STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

Appeal from Berkeley County
The Honorable Kristi Lea Harrington, Circuit Court Judge
Appellate Case No. 2017-000972

In the Matter of the Care and Treatment of Craig Allen Carroll,

Appellant.

INITIAL BRIEF OF RESPONDENT

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ATTORNEYS FOR RESPONDENT

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STATEMENT OF ISSUE ON APPEAL

The circuit court properly denied Appellant's directed verdict motion because there was ample relevant evidence in the record to support sending the case to the jury.

STATEMENT OF THE CASE

The State concurs with Appellant's procedural Statement of the Case.

\STATEMENT OF FACTS

On May 13, 2014, Appellant Craig Allen Carroll was direct indicted on multiple counts of criminal sexual conduct with a minor, second degree, and one count of lewd act on a minor, arising from his sexual molestation of several minors in Berkeley County over a significant period of time. He pled guilty to one count of criminal sexual conduct with a minor on August 14, 2014, and was sentenced to seven years incarceration, suspended to three years and five years probation, with 251 days credit for time served. (State's Exhibit 1 (Sentencing Sheet & Indictment); Record on Appeal [R.], pp. _____)

Prior to Appellant's release from prison, the State commenced a civil proceeding pursuant to the South Carolina Sexually Violent Predator Act (SVPA), seeking his commitment for long term control, care and treatment as a sexually violent predator. The case was called for a jury trial on April 10, 2017, before the Honorable Kristi Lea Harrington, Circuit Court Judge.

The court appointed evaluator, Marie E. Gehle, Psy.D., was qualified as an expert in forensic psychology. She testified her evaluation of Appellant included reviewing documents related to his offenses, such as legal records regarding any criminal offenses, records from the Department of Juvenile Justice and the Department of Corrections, any prior mental health evaluation report, and a four and a half hour interview with Appellant. (Trial Transcript [TT], pp. 81-90; R., pp. _____).

Dr. Gehle testified "past behavior is one of best predictors of future behavior," and "people tend to remain fairly consistent in their behavior over time, especially in regards to their sexual behavior." She stated Appellant's sexual behavior problems began at an early age, possibly as early as five years old, and his nonsexual criminal offenses began as early as eleven years old. Appellant's offenses spanned over a decade, and his sexual offense victims ranged in age from two years old (step-sister), ten years old (step-niece), three years old (step-sister), five

years old (step-sister), eight years old (neighbor) and twenty-one year old (half-sister). The eight year old female neighbor was a stranger to Appellant, which Dr. Gehle testified increased his risk to reoffend sexually. Many of the victims reported they were asleep with the assaults began.

During their lengthy interview, Appellant told Dr. Gehle he was a pretty bad kid with a lot of behavior problems, including problems with his sexual behavior when he was younger. He also said he had violent tendencies, and he his sexual problems continued while he was in a sex offender treatment program. (TT, p. 105; R., p. ____).

Dr. Gehle talked with Appellant about his last offense involving his half-sister, who was sleeping when he attacked her, and he told Dr. Gehle "he doesn't really care if the person is engaging with him or not." He also said "he's done this before, engaged in sexual behaviors with people who were, you, know, asleep, not consenting" (TT, p. 103; R., p. ____).

Dr. Gehle diagnosed antisocial personality disorder based on his lengthy criminal history going back to childhood. According to the Diagnostic and Statistical Manual for Mental Disorders, 5th Edition (DSM-5), the criteria for antisocial personality disorder include a pervasive pattern, and disregard for, and violation of the rights of others occurring since age of fifteen. Dr. Gehle explained an individual must exhibit at least three of the following criteria to qualify for the diagnosis: 1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; 2) deceitfulness as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure; 3) impulsivity or failure to plan ahead; 4) irritability and aggressiveness as indicated by repeated physical fights or assaults; 5) reckless disregard for safety of self or others; 6) consistent irresponsibility as indicated by repeated failure to sustain consistent work behavior or honor financial obligations; and 7) lack of remorse as indicated by being indifferent to or rationalizing

having hurt, mistreated or stolen from another. In addition, the individual must be at least eighteen, there must be evidence of a conduct disorder prior to the age of fifteen, and the antisocial behavior is not exclusively during a course of schizophrenia or bipolar disorder. (TT, pp. 93-95; R., pp. _____). Appellant's long criminal history and evidence of behavior issues as a child satisfied many of the criteria to support the diagnosis. (TT, pp. 95-106; R., pp. _____).

Dr. Gehle reviewed information regarding the sex offender treatment Appellant received as a juvenile, which was intensive inpatient treatment, and found he offended sexually before, during and after the treatment. She concluded the treatment he had did not impact his behavior, and noted he has not had any further treatment since that time. Appellant told her he did not have a problem with his sexual behavior, even though he might have had problems in the past, which he attributed to drugs, but he did not need treatment now. (TT, pp. 112-113; R., pp. _____).

Dr. Gehle testified she also tried to determine if Appellant had any paraphilic disorders, which are "intense and persistent sexual interest, other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal physically mature, consenting human partners." The intense sexual arousal, urges or behaviors must occur over at least a six month period, and resulted in some problems in the person's life, such as being arrested. (TT, p. 116; R., p. _____). She ruled out pedophilia because the diagnosis requires that the offending behavior involving prepubescent victims take place after the person is sixteen years old, and the majority of Appellant's behavior with prepubescent children occurred before he was sixteen years old, so he did not qualify for a pedophilia diagnosis. (TT, p. 117; R., p. ____).

Dr. Gehle ultimately diagnosed Appellant with Other Specified Paraphilic Disorder – Biastophilia, which she defined as "sexual arousal towards engaging in sexual acts with

nonconsenting persons." (TT, pp. 117-118; R., pp. _____). She acknowledged biastophilia is not listed as a specific paraphilia in the DSM-5, but stated there are hundreds of paraphilias, and all of them can't be listed in the DSM-5, which is why the authors of the DSM-5 included Other Specified Paraphilic Disorder and Other Unspecified Paraphilic Disorder. She further testified Appellant meets the criteria for a paraphilia because he has sex months of behavior with nonconsenting individuals, which has caused problems in his life in the form of repeated arrests, incarceration, and being sent to group homes for sex offender treatment. (TT, pp. 119-121; R., pp. _____).

Dr. Gehle indicated the affect of having both biastophilia and antisocial personality disorder was to increase Appellant's risk to reoffend. She explained:

> So he has the deviant sexual interest in having sex with nonconsenting people; and then the antisocial personality disorder is violating the rights of other people, not having remorse for it, you know, lots of behavior problems.
>
> And that means that when he does this to somebody else, he can live with himself, he doesn't feel bad, he can do it again, he can justify it and explained it way (sic). Most people when they do something mean to somebody else, hurts somebody's feelings, physically hurt somebody, you feel bad about it. He's not feeling that.

(TT, pp. 121-122; R., pp. _____).

Dr. Gehle utilized the Static-99R risk assessment tool to assist in determining Appellant's risk to reoffend sexually. The tool accounts for static factors that cannot be changed, such as number of convictions, and points are assigned for each factor. The scores range from negative three to twelve, and Appellant's score was a seven, which puts him into the high risk to reoffend when compared to other sex offenders, and makes him 5.25 times more likely to reoffend when compared to the average sex offender. (TT, 122-126; R., pp. _____).

She also testified Appellant has some significant dynamic risk factors for

reoffending, which can be changed through treatment that are not accounted for by the Static-99R. She found Appellant had sexual preoccupation, a lack of history of emotionally intimate relationships with adults, lifestyles impulsiveness, poor problem-solving, risistande to rules and supervision, grievance and hostility, and negative social influences. (TT, pp. 126-128, 131; R., pp. _____).

Dr. Gehle testified to a reasonable degree of psychological certainty that Appellant has both Other Specified Paraphilic Disorder – Biastophilia, and antisocial personality disorder, which predispose him to commit acts of sexual violence if not confined for long term control, care and treatment. She further opined to a reasonable degree of psychological certainty Appellant has significant controlling his sexually deviant behavior, he is dangerous and likely to commit future sex offenses if not confined for treatment, which is to such a degree as to pose a menace to the health and safety of others. She testified he meets the statutory criteria for commitment under the SVPA. (TT, pp. 128-132; R., pp. _____).

Appellant testified, and while he said he was sorry for what he had done, he continued to deny he ever initiated sex with anyone who was asleep, minimize his conduct by blaming everything on drugs. Even though he said he completed the treatment program in the Department of Juvenile Justice, and learned about "triggers," the only trigger he would half-heartedly claim for himself was drugs. He insisted he would go to any treatment his probation officers required him to attend, and could not identify even one area for which he needed treatment. Appellant's mother and sister testified on his behalf, stating they would support him if he was released. (TT, pp. 172-199; R., pp. _____).

The jury found beyond a reasonable doubt Appellant is a sexually violent predator, and the circuit court committed him to the South Carolina Department of Mental Health for long term control, care and treatment. (TT, pp. 523-528, Order of Commitment filed July 28, 2016; R., pp. _____). This appeal followed.

ARGUMENT

The circuit court properly denied Appellant's directed verdict motion because there was ample relevant evidence in the record to support sending the case to the jury.

Appellant contends the circuit court erred in denying his motion for a directed verdict because Dr. Gehle's diagnosis of Other Specified Paraphilic Disorder - Biastophilia is unreliable because biastophilia is not in the DSM-5, and as a result, the State failed to prove a mental abnormality beyond a reasonable doubt. As a threshold matter, the reliability of a biastophilia diagnosis under the Other Specified Paraphilic Disorder umbrella in the DSM-V is not preserved for appeal. Further, Other Specified Paraphilic Disorder is expressly recognized in the DSM-5, Dr. Gehle diagnosed Appellant with both biastophilia and antisocial personality disorder, and her testimony sufficiently linked Appellant's diagnosed paraphilic and personality disorders to his risk to commit future acts of sexual violence as a basis for commitment.

A. Standard of Review

The circuit court must deny a motion for a directed verdict if the evidence yields more than one reasonable inference, or its inference is in doubt. Jones v. Builders Inv. Grp., LLC, 415 S.C. 321, 781 S.E.2d 737, 741 (Ct. App. 2015) (*citing* Strange v. S.C. Dep't of Highways & Pub. Transp., 314 S.C. 427, 445 S.E.2d 439, 440 [1994]). When ruling on a directed verdict motion, the circuit court may not weigh the evidence, but is concerned only with its existence or nonexistence, and must view the evidence in the light most favorable to the nonmoving party. State v. Larmand, 415 S.C. 23, 780 S.E.2d 892, 895 (2015). On appeal, the appellate courts must apply the same standard as the circuit court. *Id.*

B. Issue Preservation

South Carolina law requires a party to raise an issue and obtain a ruling from the trial judge to preserve an issue for appellate review. State v. Cain, 419 S.C. 24, 795 S.E.2d 846, 851

(2017); State v. Sheppard, 391 S.C. 415, 706 S.E.2d 16, 19 (2011) (same). Further, the issue must have been raised to and ruled upon by the trial court with **sufficient specificity** to bring into focus the **precise** nature of the alleged error so it can be reasonably understood by the court. State v. Daise, 421 S.C. 442, 807 S.E.2d 710, 714 (Ct. App. 2017); State v. Passmore, 363 S.C. "A party may not argue one ground at trial and an alternate ground on appeal." State v. Dunbar, 356 S.C. 138, 587 S.E.2d 691, 694 (2003); State v. Rose, ____ S.C. ____, ____ S.E.2d _____, 2018 WL 1734534 (S.C. Ct. App. 2018) (same).

At trial, Petitioner never moved to exclude or restrict Dr. Gehle's testimony regarding biastophilia on the ground it was unreliable, either before trial or during her testimony. On appeal, however, as indicated by his references to admissibility under Rules 702 and 703, SCRE, and references to the circuit court's gatekeeper function regarding admission of evidence, he essentially argues the circuit court should have ruled the diagnosis was unreliable at the directed verdict stage, given it no weight, and then granted the directed verdict motion.[1]

After Dr. Gehle testified on direct examination about the biastophilia diagnosis, and after Appellant vigorously cross-examined her regarding the diagnosis and the basis for her opinion, Appellant did not move to strike her testimony regarding biastophilia as unreliable. Rather, waiting until the directed verdict stage, Appellant merely argued the State failed to prove "[Appellant] suffers from a mental disease or defect," because "the diagnosis of biastophilia being not found in the DSM4 (sic) is indicative of the fact that it is not a recognized mental disease or defect." (TT, p. 200; R., pp. _____).

In denying the directed verdict motion, the circuit court found:

[1]Appellant chooses to ignore the antisocial personality disorder diagnosis, which was never challenged and provided another basis for Dr. Gehle's ultimate opinion.

> The State has introduced a certified copy of the defendant respondent's prior conviction for a criminal sexual conduct with a minor in the second degree, admitted it without objection. Dr. Gehle testified that - - testified that she had reviewed this conviction in creating her report. The mental abnormality that can cause someone to commit acts of sexual violence or disorders over a period of at least six months and result in a problem - - sorry, indicated that she diagnosed]Appellant] with Other Specified Paraphilic Disorders (sic), biastophilia.
>
> Based upon the tests administered to [Appellant], his score of seven indicated that he is at a high risk to reoffend, and out of those who scored a seven, 27.2 percent re-offended within five years based upon the research examined by Dr. Gehle. [Appellant], according to the testimony, is 5.25.times more likely to re-offend compared to the average sex offender. She also found that [Appellant] has dynamic risk factors.
>
> To a reasonable degree of psychological certainty, Dr. Gehle is of the opinion that [Appellant] suffers from both a mental abnormality, Other Specified Paraphilic Disorders (sic), and personality disorder, and testified that she is of the opinion that these predispose [Appellant] to commit acts of sexual violence if he is not civilly committed.
>
> She is also of the opinion that he's dangerous and likely to re-offend to such a degree that it causes a menace to society and that he has significant difficulty controlling his behavior.

(TT, pp. 202-203; R., pp. _____). Thus, it is clear the circuit court viewed the directed verdict motion as a challenge to the sufficiency of the evidence, not the reliability of the diagnosis. Therefore, the issue of whether the biastophilia diagnosis was admissible because it was unreliable is not preserved for appellate review.

C. Other Specified Paraphilic Disorder/Biastophilia

Appellant's argument regarding the validity of Dr. Gehle's biastophilia diagnosis blatantly ignores the DSM-5 discussion of Other Specified Paraphilic Disorder, which explains its purpose and the circumstances under which a clinician could use the diagnosis. Recognizing the complexity of mental health disorders cannot be reduced to simple summaries of symptoms covering every situation practitioners face, the DSM-5 authors provided two categories designed to "enhance diagnostic specificity."

To enhance diagnostic specificity, DSM-5 replaces the previous NOS [not otherwise specified] designation with two options for clinical use: *other specified disorder* and *unspecified disorder*. The other specified disorder category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, for an individual with clinically significant depressive symptoms lasting 4 weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record "other specified depressive disorder, depressive episode with insufficient symptoms."

* * * *

The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral and physiological processes that are far more complex than can be described in these brief summaries. Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course.

* * * *

Although decades of scientific effort have gone into developing the diagnostic criteria sets for the disorders included in Section II, it is well recognized that this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world. As noted previously in the introduction, the range of genetic/environmental interactions over the course of human development affecting cognitive, emotional and behavioral function is virtually limitless. As a result, it is impossible to capture the full range of psychopathy in the categorical diagnostic categories that we are now using. Hence, it is also necessary to include "other specified/unspecified" disorder options for presentations that do not fit exactly into the diagnostic boundaries of disorders in each chapter.

* * * *

Following the assessment of diagnostic criteria, clinicians should consider the application of disorder subtypes and/or specifiers as appropriate. Severity and course specifiers should be applied to denote the individual's current presentation, but only when the full criteria are met. When full criteria are not met, clinicians should consider whether the symptom presentation meets criteria for an "other specified" or "unspecified" designation.

DSM-5, pp. 15-16, 19, 21 (emphasis in original).

In the DSM-5's paraphilic disorder section, Other Specified Paraphilic Disorder (302.89) is defined as "presentations in which **symptoms characteristic of a paraphilic disorder** that **cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate** but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class." DSM-5, p. 705 (emphasis added). "The Other Specified Paraphilic Disorder diagnosis is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder," which is done by recording Other Specified Paraphilic Disorder followed by the specific reason (e.g., "zoophilia")." *Id.*

The DSM-V expressly states the Other Specified Paraphilic Disorders examples listed therein are **not** exhaustive. *Id.* Some paraphilias not specifically included in the DSM-5 list, but that can properly be included under the Other Specified Paraphilic Disorder umbrella, are biastophilia, erotic asphyxiation, olfactophilia, emetophilia, kleptophilia, mysophilia, partialism, piquerism and somnophilia.

The very inclusion of Other Specified Paraphilia Disorder in DSM–5, which has been universally accepted as the standard diagnostic handbook used by mental health professionals for more than sixty years, indicates its general acceptance as a valid diagnosis by the mental health community. State v. Daryl W., 19 N.Y.S.3d 396, 398 (N.Y. Sup. Ct. 2015) (*citing* McGee v. Bartow, 593 F.3d 556 (7th Cir.2010) (Manual highly influential and useful tool); Fuller v. J.P Morgan Chase, 423 F.3d 104 (2d Cir.2005) (finding fourth edition to be "objective authority" on mental disorders; U.S. v. Johnson, 979 F.2d 396 (6th Cir.1992) [taking judicial notice of

Manual); In re Sawyer, 14 Misc.3d 718, 829 N.Y.S.2d 865 (Sup.Ct. Oneida Co. 2006)(recognizing diagnosis from Manual as authoritative).

"'DSM diagnoses are generally admissible in court because they are considered by the field of psychiatry to be widely recognized and clinically valid.'" State v. Harris, 48 Misc. 3d 950, 12 N.Y.S.3d 762, 770 (N.Y. Sup. Ct. 2015) (*quoting* Michael B. First, M.D., DSM–5 and Paraphilic Disorders, J. Am. Acad. Psychiatry Law 42; 191–201 [2014]). The mere fact a diagnosis is the subject of debate does not warrant the conclusion that it is not generally accepted; rather, all that is required is the general consensus of acceptance, and even if some experts dispute its legitimacy, the decision to include the diagnosis in the DSM-5 clearly indicates its general acceptance. *Id.* at 769–72. General acceptance does not require that a majority of professions involved in the field subscribe to the conclusion, only that those espousing the theory or opinion have followed generally accepted scientific principles and methodology in evaluating clinical data to reach their conclusions. Daryl W., 19 N.Y.S.3d at 398.

In State v. Shannon S., 20 N.Y.3d 99, 956 N.Y.S.2d 462, 980 N.E.2d 510 (2012), the State's expert psychologist diagnosed the respondent with paraphilia NOS and hebephilia (sexual attraction to pubescent girls below the age of consent).[2] The Court of Appeals acknowledged at the outset that "certain diagnoses may, of course, be premised on such scant or untested evidence and be so devoid of content, or so near-universal in their rejection by mental health professionals, as to be violative of constitutional due process and preclude their meaningful use

[2]Hebephilia is another paraphilia not included in the DSM-5, and hotly contested in the mental health community, but the court concluded it was sufficient to support sexually violent predator commitment.

in civil confinement proceedings." *Id.* at 514 (internal citations omitted). The Court then expressly excluded paraphilia NOS from that category of suspect diagnoses stating:

> Paraphilia NOS, however, has been found to be a viable predicate mental disorder or defect that comports with minimal due process. Furthermore, **any issue pertaining to the reliability of paraphilia NOS as a predicate condition for a finding of mental abnormality has been viewed as a factor relevant to the weight to be attributed to the diagnosis, an issue properly reserved for resolution by the factfinder. Any professional debate over the validity and reliability of paraphilia NOS is subject to the adversarial process which, by vigorous cross-examination, would expose the strengths and weaknesses of the professional medical opinions offered in reaching a considered legal determination as to whether respondent suffers a mental abnormality, as defined by statute.**

Id. (internal citations omitted) (emphasis added). "[A] mental abnormality "'need not necessarily be one so identified in the DSM in order to meet the statutory requirement.'" *Id.* (citing United States v. Carta, 592 F.3d 34, 40 [1st Cir. 2010]).

In this case, Dr. Gehle testified "a paraphilia is really any sexual interest that is outside the norm," but a paraphilic disorder requires "that intense sexual arousal, urges or behaviors that occur over a period of at least six months, and that have resulted in some sort of problem in the person's life." (TT, p. 116, 119; R., pp. _____). She then defined the paraphilic disorder of biastophilia as "sexual arousal towards engaging in sexual acts with nonconsenting persons," and "[h]aving sex with a nonconsenting person is abnormal." (TT, pp. 117, 119, 151; R., pp. ____).

Contrary to Appellant's insistence that biastophilia cannot be uniformly defined, Dr. Gehle's definition of biastophilia appears to be fairly well known and accepted. "Biastophilia and its Latin language-derived counterpart raptophilia, also paraphilic rape, is a paraphilia in which sexual arousal is dependent on, or is responsive to, the act of assaulting an unconsenting person." Wikipedia, (en.wikipedia.org/wiki/Biastophilia) (viewed May 16, 2018); *see also*

Urban Dictionary, (https://www.urbandictionary.com/define.php?term=biastophilia) (same); The Free Dictionary, (https://encyclopedia.thefreedictionary.com/Biastophilia) (same).

A biastophilia diagnosis was recently acknowledged in the South Carolina SVPA case of In the Matter of the Treatment and Care of Jeffrey Allen Chapman, 419 S.C. 172, 796 S.E.2d 843 (2017). "According to Dr. Gehle, biastophilia occurs "'when a person experiences recurrent, intense, sexually arousing fantasies, urges or behaviors involving corrosive sexual acts with non-consenting persons over a period of at least six months.'" *Id.* at 845. Significantly, while the validity of the bastophilia diagnosis was not an issue in Chapman, Dr. Gehle defined biastophilia the same way she did in this case.

Taken to its logical conclusion, Appellant's argument that biastophilia is not a valid mental abnormality for SVPA purposes will effective preclude the use of **any** paraphilic disorder not specially listed by name in the DSM-5 in **any** type of legal proceeding, regardless of validity, essentially removing the Other Specified and Other Unspecified classifications from the DSM-5 for legal purposes.[3] Since the DSM-5 is the leading authoritative resource for diagnosing mental abnormalities, determining the admissibility or reliability of diagnoses and classifications included in it, without regard to the Other Specified and Other Unspecified classifications, and the discussions about why they were included, and when to use them, significantly reduces the DSM-5's value as an authoritative source because many legitimate paraphilias and personality disorders will have to be ignored and remain untreated.

[3]This case presents a stark example of the horrendous impact such a conclusion would have. Under Appellant's theory, the State would have no possible way to prevent the release of a person who has repeatedly exhibited sexually deviant behavior, offended against multiple victims, and has had little (or ineffective) sex offender treatment, such as Appellant. This would completely undermine the intent and purpose of the SVPA.

Assuming for argument purposes that some experts question the viability of a biastophilia diagnosis, and two experts looking at the same information can always disagree on a result, that alone does not mandate exclusion of the diagnosis.[4] The biastophilia diagnosis is generally accepted by a consensus of the mental health community. As such it is a legitimate mental abnormality for SVPA purposes, and the jury can weigh the evidence presented on the diagnosis, including the cross-examination, and determine if the expert presenting it was credible and reliable, or completely discount her testimony.

At the directed verdict stage of this trial, the circuit court could only determine there was evidence, when viewed in the light most favorable to the State, from which the jury could find Appellant was a sexually violent predator.[5] Dr. Gehle's testimony, including her evaluation methodology, the basis for her diagnoses of biastophilia and antisocial personality disorder, and her reasons for concluding Appellant needed to be confined for long term control, care and treatment, were more than sufficient to support the circuit court's ruling on the directed verdict motion. Therefore, the court's ruling should be affirmed.

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[4] Appellant was free to subpoena any expert who believes the diagnosis is invalid to testify to that effect.

[5] In order to direct a verdict in the case, the circuit could would be required to weigh the unchallenged evidence already in the record, which is inappropriate at the directed verdict stage.

CONCLUSION

Based on the foregoing, the State respectfully submits Appellant's commitment as a sexually violent predator should be affirmed.

Respectfully submitted,

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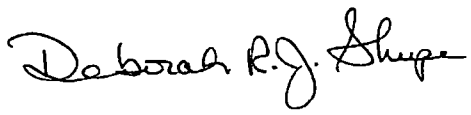

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ATTORNEYS FOR RESPONDENT

May 16, 2018

STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

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In the Matter of the Care and Treatment of Craig Allen Carroll,

Appellant.

PROOF OF SERVICE

I, Sally Ellison, certify I served the Initial Brief of Respondent and Designation of Matter on Appellant by depositing copies in the United States mail, postage prepaid, addressed to:

Taylor D. Gilliam
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I further certify all parties required by Rule to be served have been served.

This 16th day of May, 2018.

Sally Ellison

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ALAN WILSON
ATTORNEY GENERAL

May 16, 2018

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RE: In the Matter of the Care and Treatment of Craig Allen Carroll
Appellate Case No. 2017-000972

Dear Mr. Gilliam:

Enclosed are two copies of the Initial Brief of Respondent and Designation of Matter, with proof of service, in the above-referenced case. If you have any questions, please do not hesitate to contact me.

Sincerely,

Deborah R.J. Shupe

Deborah R.J. Shupe
Senior Assistant Deputy Attorney General

Enclosures

cc: Honorable Jenny A. Kitchings (original and one enclosed)
Victim Services