exams are commonly performed with individuals who have engaged in sexually abusive behavior:

1. **Instant/Index Offense Tests** are designed to explore and clarify discrepancies between the client's and the official descriptions of the conviction offense(s).

2. **Sexual History Disclosure Tests** are designed to facilitate a client's disclosure of sexual history information, which may include sexually abusive or offense-related behaviors, to their treatment provider prior or subsequent to the polygraph examination itself.

3. **Maintenance/Monitoring Tests** are designed to explore potential changes, progress, and/or compliance relative to treatment, supervision, and other case management goals, objectives, and expectations, based on specific yes/no questions pertaining to very specific and narrow expectations and goals that have been established.

4. **Specific Issue Tests** are generally designed using a yes/no format to explore a client's potential involvement in a specific prohibited behavior, such as unauthorized contact with a victim at a particular time.

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

Members must ensure that limits of confidentiality are fully disclosed to clients prior to polygraph testing, and that clients are afforded the opportunity for informed consent , specifically with respect to the ways in which the findings will be used and to whom the findings will be provided. Client disclosures of potentially incriminating information to mandated reporters can, lead to future prosecution. Members inform clients, in writing, of this potential dilemma and how it is addressed in their jurisdiction and program.

There is very limited empirical research on the use of polygraph with clients who have developmental disabilities and clients with low/borderline IQs. Therefore, further caution is advised if members use polygraphy for assessment, treatment, and management processes with these clients.

As noted in the main body of this document, 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 or to change a client's treatment status. When the polygraph is utilized, findings are to be interpreted in conjunction with other relevant information to inform decision making.

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A non-latex condom has no influence on male physiological sexual arousal

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ABSTRACT

Background/Objective: Men do not use external condoms for several reasons, which can result in public health problems. One of these is related to Condom-Associated Erectile Problems. This study aimed to examine the sexual arousal response of heterosexual men when using an external condom made of synthetic resin type AT-10.
Method: A total of 82 Colombian young men (*Mage* = 23.17 years, *SD* = 3.04, age range = 18–30) participated in this experimental study. Two random groups (experimental and control; $n = 41$ each) were compared. The experimental group used condoms, whereas the control group did not. Fit and feel condom perceptions, initial erectile scores, age, and substance use were controlled for. Erection was measured while viewing a sexual video by using penile plethysmography and subjective arousal.
Results: The results, obtained from comparing the experimental group (using pre-erection condoms) with the control group (not using condoms), revealed no significant difference in both subjective and physiological sexual arousal. This suggests that pre-erection condoms do not have an effect on the erectile response.
Discussion: More research is needed in this area to provide treatment and clinical interventions or sexual and reproductive education to mitigate the occurrence of sexual dysfunction, unplanned pregnancies, or sexually transmitted infections. Also, research addresses public health issues related to the prevention and/or intervention of sexual risk behaviors and sexual dysfunctions, highlighting their significance in sexual education and clinical practice.

Introduction

As a barrier protection method, the external condom (formerly referred to as the male condom) has been effective in preventing unintended pregnancy and Sexually transmitted infections (STIs; Beksinska et al., 2020), including HIV. In general, this barrier method is predominantly made of rubber latex (80 %) and can come in various types, sizes (ranging from snug to long), materials, internal and external variations, colors, textures, odors, and flavors. Additionally, it may include spermicides and special lubricants (Mahdy et al., 2023). According to the WHO (2023), consistent and correct use can enhance the effectiveness of preventing STIs and unplanned pregnancies. Therefore, it is crucial to complement its use with a lubricant that should be compatible with the material the condom is made of (UNAIDS, 2014). Despite being a highly effective latex barrier for preventing such infections (Steiner et al., 2021) and its availability, men worldwide do not use it consistently and/or correctly for several reasons, such as individuals, groups, or cultures (Bjekić et al., 2018; Coast, 2007; Etowa et al., 2021). Thus, STIs and unintended pregnancies remain among the most relevant public health problems today (WHO, 2022a, 2022b). Condom-associated erectile problems (CAEP) are one of the reasons for inconsistent and incorrect condom use in men (D.H. Li et al., 2020). CAEP has been proven to influence the occurrence of risky sexual behaviors (by reducing the motivation to use condoms; Adam et al., 2010; Graham et al., 2006; D.H. Li et al., 2020; Pinchoff et al., 2017) and the effectiveness of campaigns and programs that seek to prevent them (Sanders et al., 2014). Two types of CAEP have been described (Hill et al., 2015; Sander et al., 2015): 1) CAEP during condom application (CAEP-Application), and 2) CAEP while wearing a condom during intercourse (CAEP-Intercourse). CAEP is relevant to the study of sexual health because it is associated with condom use consistency and incomplete condom use (D.H. Li et al., 2020), and unprotected sex lowers self-efficacy (Graham et al., 2006). CAEP appears to occur more frequently in men with weak erectile function without falling into the dysfunctional category (Janssen et al., 2014). The reported prevalence varies from 9 % to 47 % (Adam et al., 2005; Crosby & Sanders, 2017; Li

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version, that was answered on a 7-choice Likert-type response scale. The second dimension used only one item, which referred to a self-evaluation of the intensity of genital sensations. Again, this dimension used a 7-choice Likert-type scale instead of the 11 typically used as the orgasm alternatives were suppressed. Both dimensions are considered global indicators of SSA. Cronbach's alpha for this study was 0.85.

Sexual physiological arousal

Physiological signals were collected using the Biopac MP150 data acquisition central module and the Acknowledge IV software, version 4.4.0 (Biopac Systems, Inc. USA). This arousal was assessed as the change in penile circumference increased due to blood supply and was recorded with a penile plethysmograph using a strain gauge of Indium Gallium (I-G), which was connected to the DA100C module. The first assessment was performed using an 85–95 mm circumference plethysmograph. If the basal circumference exceeded 110 mm, the sensor was replaced by a larger one. Each participant applied the sensor according to previously standardized instructions.

Sexual stimulus

The stimuli used in the present study were validated for Colombian men, who were exclusively or mainly heterosexual (Vallejo-Medina et al., 2017). Six videos are edited and available in our laboratory. Three of these videos had neutral content (NS: e.g., plants, water, forests, clouds, landscapes, etc.), while the other three had explicit sexual content (SS). All videos were three minutes and fifteen seconds long. For the SS, the first 15 s showed non-genitalized scenes that allowed the participant to prepare for the video and decide whether to participate. The next minute corresponds to the cunnilingus scene, the following minute to fellatio, and the remaining minute to vaginal intercourse. The six videos were presented in an alternating sequence (i.e., NS1 - SSx - NS1 - SSx - NS3 - SS3; Vallejo-Medina et al., 2017) that were previously set and balanced to guarantee their presentation to the same number of participants.

Smart pre-erection condom

The Smart Pre-erection Condom by Unique was used in this study. It is a condom manufactured in Colombia with sanitary registration (it is also authorized in other countries). It is made of AT-10 Synthetic Resin with a nominal width of 60 mm and is transparent in color. The Smart Pre-erection Condom should be inserted when the penis is in a flaccid or basal state. When an individual's penis begins to develop an erection, the condom is molded according to its size and shape. Instructions on how to insert a condom into the package. For information on how to use or purchase condoms, please consult the following links: https://www.youtube.com/watch?v=mykdJl96V8g

Procedure

Screening

Both screening and experimental processes were simultaneously conducted. All screening questionnaires (i.e., sociodemographic and psycho-sexual information) were mapped using the SurveyMonkey© platform to obtain a survey. This survey was published and promoted on our institutional SexLabKL Facebook page. The participants voluntarily signed the screening questionnaire. To safeguard the anonymity and confidentiality of participants, a coding system was implemented during the recruitment phase. Each participant was assigned a code composed of their initials and three numbers from their identity cards. No information that could reveal their identities was solicited, ensuring the preservation of their confidentiality, anonymity, and autonomy throughout the study. Eligible participants were then contacted through WhatsApp©, and the experimental sessions were scheduled based on their availability and willingness to participate. To prevent duplication of participant information, control measures were implemented, including checks on IP addresses, age, and WhatsApp© numbers, following similar protocols as described in other studies (Vallejo-Medina et al., 2017).

Experimental session

Prior to the participants' visit, all equipment was prepared together with plethysmograph calibration. All the participants were randomly assigned to each group (i.e., experimental and control). Once the participants arrived at the laboratory, we explained to them the instruments to be used and the stimuli to be seen and guided them to the laboratory. The SexLab KL is made up of two rooms: 1) the control room, which houses the computers and the central modules to collect physiological signals, and 2) the experimental room, equipped with a monitor to present the stimuli and the MISSA and a chair. Both rooms were separated by a door that was closed during the experimental session. The experimental room was acoustically isolated and had temperature conditions varying from a minimum range of 20.21 °C to a maximum of 20.24 °C. An intercom was used to communicate between the rooms. Once the participant had cleared any doubts, they signed the informed consent form and were asked questions about their situation 24 h before the session (i.e., substance use, exposure to explicit erotic content, etc.). All participants then put on the penile plethysmograph and the condom, and the experimental group performed this action by themselves (the Smart Pre-erection Condom before the plethysmograph). All participants watched sequences of six videos; the erotic videos were randomly alternated. It took three minutes to stabilize the signal and detect any irregularities at the beginning of each session. At the end of each SS, MISSA was presented to assess its SSA. Each session lasted approximately one hour. When the third MISSA was presented, the participants were asked to remove the penile plethysmograph and put their clothes back on. The participant then met with the evaluator in the control room and was asked to complete the Fit and Feel Scale if they were in the experimental group, while also receiving feedback on their physiological responses. All participants received another smart protection condom packet containing three condoms and a copy of the informed consent form at the end of the session. All participants were informed of their willingness and freedom to participate in the research and could decide whether to continue or stop the session at any time they wished.

Data analysis

After concluding the experimental session and obtaining the penile plethysmograph report (i.e., changes in penile circumference due to increased blood supply), we collected data on four erection properties: 1) the average percentage of circumference increase (i.e., average percentage increase obtained during the visualization of each SS of penile girth); 2) the maximum percentage of penile circumference increase (i.e., maximum percentage of penile girth increase reached in each SS); 3) the latency (i.e., the time it takes to obtain an increase in girth greater than 5 % from the time the SS is initiated); and 4) the duration (i.e., the time at which penile girth remains above the 5 % increase at each SS) of erection. We conducted Mann-Whitney U tests due to the non-normality of the sample data in each group and its size. Additionally, we selected this test because of its robustness in small samples and its ability to handle non-parametric data. Measures of effect size were not computed in this study. Comparisons were carried out between the experimental and control groups at one temporal points: after the evaluation. We performed regressions on the descriptive data of the sample. We use R software for data analysis (Team R, 2013). Additionally, we used the ggplot2 (Wickham et al., 2021) package of the same software with the R programming language to plot the results of this research, and the

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Data availability

The data and syntaxis will be available in the last author public Github https://github.com/pableres/CAEP.git.

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Appendix

Table A.1
Sample Sociodemographic Data.

		Experimental *M*(*SD*) or *n*(%)	Control *M*(*SD*) or n(%)	Statistical contrast
Age		22.78 (3.07)	23.58 (2.99 %)	$t(80) = -1.19$ $p = .23$
Sexual orientation				
	Exclusively heterosexual	35 (85.4 %)	39 (95.1 %)	Fisher: $p = .26$
	Mainly heterosexual	6 (14.6 %)	2 (4.9 %)	
IIFE-5		22.21 (2.11 %)	22,78 (2.06 %)	$t(80) = -1.21$; $p = .23$
CAEP-A				
	Never	31 (75,6 %)	32 (78 %)	$\chi^2(1) = 0.00$; $p = 1$
	Occasionally	10 (24.4 %)	9 (22 %)	
CAEP-I				
	Never	26 (65 %)	31(75.6 %)	$\chi^2(1) = 0.643$; $p = .42$
	Occasionally	14 (35 %)	10 (24.4 %)	

Note: M, Mean; SD, Standard deviation; n, number of cases; IIFE-5, International Index of Erectile Function; CAEP-A, Condom-Associated Erectile Problems Application; CAEP-I, Condom-Associated Erectile Problems Intercourse.

Table B.1
Participants' Conditions 24 H before the Experimental Session.

		Experimental *n* (%)	Control *n* (%)	Statistical contrast
Erotic explicit content exposure (videos and/or photos)				
	Yes	1 (2.4 %)	1 (2.4 %)	Fisher: $p = 1$
	No	40 (97.6 %)	40 (97.6 %)	
Sexual activity				
	Yes	2 (4.9 %)	3 (7,3 %)	Fisher: $p = .26$
	No	39 (95.1 %)	38 (92.7 %)	
Viagra or phosphodiesterase 5 (PDE5) inhibitors consumption				
	Yes	0 (0 %)	0 (0 %)	Fisher: $p = 1$
	No	41 (100 %)	41 (100 %)	
Another medication				
	Yes	3 (7.3 %)	3 (7.3 %)	Fisher: $p = 1$
	No	38 (92.7 %)	38 (92.7 %)	
Psychoactive substance consumption				
	Yes	3 (7.3 %)	1 (2.4 %)	Fisher: $p = .61$
	No	38 (92.7 %)	40 (97.6 %)	

Note: n, number of cases.

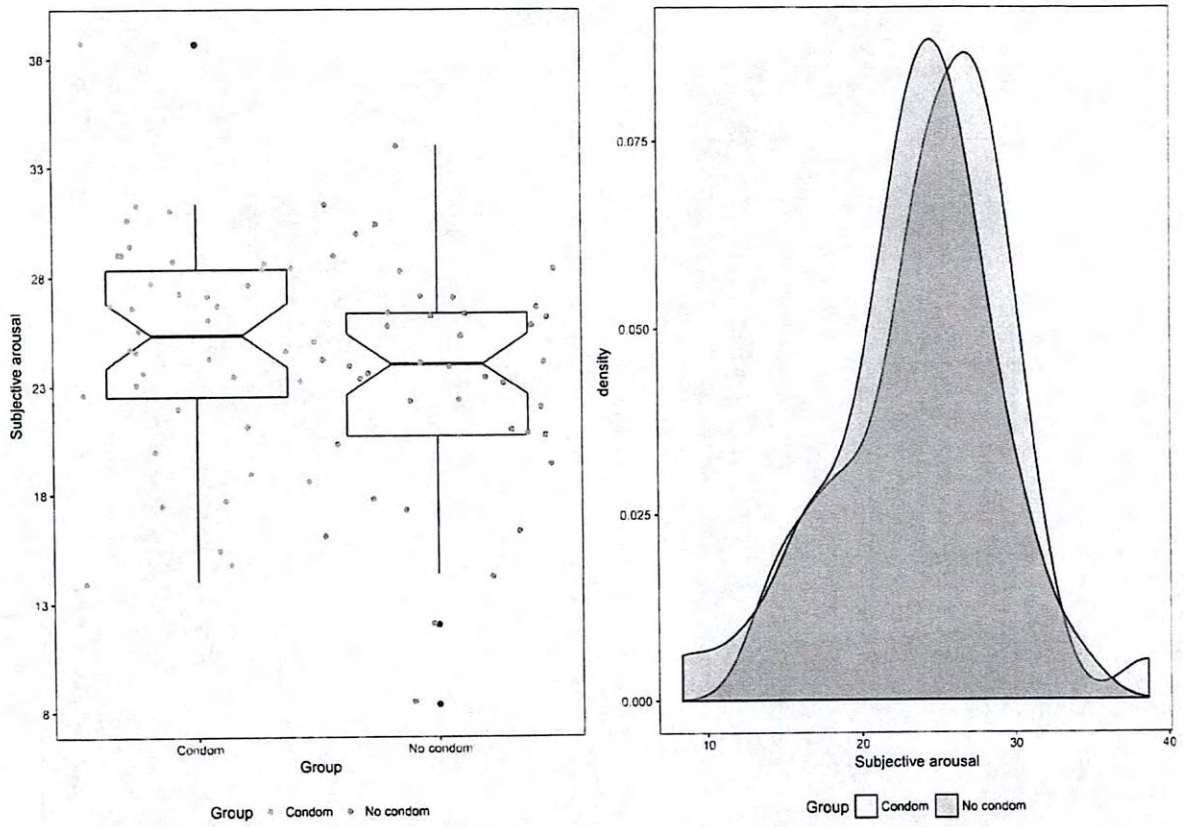

Fig. B.1. Box and Density Depictions Plots of Subjective Sexual Arousal Differences Between Groups Note. Box and density plots of statistical differences between groups (i.e., control and experimental) of subjective sexual arousal are shown.

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Review

When the brain turns on with sexual desire: fMRI findings, issues, and future directions

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Abstract

Introduction: More than 2 decades of neuroimaging research has sought to uncover the neurologic basis of sexual desire. However, the lack of a clear conceptual distinction between sexual desire and sexual arousal or even a broadly accepted definition of sexual desire has led to confusion in the literature regarding brain areas uniquely associated with sexual desire.
Objectives: (1) To critically review the neuroimaging literature that seeks to identify brain areas and networks involved in sexual desire; (2) to identify and discuss those brain areas and potential networks that are most promising for providing insights to sexual desire; and (3) to offer recommendations for future studies.
Methods: Existing meta-analyses were used as a starting point to identify relevant neuroimaging studies on sexual desire, arousal, and love. This base was then expanded via Google Scholar and forward citation tracking of already identified studies.
Results: Brain areas that are commonly associated with sexual desire and arousal include the amygdala, hypothalamus, dorsal and ventral striatum, anterior cingulate, insula, and prefrontal and orbitofrontal cortex. However, because the same basic paradigm has been used to study sexual desire and arousal, unambiguous conclusions regarding areas uniquely involved in sexual desire cannot be drawn. Moreover, the lack of connectivity analyses and a failure to acknowledge negative BOLD (blood-oxygen level dependent) significantly limit conclusions on the neural basis of sexual desire.
Conclusion: Five recommendations are made. First, stimulus types (ie, erotic vs sexually explicit) should be selected by the meaningful theoretical conceptualization of the constructs of interest. Second, participants should be provided with definitions of *sexual desire, mental sexual arousal*, and *perceived genital sexual arousal*, so they can choose which terms best describe their experience. Third, event-related designs should be used with caution when investigating sexual desire. Fourth, time series analyses should be used to identify both positive and negative BOLD. Fifth, connectivity analyses should be performed to identify brain networks.

Keywords: sexual desire; neuroimaging; fMRI; sexual arousal; effective connectivity; negative BOLD.

Based on our lack of progress in developing a clear definition and measurement strategy, it could be argued that sexual desire is the most elusive aspect of human sexual response yet studied. Sexual desire itself became important in sexuality research when sex therapists understood that the complaints of some patients were focused on a "loss" of something that preceded arousal. These were patients who did not respond to treatments that were based on Master and Johnson's model,[1] which focused on the mid- and late stages of sexual response—namely, arousal, orgasm, and resolution. What these patients seemed to be missing was a drive, an interest, a desire for having sex, which consequently impaired the rest of their sexual response.[2]

Past attempts to define sexual desire have ranged from the very broad to the very specific. For example, Levine[3] defined sexual desire as "the sum of the forces that incline us towards and away from sexual behavior," whereas Bolmont et al[4] operationalized sexual desire as feelings of sexual interest, sexual thoughts, or fantasies when viewing erotic images. While Levine's definition may better capture the complexity that characterizes sexual desire, Bolmont's definition serves as a practical solution for dealing with that complexity in a laboratory context. To date, however, there is no commonly accepted definition of sexual desire that researchers and/or clinicians agree on, and paradoxically there seems to be more agreement on what is meant by *a lack of* sexual desire than by the presence of it. In addition to providing a valid definition, researchers must understand how to adequately conceptualize and measure sexual desire as distinct from sexual arousal—a distinction that can be particularly complex for women.[5] Thus, prior to examining the research on the neuroscience of sexual desire, we comment on the difficult distinction between sexual desire and arousal.

Desire vs arousal: theory and diagnostics

According to Kaplan,[2] sexual desire is located only in the brain, whereas arousal and orgasm also involve autonomic reflexes of the genitals. At the time, Kaplan's assertions were highly speculative, and the emphasis on defining sexual desire as a distinct precursor to the later phases of sexual response was an important, although possibly not accurate, step forward. In this regard, 23 years later, Basson[6-8] proposed that for some women, especially those in long-term relationships, desire transitions from being spontaneous to responsive; thus, in that context, sexual desire does not precede arousal but is consequent to it. Clearly, this complicates the study of a mental state that had previously been defined and studied as a distinct and isolable precedent to arousal.

Contemporary to Basson's proposal[6-8] of responsive sexual desire, Bancroft and Janssen[9] proposed the dual control model of sexual response to characterize people's propensity for

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sexual excitation and inhibition. In this framework, sexual excitation and inhibition reflect the easiness or difficulty that people have in achieving and maintaining sexual arousal. Although a later article does discuss the importance of the dual control model to sexual desire,[10] sexual desire was not mentioned in the original model. Finally, to better understand sexual desire and hypoactive sexual desire disorder (HSDD), Pfaus[11] reviewed research on the neural systems purported to be involved in sexual excitation and inhibition, proposing that sexual desire is controlled by the same neurochemical and neuroanatomic systems that control sexual excitation and inhibition. The direct implication is that sexual desire may be neuroanatomically indistinguishable from arousal. If so, the study of sexual desire, independent from sexual arousal, is in a difficult-to-negotiate conundrum. Specifically, while most people would make a distinction between perceiving sexual desire and arousal, these states may not easily be distinguishable at the neuroanatomic/neurophysiologic level.

Poorly defined psychological constructs do not facilitate clinical diagnoses or the development of diagnostic nosology. The difficulty in distinguishing sexual desire from sexual arousal is thus one reason for inconsistencies across nosologic systems in how low or absent sexual desire is conceptualized. For example, while the *ICD-11* and *DSM-IV* treat sexual desire disorders as being separate from sexual arousal disorders,[12,13] in the *DSM-5*, sexual desire and arousal have been amalgamated as *female sexual interest/arousal disorder*.[14] This change led the International Society for the Study of Women's Sexual Health to form an expert panel that was tasked with reviewing state-of-the-art knowledge and proposing a consensus on diagnosing low sexual desire among women. The panel decided to maintain *female hypoactive sexual desire disorder* separate from *female sexual arousal disorder*.[15] Unfortunately, confusion created by the *DSM-5* likely contributes to the continued mislabeling of desire and arousal in neuroscientific research.

Brain architecture of sexual desire/arousal

Investigating the brain's response to visual sexual stimuli: first attempts

In functional magnetic resonance imaging (fMRI) and positron emission tomography (PET) studies, sexual desire and sexual arousal are investigated in the same way: once in the scanner, participants are shown visual sexual stimuli, and brain activity in response to those stimuli is recorded[16-20] (see Table 1 for a complete list). Despite close similarities in the research design, results have been far from consistent. In addition, results are typically discussed in the framework of the initial research questions, depending on whether a model of desire or arousal is being tested, and issues regarding incongruence in terminology are simply avoided. Therefore, in the present article, the composite term *sexual desire/arousal* is used to discuss past findings. It is worth underlining that because these designs always use visual sexual stimuli, only responsive sexual desire can be studied (ie, elicited by sexual cues), but not spontaneous sexual desire (per Basson's terms[6-8]). Note also that, given the cold and noisy context of a magnetic resonance imaging scan, studying spontaneous sexual desire would in any case be very challenging.

The first neuroimaging studies investigating neural response to visual sexual stimuli were conducted by Stoléru et al[19,20] and Redouté et al[18] using PET. In the Stoléru[19] and Redouté studies, men without sexual dysfunction were exposed to neutral, humorous, and sexual visual stimuli while inside the scanner. Although these 2 studies found different brain areas activated in response to sexual vs neutral stimuli, they presented functionally similar brain networks for sexual arousal. That is to say, in the conclusions they proposed networks, activated in response to sexual stimuli, that were structurally dissimilar but presumed to be functionally similar. As presented in Table 2, the sexual arousal network described by Stoléru[19] is characterized by 3 components (cognitive, emotional/motivational, and autonomic), whereas Redouté et al divided the emotional/motivation component into 2 distinct ones so that the final network is composed by 4: cognitive, emotional, motivational, and autonomic. Involvement of brain areas responsible for inhibition of sexual arousal is also mentioned,[18] but these are not discussed in the proposed model.

While the Stoléru[19] and Redouté[18] studies represent an important point of reference for neuroscience research on human response to sexual stimuli, they need to be taken with caution. First, as already mentioned, replication across the 2 studies was poor, even though the same methodology and stimulus sets were used. Second, both studies were conducted with PET imaging, which, as compared with fMRI, presents significantly lower spatial and temporal resolution. Third, because Stoléru's model was developed for sexual arousal, its relevance to sexual desire, as suggested by Cacioppo,[21] is questionable. Keeping these limitations in mind, we now turn to examine the bulk of research on sexual desire/arousal based on fMRI.

Building blocks of the brain's response to sexual desire/arousal

Regardless of the stated limitations, most researchers seem to agree on what to expect when investigating sexual desire or sexual arousal. The answer is a network. Sexual desire and arousal are complex mental and affective states, involving multiple cognitive processes, such as memory and mental imagery, together with the core components of the reward response, namely wanting and liking.[22] However, before we look at network models that have been proposed and discuss how numerous brain areas communicate with one another to give rise to the feeling of sexual desire or arousal, it is important to analyze at least some of the pieces that make up the entire puzzle. Note that despite close similarities in the implemented research design, variability in results across studies remains. In the current section, we present some of the areas commonly reported to be active in response to visual sexual stimuli and thus presumed to be associated with sexual desire or arousal.

Activation in structures associated with affect, reward, and motivation, especially in limbic and paralimbic structures, is typically reported in relation to visual sexual stimuli and presumably sexual desire. For example, increased amygdala activity in response to sexual stimuli has been highlighted in several studies,[18,23-28] which is not surprising given the ample evidence supporting its role in the processing of emotional stimuli (see Costafreda et al[29] for a review). However, conjunction analyses have shown that the amygdala is differently activated in response to sexual stimuli when compared with positive and neutral stimuli but not negative stimuli.[30] Other studies have also shown an amygdala response similar for

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Table 1. PET and fMRI studies on Sexual Desire and Sexual Arousal.[a]

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
Cacioppo (2012)[46]	Love vs sexual desire	Meta-analysis: fMRI studies	Love Anterior insula Sexual desire Posterior insula			
Cacioppo (2017)[21]	Sexual desire in HSDD vs controls	Meta-analysis: fMRI studies	Sexual > nonsexual; HSDD < controls Bilateral posterior insula Bilateral OFC Dorsomedial PFC ACC Left amygdala Bilateral caudate Bilateral thalamus R hypothalamus L medial global pallidus			
Arnow (2009)[35]	Sexual desire in HSDD vs controls	fMRI	Sexual > sport; HSDD > controls Medial frontal gyrus R inferior frontal gyrus Bilateral putamen Sexual > sport; controls > HSDD Entorhinal cortex	Videos: Sexual Sport Relaxation	20 females with HSDD 16 females without HSDD	Continuous rating of arousal Pseudo-random ordering of 12 videos
Beauregard (2001)[23]	Sexual arousal	fMRI	Sexual > neutral R amygdala R anterior temporal pole Hypothalamus	Videos: Sexual Neutral	10 males	Passive viewing and active inhibition of arousal Block design
Bianchi-Demicheli (2011)[16]	Sexual desire in HSDD vs control	fMRI	Erotic > nonerotic; controls Temporal lobe Medial temporal gyrus Fusiform gyrus Ento-/perirhinal region Cingulate gyrus Parietal lobe Superior parietal lobule Frontal lobe Inferior frontal gyrus Orbitofrontal area Superior frontal gyrus Occipital lobe Medial occipital gyrus Erotic > nonerotic; HSDD Temporal lobe Parietal lobe Superior parietal lobule Postcentral gyrus Inferior parietal lobule Frontal lobe Inferior frontal gyrus Prefrontal gyrus Occipital lobe Medial occipital gyrus Erotic > nonerotic; controls > HSDD Intraparietal sulcus Dorsal anterior cingulate gyrus Ento-/perirhinal region Erotic > nonerotic; HSDD > controls Inferior parietal lobule Inferior frontal gyrus Posterior medial occipital gyrus	Pictures: Erotic Nonerotic	13 women with HSDD 15 women without HSDD	One-back task: detect repetition of the same picture
Bühler (2008)[50]	Clarify how research designs affect brain response to sexual stimuli	fMRI	Erotic > neutral; blocked Bilateral occipitotemporal cortex Bilateral parietal lobe Bilateral frontal lobes L cerebellum Neutral > erotic; blocked R temporal lobe Erotic > neutral; event related Bilateral occipitotemporal cortex Bilateral temporal regions Bilateral parietal lobe	Pictures: Erotic Neutral	10 males	Passive viewing Block and event-related presentations

(*Continued*)

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Table 1. Continued

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
			Bilateral frontal lobes Bilateral insula Bilateral cingulate gyrus R OFC L thalamus L parietal cortex L cerebellum Neutral > erotic; event related None			
Ferretti (2005)[24]	Sexual desire, sexual arousal, and penile tumescence	fMRI and pneumatic cuff	Sexual > sport; video and pictures Bilateral inferior parietal lobule and precuneus Cuneus Extrastriatal visual cortices Frontal cortices Mesial temporal structures (hippocampus and amygdala) Sexual > sport; videos Bilateral thalamus ACC and hypothalamus Insula Secondary somatosensory cortex (SII) Areas positively correlated with penile tumescence Bilateral hypothalamus Bilateral anterior cingulate Bilateral amygdala Bilateral insula Bilateral secondary somatosensory cortex	Study 1: Videos Sexual Sport Study 2: Pictures Sexual Sport	10 males	Passive viewing Study 1: 24 videos presented in pseudo-random order Study 2: event-related design
Gizewski (2006)[66]	Response to erotic stimuli: gender differences and differences across midluteal and menses	fMRI	Erotic vs neutral; male vs females (luteal) Bilateral orbitofrontal Bilateral amygdala/parahippocampal L thalamus R cingulate Bilateral Insular Erotic vs neutral; luteal vs menstruation R cingulate L orbitofrontal Bilateral insula	Videos: Erotic Neutral	22 females and 22 males	Passive viewing Block design
Hamann (2004)[25]	Gender differences in sexual arousal	fMRI	Sexual neutral; men > women Bilateral amygdala Hypothalamus R cerebellum R posterior thalamus	Pictures: Sexual explicit Erotic Neutral	14 males 14 females	Passive viewing Block design
Karama (2002)[26]	Gender differences in sexual arousal	fMRI	Sexual > neutral; men and women Bilateral cingulate gyrus Bilateral medial prefrontal and OFC Bilateral insular cortex Bilateral occipitotemporal cortices Bilateral amygdala Bilateral ventral striatum Sexual > neutral; men > women Thalamus Hypothalamus Self-reported level of sexual arousal (only in men) Hypothalamus	Videos: Erotic Neutral	20 males 20 females	Passive viewing Block design
Kawabata (2008)[34]	Neural correlates of desire	fMRI	Desirable > undesirable (conjunction) Superior OFC Desirable > indifferent (conjunction) Midcingulate gyrus Anterior cingulate Superior OFC shows a linear relationship with desirability across the 3 categories for desirability.	Nonsexual pictures: Desirable Undesirable Indifferent	9 males 9 females	Classification of stimuli Event-related design

(*Continued*)

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Table 1. Continued

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
Kim (2013)[17]	Sexual arousal	fMRI	Sexual > neutral Hippocampus Cingulate gyrus Insula Putamen Thalamus Hypothalamus Amygdala Septal area Parahippocampal gyrus Head of the caudate nucleus	Videos: Sexual Neutral	23 females	30 s of neutral >9 min of sexual videos Passive viewing
Kim (2006)[64]	Sexual arousal in middle-aged men	fMRI	Sexual vs sport R parietal lobe L supramarginal gyrus R occipital lobe R superior frontal gyrus R inferior frontal gyrus Bilateral orbitofrontal gyrus L cingulate gyrus Bilateral caudate nucleus R superior temporal gyrus R corpus callosum R insula	Videos: Relaxing Sports Sexual	10 males	Block design
Mouras (2003)[65]	Sexual arousal	fMRI	Sexual > neutral Bilateral superior parietal lobule L intraparietal sulcus L inferior parietal lobule R postcentral gyrus R parietoccipital gyrus L superior occipital gyrus Bilateral precentral gyrus Neutral > sexual R posterior cingulate gyrus L precuneus	Pictures: Sexual Neutral	8 males	Block design
Mouras (2008)[41]	Neural correlates of erection	fMRI and VPP	Erection concurrent with BOLD signal R frontal operculum R precentral gyrus R middle frontal gyrus Postcentral gyri Inferior parietal lobules L supramarginal gyrus Bilateral insulae Erection preceded BOLD signal Paracentral lobule BOLD signal preceded erection L frontal operculum R inferior parietal lobule	Silent videos: Humorous Neutral Sexual	10 males	Passive viewing + button press as attentional check 9 videos presented in pseudo-random order
Ponseti (2006)[68]	Neural correlates of sexual preferences	fMRI	Sexual > nonsexual; all together L temporo-occipital junction L postcentral sulcus Supramarginal gyrus Posterior intraparietal sulcus R parietal opercular cortex Inferior parietal lobule Posterior intraparietal sulcus Mesial anterior cingulate Bilateral OFC Centromedian thalamus Ventral striatum Pulvinar Preferred sexual > nonpreferred sexual Mesial ventral striatum Pulvinar Centromedian thalamus Bilateral ventral premotor cortex R posterior intraparietal sulcus Bilateral superior parietal lobule Precuneus Parieto-occipital sulcus	Pictures: Sexual (genitals) Nonsexual	12 heterosexual females 12 heterosexual males 15 homosexual males 14 homosexual females	Passive viewing Event-related

(*Continued*)

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Table 1. Continued

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
Redouté (2000)[18]	Brain response to sexual stimuli	PET	Sexual > neutral L anterior cingulate gyrus (caudal and rostral peak) L midcingulate R medial frontal gyrus R OFC Bilateral claustrum Bilateral putamen Bilateral thalami R head of the caudate nucleus L pre- and postcentral gyri Central sulcus R parietal lobules Sexual < neutral (interpreted as deactivations) Bilateral inferior and middle temporal gyri R superior temporal gyrus Parahippocampal gyrus L uncus L fusiform gyrus L middle occipital gyrus L posterior cingulate L precuneus R orbital gyrus	Videos: Humorous Neutral Sexual Videos of picture: Nonarousing Moderately arousing Highly arousing	9 males	Passive viewing Two videos of each type 12 videos, blocked within type, presented in fixed order
Sabatinelli (2007)[32]	Role of NAcc and mPFC in response to rewarding stimuli	fMRI	Sexual > neutral NAcc mPFC	Grayscale pictures: Sexual Neutral	11 males 11 females	Passive viewing Event-related design
Seok (2015)[33]	Sexual desire in PHB	fMRI	Sexual > nonsexual; controls Bilateral middle/inferior frontal gyri Cuneus/precuneus Striatum Thalamus L cingulate gyrus Sexual > nonsexual; PHB > controls R dACC Bilateral thalamus L caudate nucleus R DLPFC R supramarginal gyrus BOLD correlated with scores of hypersexuality R thalamus DLPFC	Pictures: Sexual Nonsexual	23 males with PHB 22 males without PHB	Passive viewing Event-related design
Stark (2005)[27]	Response to erotic stimuli in SM vs controls	fMRI	Erotic > neutral SM: Left hippocampus Bilateral amygdala Non-SM: Right temporal/occipital lobe Right ventral striatum Right amygdala Right hypothalamus Right thalamus Bilateral brainstem Erotic > disgusting SM: Left frontal lobe (vmOFC) Non-SM: Right ventral striatum Left hypothalamus Right brainstem	Pictures: Neutral Disgusting Erotic Sado-masochistic	6 females SM 6 males SM 6 females non-SM 6 males non-SM	Passive viewing Block design

(*Continued*)

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Table 1. Continued

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
Stoléru (2003)[20]	Sexual arousal in HSDD	PET	Controls > HSDD; conjunction: sexual-neutral; high sexual–nonsexual L anterior cingulate gyrus Bilateral parietal cortex Somatic sensory cortex Inferior parietal lobule L precentral gyrus Bilateral supplementary motor area R caudate nucleus (head) Controls < HSDD; conjunction: sexual-neutral, highly sexual–nonsexual) Left gyrus rectus Penile tumescence correlated with BOLD: higher in controls Hypothalamus	Videos: Humorous Neutral Sexual Videos of picture: Nonarousing Moderately arousing Highly arousing	7 males with HSDD 8 males without HSDD	Passive viewing 2 videos of each type 12 videos, blocked within type, presented in fixed order
Voon (2014)[28]	Sexual cue reactivity in CSB	fMRI	Sexual > exciting; CSB > controls R ventral striatum dACC R amygdala Substantia nigra Functional connectivity: sexual > exciting; CSB and controls Increase connectivity between dACC: amygdala dACC: right ventral striatum Ratings of sexual arousal: CSB and controls Positive correlation with dACC	Videos (9 s long): Explicit sexual Erotic Nonsexual exciting Money Neutral	19 men with CSB and 19 men without CSB	Answer 1 question about background Block design with order of condition randomized
Walter (2008)[31]	Distinguish sexual and general emotional effects	fMRI	Sexual > nonsexual Ventral striatum Hypothalamus Perigenual ACC VMPFC Precuneus R occipital cortex Areas where subjective ratings of sexual stimuli intensity and BOLD signal were correlated pgACC ventral striatum MPOA R superior parietal lobe	Pictures: Sexual Emotional Neutral	11 males 11 females	Passive viewing
Wehrum (2013)[30]	Gender differences in processing sexual stimuli	fMRI	Conjunction: sexual > all others; men and women Hypothalamus Rostral ACC Bilateral NAcc Bilateral OFC Bilateral lateral OCC Bilateral superior parietal cortex L middle frontal gyrus (bordering precentral gyrus) R precentral gyrus R inferior temporal gyrus Conjunction: sex-neutral; sex-positive Amygdala Anterior insula Thalamus Sex > neutral; men > women Left thalamus Right superior parietal cortex Sex positive: men > women Left thalamus OCC Sex negative: men > women ACC/middle cingulate gyrus L inferior parietal cortex Thalamus OCC	Pictures: Sexual Negative Positive Neutral	50 males 50 females	Passive viewing Block design

(*Continued*)

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Table 1. Continued

First author	Aim	Method	Condition/contrast brain areas	Stimuli	Sample	Task
Woodard (2013)[67]	Response to sexual stimuli in pre-menopausal women with HSDD	fMRI	Sexual > neutral; controls R lingual gyrus R inferior parietal lobule R thalamus R superior tempiral gyrus L culmen of vermis L parahippocampal gyrus L hippocampus L precentral gyrus Bilateral insula Bilateral claustrum Sexual > neutral; HSDD R middle temporal gyrus R fusiform gyrus L caudate Body L declive L precuneus L anterior cingulate L amygdala L middle occipital gyrus Bilateral thalamus Bilateral culmen Bilateral medial frontal gyrus	Pictures and videos: Neutral Sexual	10 women with HSDD 6 women without HSDD	Block design

Abbreviations: ACC, anterior cingulate cortex; BOLD, blood oxygen level dependent; CSB, compulsive sexual behavior; dACC, dorsal anterior cingulate cortex; DLPFC, dorsolateral prefrontal cortex; fMRI, functional magnetic resonance imaging; HSDD, hypoactive sexual desire disorder; L, left; mPFC, medial prefrontal cortex; MPOA, medial preoptic area; NAcc, nucleus accumbens; OCC, occipital cortex; OFC, orbitofrontal cortex; PET, positron emission tomography; PFC, prefrontal cortex; pgACC, perigenual anterior cingulate cortex; PHB, problematic hypersexual behavior; R, right; SM, sadomasochistic; vmOFC, ventromedial orbitofrontal cortex; VMPFC, ventral medial prefrontal cortex; VPP, volumetric penile plethysmography. [a] It is important to highlight that other neuroimaging studies have addressed important aspects of human sexual function and response, such as neural activity specific to orgasm,[60] mapping the male somatosensory cortex of urogenital structures,[69] and assessing spinal cord activity in response to sexual stimuli among patients with spinal cord injury.[70] However, because these studies are not germane to the present discussion on desire, we have not included them.

Table 2. Proposed neurologic components/brain areas involved in sexual arousal.

First author	Cognitive	Emotional	Motivational	Autonomic
Redouté[18]	Right orbitofrontal cortex	Sulcus between the anterior cingulate and the dorsolateral/medial prefrontal cortex	Anterior cingulate gyrus (caudal part) Claustrum Putamen Nucleus accumbens	Rostral portion of the anterior cingulate Part of the hypothalamus
Stoléru[19]	Inferior temporal cortices	Right insula Right inferior frontal cortex Left cingulate cortex		Left anterior cingulate

sexual and negative/disgusting stimuli.[27,31] Together, these findings suggest that the amygdala has a role in processing general salient stimuli and not exclusively sexual stimuli.

Another limbic area that appears to be important is the hypothalamus, whose activity has been found to increase in response to sexual stimuli.[23,24,27,28,31] Some studies have provided evidence for differences between men and women,[25,26] possibly because hypothalamic activity plays a specific role in male genital arousal; nonetheless, a gender difference has not consistently been reported (eg, Wehrum et al[30]). Because of the specific association between the hypothalamus and penile tumescence, Stoléru[19] and Redouté[18] classified the hypothalamus as part of the "autonomic" component of their model of sexual arousal.

It should be noted that, in the literature considered here, structures such as the amygdala and hypothalamus are often described as unitary regions, as if they are functionally homogenous structures, even though they are not. Rather, they are made up of many nuclei that are not large enough to be studied distinctly via fMRI or PET imaging. This is especially important considering that, for example, the medial preoptic area has been clearly identified in animal models as being relevant to the male sexual response, although among the studies considered in the current article, only Walter et al[31] and Wehrum et al[30] attempted to isolate the medial preoptic area from the rest of the hypothalamus.

Sexual desire is basically a state of wanting, and probably the most famous brain region that comes to mind regarding wanting and motivation is the ventral striatum, which includes the nucleus accumbens (NAcc). Not surprising then, the ventral striatum has been commonly implicated in the brain's response to sexual stimuli.[26,28,30-33] Moreover, different from the amygdala, increased activity in the ventral striatum has been observed in response to sexual stimuli when contrasted with disgusting[27] and other highly emotional[31,32] stimuli in

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men and women.[30] Although it seems safe to conclude that the ventral striatum and the NAcc play important roles in anticipating sexual reward or pleasure, because of the lack of studies using nonsexual rewarding stimuli as a control (see Kawabata and Zeki[34] for an exception), it is difficult to determine whether changes in activity in this brain region are associated with anticipating sexual rewards specifically or rewards in general (eg, Sabatinelli et al[32]).

In addition to the ventral striatum (ie, NAcc), the dorsal part of the striatum, comprising the caudate nucleus and putamen, has often been linked with sexual desire/arousal.[18,20,33,35] For example, the caudate was found to be more active in response to sexual stimuli in men with compulsive sexual behavior as compared with controls[33] and less active in men with HSDD vs controls.[20] That is, there appears to be a positive association between caudate activation and a propensity toward sex. Thus, the caudate could be considered a potential target for future research focusing on out-of-balance levels of sexual desire/arousal for excessive and hypoactive sexual desire.

The anterior cingulate cortex (ACC) is another brain area commonly highlighted in sexual desire/arousal studies.[24,28,31,33-35] The ACC has been associated with emotional processing (see Etkin et al[36] for a review) as well as multiple cognitive processes, such as attentional shifting[37] and conflict monitoring (see Botvinick et al[38] for a review), but also interoceptive awareness (eg, Critchley et al[39]). Its specific role in interoception may help explain the association between BOLD signal (blood oxygen level dependent) in the ACC and genital arousal in men.[24] Indeed, because of its triple involvement in cognitive, emotional, and interoceptive processes, the ACC has been included as part of the autonomic and motivational components in the model of sexual arousal by Stoléru.[19]

The insula is another important interoceptive center of the brain, being involved, for example, with monitoring changes in heartbeat.[39,40] The changes in insular activity found in response to visual sexual stimuli[24,26,30,41] may be linked to awareness of visceral and physical sensations associated with genital sexual arousal (eg, changes in erection). Specifically, the insula's role in sexually relevant interoception is supported by a recent resting-state fMRI study in which men with psychogenic erectile dysfunction, when compared with healthy controls, showed a different pattern in connectivity not only within the insula but also between the right insula and right dorsolateral prefrontal cortex (PFC), as well as the right superior temporal gyrus.[42] Given the insula's possible role in sexual interoception and the low concordance between mental and genital sexual arousal among women,[43] future research should try to disentangle the areas involved in one or the other, considering the insula as a target area. Such research would provide a step forward in understanding the bidirectional influences between the bodily and mental aspects of sexual response, helping to explain the presence or absence of concordance between "feeling turned on" and, for example, lubrication.[44]

In addition to the affective and perceptual processes discussed earlier, higher-level cognitive processes are also involved with experiencing sexual desire/arousal. Specifically, thoughts and narratives associated with exposure to sexual stimuli can include feelings of pleasure and motivation (eg, "this really turns me on"), as well as feelings of shame, guilt, or simply inhibition of a contextually inappropriate sexual response. In this regard, whereas some studies have shown increased activity in the PFC and orbitofrontal cortex (OFC) in response to sexual stimuli,[16,26,30] Stoléru[20] found that the medial OFC was deactivated among men with no sexual dysfunction, but not in men with HSDD, when exposed to sexual stimuli. These apparently contradictory results could be an artifact of either different subdivisions of the OFC being considered across studies or different areas of the OFC corresponding to excitation or inhibition. Nonetheless, given inconsistent results, the actual function seems uncertain.

Looking at the big picture: brain networks involved in sexual desire/arousal

Sexual desire brain network[21]

Whereas the previous section focused on specific brain areas commonly found to be active in response to visual sexual stimuli, in the present section we address the networks themselves. It is worth noting that the proposed structures of these networks are based only on correlated activations identified through fMRI or PET contrasts. This is a fairly low bar as those areas could be activated independently from one another and thus functioning, not as a true network, but as a set of concurrently activated but distinct "nodes."

Although individual studies sometimes refer to networks of activated brain areas,[18-20,45] an important step forward in identifying a sexual desire–related network was the meta-analysis by Cacioppo et al,[46] in which they sought to disentangle neural activations associated with love vs sexual desire, considering 20 fMRI studies. Given data from a combined sample of 309 participants with no sexual dysfunction, Cacioppo et al concluded that what seems to differentiate feelings of sexual desire from love is the activity of the insula, with its posterior part activated in response to sexual desire and its anterior part activated in response to love. Nonetheless, if we exclude the insula, which appears to respond differentially to desire and love, brain activation across multiple areas seems to be similarly associated with love and sexual desire—such as the striatum, thalamus, and hippocampus at the subcortical level, as well as the ACC, middle frontal gyrus, and occipitotemporal cortices at the cortical level.

More recently, Cacioppo[21] made another important step forward and identified areas that are differentially activated in women with HSDD as compared with controls and proposed the existence of the sexual desire brain network (SDBN). In doing so, Cacioppo refers to the Redouté et al[18] and Stoléru et al[20] models that include the cognitive, emotional, motivational, and autonomic components and concluded that women with HSDD show both hypoactivation of the SDBN and hyperactivation of the self-referential brain network in response to sexual stimuli as compared with controls. Thus, Cacioppo interprets differences in activation of specific brain structures as reflecting group-specific differences in network activity, which is presumably associated with between-group differences in cognitive and affective processes.

While Cacioppo's review[21] provides important insights on past research and stands as a good base for discussing fMRI findings on female sexual desire, the article presents 2 issues that need to be considered. First, the conceptualization of the SDBN is largely based on the Redoutè[18] and Stoléru[19,20] models, which may not be the best point of reference to discuss findings on female sexual desire, given that those models were developed to describe male sexual arousal. Second, although neural networks seem necessary when addressing any mental and affective state as complex as sexual desire, the

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fMRI results obtained through cognitive subtraction that are presented in the reviewed studies are not sufficient to draw conclusions about neural networks. To do that, analyses of brain connectivity are needed.

A general motivational network

Using the classic paradigm of exposing participants to visual sexual and nonsexual stimuli, Voon et al[28] examined differences in brain activity in men with and without compulsive sexual behavior. Between-group differences in the ventral striatum, dorsal anterior cingulate cortex (dACC), amygdala, and substantia nigra were observed and interpreted as reflecting dopaminergic involvement in the processing of sexual stimuli. In this case, the authors did not discuss differences in brain activity as reflective of changes in a sexual desire or arousal network (eg, Cacioppo et al[21,46]) but rather as reflective of changes in a general reward network (ie, not specific to sex).

A similar approach to interpreting results was adopted by Aron et al[47] when investigating brain activity associated with feelings of love. Specifically, when participants viewed pictures of a romantic partner vs a relative, higher levels of activity were recorded in the ventral tegmental area and multiple regions of the caudate. Since love was discussed as a "motivation state," results were interpreted in the framework of reward and motivation networks rather than a love-specific network.

Note that motivation can be linked with different types of salient stimuli (ie, sexual, positive, and negative); thus, it is important to explore differences in brain activity elicited specifically by sexual vs other salient stimuli. Sabatinelli et al,[32] in fact, attempted to disentangle brain activity associated with salient negative stimuli (eg, pictures of mutilations, threats, snakes), salient pleasurable stimuli (ie, sexual and romantic pictures), and neutral stimuli (people). Two areas were highlighted and described as key to decoding salient pleasurable stimuli (sexual/romantic): the NAcc and the medial prefrontal cortex (mPFC). Interestingly, whereas activity in the NAcc peaked 6 seconds after presentation of the sexual/romantic stimulus before gradually decreasing, activity in the mPFC maintained a peak activation for the entire 12 seconds of picture presentation. These findings suggest that the NAcc's role is in the very first stages of processing sexual/romantic stimuli before the signal gets processed more frontally, at the level of mPFC, where reward anticipation and planning may occur. However, because salient pleasurable stimuli were limited to sexual/romantic images with no nonsexual positive stimuli, it is unclear whether NAcc and mPFC activity is exclusively associated with sexual/romantic stimuli or generally with positive stimuli (eg, friendship, food). In this regard, the mPFC seems to be involved with generally desirable—though not exclusively sexual—stimuli processing, as supported by Kawabata and Zeki,[34] who found that this region responds to multiple types of desirable stimuli (ie, persons, objects, and events, although the brain coordinates are slightly different). Therefore, evidence exists for a distinction between brain areas involved in processing salient pleasurable and salient negative stimuli, yet it is not clear whether or to what extent sexual stimuli are processed by a unique network (the SDBN) or a more general motivational network, such as the SEEKING system proposed by Panksepp.[48,49]

In conclusion, there are currently 2 candidate networks for sexual desire. One hypothesizes the existence of a network activated specifically for sexual desire[21]; the other posits that sexual desire is simply one of many types of motivational states or desires and is thus associated with activity in the same network that governs, for example, desire for food (not actually proposed as a network but derived from the literature; see Hamann et al[25] and Versace et al[45]). This general network, usually defined as the reward network, is consistent with Panksepp's conceptualization of the SEEKING system, which is neuroanatomically linked to dopamine release and to regions within the medial forebrain bundle.[48] The SEEKING system is hypothesized to promote the arousal that all mammals need to pursue actions that lead them toward rewards or basic needs—sex included. Within this theoretical framework, though, a general motivational system (ie, the SEEKING system) is not considered solely responsible for generating feelings of sexual desire/arousal. In fact, Panksepp proposed the existence of a LUST system that promotes feelings of "sexual urge," mostly through hormonal mechanisms: driven by testosterone and vasopressin in the preoptic area of the anterior hypothalamus in men and by estrogen, progesterone, and oxytocin in the ventromedial hypothalamus in women.[49] Therefore, there is a solid theoretical background suggesting that human sexual desire is triggered by a dedicated system (whether called the SDBN or the LUST system), which however must work with a general SEEKING system. According to Panksepp, such combined activation is what drives a person to search for a sexual outlet (eg, a sexual partner, a porn video).[49] How to disentangle the involvement or the degree of involvement of these systems in fMRI human research adds a layer of complexity, as does the limited size of some brain areas such as the medial preoptic area, which is not often distinguished from the rest of the hypothalamus.

Stimulus and data analysis issues affecting results and interpretation

So far, we have discussed findings from past literature regarding sexual desire/arousal and the theoretical frameworks proposed to discuss those findings. However, it is important to be mindful that, while theory helps structure the interpretation of data, the data itself depend on the chosen experimental design and stimulus selection. In addition, the chosen task defines the possible types of analyses that one can perform on the data. Thus, in the next section, we present the rationale behind the selection of specific tasks and stimuli. Additionally, we discuss the presence and importance of negative BOLD signal in the current area of research. We believe that to improve our understanding of sexual desire, more attention needs to be given to both topics.

Stimulus selection

In the present area of research, while similar experimental paradigms have been applied across studies,[23,24,31-33,35,38,41,45] different types of stimuli have been used. This is important because different types of stimuli and modalities of presentation will likely trigger different cognitive and emotional processes, thus having implications for results and interpretations.

One key difference regards the use of pictures or videos, and whereas most studies choose one type of stimulus, Ferretti et al[24] investigated brain activity (fMRI) and penile tumescence in response to sexual stimuli using pictures and videos. Because different brain areas were activated in response to pictures vs videos and because increased penile tumescence (ie, genital arousal) was found only with video presentation,

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one could claim that sexual videos are more effective than pictures for studying sexual arousal. At the same time, if sexual response is a linear process, starting with desire that precedes arousal, then pictures could be preferable to videos for eliciting sexual desire.

Another difference regarding stimuli is whether they are presented in an event-related design or a block design. Because pictures can be presented very quickly, they are more often used in event-related designs.[31,33,45] To clarify whether and how different modalities of stimulus presentation affect results, Bühler et al[50] used the same sexual pictures in block- and event-related presentations. These authors concluded that by using event-related designs, one can avoid the recording of brain activity associated with attentional and other higher-level cognitive processes and therefore represent a better choice for capturing "networks associated with immediate processing of erotic stimuli" and thus, presumably, sexual desire. Their conclusions are in line with Seok and Sohn's[33] rationale for using pictures rather than videos, according to which, pictures in a event-related design, rather than videos within a block design, allow one to capture an immediate strong emotional response to the sexual stimulus, without contamination by brain activity associated with higher cognitive processes (eg, sustained attention, top-down control, and inhibition of sexual arousal). With Stoléru's model[19] as a reference, this can be seen as an attempt to isolate the emotional component from the cognitive and motivational components of response to sexual stimuli.

A third point, not empirically addressed in any of these studies, regards the difference between erotic and sexual stimuli. For the sake of simplicity and because of inconsistencies in the use of these labels in past research, in the current article we use the term *sexual* to indicate any type of erotic or sexual stimulus included in the reviewed studies. However, recognizing the difference between visual stimuli showing dressed or half-naked individuals (erotic stimuli) and stimuli showing couples involved in sexual activity (sexual stimuli) could be pivotal for this area of research. In this regard, one creative approach would be to use a psychophysics "just noticeable difference" type of paradigm and test for a tipping point at which participants recognize a change in stimulus intensity going from erotic to sexual. Moreover, research investigating differences in brain activity elicited by erotic vs sexual stimuli, while recording changes in genital arousal (ie, penile tumescence or vaginal blood flow), may provide an additional tool for disentangling feelings of sexual desire and genital sexual arousal.

In conclusion, whereas Ferretti et al[24] reported that presentation of videos, but not pictures, is associated with genital arousal and a broad network of activated brain areas, Bühler et al[50] found that still images, presented in an event-related design, elicited only a subset of this network. As such, these studies suggest that pictures may be preferable when studying sexual desire, while videos may be preferable when investigating sexual arousal. Moreover, erotic visual stimuli may be more suitable to elicit sexual desire, while sexually explicit visual stimuli may be more effective for eliciting sexual arousal. If we were to offer recommendations for future fMRI studies investigating sexual desire or arousal based on the classic methodology of exposing subjects to visual sexual stimuli, we would likely follow those guidelines—thus, using erotic images presented in an event-related design to study sexual desire, while using videos showing explicit sexual activity in a block design to study sexual arousal.

Whereas we have confidence that explicit sexual stimuli can be used to study sexual arousal, we have concerns that repeatedly exposing individuals to sexual pictures may not be the best way to elicit and isolate sexual desire. In particular, in the case of event-related designs, where pictures from different categories (eg, sexual, negative, neutral) are briefly presented to participants in a random order, the time needed to turn on and off feelings of sexual desire might not be sufficient. Therefore, because sexual desire cannot be defined as a mere sensory perception but rather a complex state, the time scale of event-related designs may simply not be adequate. For example, while a BOLD signal in response to visual perception (eg, circles vs squares) can be appropriately recorded through event-related designs, the same might not apply for sexual desire, which might require more time to be triggered and to reach an adequate level that can be captured through fMRI and then turned off again before the next stimulus presentation. We argue that the data at hand are not sufficient to conclude so and that future research should attempt to modify and improve the research designs currently used to investigate sexual desire.

Negative BOLD: a neglected result with potentially important implications

In the studies and meta-analyses previously discussed, attention is almost universally given to positive BOLD signal, thereby ignoring the presence and theoretical significance of negative BOLD signal—namely, a decrease in BOLD signal during the 3 to 11 seconds after stimulus onset (thus, different from the initial dip, which occurs in the first 3 seconds; see Sten et al[51]). Although the interpretation of negative BOLD remains unclear, there seems to be a growing consensus that it reflects inhibition of the areas showing the negative BOLD signal. (Research also suggests that negative BOLD may occur in relation to increased neural activation during pharmacologically induced seizures in rats[52,53] and developmentally in infants,[54] but these sources are not deemed relevant to the present discussion.)

It is worth noting that the meta-analysis by Cacioppo[21] is the only study among those reviewed here in which the idea of negative BOLD is presented. Specifically, Cacioppo discusses a "hypoactivation" of brain areas in patients with HSDD in terms of "negative BOLD." However, none of the 5 studies in Cacioppo's meta-analysis present results that would allow the detection of negative BOLD: the direction of BOLD change, whether positive or negative, can be determined only with time series data, such as percentage of signal change from baseline (see Figure 1 for example). Nonetheless, several studies in the current review do present evidence of negative BOLD and demonstrate that interpretations based solely on condition or group contrasts will miss important information, thereby significantly limiting the conclusions and insights that could be drawn from the data.

For example, Versace et al[45] found that whereas the anterior cingulate demonstrates a slow increase in BOLD peaking at around 12.5 seconds in response to sexual pictures, it also demonstrates a negative BOLD response, with a maximum trough occurring at 7.5 seconds after stimulus onset for nonsexual pictures. Thus, when participants viewed sexual

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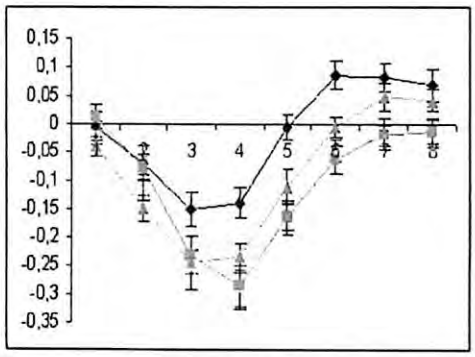

Figure 1. Time course of BOLD signal change (percentage) for 16 seconds post–stimulus onset shows negative BOLD change from baseline in all conditions. BOLD, blood-oxygen level dependent. Used with permission from Walter et al.[31]

pictures, they showed an increase in anterior cingulate activation, whereas when they viewed nonsexual pictures, they showed a putative inhibition in the same area (see Walter et al,[31] Sabatinelli et al,[32] and Kawabata and Zeki,[34] who also present data showing a negative BOLD signal in response to nonsexual stimuli).

An important finding observed by Walter et al[31] is that the same areas that demonstrated a negative BOLD signal to nonsexual stimuli (perigenual anterior cingulate cortex, dorsomedial prefrontal cortex, ventral striatum) also showed a negative BOLD signal to sexual stimuli, although relatively weaker. Thus, an attenuated inhibition (weaker negative BOLD) in those areas may be the defining response to sexual stimuli (Figure 1). Note that, without presenting time series data, the classic contrasts from the data in Figure 1 would show "activations" in the sexual stimuli condition, even though there was no positive BOLD signal for any of the conditions. In fact, Walter et al present and discuss contrasts that they claim indicate "higher activity" in target brain areas (eg., perigenual anterior cingulate cortex in Figure 1) for sexual vs nonsexual stimuli, without discussing the presence of negative BOLD across all conditions. This insight fundamentally changes the interpretation of neural mechanisms in those areas in response to sexual stimuli (eg, a lack of inhibition rather than an activation) and therefore represents a nontrivial concern for past and future research.

Finally, in a study of men with problematic hypersexual behavior (PHB), Seok and Sohn[33] present evidence that, in response to sexual images, negative BOLD in the dACC, supramarginal gyrus, and caudate nucleus differentiate men with PHB from controls. Specifically, whereas control participants demonstrated negative BOLD in response to sexual images, men with PHB showed a clear positive BOLD signal. Thus, if one conceptualizes the negative BOLD response demonstrated by controls to be normal, the positive BOLD in these areas shown by the men with PHB appears to be an out-of-balance response. Note that the unique comparison between positive and negative BOLD suggests more than group differences in magnitude or level of change; that is, the 2 groups are engaging in fundamentally different mental processes given the same stimuli—an observation not made in the article. If true, this holds possible implications at the theoretical level as well as diagnostically and therapeutically for men with PHB. These insights are made possible only by examining time series data and distinguishing positive and negative BOLD.

It is important to note that with temporal contrasts, the baseline condition itself can influence the size and direction of BOLD signal change. However, in all studies discussed here, the baseline condition was the same across comparisons (eg, experimental stimulus type, task); therefore, differences in baseline conditions cannot explain differences in the size or direction of the BOLD signal change.

The above discussion reports that a negative BOLD signal appears to be commonly present in fMRI studies, although it is rarely addressed and data are rarely presented that would even allow the observation of such a change in BOLD signal. Moreover, across the present studies, consideration of negative BOLD signal provided nontrivial changes in interpretation of the observed results. Sexuality research would particularly benefit from a better understanding of negative BOLD, which, if truly reflecting inhibition, would provide a breakthrough in targeting those inhibitory mechanisms that have been widely theorized but never demonstrated at a neurologic level (eg, in the case of Komisaruk and del Cerro's model[55] or the dual control model[56]).

Future directions: why effective connectivity?

Cognitive subtraction used in fMRI paradigms is clearly problematic when studying sexual desire and arousal because, as compared with highly specific cognitive tasks, sexual response will likely involve multiple systems, including memory, mental imagery, motor activation and inhibition, and social monitoring—all of which will heavily depend on the individual's past experience. Moreover, the method of cognitive subtraction used in fMRI studies provides information only regarding relative differences across conditions. Thus, areas that are identified as being "active" are only relatively more active. Consequently, in the presence of a negative BOLD signal, there may actually be no increase in activation at all but rather a greater decrease in the control condition as compared with the sexual stimulus condition (or vice versa). As such, what may be described as an area "lighting up" in one condition may simply be that area "turning off" or being inhibited in the contrast condition. Moreover, the classic cognitive subtraction paradigm in fMRI research provides just a snapshot of what areas are active, from which inferences regarding networks are often made, without actually testing the inferred connectivity across network areas.

To illustrate the limitations of this approach, let us consider a metaphor of trying to assemble a puzzle from a box containing pieces of multiple puzzles all mixed up and from which some pieces are shared among puzzles. Classic cognitive subtraction paradigms allow us to identify only the pieces of our puzzle of interest, without actually providing information on how to assemble those pieces. To understand how to put the pieces together in a meaningful way, we must first understand how these areas are interconnected and how they work together. Multiple approaches can be used to reach this goal, with some making no inference about causality between brain areas (functional connectivity[57]), others specifically testing hypotheses of causal associations between areas (effective connectivity[57]), and others being mathematical and either exploratory or theory driven (graph-theoretical approaches[58]). In the present discussion, we consider 2 well-developed strategies: functional and effective connectivity.

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To our knowledge, so far only Voon et al[28] have performed functional connectivity analyses when investigating sexual desire, finding a correlation between increased connectivity among the dACC, right ventral striatum, and right amygdala and self-reported sexual desire in response to sexual stimuli. However, it is important to specify that functional connectivity analyses can tell us only whether there is a temporal correlation among different sources of neuronal activity, which is not sufficient to draw conclusions regarding directional causation among them. Effective connectivity analyses, though, are based on causal models, which allow one to test and make inferences about directional causal relations among sources of neural activity. Thus, with effective connectivity, one can test the plausibility of directional influences among sources of neuronal activity and therefore the involvement of networks of brain areas that function in a coordinated way in response to specific events or conditions.[57]

In the context of fMRI, investigating changes in effective connectivity among areas of interest could therefore provide a more appropriate test and better understanding of (1) the networks presented, for example, in Redouté and Stoléru's models of sexual arousal[18,20]; (2) the neural mechanisms driving the within-person experience across different levels of sexual desire or arousal; and (3) the neural changes characterizing different phases or states of sexual response. For instance, using effective connectivity analyses, we could gain a better understanding of the possible role of the PFC in regulating limbic activity around orgasm and vice versa: PFC activity was indeed found to decrease during orgasm according to PET[59] but to increase during orgasm with fMRI.[60]

Conclusions and recommendations

Neuroimaging research aimed at identifying brain areas and networks associated with sexual desire has been reviewed. Although >20 empirical studies were examined, problems inherent to defining sexual desire and sexual arousal limit the confidence that we have in providing specific conclusions of what brain areas, especially brain networks, are involved in sexual desire. For example, although specific limbic structures and areas of the prefrontal cortex are consistently activated when participants are presented with sexual vs nonsexual material, it is simply not clear whether those areas are active in response to desire in general, to sexual desire or sexual arousal specifically, or to sexual desire and arousal.

To better distinguish sexual desire and arousal, we suggest that researchers start by differentiating between sexual desire and genital sexual arousal (ie, erection and lubrication). This is likely to be the easiest of the distinctions that will need to be made. Similarly, researchers must distinguish between mental and genital sexual arousal. Indeed, these are distinct aspects of sexual arousal that can be measured separately via different methods (eg, photoplethysmography for genital sexual arousal and self-report for mental sexual arousal). Finally, what is likely the most problematic and difficult issue is whether sexual desire and mental sexual arousal should be considered 2 separate states or as a unidimensional continuum. In fact, it is at this level that most studies fail to make a clear distinction. Whether to consider sexual desire and mental sexual arousal as 2 separate states or to merge and consider them along a continuum is a complex matter of debate for which the final decision is left to the researcher—a decision, though, that should be clearly stated and justified.

With the goal of improving the current area of research, we have provided a number of recommendations. The following is a summary of these recommendations.

(1) Researchers should make a careful distinction between erotic stimuli (ie, dressed or half-naked attractive individuals) and sexually explicit stimuli (ie, scenes depicting sexual activity) and justify the choice based on what state the researcher hopes to activate.
(2) Participants should be provided with definitions of sexual desire and mental sexual arousal (and, eventually, perceived genital sexual arousal) so that they can specify for themselves which terms best describe how they feel.
(3) Event-related design should be used with caution. If sexual desire is conceptualized as a complex state, it is important that research designs utilize an adequate window of time to let the state of sexual desire arise and eventually return to baseline before a new stimulus is presented.
(4) Time series data (eg, percentage change from baseline) should be used so that both positive and negative changes in BOLD signal can be detected. Identifying the direction of change in BOLD will allow meaningful inferences regarding activation and putative inhibition of local brain activity and help disambiguate what mental processes are associated with different stimulus types and designs, as well as with sexual function and dysfunction.
(5) Functional and effective connectivity analyses should be performed to provide more meaningful tests of network structure and function. Building theories around a collection of active brain regions is an appropriate first step but is not an adequate test of a network model, nor does it provide a clear understanding of how the individual components of a network function together. Moreover, by combining a basic understanding of what areas are activated or inhibited in response to sexual stimuli with new theories of sexual function considering neural inhibition (eg, Komisaruk and del Cerro[55]), researchers could make specific predictions regarding how those brain areas interact within a network structure.

What is the next step then? In our view, one approach to addressing the confusion of what we are actually investigating by exposing people to visual sexual stimuli would be to do a continuous recording of BOLD signal in response to an erotic video that gradually becomes explicitly sexual and let the participants indicate (eg, through a button press) when they begin to experience sexual desire and/or mental sexual arousal (ie, when do they feel "turned on"). Before the scan is performed, participants should be provided with definitions of what these terms mean, thus requiring researchers to precisely define sexual desire and mental sexual arousal. This approach would avoid making assumptions of what the stimulus means to the participant and what the participant's subjective experience is, and it would allow interpretation of BOLD signal to be uniquely linked to the participant's internal state. Data could then be analyzed with functional or effective connectivity so that changes in neural networks could be explored.

In addition to the recommendations made here, other creative paradigm changes may benefit this area of research. For example, concerning stimulus type and presentation, future studies could consider either tailoring stimuli to the participant's preferences to ensure that specific feelings of

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sexual desire or sexual arousal are elicited[61] or using stimulus presentation that is below conscious awareness.[62] In the case of individual-based stimuli selection, we could hope to maximize feelings of desire/arousal, while in the case of below-conscious stimulus presentation, we might be able to reduce cognitive control (inhibition) of affective response (eg, anxiety, shame, embarrassment). Finally, a multidimensional neurofocused approach could lead to a innovative paradigm shift. In this sense, efforts could be made to integrate fMRI information about "where" changes in brain activity occur in response to stimulus, with precise information on "when" these changes occur according to electroencephalography. Integration could also include physiologic dimensions relevant to sexual arousal, such as heart rate variability and galvanic skin response but unfortunately not sexual desire, for which objective markers have not yet been defined.

General methodological concerns in this area should be mentioned. First, the small sample sizes in these studies lower the confidence in the data, likely contribute to poor replication, and limit our ability to study individual differences. Second, studying the absence or loss of sexual desire/arousal presents unique challenges regarding the best comparison condition. One novel approach is to use a longitudinal design in which individuals who are at risk for losing sexual desire/arousal are followed before and after the expected loss (eg, following cancer treatment[45]), although ethical and practical concerns would often preclude such a design. Third, given the plethora of possible causes of sexual dysfunctions (eg, self-body image, menopause, quality of relationship, drug use, depression), attention should be given to ensure homogeneity in the presumed cause of functional loss within each study.

In conclusion, if sexual desire and arousal are neuroanatomically indistinguishable, as suggested by Pfaus,[11] but perceptually distinguishable,[63] steps are needed to improve our research so that clarity can be made at the level of directional changes in BOLD signal and in the actual functioning of hypothesized networks. We believe that applying the aforementioned suggestions, as well as others not yet conceived, will help research on the neuroscience of human sexuality successfully resolve the difficult-to-negotiate conundrum of distinguishing the neuroanatomically overlapping experiences of sexual desire and arousal.

Supplementary material

Supplementary material is available at *Sexual Medicine Reviews* online.

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Validation of the Spanish Version of the Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ) with Sexual Arousal Measures in Men

Validación de la versión española del Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ) mediante medidas de excitación sexual en hombres

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Abstract.
Objective. Provide new validity evidence of the Spanish version of the Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ) by associating its scores with measures of sexual arousal. **Method.** In a sample of 48 men, using a quasi-experimental design, sexual functioning, propensity for sexual inhibition/excitation, subjective sexual arousal, and genital response (penile plethysmography recorded with Biopac MP150 equipment) were evaluated. **Results.** Arousal and erection scores correlated with sexual inhibition due to the threat of performance failure ($r = -.29$; $p < .05$) and genital response ($r = .31$; $p < .05$), respectively. Participants with difficulties in sexual functioning indicated greater sexual inhibition due to the threat of performance failure ($p = .04$) and lower intensity in their genital response ($p = .05$). **Conclusions.** The validity of the measures obtained with the Spanish version of the MGH-SFQ is supported, showing the erection item to be useful for the detection of possible erectile disorders.

Resumen.
Objetivo. Aportar nuevas evidencias de validez a la versión española del Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ), asociando sus puntuaciones a medidas de la excitación sexual. **Método.** En una muestra de 48 hombres, mediante un diseño cuasiexperimental, se evaluó el funcionamiento sexual, la propensión para la excitación/inhibición sexual, la excitación sexual subjetiva y la respuesta genital (pletismografía peniana registrada con un equipo Biopac MP150). **Resultados.** Las puntuaciones en excitación y erección del MGH-SFQ correlacionaron significativamente con la inhibición sexual por miedo al fallo en el rendimiento sexual ($r = -.29$; $p < .05$) y con la respuesta genital ($r = .31$; $p < .05$), respectivamente. Los participantes con dificultades en el funcionamiento sexual, en comparación con los que mostraron un adecuado funcionamiento, indicaron mayor inhibición sexual por miedo al fallo en el rendimiento sexual ($p = .04$) y menor intensidad en su respuesta genital ($p = .05$). **Conclusiones.** Se avala la validez de las medidas obtenidas con la versión española del MGH-SFQ, mostrándose el ítem de erección útil para la detección de posibles trastornos eréctiles.

Keywords.
MGH-SFQ, Sexual Functioning, Sexual Arousal, Plethysmography, Validity Evidence.

Palabras Clave.
MGH-SFQ, funcionamiento sexual, excitación sexual, pletismografía, evidencias de validez.

1. Introduction

Sexual functioning is closely related to sexual health, constituting a relevant element in interpersonal relationships, sexual well-being, and quality of life. Adequate sexual functioning is characterized by the absence of difficulties in the ability to respond sexually or experience sexual pleasure (American Psychiatric Association, 2013) without altering the sexual response components, and is associated with subjective satisfaction regarding individual and partner sexual behavior (Fielder, 2013).

In recent years, there has been a growing interest in the study of problems associated with sexual functioning (c.f., Alidost et al., 2021; Irfan et al., 2020). The American Psychiatric Association (2013) establishes explicitly the diagnostic category "Sexual Dysfunctions", including disorders related to desire, arousal, orgasm, pelvic or genital pain, erection, and ejaculation. The current International Classification of Diseases ICD-11 (World Health Organization, 2022) is positioned in the same line. Worldwide, sexual dysfunctions have a high prevalence, both in women (Alidost et al., 2021) and men (Irfan et al., 2020), estimated to be between 20% and 40% (Lewis et al., 2004; Sierra et al., 2012). In the specific case of the younger population, the overall symptomatology percentages range between 48-53% in women and 23-31% in men (Ljungman et al., 2020; Moreau et al., 2016).

In the clinical setting, standardized assessment questionnaires help detect symptoms of sexual dysfunctions, their periodic follow-up, and the evaluation of the efficacy of different treatments (Grover & Shouan, 2020). The assessment of sexual functioning requires instruments that provide reliable and valid measures and, if possible, have a brief and simple application (Sierra et al., 2014). The Massachusetts General Hospital-Sexual Functioning Questionnaire (MGH-SFQ; Labbate & Lare, 2001) is among the assessment instruments that meet these requirements. It is a five-item scale that measures desire, arousal, orgasm, erection, and sexual satisfaction. This instrument has been adapted and validated in different countries: Spain (Sierra et al., 2012), Colombia (Marchal-Bertrand et al., 2016), Portugal (Pereira, 2018), and Mexico (Hernández-Soberón et al., 2022). It is also a highly versatile measure used to identify sexual dysfunctions in the general population (Sierra et al., 2012) or to assess sexual functioning in different medical conditions (Domínguez et al., 2015; Lermann et al., 2019). Although the original version of the scale was intended to assess male sexual dysfunctions (Fava et al., 1998; Labbate & Lare, 2001), the Spanish validation of the MGH-SFQ was conducted in both men and women, obtaining reliability values of .90 and .93, respectively (Sierra et al., 2012). Evidence of the validity of its measures was also provided, in men and women, by significantly correlating its scores positively with sexual assertiveness, sexual desire, and sexual satisfaction (Sierra et al., 2012).

An essential labour in constructing or validating a test is to collect evidence about its validity, including the association of its measures with others (American Educational Research Association et al., 2014; Muñiz & Fonseca-Pedrero, 2019). The use of laboratory measurements helps to reduce uncertainty and provide better monitoring of variables in a more controlled manner (Wawersik, 2000). In the field of human sexuality, psychophysiological assessments of sexual arousal stand out among these measures (Arcos-Romero et al., 2020). Sexual arousal is an emotional/motivational state that can be activated by internal and external stimuli and can be inferred from central, peripheral, and behavioral responses (Janssen, 2011). According to this definition, on the one hand, the deduction or appraisal of that state of arousal has been categorized as subjective arousal (Sierra et al., 2017) and, on the other hand, in reference to the aroused responses, the most specific physiological reaction of sexual arousal is genital response (Velten, 2017). The latter is usually assessed through penile plethysmography (i.e., registration of changes in penile circumference as erection occurs; Janssen, 2002) and vaginal photoplethysmography (i.e., registration of changes in vaginal pulse amplitude as vasocongestion occurs; Sintchak & Geer, 1975). Its use has been reported on numerous occasions in the scientific literature to associate sexual arousal with other constructs or variables related to sexual functioning. Such is the case of sexual desire (Cervilla, Jiménez-Antón et al., 2023; Sierra et al., 2019) or orgasmic experience (Arcos-Romero et al., 2019; Cervilla, Sierra et al., 2023). In addition, from this consideration of sexual arousal as a state, the Dual Control Model of sexual response also describes it as an individual trait in the propensity to become sexually aroused or inhibited (c.f., Bancroft et al., 2009). Overall, the various measures of sexual arousal that can be assessed in a laboratory setting are useful for providing evidence of the validity of a scale that evaluates sexual functioning, as is the case of the MGH-SFQ.

Therefore, the general objective of the present study was to provide evidence of clinical validity to the Spanish version of the MGH-SFQ, to provide a useful assessment instrument for detecting difficulties in sexual functioning. For this aim, the specific objectives were (a) to associate MGH-SFQ scores with the propensity for sexual inhibition/excitation (i.e., trait excitation) and the subjective assessment of sexual arousal and genital sensations, and objective (genital response) sexual arousal to sexual film viewing (i.e., state arousal); and (b) to determine the ability of MGH-SFQ scores to differentiate between trait and state sexual arousal. It is hypothesized that MGH-SFQ scores for arousal and erection —as opposed to desire, orgasm, and satisfaction— will correlate positively with the propensity for sexual exci-

tation, and subjective and objective sexual arousal in response to visual sexual stimuli, and negatively with the propensity for sexual inhibition. In addition, men whose MGH-SFQ arousal and erection scores reflect sexual difficulties will manifest lower levels of sexual excitation (trait and state) and greater sexual inhibition, compared to functional ones (Sánchez-Fuentes et al., 2019; Sarin et al., 2014).

2. Method

2.1 Participants

The sample consisted of 48 heterosexual men aged 18-28 years ($M = 21.40$; $SD = 2.89$). By considering the statistical power calculation ($\alpha = .05$, power = .85, correlation ρ H1 = .40) performed with the program G*Power (Faul et al., 2007), a minimum of 42 participants was estimated to be necessary to perform the analysis. Inclusion criteria were: (a) being between 18 and 30 years of age, (b) having Spanish nationality, and (c) engaging in heterosexual sexual relationships. Exclusion criteria were: (a) having medical problems and/or psychological disorders, (b) using medication (e.g., antidepressants, antihypertensives or antipsychotics), (c) abusing drugs and/or alcohol, and (d) having a history of sexual abuse (i.e., sexual contact, sexual coercion, attempted rape, and rape). In this sample, 29 men were found to have difficulties in some dimension of sexual response (i.e., desire, arousal, orgasm, erection and/or satisfaction) and 19 men with no difficulties in sexual response. No significant differences in sociodemographic characteristics were found between the two groups (see Table 1).

2.2 Instruments and Materials

• Sociodemographic and Sexual History Questionnaire. Items were created *ad hoc* to collect information about sex, age, nationality, sexual orientation, romantic relationship, age of first sexual relationship, number of sexual partners, and exclusion criteria.

• Spanish version of the Massachusetts General Hospital Sexual Functioning Questionnaire (MGH-SFQ; Labbate & Lare, 2001) by Sierra et al. (2012). Assessed sexual functioning in the last month through five items about desire, arousal, orgasm, erection, and satisfaction (e.g., "How has your ability to get sexually aroused or excited been over the past month?"), which are answered on a 5-point Likert scale, from 0 (*totally impaired*) to 4 (*normal*). In the present study, Cronbach's alpha coefficient was .67.

• Spanish version of the Sexual Inhibition/Sexual Excitation Scales-Short Form (SIS/SES-SF; Carpenter et al., 2011) by Moyano and Sierra (2014). They assessed the propensity for sexual inhibition and excitation through 14 items answered on a 4-point Likert scale, from 1 (*completely agree*) to 4 (*completely disagree*). These items are divided into three subscales: Sexual excitation (SES; e.g., "When I talk to someone on the telephone who has a sexy voice, I become sexually aroused"), Sexual inhibition 1 or inhibition due to fear of failure in sexual performance (SIS1; e.g., "When I have a distracting thought, I easily lose my erection/my arousal"), and Sexual inhibition 2 or inhibition due to the fear of sexual activity consequences (SIS2; e.g., "If I am having sex in a secluded, outdoor place and I think that someone is nearby, I am not likely to get very aroused"). Cronbach's alpha coefficients range from .60 to .72 (Moyano & Sierra, 2014). In this study, the ordinal alpha was .78 for SES, .75 for SIS1 and .67 for SIS2.

• The Spanish version of the Rating of Sexual Arousal (RSA) and the Spanish version of the Rating of Genital Sensations (RGS; Mosher, 2011) by Sierra et al. (2017). RSA assessed subjective sexual arousal using five items (e.g., "A subjective estimate of your overall level of sexual arousal") that are answered on a 7-point Likert scale, from 1 (*no arousal at all*) to 7 (*extreme aroused*): the global rating of sexual arousal, rating of the intensity of genital sensations, rating of the sensation of warmth, rating of non-genital physical sensations, and rating of the level of sexual absorption. RGS evaluated with one item the level of intensity of genital sensations from 1 (*no genital sensations*) to 11 (*multiple orgasm*). RSA presented a Cronbach's alpha of .90 (Sierra et al., 2017), a value similar to the one obtained in this study.

• Penile plethysmography. An indium/gallium ring registers changes in penile circumference expressed in millimetres when an erection occurs (Janssen et al., 2002).

• Biopac Polygraph MP150 (Biopac Systems Inc., Goleta, CA, USA) using the software Acqknowledge 5.0 for psychophysiological data processing. Genital response was identified in terms of differences between scores on the sexual film and the neutral or baseline film (Granados et al., 2021).

• Films. A 3-minute neutral content video (nature documentary) was used as a baseline for the genital response. This was followed by a 3-minute sexually explicit video (heterosexual sexual relationship scenes). The sexually explicit films had been previously shown to induce sexual arousal (Sierra et al., 2015).

2.3 Procedure

This quasi-experimental study (Montero & León, 2007) was approved by the Human Research Ethics Committee from the University of Granada (code 109/CEIH/2015). Participation was entirely voluntary without compensation, and anonymity and confidentiality were guaranteed. Young male students at the University of Granada (Spain) were invited to participate through e-mails, publications on social media, paper flyers, and posters. In the first phase, participants responded to an online survey through the *LimeSurvey* platform in which inclusion/exclusion criteria, the propensity for sexual inhibition/excitation, and sexual functioning were assessed,

Table 1

Sociodemographic Characteristics of the Participants

	Total sample $N = 48$	No difficulties in sexual functioning ($n = 19$)	Difficulties in sexual functioning ($n = 29$)	U/χ^2
Age M (SD)	21.40 (2.89)	22.42 (0.77)	20.72 (2.36)	197.50
Current relationship status n (%)				1.01
Yes	21 (43.80)	10 (52.6)	11 (37.90)	
Age of first sexual experience M (SD)	16.22 (2.25)	16.37 (2.14)	16.11 (2.36)	252.50
Sexual partners number M (SD)	4.45 (8.18)	4.95 (6.48)	5.79 (9.26)	261.00

accepting beforehand informed consent that included the aim of the study and the methods used in the experiment. All eligible participants were invited to the laboratory. They were asked to abstain from consuming caffeine, alcohol and engaging in sexual activity during the 24 hours before the experimental session to minimize possible factors that could vary the physiological response. Once in the laboratory, a researcher individually explained all the information related to the study, and the participant signed a new informed consent form. The plethysmograph was then shown, and the participant was instructed on its correct positioning. After this, the researcher left the experimental room, and, once the participant was alone, the plethysmograph was placed to record the genital response. Once the device was in place, a five-minute adjustment period was given. The experimental task consisted of the viewing of two videos: (a) one of neutral content to obtain a baseline and (b) a video of explicit sexual content in order to induce sexual arousal. The genital response was recorded throughout the session. At the end of the sexual content stimulus, participants answered the RSA and RGS scales.

2.4 Data Analysis

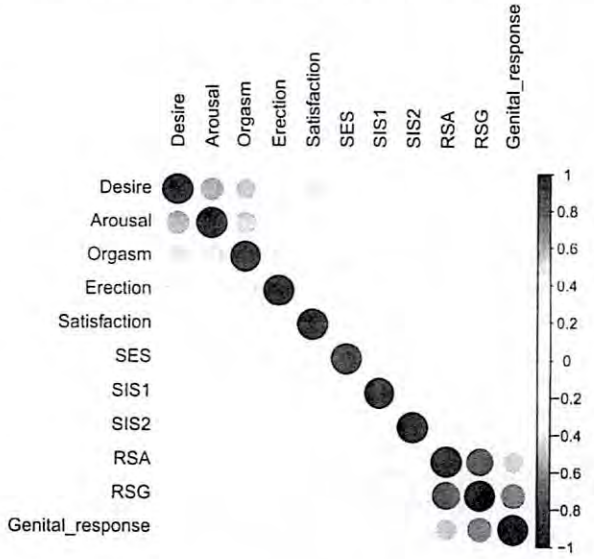
Non-parametric statistical analyses were performed because the sample did not meet the normality criteria (Kolmogorov-Smirnov, $p < .001$, and Shapiro-Wilks, $p < .001$). First, using Spearman's correlation, the association between the MGH-SFQ item scores and the different dimensions of sexual arousal was examined. Second, according to the score on each MGH-SFQ item, participants were distributed into two groups: functional (score of 4: *Normal*) and impaired (scores below 4, from *Totally impaired* to *Minimally impaired*). Comparisons in sexual arousal of both groups were performed using the Mann-Whitney U test. SPSS® v.22 statistical software was used.

2.5 Results

The MGH-SFQ arousal item score correlated significantly negative with the propensity for sexual inhibition due to fear of performance failure (SIS1; $r = .29$, $p < .05$). The MGH-SFQ erection score correlated positively with the genital response ($r = .31$, $p < .05$). No correlations were obtained between the scores of the desire, orgasm, and satisfaction items and the different variables related to sexual arousal (see Table 2 and Figure 1).

Figure 1

Correlations between Dimensions of Sexual Functioning and Measures of Sexual Arousal



The comparison between groups of men with and without difficulties in sexual functioning, based on MGH-SFQ scores, is shown in Table 3. Significant differences in propensity to sexual inhibition due to fear of performance failure (SIS1) were found between men with and without difficulties in arousal ($U = 149.50$, $p = .04$) and orgasm ($U = 100.5$, $p = .09$), with higher scores in the groups with difficulties. The group with difficulties presented lower scores in the penile response to sexual films. No significant differences were observed for the items related to sexual desire and satisfaction.

3. Discussion

The MGH-SFQ (Labbate & Lare, 2001) is a brief and easily applied assessment scale adapted to several countries —including Spain— to provide a tool that quickly identifies possible sexual dysfunctions. Although, in some of the validations conducted, its measures were

Table 2

Correlations between MGH-SFQ Item Scores and Sexual Arousal

Sexual excitation	Desire	Arousal	Orgasm	Erection	Satisfaction
SES	.10	.19	−.08	−.08	−.02
SIS1	−.23	**−.29***	−.23	.00	.15
SIS2	.05	−.17	−.18	−.08	.00
RSA	−.05	−.05	−.07	−.11	−.05
RSG	−.10	−.15	−.05	−.01	−.13
Genital response	.01	−.18	.10	**.31***	.01

Note. SES= propensity for sexual excitation; SIS1= propensity for sexual inhibition due to fear of failure in sexual performance; SIS2= propensity for sexual inhibition due to fear of the consequences of sexual activity; RSA= rating of sexual arousal; RGS= rating of genital sensations. *$p < .05$.

Table 3

Comparison of Sexual Arousal between Men without and with Difficulties in Sexual Functioning

MGH-SFQ item	No difficulties in sexual functioning M (SD)	Difficulties in sexual functioning M (SD)	U	p	Cohen d
Desire	$n = 36$	$n = 12$			
SES	16.03 (3.15)	14.92 (4.12)	179.5	.38	–
SIS1	7.69 (2.27)	8.67 (2.35)	157.5	.16	–
SIS2	11.03 (2.62)	10.33 (2.84)	198	.66	–
RSA	3.08 (1.7)	3.17 (1.27)	206.5	.82	–
RGS	17.86 (7.03)	18.33 (6.01)	193.5	.58	–
Genital response	11.74 (10.52)	9.92 (8.10)	207	.83	–
Arousal	$n = 34$	$n = 14$			
SES	16.15 (3.39)	14.79 (3.38)	179.5	.18	–
SIS1	**7.50 (2.25)**	**9 (2.15)**	**149.5**	**.04***	**−.68**
SIS2	10.56 (2.78)	11.57 (2.31)	185.5	.22	–
RSA	2.97 (1.62)	3.43 (1.51)	225.5	.77	–
RSG	17.79 (7.36)	18.43 (5.17)	193.5	.29	–
Genital response	9.88 (8.83)	14.7 (11.84)	179	.18	–
Orgasm	$n = 40$	$n = 8$			
SES	15.60 (3.51)	16.5 (2.93)	138.5	.55	–
SIS1	**7.73 (2.39)**	**9 (1.51)**	**100.5**	**.09†**	**−.64**
SIS2	10.65 (2.8)	11.87 (1.64)	110	.16	–
RSA	3.08 (1.62)	3.25 (1.49)	143	.63	–
RSG	17.77 (7.1)	19 (5.01)	145	.66	–
Genital response	11.78 (10.34)	8.78 (7.52)	138	.54	–
Erection	$n = 37$	$n = 10$			
SES	15.7 (3.43)	16.2 (3.52)	163.5	.57	–
SIS1	8 (2.43)	8 (1.76)	179	.87	–
SIS2	10.78 (2.69)	11.3 (2.75)	167	.63	–
RSA	3.14 (1.60)	3.2 (1.55)	160	.51	–
RGS	17.57 (7.12)	19.1 (5.45)	184.5	.98	–
Genital response	**12.71 (10.18)**	**6.82 (7.83)**	**111**	**.05†**	**.65**
Satisfaction	$n = 21$	$n = 27$			
SES	15.67 (4.03)	15.81 (2.91)	271.5	.80	–
SIS1	7.95 (2.29)	7.93 (2.35)	281.5	.96	–
SIS2	10.71 (2.37)	10.96 (2.91)	258	.59	–
RSA	3.1 (1.87)	3.11 (1.37)	268.5	.75	–
RGS	18.29 (7.82)	17.74 (5.88)	265	.69	–
Genital response	12.21 (11.19)	10.56 (8.96)	267	.73	–

Note. SES= propensity for sexual excitation; SIS1= propensity for sexual inhibition due to fear of failure in sexual performance; SIS2= propensity for sexual inhibition due to fear of the consequences of sexual activity; RSA= rating of sexual arousal; RGS= rating of genital sensations. †$p < .10$; *$p < .05$.

related to other similar variables, such as sexual self-esteem, sexual assertiveness, erotophilia or sexual satisfaction (Marchal-Bertrand et al., 2016; Sierra et al., 2012), they have not been related to psychophysiological measures of sexual response to date.

Therefore, the present study extends the validity evidence of the MGH-SFQ based on relationships with other measures, thus following current guidelines in the construction and validation of assessment tests (American Educational Research Association et al., 2014; Muñiz & Fonseca-Pedrero, 2019). Specifically, scores on each of the MGH-SFQ items were correlated with subjective and objective measures of sexual arousal: (a) propensity to become sexually excited/inhibited (i.e., trait excitation) and (b) rating of sexual arousal and genital sensations, and genital response to sexual film viewing (i.e., state excitation). In addition, based on the scores on each of the MGH-SFQ items (i.e., desire, arousal, orgasm, erection, and satisfaction), groups of men without and men with difficulties in sexual functioning were established to compare them on the different measures of sexual arousal.

Overall, the results support the initial hypotheses, although not fully for all measures of sexual arousal. As hypothesized, scores on the MGH-SFQ arousal item correlate negatively with the propensity for sexual inhibition due to fear of failure in sexual performance (SIS1), but not with the rest of the variables associated with sexual excitation, specifically with the propensity for sexual arousal (SES), the propensity for sexual inhibition due to fear of the consequences of sexual activity (SIS2), the assessment of sexual arousal and genital sensations, and the genital response. On the other hand, the MGH-SFQ erection item scores correlate positively, as expected, with the intensity of erection of the participants in the presence of sexually explicit films, but not contrary to what was hypothesized, with the rest of the variables related to sexual arousal, i.e., propensity for sexual excitation, propensity for sexual inhibition due to fear of failure in sexual performance, propensity for sexual inhibition due to fear of the consequences of sexual activity, and rating of sexual arousal and genital sensations. These results are further supported by the fact that the groups of men without and men with difficulties in sexual functioning —formed from the scores on the MGH-SFQ arousal and erection items— differ in the propensity for sexual inhibition due to fear of failure in sexual performance and genital responsiveness, respectively.

The results found regarding inhibition due to fear of failure in sexual performance are consistent with previous studies in which this trait was related to difficulties in sexual functioning (Bancroft & Janssen, 2000; Sánchez-Fuentes et al., 2019; Velten, 2017). Sierra et al. (2019) previously found identical results when comparing the propensity for sexual inhibition/excitation between men with and without difficulties in sexual arousal assessed using the MGH-SFQ: both groups differed in the propensity for sexual inhibition due to fear of failure in sexual performance, but not in the propensity for sexual excitation nor in the propensity for inhibition due to fear of consequences derived from sexual activity. Furthermore, this inhibition trait (SIS1) showed a capacity of 81.7% to classify functional and dysfunctional men in terms of their sexual arousal (Sierra et al., 2019). Difficulties in sexual arousal would be associated with an excessive focus on sexual performance, which is counterproductive for adequate sexual functioning (Barlow, 1986; McCabe, 2005). In short, the role of trait sexual inhibition in sexual functioning is once again ratified (Bancroft et al., 2009; Bancroft & Janssen, 2000; Hodgson et al., 2016), as well as its potential ability to discriminate between men with and without difficulties in sexual functioning (Sierra et al., 2019).

Regarding erection, it was expected that the scores on this item of the MGH-SFQ would be those most clearly associated with the intensity of erection experienced by the participants when viewing sexual films. We assume that the ability of this item to discriminate the intensity of erection registered in men without a diagnosis of sexual dysfunction, such as those in this study, would be significantly increased if we compare functional and dysfunctional men with a diagnosis of an erectile disorder. Similar laboratory studies have already evidenced that men with erectile difficulties present smaller increases in their genital response compared to sexually functional men (Sarin et al., 2014; Stone et al., 2009). This result enhances the importance of this item in identifying possible cases of erectile dysfunction, making it an excellent screening tool in clinical sexology.

It is essential to note some limitations of this study, which lead us to be cautious when generalizing the results. When selecting the sample, a non-probabilistic sampling technique was used, which included a group of young heterosexual college men exclusively without a diagnosis of sexual dysfunction, so future research should ensure the representativeness of the sample (Díaz-Gutiérrez et al., 2022; Riveros Munévar et al., 2021). On the other hand, the artificiality of laboratory studies prioritizes internal validity at the expense of external validity. Finally, it should be mentioned that the artificiality of the evaluation context could influence the results, since the measurement is performed in an room that differs from a context in which viewing erotic images would commonly occur. Despite these limitations, the presence of sexual arousal was observed in the participants. Future research should include individuals with diverse sexual identities and sexual orientations. In addition, examining clinical samples with diagnosed sexual dysfunctions would yield relevant and useful information.

4. Conclusions

This study provides additional validity evidence to the assessment provided by the Spanish version of the MGH-SFQ, especially highlighting the ability of the erection item to discriminate between different levels of penile psychophysiological response. The findings support its use as a valid measure to assess sexual functioning in men. Therefore, the Spanish version of the MGH-SFQ can be used as a useful tool in assessing the dimensions of sexual functioning in heterosexual men and for detecting the possible presence of difficulties, providing an opportunity to advance research and intervention in sexual response.

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REVIEW ARTICLE

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Nocturnal penile tumescence devices: past, present and future

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Erectile function is an important part of men's health that can significantly impact quality of life. Naturally occurring nighttime erections experienced by men throughout their lifespan provides insight into penile health as well as overall health. Nocturnal penile tumescence (NPT) and nocturnal penile tumescence and rigidity (NPTR) devices that can non-invasively evaluate the presence and quality of erections can have valuable diagnostic and clinical utility. Early devices have several limitations that limit their current use. New, wearable devices have promising applications for the evaluation of erectile function over time. Continued advancements in this technology have the potential to render future generations of these devices as invaluable tools that are useful for both men and healthcare professionals.

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INTRODUCTION

Erectile Dysfunction (ED) is the consistent or recurrent inability to attain and/or maintain penile erection sufficient for sexual satisfaction [1]. The etiology is often multifactorial and can include psychological and organic causes [1]. Nocturnal penile tumescence (NPT) and nocturnal penile tumescence and rigidity (NPTR) devices are noninvasive tools that can be used to detect the presence or absence of naturally occurring erections during rapid eye movement (REM) sleep, which could help distinguish between psychological or organic causes of ED [2, 3]. Absence of nocturnal erections is concerning for an organic cause of ED, while presence of nocturnal erections may indicate that the patient has a psychological or multifactorial cause of ED. More insight into the etiology of the cause of ED can be elicited by understanding the quality of nocturnal erections. The quality of erections can be inferred based on additional data from these devices. The objective data that is obtained can be incorporated into individualized treatment plans that guide ED management. In this article, we will review the history of NPT and NPTR devices and discuss the new generation of devices that have emerged through advancements in technology as well as the future of these devices.

METHODS

A literature search was performed via PubMed using the search terms "NPT," "NPT devices," "NPT monitoring," "NPTR," "NPTR devices," "NPTR monitoring," "nocturnal erection," "nocturnal erection monitoring," "nocturnal tumescence," and "nocturnal tumescence monitoring." Original articles and more recent reviews were reviewed that focused on the clinical utility of NPT and NPTR devices. Manual searches of references from retrieved articles were also performed to identify any additional relevant articles missed by online indexes. A web-based Google search was used to look for newer devices without published literature.

Early devices

Several devices have been previously developed to measure sleep-related erections, including sleep laboratory testing, the Mercury strain gauge with elastic silicone plastic tubing (Becton, Dickinson & Co.; Rutherford, NJ), the stamp test (University of Oregon Medical School; Portland, Oregon) and PotenTest (The University of Texas Medical School; Houston, Texas), the Snap*-Gauge® (Dacomed Co.; Minneapolis, Minnesota), the erectometer (Queen's University; Kingston, Ontario, Canada), the RigiScan® (Dacomed Co.; Minneapolis, Minnesota; Timm Medical Technologies, Inc. Minneapolis, Minnesota; a division of Plethora Solutions Holdings, Ltd., UK) and RigiScan® Plus (Dacomed Co.; Minneapolis, Minnesota), and nocturnal electrobioimpedance volumetric assessment (NEVA)™ (Urometrics, Inc; St. Paul, Minnesota, USA) (Table 1). While these devices have the potential to provide useful information in particular clinical scenarios, NPT and NPTR measurements are rarely performed in clinical practice anymore due to drawbacks of each device, which limit the clinical utility.

Sleep laboratory testing. Continuous NPT measurements have been performed in sleep laboratories for several decades [4–6]. Technicians monitor spontaneous erections and document number, frequency and duration of erections and obtain penile measurements manually. Additional information, such as electroencephalogram (EEG), electro-oculogram, and/or electromyogram monitoring can also be obtained in this setting [4, 6]. Sleep laboratory testing was later combined with mercury strain gauge recordings to measure the quality of erections more thoroughly and efficiently [4]. It is also possible to separately measure axial rigidity, which provides information on penetrative capability [5]. This may be assessed by a technician near the time of maximum tumescence with an external device applied to the penis to determine the buckling pressure [5]. Not only is this testing expensive, complicated and prone to technician error, but this artificial environment combined with the uncomfortable

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Table 1. Early device characteristics.

Method	Year	Measurements	Advantages	Disadvantages
Sleep laboratory testing [4–6]	N/A	Number, frequency and duration of erections, circumference, tumescence and axial rigidity	Able to determine penetrative capability with axial rigidity	Uncomfortable environment and measurements that could impact sleep quality and erections; expensive; complicated; require lab technicians and prone to technician error
Mercury strain gauge [3]	1965	Circumference and tumescence	Eliminate need for technicians	Only measure changes in one location on the penis; unable to assess rigidity; require in hospital monitoring; expensive
Phallo-Plethysmography [7]	1982	Circumference, tumescence and radial rigidity	Modified mercury strain gauge that provides measurements at two locations; assesses rigidity	Pressure required to evaluate rigidity that could impact sleep quality and erections; require in hospital monitoring; expensive
Stamp test [8]	1980	Circumference, tumescence and radial rigidity	Simple and cheap device that can be used at home	Provides dichotomous results; no continuous monitoring; unable to assess penetrative capability
PotenTest [9]	1986	Circumference, tumescence and radial rigidity	Modified stamp test that is standardized and more hygienic	Provides dichotomous results; no continuous monitoring; unable to assess penetrative capability
Snap*gauge® [10]	1983	Circumference, tumescence and radial rigidity	Simple and cheap device that can be used at home; graded rigidity measurements	No continuous monitoring; unable to assess penetrative capability
Erectometer [12]	1983	Maximum change in circumference	Quantitative assessment	No continuous monitoring; unable to assess rigidity
RigiScan® [14]	1985	Number, frequency and duration of erections, circumference, tumescence and radial rigidity	Portable device that can provide the most objective, comprehensive data with higher sensitivity and specificity	Unable to measure axial rigidity to assess penetrative capability; expensive; complicated; outdated software
RigiScan Plus® [16]	1994	Number, frequency and duration of erections, circumference, tumescence activity unit (TAU) and rigidity activity unit (RAU)	Modified RigiScan® that can provide time-intensity area measures of tumescence and rigidity	Unable to measure axial rigidity to assess penetrative capability; expensive; complicated; outdated software
Nocturnal electrobio- impedance volumetric assessment (NEVA)™ [26]	1999	Number, frequency and duration of erections, tumescence and percent increase in blood volume	Portable device that can assess blood flow	Unable to assess rigidity; expensive; complicated

measurements potentially disrupts sleep and nocturnal erections and thus the quality of data.

Mercury strain gauge. The Mercury strain gauge was developed by Fischer et al. in 1965 as a method of measuring penile tumescence [3]. The device consists of a 1 mm in diameter elastic silicone plastic tube filled with mercury and sealed at both ends with platinum electrodes creating a loop [3]. The gauge forms one leg of a circuit and enables minute variations in resistance to be detected as the tubing stretches around the penis during erections [3]. Specifically, when an erection occurs, the ring circumference changes and alterations in the distribution of the mercury are detected [3]. Changes in circumference based on the mercury gauge are amplified and recorded to generate reports that are similar in appearance to an EEG [3]. Although the changes in circumference provide some information regarding the quality of erections, rigidity is not able to be measured by this device. The device is best suited for hospital or laboratory settings, rather than home use.

In 1982, Leliefeld et al. reported on a modified use of Mercury strain gauges, called phalloplethysmography [7]. The device incorporates two mercury strain gauges, one placed at the base and the other placed towards the glans, that are attached to a recorder [7]. While the device is able to provide more information about the changes in circumference and tumescence along the shaft of the penis as well as radial rigidity through application of pressure, it still lacks a formal rigidity test for assessments of penetrative capability [7].

Stamp test and PotenTest. The stamp test, which is arguably the simplest and cheapest of all the NPT devices, can be used as a screening test to detect the presence of at least one nighttime erection. The specific method Barry et al. promoted in 1980 involves four stamps with a total width of five inches that were applied snuggly to the shaft of the penis by moistening overlapping stamps [8]. Any break along the perforations of the stamp ring indicates an erection [8]. The PotenTest was developed in 1986 by Bertini and Boileau as a standardized, hygienically packaged and reliable stamp test [9]. Although these devices provide insight about radial rigidity and whether patients have erections strong enough to break the stamps, the results are not a complete reflection on axial rigidity or the ability of a patient to have penetrative intercourse. Furthermore, based on the design, the tests cannot provide any additional information about the quality of erections, such as the number of erections, frequency of erections, duration of erections, or changes in circumference or rigidity, which ultimately led to commercial failure [5].

*Snap*Gauge®.* Ek et al. published on the Snap*Gauge® as a screening device that could also provide rigidity estimates in 1983 [10]. This device consists of one piece of non-stretchable fabric with Velcro tape that could be adjusted to fit around the shaft of the penis with three pre-set snap-release fasteners with release forces of 8, 12, and 16 ounces, representing 90–160 mmHg of intracavernous pressure [10]. The degree of rigidity is estimated based on which fasteners were released, if any. It is a simple, inexpensive and more objective way of measuring penile erections, however, there are concerns regarding how well this test actually determines erectile function and penetrative capability [11]. Like the stamp test, this test is also limited in its ability to provide a quantitative analysis that includes the duration, frequency and number of erections per night.

Erectometer. In 1983, Morales et al. invented a new device called the erectometer [12]. The device fits circumferentially around the shaft of the penis, like the stamp test and Snap gauge. The band has the ability to slide and has a small window that can be used to mark the circumference of the penis in the flaccid and erect state to provide information about the maximum penile circumferential change [12, 13]. Although this device can provide quantitative information that the stamp test and Snap gauge were unable to, it is still unable to provide information on erection number, frequency or duration or penile rigidity [12, 13].

RigiScan® and RigiScan® Plus. Bradley et al. invented the RigiScan® in 1985, which became the gold standard for objectively and continuously measuring penile circumference, axial and circumferential dilation rates, erection number, frequency and duration, and rigidity during sleep [14]. The device consists of an ambulatory unit and a microcomputer. The ambulatory unit of the initial device connects to a patient's thigh and a nonelastic cable loop ranging from 5–15 cm in circumference attaches to a position sensor placed at the mid-shaft of the penis [14]. A second loop was later incorporated that can provide more comprehensive data from measurements at the base and distal shaft of the penis [5]. Circumference is assessed every 15 s based on feedback from the position sensor when the loops tighten [14]. Rigidity is monitored at least every three minutes by a spring constant, which is analogous to the circumferential stiffness, and based on displacement of the loop and relative to the spring constant of a semirigid rubber cylinder [14]. The data is received by a microcomputer and subsequently processed. Normal NPTR is based on 3–6 tumescence periods, with at least 1 erectile event having tip rigidity >60% lasting an average of 10–15 min during 8 h of monitoring [14, 15]. The test can be completed in a laboratory, but home use is also possible.

The RigiScan® Plus was subsequently developed in 1994 (Fig. 1A) [16, 17]. This device includes updated user-friendly features as well as integrated time-intensity area measures of tumescence (tumescence activity unit, TAU) and rigidity (rigidity activity unit, RAU) as added measurements to facilitate the interpretation of the time-dependent nature of tumescence and rigidity [16].

A prospective, randomized trial that evaluated 64 men with RigiScan® compared to comprehensive work-up, including history, penile color doppler sonography and dynamic cavernosometry, found the sensitivity, specificity, positive predictive value, and accuracy rate of RigiScan® discriminating organic from psychogenic ED was 80.9%, 81.8%, 89.4% and 81.2%, respectively [18]. Another study found the highest diagnostic accuracy of the device with TAU and RAU measurements did not exceed 75.9% [19]. A study that assessed whether the RigiScan® could distinguish between arterial and venous ED found that it could with a sensitivity of 81.4% and a specificity of 100% at a cutoff value of 12.5 min for erection duration [20].

Although these devices have robust data and remain the gold standard for NPTR testing, there are several limitations that call the accuracy and reliability of these devices into question. An important limitation is that these devices measure radial rigidity, not axial rigidity, which is the most accurate parameter associated with penetrative capability. Radial rigidity and axial rigidity are both dependent on intracavernosal pressure, but radial rigidity also involves tunical surface wall tension, whereas axial rigidity also involves cavernosal erectile tissue properties and penile geometry [21]. Although there is a correlation between the two, axial and radial rigidity may increase at different rates and a radial rigidity of 60% or greater must be cautiously interpreted as it does not always correlate with a normal result [22, 23]. Additional limitations of the devices are that they are relatively large and uncomfortable, expensive, and the results have been reported to be impacted by several factors, including the environment, depression, negative dream content, sleep disorders and smoking [15]. Furthermore, the software is not compatible with newer operating systems on computers, tablets and smartphones [24–26].

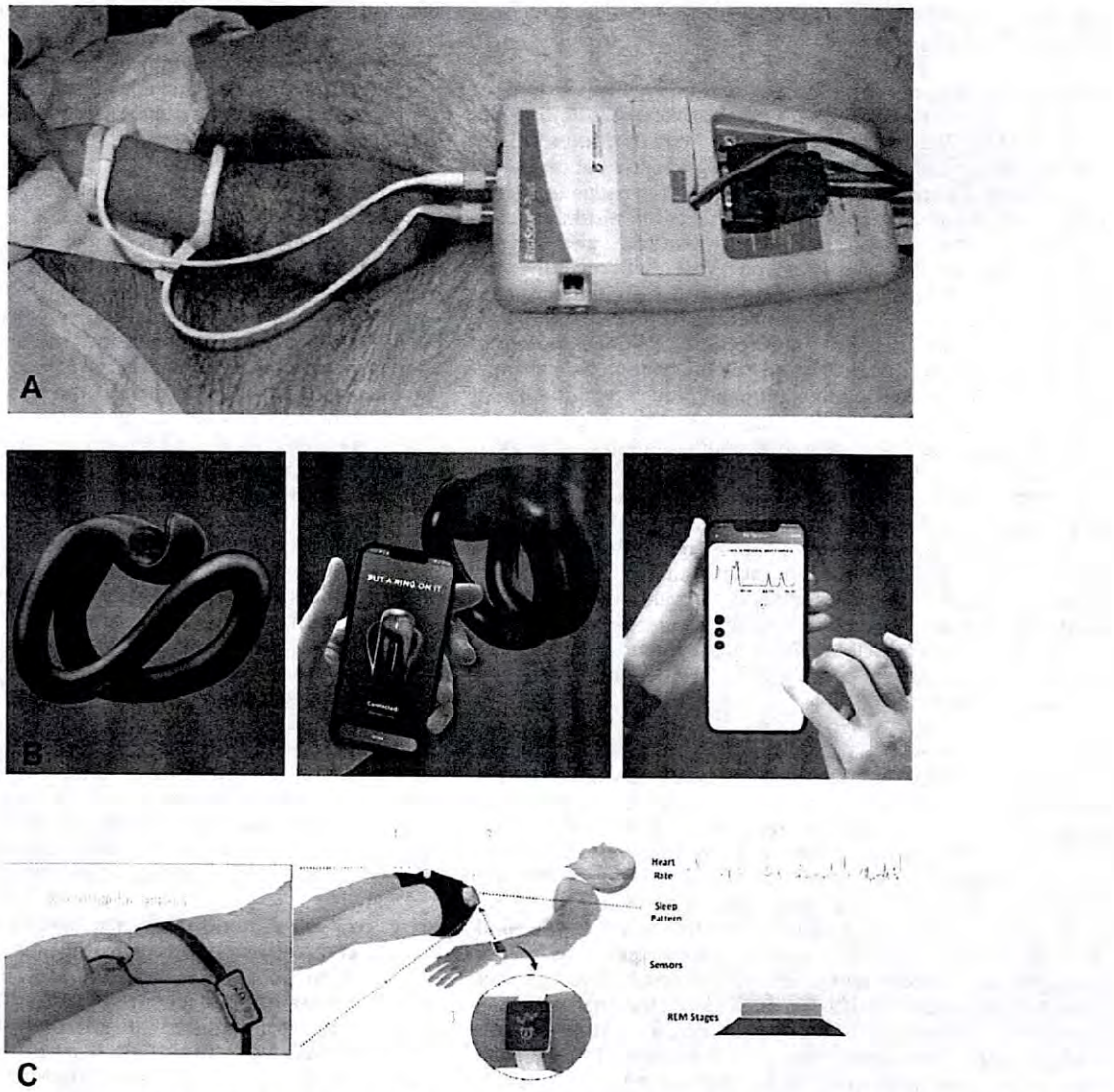

Fig. 1 Past, Present and Future Devices. Past, Present and Future Devices (**A**) The RigiScan® Plus was developed in 1994 to study nocturnal tumescence and rigidity using two transducing cable loops. (Image reprinted from Konstantinidis C. Erectile dysfunction in paraplegic males. Erectile Dysfunction—Disease-Associated Mechanisms and Novel Insights into Therapy, InTech; 2012.) (**B**) FirmTech® represents a new generation device from 202 that uses an electronic penile ring with a sensor that synchronizes with a patient's smartphone to continuously measure erections. (Image downloaded from Firm Tech Inc. Male Enhancement Erection Band | Penoscrotal & Constriction Rings. 2023. https://myfirmtech.com.) **C** The Erectile Dysfunction SENsor (EDSEN) is a proposed device consisting of (1) a pair of looped microtubular sensors, (2) a wireless wearable detector, and (3) a smartwatch for monitoring REM sleep. (Image reprinted from Sng CMN, Wee LMC, Tang KC, Lee KCJ, Wu QH, Yeo JC, et al. Wearable Soft Microtube Sensors for Quantitative Home-Based Erectile Dysfunction Monitoring. Sensors 2022;22. https://doi.org/10.3390/s22239344).

Nocturnal electrobioimpedance volumetric assessment (NEVA)™. Nocturnal electrobioimpedance volumetric assessment (NEVA)™ is a small device developed in 1999 by Knoll et al. to non-invasively monitor the number, frequency and duration of erections as well as the percent increase of blood volume during erections [27]. The system consists of four components: a disposable electrode set, a portable battery powered recorder that weighs five ounces, a host interface unit, and a corresponding computer program [27]. Changes in blood volume are determined by assessing the impedance within the penis [27]. This device is unable to assess rigidity or penetrative capacity.

New generation devices

The new generation wearable devices emerged in an attempt to overcome the limitations with the earlier devices and satisfy the increasing demand for healthcare-monitoring products that facilitate medical care (Table 2). Wearable devices that can generate health information have already proven to have wide applicability in healthcare and have significant potential in the diagnosis and management of ED [21]. These devices can allow any man to understand his current erectile function and how it is impacted by certain behaviors or interventions. For men who have concerns related to their sexual or erectile function, these devices can allow those men to engage in their healthcare more readily since it generates shareable data that is accessible to the man as well as any member of his healthcare team that he chooses. The data can provide an assessment of how lifestyle changes and medications impact the man's erectile function, which can inform individual treatment plans. In addition, these devices can help men overcome psychosocial barriers to receiving healthcare and

enhance access to care in underserved areas since the data can be shared without an in-person visit.

The Adam Sensor. The Adam Sensor (AdamHealth of The Andrology Company Ltd., London, UK) was developed and presented as a novel, low-cost wearable device to measure NPT in patients with ED in 2021 [28]. It is a non-obstructive ring-shaped device with a sensor that is worn around the base of the penis to detect changes in NPT [28]. It specifically measures the number, frequency and duration of erections and TAU [28]. This data is continuously transmitted to the user's cell phone via Bluetooth and analyzed by a dedicated mobile application [28]. It is also advertised as a way for all men to monitor erections and make changes that improve their erections although the device is currently only available in London for men who are seeking care with a specialist for ED.

FirmTech®. FirmTech® (FirmTech Inc., Bozeman, Montana, USA) is a commercially available wearable device that was developed and launched in the United States in 2022 to quantify erectile fitness [29]. It is an electronic penile ring with a sensor that synchronizes with a patient's smartphone to continuously measure the number, duration and firmness of erections (Fig. 1B) [29]. The device can also be worn during intercourse to sustain erections by limiting blood from leaving the penis and allow men to have more fulfilling sexual experiences with their partners [29]. While FirmTech® presents a more modern approach to understanding erectile function, more evidence is needed on its efficacy and how it can be best incorporated into healthcare decision making as there is currently no data published on this device.

Future devices

Despite the increasing interest in wearable devices and the advances in modern technologies, development of new generation NPT and NPTR devices that are available to men is still lacking. An ideal wearable device that could be developed in the future has been described as user friendly, inexpensive, comprehensive and accurate [5]. A device that could also measure penile curvature in patients with Peyronie's disease would be useful. Devices that have been proposed for future use include PT-Scan, penile tumescence continuous observation device, wearable electronic textiles and carbon nanotube sensors and wearable soft microtube sensors (Table 2). Advances in technology incorporating design elements from these proposed devices and other applications will lead to the next generation of devices with enhanced capabilities.

PT-Scan. Choi et al were the first to introduce a wearable smart device coupled with advanced sensor technology that could connect to any smartphone through wireless communication for NPT in 2015 [30]. The proposed device, the PT-scan, consists of a progressive-sensor with multiple wires, a rubber band and Velcro that are placed circumferentially around the base and distal penis and connected to a controller [30]. It was evaluated simultaneously with a RigiScan test on 10 men in over 30 sessions totaling >100 h [30]. When the measurements were compared to RigiScan results, a 0.96 ($P < 0.001$) correlation coefficient was obtained [30]. The evidence from the study suggested that the PT-scan is reliable, however, the authors mentioned they planned to incorporate more advanced biological signal processing algorithms to further optimize data processing and the device has yet to become available.

Penile tumescence continuous observation device. In 2020, Matsumoto and Takeuchi developed a prototype for a wireless real-time continuous observation device for NPT [31]. The prototype was a soft-silicone ring equipped with a built-in variable inductance, variable frequency oscillator and micro-battery that fit over the middle of the penis [31]. The oscillating frequency was responsible for the internal stress of the ring, which represented penile tumescence [31]. The device was able to successfully measure the change in circumference and peripheral arterial pulse wave in a feasibility test [31]. After a few minor modifications, the authors reported they plan to pursue a pre-clinical trial with healthy volunteers.

Wearable electronic textiles and carbon nanotube sensors. Condom-shaped wearable devices that could quantitatively measure the length and circumference of the penis using electronic textile (E-textile) sensors and carbon nanotube (CNT) sensors were initially described in 2021, but are not available at this time [32]. The sensors are integrated into one device that is worn over the shaft of the

Table 2. New generation wearable devices.

Device	Year	Design	Measurements
Available devices			
The Adam Sensor [28]	2021	Non-obstructive ring-shaped device with a sensor that is worn around the base of the penis with data transmitted to a mobile application	Number, frequency and duration of erections, and tumescence activity unit (TAU)
FirmTech® [29]	2022	Adjustable, electronic penile ring with a sensor that sync to a smartphone	Number, frequency and duration of erections, and tumescence
Proposed future devices			
PT-Scan [30]	2015	(1) Progressive sensor with multiple wires, a rubber band and Velcro that are placed around the penis and attached to a (2) controller that transmits data to a (3) smartphone	Circumference and tumescence
Penile tumescence continuous observation device [31]	2020	Soft silicone ring with a built-in variable inductance, variable frequency oscillator and micro-battery that fits over the middle of the penis and transmits data wirelessly	Circumference, tumescence and peripheral arterial pulse wave
Wearable e-textiles and CNT sensors [32]	2021	Condom-shaped device worn over the penis that transmits data through mobile applications	Length, circumference and tumescence
Erectile Dysfunction SENsor (EDSEN) [33]	2022	(1) Looped T and R microtube sensors placed around the shaft of the penis connected to a (2) wearable detector around the waist that transmits data about the quality of erections, as well as REM sleep based on a (3) smartwatch worn around the wrist	Tumescence and axial rigidity

penis at night and provides real time data through mobile applications [32]. Although more reliable sensors and signal processing algorithms are still being developed and optimized, the results of the conceptual study support the development of new devices with sensors that combine innovative technology.

Wearable soft microtube sensors. The Erectile Dysfunction SENsor (EDSEN) was proposed by Sng et al. in 2022 as a home-based wearable device for quantitative penile health monitoring [33]. The device consists of looped T and R microtube sensors that fit around the penile shaft and measure penile tumescence and axial rigidity, respectively, a wireless wearable detector around the waist and a smartwatch for REM sleep monitoring (Fig. 1C) [33]. Conical models of different circumferences and degrees of hardness mimicking the penile shaft were evaluated using the device [33]. A buckling force was determined and correlated with penetrative capability [33]. Based on these models and several verification tests, the sensors were determined to appropriately measure tumescence and rigidity [33]. EDSEN is still undergoing design improvements for improved useability and to be able to measure additional physiological parameters, such as length, before it is commercially available [33].

Advanced technologies. Incorporating different types of sensors into new devices can allow for the simultaneous measurement of several physiological changes during nocturnal erections, including length, circumference, rigidity, arterial pulse, temperature and oxygen saturation [24]. Resistive and capacitive sensors already exist for medical applications and can be used to measure penile length based on changes in displacement [24]. A strain gauge or a tactile sensor can provide information on circumference and radial rigidity as seen in prior devices [24, 34]. R microtube sensors, like those used in the design of the EDSEN device, have the potential to measure axial rigidity [33]. There is also a patent on a deformable support surface device with an electronic pressure sensor and pressure transmission element that can be used for at-home measuring of axial rigidity [21]. A photoelectric plethysmograph sensor could be used to measure arterial pulse according to optical absorption [24]. Temperature sensors that use infrared measurements have already been developed for wearables in other settings and could be used to measure temperature changes during erections, which is expected to increase 2 to 3 degree Fahrenheit with increased blood flow [3, 35]. Tissue oxygenation sensors have also already been developed and could be used to provide insight regarding the relationship between saturation levels and intensity of erections [24]. The clinical usefulness of sensors measuring arterial pulse, temperature and oxygen saturation can be further examined once these devices have been developed.

With continued advancements, NPT and NPTR devices could have a key role in the diagnosis and management of ED. These devices also empower men to understand their own erectile function and how it is influenced by lifestyle changes or interventions and how it changes over time. Sustained negative changes can be a marker of poor cardiovascular health and signify to a man he needs to seek evaluation from a healthcare professional for his overall health and erectile function. Rather than relying on a subjective questionnaire for ED, the data can be shared and interpreted by a medical professional to develop an individualized treatment plan. After an intervention is implemented, additional data from the device can further guide ED management.

CONCLUSION

Although NPT and NPTR devices are outdated and of little clinical utility in the modern world, new wearable devices with advanced technologies that can provide insight into erectile function are promising. Developing easier and more effective NPT and NPTR devices that assist with counseling as well as the management and treatment of ED will be especially helpful with the increasing prevalence of ED.

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AUTHOR CONTRIBUTIONS

Both authors were involved in all aspects of this publication, including designing the work that led to the submission, acquiring data, interpreting the results, drafting or revising the manuscript and approving the final version.

COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

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Forensic Implications of the Parasomnias

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KEYWORDS

• Parasomnia • Sexsomnia • Sleep-related violence • Sexual behavior in sleep • Paraphilias
• Paraphilic disorders • Malingering

KEY POINTS

- Sleep-related violence (SRV) and sexual behavior in sleep (SBS) can occur in various sleep disorders, including confusional arousal, non-rapid eye movement parasomnias, rapid eye movement behavior disorder, and nocturnal frontal epilepsy.
- SRV and SBS can result in injury, sexual assault, or death of bed partners or other individuals, resulting in criminal charges and request for forensic assessment.
- Forensic experts evaluating alleged SRV and SBS may be asked to clarify a defendant's diagnosis and assess his or her criminal responsibility and risk of violence.

INTRODUCTION

Parasomnias are undesirable physical events or experiences that occur at the onset of sleep, during sleep, or on arousal from sleep. Non-rapid eye movement (NREM) parasomnias are often benign, whereas rapid eye movement (REM) parasomnias are usually more aggressive because the individual reacts to distressing dream imagery. NREM and REM parasomnias, along with rare conditions such as nocturnal frontal lobe epilepsy, have been implicated in interpersonal aggression toward bed partners or others, also known as sleep-related violence (SRV). Increasingly, parasomnias are also recognized as a cause of sexual behavior in sleep (SBS). Due to adverse outcomes to bed partners and others including injury, sexual abuse, and death, individuals who engage in SRV or SBS may be charged with violating criminal statutes. In such cases, the defendant's attorney or the court may request an expert assessment to clarify an individual's diagnosis. Relevant forensic questions may include the effect of the defendant's alleged parasomnia on criminal responsibility, the risk of future SRV or SBS, and the risk of future physical and sexual violence when awake. This article reviews the available literature on SRV and SBS, identifies forensic issues relevant to the diagnosis of a parasomnia in the forensic context, and delineates additional considerations related to criminal responsibility and violence risk assessment that expert evaluators assessing alleged SRV and SBS may face.

OVERVIEW OF SLEEP-RELATED VIOLENCE AND SEXUAL BEHAVIOR IN SLEEP

SRV may occur in the context of NREM parasomnias, REM parasomnias, and nocturnal seizures and includes acts of aggression toward oneself, one's bed partner, other people, animals, and inanimate objects.[1] NREM parasomnias are often benign and include sleepwalking, confusional arousals, and night terrors but they may sometimes result in physical aggression, including striking, kicking, pulling hair, or use of a weapon. Individuals with NREM parasomnias may be unresponsive and difficult to arouse or become combative with attempts to interact with or restrain them. They typically do not remember their actions

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following the parasomnia episode.[2] Patients with REM behavior disorder (RBD), however, present with dream enactment behaviors resulting from violent or frightening dreams including kicking, punching, running, and yelling. RBD is most often encountered in older men without a history of violence and often serves as a prognostic indicator of alpha-synucleinopathies. REM parasomnias are more common in the second half of the night and individuals typically remember their dream content when awakened from the episode.[3] Finally, SRV may occur in seizure disorders, such as sleep-related epilepsy. Individuals with such conditions may exhibit brief, vigorous, or ballistic behaviors such as screaming, flipping over, or thrashing of limbs, although movements are nondirected and lack a purposeful appearance.[4]

The first epidemiologic survey of SRV, conducted in the United Kingdom, found that approximately 2.1% of a sample between the ages of 15 and 100 years reported currently engaging in SRV. Those who reported SRV were more likely to experience sleep talking, bruxism, hypnic jerks, and hypnagogic hallucinations and to have substance use and mental health problems.[5] The next epidemiologic study of SRV included nearly 20,000 subjects interviewed from 6 European countries, of whom 1.6% reported current SRV.[6] The prevalence of SRV did not differ between men and women except in the United Kingdom, where more men than women reported SRV. Subjects aged 34 years or younger had a higher prevalence of SRV. SRV varied in frequency, with more than half of respondents reporting SRV 1 night per month, a quarter reporting SRV several nights per week, and the remainder reporting SRV at an intermediate frequency. Notably, three-quarters of subjects indicated that they experienced vivid dreams at the time of the SRV, including dreams of being attacked by a person or animal or attempting to protect a loved one from harm, whereas only 10% noted no dreaming associated with SRV. Such a description suggests that REM parasomnias are more common than NREM parasomnias because most patients with NREM parasomnias do not recall associated dream imagery. Additional symptoms of parasomnias were more common in the SRV group, with 72.8% reporting at least 1 symptom compared with 34.3% in the non-SRV group. Hypnagogic hallucinations were the most reported symptom (55.0% vs 24.6%) but SRV subjects were 9 times more likely to endorse sleepwalking and sleep terrors than non-SRV subjects. Nearly one-third (31.4%) of SRV subjects indicated they had hurt themselves or someone else during SRV regardless of frequency with injuries including bruises (42.9%), nose bleeds (25.5%), fractures (21.6%), abrasions (15.7%), pulled hair (23.5%), and head contusions (13.7%).

There are various aspects of an individual's history that may support a finding of SRV. SRV due to an NREM parasomnia typically occurs during the first third or half of the sleep period during which there is a greater proportion of NREM sleep. Individuals reporting SRV are significantly more likely to have family members with SRV, sleep terrors, and sleepwalking. Mood disorders and physical illness are also significantly associated with SRV.[6] Early research suggested that factors such as psychological distress and substance abuse are more common in individuals with SRV,[5,7] whereas Ohayon and Schenk's large-scale epidemiologic survey did not find stress or tobacco, alcohol, caffeine, illicit drug, or psychotropic medication use to be significantly related to SRV.[6] Individuals with SRV tend to report difficulty initiating sleep and breathing pauses during sleep but sleep–wake schedules and sleep duration that are similar to those without SRV.

There is much less known about SBS. In 1997, Fedoroff and colleagues first described parasomnia-related sexual behavior in a case series evaluating the motivations of men who sexually assaulted sleeping victims.[8] Shapiro and colleagues later coined the term "sexsomnia,"[9] which entered the lexica of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) in 2013[10] and the *International Classification of Sleep Disorders, Third Edition* (ICSD-3) in 2014.[11] SBS includes sexual acts that one may perform during wakefulness, such as masturbation, sexual vocalizations, fondling, and anal, oral, or vaginal penetration, as well as spontaneous orgasm.[12] Schenck reports that the 2 most common causes of SBS in clinical populations are NREM parasomnias, including confusional arousals and sleepwalking, and obstructive sleep apnea.[13] He also identifies nocturnal seizures and treatment with pramipexole in Parkinson's disease and selective serotonin reuptake inhibitors (SSRIs) as potential causes. Although documented cases of SBS are relatively sparse compared to SRV, it is potentially more common than SRV. In a cross-sectional analysis of 1000 adult Norwegians, Bjorvatn and colleagues found a lifetime and current prevalence of SBS of 7.1% and 2.7%, respectively.[14] In contrast, lifetime and current prevalence of SRV causing self-injury were 4.3% and 2.7%, respectively, and lifetime and current prevalence of SRV causing injury to others were 3.85% and 0.4%, respectively.

Sexsomnia has been linked to priming factors such as alcohol and other drug use, psychotropic medication, sleep deprivation, circadian rhythm disruption, fatigue, psychological stress, and other

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Date: Thursday, June 26, 2025 3:54:00 PM
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Good Afternoon,

Attached for service in the above-referenced case is Volume 1 of the Record on Appeal, which will be filed with the Court of Appeals today, June 26, 2025, via email filing. Due to the sizes of the files, Volume 2 of the Record on Appeal will be served in a separate email.

Respectfully,

Sara McInnis
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