

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM AIKEN COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

Case No. 2013-CP-02-01005

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SC Court of Appeals

In the Matter of the Care and Treatment of:

Richard D. Ridley Appellant

RECORD ON APPEAL

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1 State of South Carolina) In the Court
2 County of Aiken) Of Common Pleas

3
4 Docket No: 2013CP0201005

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6 In The Matter Of The,)
7 Care And Treatment of)

8) Transcript of Record
9) Volume I

10 Richard Ridley,)
Petitioner.)

11
12 February 26-27, 2018
13 Aiken, South Carolina

14
15 B E F O R E:

16 The Honorable Doyet A. Early III, Judge and a jury.
17

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19 Christopher A. Morrow, Assistant Attorney General
20 Attorney for the State

21 A. Bea Hightower, Esquire
22 Attorney for the Defendant

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24 Brenda J. Sigwald, Circuit Court Reporter
25 To The Honorable Doyet A. Early III
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JURY VOIR DIRE

THE COURT: All right. Ladies and gentlemen, what we're going to do now is draw the jury in the case of, or it's entitled: In the matter of the Care and Treatment of Richard E. Ridley, R-I-D-L-E-Y. Mr. Ridley is seated in court with us today, right with his counsel by his side.

This case is being brought pursuant to what we -- the legislature has enacted a statute or a series of laws that's entitled sexual violent predator cases. In this case, you will be asked to decide whether or not the State is able to prove to you beyond a reasonable doubt that Mr. Ridley, basically, is in need of treatment under this particular program. And to do so, they have to prove that he has a mental abnormality and that because of that abnormality that he is likely to recommit certain offenses in the future.

This is a program that's been in -- in course for a number of years, but basically someone such as Mr. Ridley, he's currently incarcerated and he is close to his release date or perhaps passed the release date.

Passed?

MS. HIGHTOWER: Your Honor, it's passed, Your Honor.

THE COURT: His release date is passed and this statute is a law enacted by the legislature that if certain

1 requirements under the act is met, then Mr. Ridley can
2 remain committed, notwithstanding the fact that his time is
3 up, where he would normally be released because of certain
4 offenses he has committed in the past. I'll explain all of
5 that in much more detail as we go along, but that's what
6 this case is about.

7 And here today is Mr. Morrow representing the
8 attorney general's office, he'll be prosecuting the case.
9 He will bring to the trial of the case a position through
10 all the testimony. Likewise, Mr. Ridley will have a
11 position to testify and he probably will testify himself.
12 And then I'll explain the charge and the law in the case
13 and then you'll have to make a decision, notwithstanding
14 that this is a civil matter, the State has the burden to
15 prove their responsibility or their burden of proof is
16 beyond a reasonable doubt. So we'll go over all that as we
17 move along.

18 But let me ask you some questions to start off with
19 that we have to answer to make sure that everyone is
20 qualified to serve. I remind you that you're still under
21 oath.

22 My first question is: Do I have any member of the
23 jury panel who is related by blood or marriage or do you
24 now or have you in the past had a close personal or social
25 relationship with Mr. Richard D. Ridley, who is seated at

1 the counsel table? If so, please stand.

2 (No one stood.)

3 THE COURT: I am told that the following people
4 will be witnesses in the trial of the case, including
5 Mr. Ridley, Dr. Selman Watson who is a sikh /KOLGS in
6 Columbia.

7 Dr. Watson are you in the courtroom?

8 (Dr. Watson stood and faced the jury.)

9 THE COURT: Good morning, thank you.

10 And of course, Mr. Ridley.

11 And Mr. Morrow your doctor's name is?

12 MR. MORROW: He's Dr. Gordon Brown, Your Honor,
13 with the department of mental health.

14 THE COURT: Gordon Brown. There's Dr. Brown.

15 Good morning, sir. How are you? You may be
16 seated.

17 Those are our three main witnesses in the trial of
18 the case. So let me ask you the same question: Any member
19 -- does any member of the jury panel have a close personal
20 or social relationship or are you now or have you in the
21 past been related by blood or marriage to any of the three
22 potential witnesses in the trial of the case? If so,
23 please stand.

24 (No one stood.)

25 THE COURT: As I told you earlier, the State a

1 represented by Mr. Cam Morrow, who is a lawyer at the
2 attorney general's office, recent new father of twin
3 children, who were less than -- right at 2 pounds when they
4 were born, stayed in the NIC unit for a long time and now
5 are home and Mr. Morrow tells me he's not getting a lot of
6 sleep.

7 And Mr. Ridley is represented by Ms. Bea Hightower
8 of the Columbia bar. She practices in Columbia. You're
9 very fortunate, you have two excellent lawyers who are very
10 dedicated to their profession. I've had both of them
11 before me on previous occasions and they do, they're very
12 well prepared and do excellent work, so we're very
13 fortunate to have two outstanding lawyers today.

14 My question to you is this: Do I have any member
15 of the jury panel now or in the past have had legal
16 services performed for you or your family by either
17 lawyers? If so, please stand.

18 (No one stood.)

19 THE COURT: Do I have any member of the jury panel
20 who's related by blood or marriage now or in the past or do
21 you now or have you in the past had a close personal or
22 social relationship with either of the lawyers? If so,
23 please stand.

24 (No one stood.)

25 THE COURT: Ladies and gentlemen, let me just sort

1 of explain a little bit about the procedure as we try cases
2 around the state or as I try cases or any cases that will
3 be tried. I've been practicing law -- I did practice law
4 for 30 years. I've been on the bench now 14 years, so that
5 little white lie I told you this morning about being under
6 65, obviously is not true. I turned 70 in January. But
7 I've enjoyed my legal career and I think, I know, I'm
8 confident that we have the best legal system in the world.
9 And when we have situations such as this, we call upon
10 citizens from the community to decide whether the State's
11 able to prove their case to you beyond a reasonable doubt.

12 And we do that through a trial. We're going to do
13 that with twelve jurors. So we'll hear testimony and then
14 you will hear me charge you the law and then you apply that
15 law to the facts and you'll be in a position to render a
16 verdict.

17 So in all cases that we try, whether it's over here
18 in a civil matter, across the hall with Judge Keesley in a
19 criminal matter, we have two judges that participate in all
20 the trials. When I was elected by the legislature, my
21 position makes me the judge of the law in the case. So I
22 will instruct and tell you what the law is dealing with
23 this particular statutory scheme called sexually violent
24 predator. And you are sworn to accept the law as I give it
25 to you.

1 My other responsibility is to rule on the
2 admissibility of evidence. I have to make sure that the
3 lawyers ask their questions and present their evidence
4 pursuant to our rules of civil procedure and our rules of
5 evidence. And once they do that, the testimony comes into
6 the trial of the case. So my job is relatively easy.

7 The second judge that we have in all of these
8 cases, that judge has a tough, tough task because that
9 judge is the judge of the facts. And that judge is twelve
10 jurors collectively acting as one. And you have to
11 determine the credibility or the believability of the
12 witnesses who testify in the case and determine what the
13 true facts are in the trial. And once you determine what
14 those true facts are, you apply it to the law as I give it
15 to you and make a determination as to whether or not the
16 State in this particular case has met its burden of proving
17 to you that the -- Mr. Ridley, should be confined or
18 committed civilly for further treatment under the program;
19 or whether they have not met their burden of proof.

20 So you are the judges of the facts and that's the
21 toughest part of the case.

22 Now, having said that my question is this: Do I
23 have any member of the jury panel who the unable to perform
24 that civic duty of serving as a judge of the facts;
25 listening to the testimony and determining what testimony

1 convinces you of its truth and applying those true facts to
2 the law as I give it to you. And determining whether or
3 not the State has reached its burden of proof. That can be
4 any personal beliefs, religious believes, political
5 beliefs, any kind of beliefs, but I need to know now
6 whether you can perform that duty. If you can't, I need to
7 know now.

8 And in this case, obviously, from the title of the
9 case, they're are some allegations and there will be some
10 testimony that previous criminal acts involved sexual
11 activity or violation of the sexual laws. So I need to
12 know, is there anybody that cannot, in the situations in
13 this case, cannot perform your duties and be a juror, you
14 can't be impartial both to the State and to Mr. Ridley? I
15 need to know now. Please stand.

16 If you need to discuss anything with me in private,
17 I'll be more than happy to listen to you.

18 (No one stood.)

19 THE COURT: Do I have any member of the jury panel
20 who you or your immediate family has been a victim of a
21 violent crime in the past? Whether it be a burglary or,
22 God forbid a murder, or some type of sexual assault, some
23 type of home invasion, some type of domestic violence.
24 Please stand. And if you would like to, you can discuss it
25 with me in private, I'd be glad to, but my question is

1 simply this: The fact that you or some member of your
2 family has been involved in a -- as a victim in a criminal
3 matter, I want to know, be able to know if that experience
4 would preclude or keep you from being a fair and impartial
5 juror in the case. And I will start on my far left, your
6 right.

7 Ma'am, your name and number?

8 THE JUROR: Juror Number 100 Krystal Lucas, and I
9 don't think --

10 THE COURT: Well, how about walk up here and talk
11 to me in private, please.

12 THE JUROR: Right now?

13 THE COURT: Yes, ma'am, come right up and stand
14 right there.

15 (Bench conference with the juror:)

16 THE COURT: Good morning.

17 THE JUROR: Good morning.

18 THE COURT: Name and number, please.

19 THE JUROR: Krystal Lucas, Number 100.

20 THE COURT: Tell me --

21 THE JUROR: My stepsister -- my mother was married
22 to a man a couple of years ago that my stepsister, she was
23 raped and almost killed.

24 THE COURT: Okay. And because of that situation,
25 you don't think you could serve in this particular case

1 with sexual matters.

2 THE JUROR: Yes, sir.

3 THE COURT: I understand. 100. Just go back and
4 have a seat.

5 She's excused.

6 Next, please? Yes, ma'am?

7 Good morning, how are you?

8 THE JUROR: I'm good.

9 THE COURT: You're name and number.

10 THE JUROR: 140 Tina Rhineholt.

11 THE COURT: 140. Tell me what's going on.

12 THE JUROR: Well, we had a robbery at our house,
13 but I also have been sexually assaulted many years ago.

14 THE COURT: Yes, ma'am.

15 THE JUROR: By a military person. My husband was
16 in the service.

17 THE COURT: And the fact that that happened many
18 years ago and the fact that you had your home broken into,
19 would that keep you from being fair and impartial, or could
20 you set that aside and decide this case based solely on the
21 evidence?

22 THE JUROR: I don't know if I can.

23 THE COURT: Huh?

24 THE JUROR: I don't know if I can.

25 THE COURT: It's okay. You don't think you can.

1 THE JUROR: I don't think I can.

2 THE COURT: I understand. Just go back and have a
3 seat.

4 Come on up, sir, please.

5 Good morning sir.

6 THE JUROR: Carl Morgan.

7 THE COURT: What number?

8 THE JUROR: 119.

9 (There was a bench conference out of the hearing of
10 the court reporter.)

11 THE COURT: Would you be able to set that aside and
12 be able to decide this case based on the facts in the case
13 or is that too traumatic to sit on this.

14 THE JUROR: Well --

15 THE COURT: I think I know the answer.

16 THE JUROR: I just don't know --

17 THE COURT: I understand. That's fair. All right.
18 I'm going to excuse him.

19 Thank you.

20 Good morning, sir.

21 THE JUROR: I have a little trouble hearing you.
22 Did you say violent crime or sexual crimes?

23 THE COURT: Either or.

24 THE JUROR: My father shot me when I was 18.

25 THE COURT: And the fact that you had to undergo

1 that unpleasant experience, would you be able to serve as a
2 juror --

3 THE JUROR: Oh, yeah.

4 THE COURT: You could? Put that aside and serve.

5 THE JUROR: I mean, people ask me, how can you talk
6 about it, but --

7 THE COURT: But it is what it is.

8 THE JUROR: That's right. I wouldn't have met my
9 wife and kids, I'd been somewhere else.

10 THE COURT: Yes, sir. Good to have you with us.
11 Thank you.

12 Your name and number again?

13 THE JUROR: Mark Adams, Juror Number 2.

14 THE COURT: Thank you, Mr. Adams.

15 Good morning, good morning.

16 THE JUROR: I'm Juror Number 84.

17 THE COURT: Yes, ma'am.

18 THE JUROR: And I have two grandsons who went to
19 jail for -- one for armed robbery and the other for
20 assaulting someone.

21 THE COURT: And the fact that you have family
22 members that are incarcerated now, are they still in jail?

23 THE JUROR: One of them is out.

24 THE COURT: One's out, one's in.

25 THE JUROR: And when they did the armed robbery, he

1 still in?

2 THE COURT: But the other one's out.

3 THE JUROR: The other one's out.

4 THE COURT: And the fact that you've had that
5 situation in your household, would that keep you from being
6 able to serve as a juror in this case, being able to listen
7 to the evidence and not be influenced by your personal
8 situation? Can you do that?

9 THE JUROR: I don't think so.

10 THE COURT: What number?

11 THE CLERK: She's 84.

12 THE COURT: Just this particular case, so have a
13 seat.

14 Good morning, how are you. Your name and number,
15 please.

16 THE JUROR: Carly Brian, 23.

17 THE COURT: 23.

18 THE JUROR: I will be fine, I just wanted you to be
19 aware I was assaulted five years ago and my cousin had a
20 trial last month. So I think I'll be fine, I just wanted
21 to let you know.

22 THE COURT: So you would be able to set that aside
23 and be fair and impartial?

24 THE JUROR: Yes, I just wanted y'all to be aware.

25 MS. HIGHTOWER: Your Honor, she said the second

1 thing that she mentioned?

2 (Bench conference out of the hearing of the court
3 reporter.)

4 THE COURT: Thank you, ma'am.

5 Good morning.

6 THE JUROR: Good morning.

7 THE COURT: How are you? Name and number? Herbert
8 Brenhardt Number 13.

9 Mr. 13, tell me what's going on.

10 THE JUROR: My wife was a victim of a shooting.
11 They were actually young and over the years, she's repeated
12 what went on as far as coming in and seeing it. And the
13 other -- the other point is my wife is an elementary school
14 teacher for 36 years. I was married to her at various
15 times when students had things going on that were abusive
16 or of sexual nature and she kind of brought that home and
17 so I just want to make you aware of that.

18 THE COURT: I do appreciate that. The fact that --

19 THE JUROR: It wouldn't bother me at all.

20 THE COURT: Wouldn't bother you at all.

21 THE JUROR: Not bother me at all, but --

22 THE COURT: It wouldn't influence your decision.

23 THE JUROR: Yes, sir.

24 THE COURT: You could decide it on the facts?

25 THE JUROR: Yes, sir.

1 THE COURT: Thank you, you may be seated.

2 (There was a bench conference out of the hearing of
3 the jury and the Court Reporter.)

4 THE COURT: Good morning.

5 THE JUROR: Michelle Floyd, Number 49. My husband
6 was a victim in a child molestation. His step father had
7 22 counts of lewd act on a minor.

8 THE COURT: And the fact that that's in your
9 family, would that -- or in your situation, would that
10 preclude or keep you from being fair and impartial?

11 THE JUROR: No.

12 THE COURT: You'd be able to serve?

13 THE JUROR: Yes, sir.

14 THE COURT: Now, I understand you've had some
15 surgery and if you need to use the bathroom, if you need to
16 be excused, raise your hand and I'll make sure that you do
17 that.

18 THE JUROR: Yes, sir.

19 MS. HIGHTOWER: Don't be --

20 THE COURT: Oh, no, let me talk to them.

21 Good morning, sir. Name and number.

22 THE JUROR: 136 Michael Prizbylowicz. Mine won't
23 cloud my judgment.

24 THE COURT: Sir?

25 THE JUROR: My reasoning won't cloud my judgment on

1 this.

2 THE COURT: Your reasoning? What you mean by that?

3 THE JUROR: What you called us up here for.

4 THE COURT: What was it?

5 THE JUROR: My wife, she was raped several times.

6 THE COURT: And that will not preclude you from
7 being fair and impartial?

8 THE JUROR: No, sir, it will not.

9 THE COURT: Thank you, be seated.

10 All right. Last but not least.

11 Good morning, sir.

12 THE JUROR: How you doing sir?

13 THE COURT: I'm doing well, how are you.

14 THE JUROR: My wife --

15 THE COURT: What is your name?

16 THE JUROR: Antonio Mitchell, 114.

17 THE COURT: Mr. Mitchell, the fact that your wife
18 was involved in that situation, would you be able to set
19 that aside and decide this case based solely on what you
20 hear in the courtroom?

21 THE JUROR: What you mean? Put it aside and decide
22 if I want to stay here?

23 THE COURT: No, I need to know, notwithstanding
24 that you've had this unfortunate event in your family,
25 could you set that aside and decide this case based solely

1 on what you hear in this courtroom?

2 THE JUROR: Yeah.

3 THE COURT: Thank you. You may be seated.

4 That leaves us with how much?

5 THE CLERK: 26.

6 (There was a bench conference out of the hearing of
7 the jury and the Court Reporter.)

8 THE COURT: Do I have any member of the jury panel
9 who you or your immediate family works for law enforcement,
10 whether it be the Aiken County Sheriff's Department, police
11 department, SLED, FBI, any law enforcement office, Aiken
12 County Solicitor's Office? If so, please stand.

13 THE JUROR: Does it have to be Aiken County?

14 THE COURT: No, sir. It can be any. You were
15 chief of police where?

16 THE JUROR: My brother is chief of police in
17 Orangeburg.

18 THE COURT: And your name again?

19 THE JUROR: My name is Mark Adams, Juror 2.

20 THE COURT: And the fact that your brother is the
21 chief of police, I know your brother, would that in any way
22 preclude you from being fair and impartial in the trial of
23 this case?

24 THE JUROR: No, sir.

25 THE COURT: Thank you.

1 Any member of the jury panel know any of the facts
2 concerning Mr. Ridley's prior criminal offenses or know
3 anything about Mr. Ridley at all? If so, please stand.

4 (No one stood.)

5 THE COURT: Ladies and gentlemen, this is sort of a
6 last catch-all question, but do -- does any member of the
7 jury panel know of any reason whatsoever why you should not
8 be selected as a juror on this case, with particular
9 emphasis being placed on your ability to be fair both to
10 the State and to Mr. Ridley? If so, please stand. Any
11 reason whatsoever.

12 All right. Any additional questions by the State?

13 MR. MORROW: Nothing from the State, Your Honor.

14 THE COURT: By Mr. Ridley.

15 MS. HIGHTOWER: No, Your Honor. Thank you.

16 THE COURT: All right. I'm going to go with --
17 what we're going to do is we select it like a civil case,
18 so give me a jury panel of twenty and one alternate, so
19 I'll need four, twenty-four.

20 Those lawyers will be given this list of random
21 selection of twenty regular and then one alternate. The
22 State has four strikes, the plaintiff has -- strike that.
23 Mr. Ridley has four strikes -- if my math is right. That's
24 right.

25 So just sit with us tight for a second. And what

1 we're going to do ladies and gentlemen of the jury, once we
2 have you selected, I've got about 45 minutes worth of
3 pretrial matters that I have to go over on the record with
4 the lawyers. I've got at one o'clock, about 45 minutes
5 worth of criminal work that I've got to do that was left
6 over from a previous week. So what I'm going to do is I'm
7 going to draw you, select you, and then let you leave and
8 come back, report back about 2:15, so you don't have to sit
9 and twiddle your thumbs while I'm doing all that.

10 Some of you may have to go back over across the way
11 if you're not selected. Mr. Harte's going to let me know
12 in just a second.

13 (Waiting for the random list to be printed for the
14 attorneys.)

15 THE COURT: Ms. Hightower, Mr. Morrow, the strike
16 sheet will have twenty-six names on it.

17 MS. HIGHTOWER: Yes, sir.

18 THE COURT: Listen carefully. You have four
19 strikes each, they will come out of the first twenty.
20 Don't go beyond 20. The first alternate will come between
21 21, 22, 23, and 24, okay?

22 MS. HIGHTOWER: Yes, sir.

23 THE COURT: Well, actually 21, 22, and 23.

24 (The attorneys were going through the jury
25 selection for striking.)

JURY SELECTION

THE CLERK: Plaintiff strikes first, alternating with the defendant, four strikes each.

THE COURT: All right. Listen to me very carefully. The number that you use to strike is the number on the far left. It's not the juror's number. It's the number to the far left, far left.

Mr. Morrow?

MR. MORROW: State strikes Juror 8.

THE CLERK: Strikes 8.

MR. MORROW: 8.

MS. HIGHTOWER: Mr. Ridley would strike Number 2, please, Your Honor.

THE COURT: You have to speak up for me.

MS. HIGHTOWER: Mr. Ridley would strike Number 2, please, Your Honor.

THE COURT: Thank you. There's a microphone down there.

THE CLERK: Defendant strikes Number 2.

THE COURT: Thank you.

Mr. Morrow?

MR. MORROW: State strikes 14.

THE CLERK: State strikes Number 14.

MS. HIGHTOWER: Defense strikes Number 5, please.

THE CLERK: Defense strikes Number 5.

1 THE COURT: Third strike, Mr. Morrow.
2 MR. MORROW: State strikes 17.
3 THE COURT: Thank you.
4 THE CLERK: Plaintiff strikes Number 17.
5 THE COURT: Ma'am?
6 MS. HIGHTOWER: Mr. Ridley would strike Number 7.
7 THE CLERK: Defense strikes Number 7.
8 THE COURT: All right. Last strike, sir?
9 MR. MORROW: 13.
10 THE CLERK: Plaintiff strikes Number 13.
11 THE COURT: Last, ma'am?
12 MS. HIGHTOWER: We'd strike Number 12, please, Your
13 Honor.
14 THE COURT: All right. One alternate between
15 numbers twenty-one, twenty-two, and twenty-three.
16 MR. MORROW: State strikes 23.
17 THE CLERK: Plaintiff strikes 23.
18 THE COURT: 23, you say?
19 MR. MORROW: That's correct.
20 THE COURT: 23.
21 Ma'am?
22 MS. HIGHTOWER: We'll strike Number 21.
23 THE CLERK: Defense strikes Number 21.
24 THE COURT: All right. The clerk will review the
25 strikes first with the State.

1 THE CLERK: Plaintiff strikes the following:
2 Number 8, Number 13, Number 14, Number 17; is that correct?

3 MR. MORROW: That's correct.

4 THE COURT: And alternate?

5 THE CLERK: And alternate, Number 23.

6 MR. MORROW: Correct.

7 THE COURT: All right.

8 THE CLERK: The defense strikes Number 2, Number 5,
9 Number 7, and Number 12?

10 MS. HIGHTOWER: That's correct, Your Honor. Thank
11 you.

12 THE CLERK: And Number 21 for alternate?

13 MS. HIGHTOWER: That's correct.

14 THE COURT: All right. Ladies and gentlemen, as
15 your name is called, please come forward. If you have
16 anything personal with you, bring it and have a seat over
17 in the jury box. The bailiff will show you where to sit.

18 THE CLERK: Juror Number 14, Herbert Benhardt;
19 Juror Number 65, Joseph Greer; Juror Number 145, Thomas
20 Rose; Juror Number 116, Steven Mitchell; Juror Number 73,
21 Donald Hicks; Juror Number 151, Therese Scott; Juror Number
22 36, Jane Danko; Juror Number 192, Coty Wilson; Juror Number
23 2, Mark Adams; Juror Number 47, Dorey Feraldi; Juror Number
24 135, Kathleen Prince; Juror Number 10, Ashley Balazovich;
25 and as the alternate, Juror Number 80, Mark Jardine.

1 THE COURT: Any motions by the State in connection
2 with the selection of the jury?

3 MR. MORROW: None from the State, Your Honor.

4 THE COURT: From Mr. Ridley?

5 MS. HIGHTOWER: No motions, Your Honor. Thank you.

6 THE COURT: All right.

7 (The remaining members of the venire were sent back
8 to the jury assembly room.)

9 THE COURT: All right. Ladies and gentlemen, as I
10 said, we're going to break until 2:15. That gives me
11 plenty of time to conclude everything. When you come back
12 we'll get started right into the trial of the case. We'll
13 probably want to go until about five. Is that okay with
14 everybody?

15 But I'll be in the better position at 2:15 to tell
16 you sort of where we're going. We might get all the
17 testimony done this afternoon and come back in the morning.
18 We'll definitely be through tomorrow, more than likely
19 early tomorrow.

20 So your wonderful bailiff will show you where to
21 go, how to get there, and everything you need to know. So
22 if you'll go with her to the jury room and then she'll show
23 you how to get back up here at 2:15. Please be on time so
24 we can get started and be efficient. Thank you all.

25 (The jury left the courtroom at 11:56 a.m.)

PRETRIAL MOTIONS

1 THE COURT: All right. Thank y'all. I know we
2 have one motion in limine, basically that we need to hear.
3 What else do we need?
4

5 MR. MORROW: Your Honor, the State just has one
6 motion in limine that it submitted on Friday as well.

7 THE COURT: Yours is pretty easy, so let's do it
8 quickly and then we'll see about the other one.

9 First one is preclude any mention of being jailed
10 for life and all that stuff that's prejudicial that's set
11 out in your motion in limine; is that correct?

12 MR. MORROW: That's correct, Your Honor.

13 The State just simply seeks to limit the defense
14 from being able to discuss being in prison or incarcerated
15 for life. The reasons set forth in our motion are pretty
16 clear. It's a treatment facility, it's been found to be
17 non communicative and managed by the South Carolina Supreme
18 Court and it's referred to in the statute several times as
19 a treatment facility or a secure facility.

20 THE COURT: Normally what we do in these cases is
21 any argument or questions, it is a civil commitment and it
22 is through the department of mental health, even though you
23 can -- I'll allow it. The treatment is provided through
24 the department of corrections or it's in one of the
25 department of corrections facilities even though it's

1 administered by the department of mental health. Just
2 don't get into he's going to be in jail for the rest of his
3 life or all that sort of stuff. It's too prejudicial.

4 MS. HIGHTOWER: Yes, sir. I was going to in my
5 opening apply or talk about the statutes themselves. I'm
6 going to limit myself in anticipation of this motion
7 thinking about referring to it being a civil commitment and
8 I guess my -- the gist here is I'm not to look towards that
9 this is somehow he's in jail or he's incarcerated
10 presently. But I certainly can talk --

11 THE COURT: Well, it's defined as a civil
12 commitment or treatment until such time as he is -- if they
13 find against him -- until such a time the treatment
14 benefits him to the point that he can be released. That's
15 sort of the general gist of it.

16 MS. HIGHTOWER: Okay. And certainly, there's no
17 problem to me referring to the fact that he's done his
18 time. He's done his 20 years, he's served his sentence.

19 THE COURT: Certainly.

20 MS. HIGHTOWER: And they civilly committed him.
21 We're talking about release now.

22 THE COURT: That's correct.

23 MS. HIGHTOWER: All right. Thank you.

24 THE COURT: Anything else?

25 MR. MORROW: No, Your Honor. I just have some

1 responses to her motion in limine.

2 THE COURT: Well, the other one is the more
3 interesting motion and that's to preclude -- motion in
4 limine excluding testimony about the diagnosis of other
5 specified paraphilic disorder nonconsent or biastophilia.
6 I hope I'm saying that right. And she has submitted a
7 memorandum with the motion saying that the use of that, at
8 least I need to do sort of a gate-keeping function to
9 determine whether or not it meets the standards as set out
10 in State v. Jones, State v. Council, and others; basically
11 that it's been peer reviewed, publication supported and
12 other matters dealing with State v. Jones. So the only way
13 I know to do it is to do a proffer.

14 MR. MORROW: Yes, Your Honor. And briefly, I have
15 one issue to address. This is an annual review trial.
16 Mr. Ridley voluntarily committed to the program and the
17 State would take the position that this was his diagnosis
18 at the time that he voluntarily committed. The State would
19 take the position that he has waived any objection to this
20 diagnosis when he voluntarily committed to the program.

21 THE COURT: What do you say to that, ma'am?

22 MS. HIGHTOWER: I certainly would disagree with
23 that type of analysis. Certainly the statute and how it's
24 set out and the procedures you have to follow in the annual
25 review, specifically, my client has the right to petition

1 under the law as to whether or not he has -- he meets the
2 definitions; whether or not -- I mean the definitions of
3 mental abnormality or other personality disorder come into
4 play. I mean, we can't just chop it apart. It's a review
5 of the entire system. And certainly, I would also say,
6 Your Honor, that this is the -- you know, this is -- the
7 science we're relying on here, sir, what we're using as the
8 basis for these involuntary commitment process, I mean
9 obviously, it's an ongoing process. I mean, the DSM-5 is
10 certainly updated. It certainly has been reviewed and
11 looked at. There's as --

12 THE COURT: Please limit your argument to -- he has
13 waived that.

14 MS. HIGHTOWER: But my point is that, that
15 certainly it's ongoing and he couldn't waive something
16 that's going to change in the future, Your Honor. For a
17 full and total fair review of it. And the jury, I'm
18 prepared to argue, certainly, that the definitions, he no
19 longer meets those definitions, which the statute,
20 clearly --

21 THE COURT: Well, the statute clearly says the
22 State has to prove beyond a reasonable doubt, Number 1,
23 that he's been convicted of a sexually violent offense and
24 I don't think there will be any problem with that. I mean
25 that's almost stipulated to that. Obviously, the State

1 doesn't want to stipulate to it, they want to be able to
2 put in the facts surrounding it.

3 So then the second hurdle that they have to prove
4 beyond a reasonable doubt is that, in fact, Mr. Ridley does
5 now suffer from a mental abnormality or personality
6 disorder that makes him likely to engage in sexual violent
7 acts in the future. I think that's a -- an element of the
8 offense to which he must prove to the jury beyond a
9 reasonable doubt and if you intend to do it with diagnoses
10 such as specified paraphilic disorder or nonconsent or
11 biastophilia. She's moving to exclude any -- and comply
12 with State v. Jones and I will allow her to -- allow you to
13 proffer certain testimony if you would like to convince me
14 that as the gatekeeper, I will allow it in under State v.
15 Jones, State v. Council et al.

16 MR. MORROW: Yes, Your Honor. I do also have one
17 other matter, Your Honor. There is a -- an unpublished
18 opinion by South Carolina Court of Appeals that is State
19 versus Snow; in that opinion, Your Honor, the --

20 THE COURT: Well, you know what they say about
21 unpublished opinion, we're not to give it any precedential
22 value.

23 MR. MORROW: I'll concede --

24 THE COURT: Isn't that correct? Isn't that what
25 the rules say?

1 MR. MORROW: That's correct, Your Honor, I'll go
2 ahead and proffer the doctor's testimony.

3 THE COURT: Thank you.

4 MR. MORROW: State would call Dr. Gordon Brown to
5 the stand.

6 THE COURT: Dr. Brown, if you would come around,
7 please.

8 All right. I have to leave here at 12:20, so we
9 may have to conclude this later today.

10 DR. GORDON BROWN,
11 after having been duly sworn, testified as follows:

12 THE CLERK: Please take a seat in the witness box
13 and state your full name for the Court.

14 THE COURT: Well, Mr. Morrow, let me just ask you
15 this: And Ms. Hightower. I need to leave at 12:20 and be
16 back at one. Would y'all rather go ahead and take lunch
17 and get a bite to eat and we'll start back at one or would
18 you rather piecemeal it and -- might be the better way to
19 just break until one and then a little after one, I'll do
20 any criminal stuff -- I won't hold this up to do the
21 criminal stuff, I'll do it later this afternoon.

22 MS. HIGHTOWER: I would prefer to wait and start
23 everything at the same time, Your Honor.

24 MR. MORROW: That's fine with me, Your Honor.

25 THE COURT: All right. That will give you a chance

1 to get a bite to eat.

2 All right. We'll start back at a little after one.
3 I'm going to try to be back at one so maybe by 1 -- how
4 long do you think it will take to proffer. It won't be
5 that long will it?

6 MR. MORROW: No, Your Honor. Probably 20, 30
7 minutes, maybe a little shorter than that.

8 THE COURT: Well, for the purpose of the proffer, I
9 think we can stipulate his qualifications and then
10 obviously, when the jury comes in you'll want to qualify
11 him before the jury, but just for the proffer, let's get
12 straight to the heart of the matter. We'll go through all
13 the qualifications later.

14 MR. MORROW: Thank you Your Honor.

15 THE COURT: Fair enough?

16 MR. MORROW: Fair enough.

17 MS. HIGHTOWER: Thank you.

18 THE COURT: And here's what I intend to do, so
19 everybody's on the same page, when we get back and start at
20 2:15, obviously, I'll make a short opening statement to the
21 jury. Y'all can make your opening statements. I'd like to
22 get these two doctors completed today if at all possible.

23 MS. HIGHTOWER: Yes, sir.

24 THE COURT: I don't know if you want to put
25 Mr. Ridley up before your doctor or --

1 MS. HIGHTOWER: No, Your Honor, that is absolutely
2 fine. I can do the doctor first and then we can finish in
3 the morning with Mr. Ridley and close. That makes sense.

4 THE COURT: All right. Thank you everybody for
5 your patience this morning in trying to -- the beginning of
6 every week of court is always kind of like herding cats,
7 particularly running two courtrooms. We were that close to
8 not having enough jurors to keep us both moving. They're
9 trying a burglary case next door and they get 15 strikes on
10 that one, ten on the defense and five on the State, so we
11 were kind of short on the panel anyway this morning.

12 So any way, I think we moved rather efficiently and
13 we'll get started back up here in just a few minutes and
14 get this proffer out of the way and move forward.

15 MS. HIGHTOWER: Yes, sir.

16 THE COURT: Mr. Ridley, they -- where's the SCDC?
17 Whose got you?

18 THE OFFICER: Right here.

19 THE COURT: Make sure he gets a little bite to eat.
20 How you doing, ma'am? I didn't see you there.

21 Y'all be sure y'all get something to eat. I don't
22 have to worry about y'all, I don't think.

23 THE OFFICER: Thank you, Your Honor.

24 THE COURT: Mr. Ridley, I haven't seen you in a
25 while. You been doing okay.

1 THE DEFENDANT: Yes, sir.

2 THE COURT: Still studying all your law and
3 everything.

4 THE DEFENDANT: Studying everything.

5 THE COURT: Remember what I told you last time.

6 THE DEFENDANT: Yes, sir. Thank you, sir.

7 (A recess for lunch was observed.)

8 THE COURT: Mr. Morrow, you ready?

9 MR. MORROW: Yes, sir.

10 THE COURT: Ms. Hightower, you ready?

11 MS. HIGHTOWER: Yes, sir.

12 MR. MORROW: Your Honor, Dr. Brown ran to the
13 restroom.

14 (There was a pause in the proceedings.)

15 THE COURT: All right. If he'll come around and
16 take the stand, please. We'll get the clerk to swear you
17 in.

18 DR. GORDON BROWN,

19 having been duly sworn, testified as follows:

20 THE CLERK: Please take a seat in the witness box
21 and state your full name.

22 THE WITNESS: My name is Gordon Edward Brown Jr.,
23 B-R-O-W-N.

24 THE COURT: Dr. Brown, you okay?

25 THE WITNESS: Sir?

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 THE COURT: You okay?

2 THE WITNESS: Yes, sir.

3 THE COURT: Please accept my apologies and thank
4 you for being patient.

5 THE WITNESS: No problem.

6 MR. MORROW: The purpose of this proffer, Your
7 Honor, I believe we're going to dispense with his
8 qualifications and stipulate to his qualifications.

9 THE COURT: We are. It's just a proffer and
10 obviously, when the jury comes in, you'll be able to
11 qualify him in front of the jury.

12 Dr. Brown's appeared many times in these
13 proceedings.

14 **DIRECT EXAMINATION - IN CAMERA**

15 BY MR. MORROW:

16 Q Dr. Brown, did you evaluate Richard Ridley in
17 connection with this case?

18 A I did.

19 Q And what methodology did you use to conduct your
20 evaluation?

21 A Essentially it's a series of clinical interviews
22 over the years as well as a complete review of the records,
23 both prior to his commitment and treatment records from the
24 treatment program.

25 Q And what source of information do you use?

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 A I'm sorry?

2 Q What sources of information did you use --

3 A We use --

4 Q -- as a part of your evaluation?

5 A -- the legal documents from the initial commitment,
6 previous evaluation reports, treatment records from both
7 department of mental health and Correct Care.

8 Q And those are part of the basis of your expert
9 opinion?

10 A That's correct.

11 Q And at the time --

12 THE COURT: All right. Hold on a second.

13 Treatment records, legal documents, and there was one other
14 thing.

15 THE WITNESS: Interview; and previous evaluations.

16 THE COURT: Previous evaluations.

17 Who completed that? Who did the previous
18 evaluations?

19 THE WITNESS: Dr. Gehle did the pre-commitment and
20 I've done the previous interviews.

21 THE COURT: All right, sir. Go ahead.

22 BY MR. MORROW:

23 Q And are those the types of documents that are
24 typically and reasonably used by other experts in your
25 field?

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 A They are.

2 Q Are they part of the basis for your expert opinion?

3 A They are.

4 Q Okay. Dr. Brown, did you diagnose Richard Ridley
5 with a relevant mental abnormality of personality disorder
6 under the South Carolina sexual violent predator act?

7 A I did.

8 Q And what was that diagnosis?

9 A There were two diagnoses. One is antisocial
10 personality disorder with narcissistic traits.

11 THE COURT: Hold on a second, now. Anti--

12 THE WITNESS: Antisocial personality disorder --

13 THE COURT: With --

14 THE WITNESS: -- with narcissistic traits.

15 THE COURT: And the second, please?

16 MR. MORROW: And the other diagnosis is other
17 specified paraphilic disorder, specifically biastophilia.

18 THE COURT: Spell that last part for me.

19 THE WITNESS: I'll try.

20 THE COURT: B-I-A-S-T --

21 THE DEFENDANT: T-O-P-H --

22 THE COURT: All right. All right. Now. Even
23 though we're a little informal right now, we have to
24 maintain decorum.

25 BY MR. MORROW:

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 Q Dr. Brown, what are the criteria for someone to
2 meet other specified paraphilic disorder biastophilia?

3 A That is one of the paraphilic disorders -- and if I
4 can read from the diagnose tick manual, paraphilia denotes
5 any intense and persistent sexual interest other than
6 sexual interest in genital stimulation or preparatory
7 fondling with phenotypical normal physiologically mature,
8 consenting human partners.

9 And for it to rise to the level of paraphilic
10 disorder, it has to be currently causing distress or
11 impairment to the individual or the paraphilic whose
12 satisfaction as entailed personal harm or risk of harm to
13 others.

14 Q And are you familiar with the Diagnostic and
15 Statistical Manual, Mental Disorders 5th Edition?

16 A I am.

17 Q And what is the DSM-5?

18 A It's the official publication of the American
19 Psychiatrist Association that lists all of the diagnoses
20 and their diagnostic criteria.

21 Q Is the DSM-5 peer reviewed?

22 A It is.

23 Q Was it -- has it been -- have you used the DSM in
24 prior cases involving sexually violent predator cases?

25 A I have.

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 Q Were there quality control methods used in offering
2 the DSM-5?

3 A There were.

4 Q And was it consistent with a mechanized scientific
5 laws and procedures in the mental health community?

6 A It was.

7 Q Okay. Dr. Brown, does the DSM-5, does it cover
8 other specified paraphilic disorder, biastophilia?

9 A Not by name.

10 Q Does it cover other specified paraphilic disorders?

11 A It does.

12 Q But it doesn't mention the modifier biastophilia?

13 A That's correct.

14 Q Why not?

15 A When the DSM-5 was put together, they came up with
16 the most common, most widely recognized paraphilic
17 disorders and those are listed by name. And then there are
18 two additional categories, one the other specified and the
19 other is unspecified for any kind of paraphilic disorders
20 that may be diagnosed but are not recognized as one of the
21 eight that they did list separately. It does in that
22 section give some examples, but says it's not limited to
23 those and much like with the -- with the anxiety disorders
24 and phobias -- there are a lot of phobias that would not be
25 listed specifically in the diagnostic manual, but could

Dr. Gordon Brown - Direct Examination - In Camera by Mr. Morrow

1 still be diagnosed under that category.

2 Q Okay.

3 THE COURT: Well what is biastophilia,
4 B-I-A-S-T-O-P-H-I-L-I-A? What is it?

5 THE WITNESS: That would be someone who is sexually
6 aroused by the aspect of having nonconsensual sex with
7 someone. By having sex with someone who does not give
8 consent. It's --

9 THE COURT: Now --

10 THE WITNESS: It would also be classified as rape
11 or sometimes people just use nonconsent rather than
12 biastophilia.

13 THE COURT: And that is enumerated in the DSM-5
14 under the specified paraphilic disorder?

15 THE WITNESS: It's not one of the examples they
16 give, no, sir.

17 THE COURT: It's not an example.

18 Go ahead.

19 BY MR. MORROW:

20 Q While it's not an example that was specifically
21 listed, Dr. Brown, is biastophilia a recognized modifier of
22 other specified personality disorder in your field?

23 A In my opinion it is, yes.

24 THE COURT: In your opinion is it a mental
25 abnormality or personality disorder?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 THE WITNESS: It would be a mental abnormality.

2 THE COURT: Go ahead.

3 BY MR. MORROW:

4 Q Yes. And does the definition of paraphilic
5 disorder used in the DSM-5 discuss non consent?

6 A It does.

7 Q And how does it address it?

8 A In the very definition of paraphilia, it talks
9 about intense and persistent sexual interest in something
10 other than a consenting human partner. So the idea of
11 nonconsent is included in the very definition of
12 paraphilia.

13 Q Thank you, Dr. Brown.

14 MR. MORROW: Your Honor, I believe there has been
15 no objection made to the antisocial personality disorder
16 diagnoses or challenge to that. I don't have any further
17 questions for this witness with regards to other specified
18 paraphilic disorder.

19 THE COURT: Ma'am?

20 MS. HIGHTOWER: Your Honor, if I could have a
21 moment please, just a moment?

22 (There was a pause in the proceedings.)

23 MS. HIGHTOWER: Thank you, Your Honor if it please
24 the Court.

25 CROSS-EXAMINATION - IN CAMERA

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 BY MS. HIGHTOWER:

2 Q Dr. Brown, you testified about the nonconsent and
3 there being other, other than consenting partners. Where
4 were you reading from? Is that from the definition of a
5 paraphilia itself or what exactly were you referring to? I
6 didn't follow it.

7 A That's correct. That's from the definition of
8 paraphilia. On page 685 of the DSM.

9 Q 685 in the DSM?

10 A Correct. The paragraph that begins, The term
11 paraphilia.

12 Q So in the general description of a paraphilic
13 disorder in the DSM-5, it's talking about nonconsent --
14 where does it say biastophilia?

15 A It doesn't have that term.

16 Q Where does it say it's not otherwise specified
17 nonconsent?

18 A Again it doesn't have that -- that phrase in the
19 DSM-5.

20 Q In the DSM-4 and the DSM-3 or in other ones, there
21 have been -- there have been discussions about, again, the
22 other specified paraphilic disorders. Those -- those have
23 been described in the past as not otherwise specified, not
24 other -- is there any difference between saying
25 biastophilia versus other specified paraphilic disorder

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 nonconsent versus not otherwise specified -- those are all
2 the same things, correct?

3 A Correct, yes.

4 Q Okay. And again, you're going back to the general
5 section when you're talking about nonconsent. When you're
6 pointing to page 685 is in the general description of the
7 paraphilic disorder, correct?

8 A Description of paraphilia, yes, ma'am.

9 Q Paraphilia. Okay. And then -- but it doesn't --
10 the diagnostic manual goes on though after it generally
11 talks about it and it does, in fact, list specific
12 disorders: Voyeuristic -- and how you meet those criteria,
13 exhibitionist, and those criteria, and so on, correct?

14 A That's correct.

15 Q And of course, once again, the nonconsent, that and
16 the biastophilia is not listed, it's not brought out?

17 A Not as a specific diagnosis; that's correct.

18 THE COURT: Well, if it's not a specific diagnosis,
19 how could you refer to that manual as a basis for your
20 opinion? The DSM-5, how do you use that as a basis that he
21 has this personality disorder.

22 THE WITNESS: On page 705, it says under other
23 specified paraphilic disorder, examples of presentations
24 that can be specified using the other specified designation
25 include, but are not limited to, and then it gives several

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 others: Scatologia, necrophilia, zoophilia, coprophilia,
2 klismaphilia, and urophilia, so it gives those as examples,
3 but says that this category is not limited to those
4 specific categories.

5 BY MS. HIGHTOWER:

6 Q You --

7 MS. HIGHTOWER: I apologize, Your Honor.

8 THE COURT: No, ma'am, go ahead.

9 BY MS. HIGHTOWER:

10 Q You mentioned -- let me ask you, you mentioned the
11 other specified paraphilic disorder, that's the catchall,
12 right? That's the catchall for what isn't specifically
13 listed, correct?

14 A That's correct.

15 Q All right. And so also referred to as like the
16 waist basket of diagnoses, correct?

17 A No, ma'am, this is not a waist basket. The -- in
18 the DSM-4, the NOS, Not Otherwise Specified categories were
19 considered just as valid as those that were more specific.
20 When we say not otherwise specified, that just means that
21 we don't have enough information or enough clinical data to
22 give a specific diagnosis but that it still falls within
23 that general category.

24 Q And that's the problem. That's the crux of it.

25 There's not sufficient information, not enough statistical

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 data to have it listed as a specific diagnosis or disorder
2 as the other ones are with specific criteria and it's a
3 tool --

4 THE COURT: Wait a minute, ma'am, is that a
5 question you're asking?

6 BY MS. HIGHTOWER:

7 Q So is -- let me -- in the not otherwise specified
8 diagnosis, that is -- is that because -- or that is -- that
9 exists because what you had eluded to before in your
10 answer, that that is -- there's not enough data out there
11 to look to -- it doesn't fit any of the other established
12 diagnoses or disorders that are listed in the DSM-5?

13 A I don't think that's a question that I was asked
14 from there. This is some professional debate about whether
15 or not it should be a diagnosis. I would concede that, but
16 even within the medical field in general, it's not unusual
17 to use the NOS, not otherwise specified categories. I
18 remember a emergency room visit where I got a diagnosis of
19 gastroenteritis, not otherwise specified. I had a stomach
20 ache. They didn't know what caused it.

21 So there are a number of medical diagnoses where we
22 get those not otherwise specified diagnoses. And that's
23 because you don't know what caused it, that specific -- it
24 doesn't fit a pattern that's already there. But it fits in
25 that larger category.

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 Q And isn't that a tool that statisticians -- I mean
2 isn't that a tool that a doctor uses to, to -- that's --
3 hold on one second.

4 (There was a pause in the proceedings.)

5 BY MS. HIGHTOWER:

6 Q So what -- so what you're referring to, that would
7 be a clinical setting, correct?

8 A In terms of?

9 Q When you're dealing with a patient, your example
10 about somebody that has gastroenteritis but we're not sure
11 where it's coming from? Or what was your example?

12 A Correct.

13 Q And that -- and so that, you're using that as a
14 tool, not otherwise specified because there's not enough
15 data to tell you exactly what it is. You got to keep
16 working on it, correct?

17 A It's not necessarily there's not enough data, it's
18 that the data doesn't fit any of the clearly identified
19 diagnoses within that category.

20 Q Let me ask you this way: In terms of when they
21 developed the diagnostic standard, the diagnostic and
22 statistical manual, there was -- wasn't there a significant
23 amount of conversation about whether or not to include
24 biastophilia or nonconsent or paraphilic coercion disorder?
25 Wasn't that, that was discussed?

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 A I have seen articles saying that there was some
2 discussion about that, yes, ma'am.

3 Q There was a discussion about it.

4 And what were the concerns about including this
5 diagnosis specifically in the manual as it's -- as it's
6 listed for, like the other ones that you can easily
7 diagnose, correct? What was the basis for the concern?

8 A One of the major concerns was somewhat political in
9 nature, that basically when we talk about biastophilia,
10 what we're describing is rape.

11 Q Uh-huh.

12 A And this was some concern about making rape a
13 mental illness and there was a lot of objection to
14 including something of that category in the DSM that
15 might --

16 Q Can I stop you there --

17 THE COURT: Let him finish his answer.

18 THE WITNESS: That that might be used to excuse
19 someone's behavior.

20 BY MS. HIGHTOWER:

21 Q The concern about the rape being used as an excuse,
22 or let me put it another way: Going back to the paraphilic
23 disorder, that goes to somebody's sexual arousal is based
24 upon that thing?

25 A That's correct.

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 Q And wasn't that debate about there was -- the fact
2 that we did not understand or we do not have data or we do
3 not have -- the concern that throwing rape in there as --
4 it doesn't stand alone for the paraphilic, does it? That
5 was the concern, wasn't it?

6 A I think that was a concern, yes, ma'am.

7 Q Right because there was a -- or part of the
8 objection as raised as I understand it or is it part of the
9 problem or part of the concerns that were raised is that
10 rape is a crime and we don't know if it stems from the
11 paraphilic disorder of sexual arousal. It could be coming
12 from some other standpoint that it's -- that it's not a
13 mental abnormality, correct. That was the concern?

14 A That was a concern, yes.

15 Q And that concern, as I understand it -- isn't it
16 true that that concern, as they did the revision, led to it
17 not actually standing alone as biastophilia and, in fact,
18 the other positions of the mental health professionals that
19 did the DSM-5, it actually was rejected as a valid mental
20 health diagnosis because of those concerns, because of the
21 lack of data. And isn't it true because of the fact that
22 it doesn't actually qualify for a paraphilic, or it might
23 not qualify for a paraphilia because there's something else
24 going on, it's a crime, correct?

25 A I have seen that argument, yes, ma'am.

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 Q Okay. In the peer review literature, outside and
2 above the DSM-5, there were also concerns about this
3 diagnosis coming out in a forensic setting, correct?

4 A There are always concerns about misdiagnosis, yes,
5 ma'am.

6 Q Uh-huh.

7 But the specific concern is that it's being used in
8 a courtroom, in a forensic setting and being used to put
9 people in a program, actually violent predator program
10 under a auspices or under the idea that they have a mental
11 abnormality, correct? That was part of the concerns?

12 A That would be one of the concerns, yes, ma'am.

13 THE COURT: Well, do you have that concern?

14 THE WITNESS: I don't have that concern. It's not
15 one that I've used a great deal. I don't think I've used
16 that in any other case. It's not one I've seen a great
17 deal by other practitioners in the department of mental
18 health. I think we have to be very careful in making the
19 diagnosis.

20 THE COURT: Is this the first time you've ever used
21 it?

22 THE WITNESS: To my knowledge, it is. I don't
23 recall having used it in another case. Now, I do talk
24 about nonconsent in a lot of evaluations.

25 THE COURT: Yes, sir.

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 Well, you mentioned a while ago that it has been
2 peer reviewed. Do you have any of the peer review material
3 that I could review.

4 THE WITNESS: Well, what I -- what I do have is a
5 book by Dennis Doren on Evaluating Sex Offenders and the
6 subtitle is A Manual for Civil Commitments and Beyond. And
7 he spends an entire section dealing with using the DSM-4
8 terminology what he called paraphilia not otherwise
9 specified nonconsent. So he has several pages where he
10 deals with that very issue.

11 THE COURT: Yes, sir. But understand we're not --
12 defense counsel and I'm not being critical of what you're
13 doing, but the problem or the exercise that I have to go
14 through is that it has been peer reviewed enough so that it
15 is reliable. And there are cases, defense counsel,
16 Mr. Ridley's counsel has given me some cases where they
17 have not allowed this diagnosis in the court system and
18 they go through this great analysis of it not being
19 reliable and not being in the DSM-5 so to speak and the
20 controversy surrounding it to a point where I have to make
21 a finding under the law that it is a reliable type or I
22 have to assess the reliability of the scientific evidence,
23 so to speak.

24 That's where I'm asking, are you aware of any peer
25 reviews other than that one chapter in that book that

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 you're talking about because there have been a number of
2 courts that have disallowed it.

3 THE WITNESS: Sure, I understand.

4 THE COURT: And with that disallowing by these
5 courts under reliability standards, are you confident
6 enough to -- and I'm not questioning, you're obviously,
7 your antisocial personality disorder, but this, this
8 biastophilia, if I'm saying it correctly, is popping up in
9 a number of areas that have given courts concern about its
10 reliability as to finding that abnormality as one of the
11 elements that complies with the Sexual Violent Predator Act
12 or it not complying with meeting the definition of sexually
13 violent predator. That's what gives me concern.

14 THE WITNESS: Sure, I understand that, sir.

15 THE COURT: All right, ma'am. Anything else?

16 MS. HIGHTOWER: Just one additional question, Your
17 Honor, if I may.

18 THE COURT: Yes, ma'am.

19 BY MS. HIGHTOWER:

20 Q Certainly in -- in -- in the peer review articles
21 are you --

22 THE COURT: Which article --

23 MS. HIGHTOWER: I'm trying to get this site back --

24 BY MS. HIGHTOWER:

25 Q Its doctor first who asserts that the OSPD or the

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 other specified paraphilic disorder --

2 THE COURT: Are you aware of this publication or
3 articles? F-I-R-S-T, I think it is.

4 THE WITNESS: I have seen it. I don't recall the
5 details off the top of my head.

6 THE COURT: Yes, sir.

7 BY MS. HIGHTOWER:

8 Q Are you aware that he purports, tells that actually
9 using this diagnosis may be a violation of the APA ethical
10 standards because the diagnosis itself is not specified,
11 established scientific and professional knowledge. It's
12 not even rape because paraphilia -- because of paraphilia,
13 but more research needs to be done to allow -- before you
14 can allow it -- are you aware that that's been issued as a
15 concern?

16 A I'm aware that that's an issue, yes, ma'am.

17 Q Not using it --

18 And finally -- am I understanding and it was
19 unclear about your annual report that is you wrote. It's
20 unclear in my mind, did you come forward with Dr. Gehle's
21 -- Dr. Gehle is that how you say her -- Dr. Gehle?

22 THE COURT: Dr. Gehle, isn't it G-A-L-E?

23 THE WITNESS: G-E-H-L-E, Gehle.

24 BY MS. HIGHTOWER:

25 Q How do you pronounce it?

Dr. Gordon Brown - Cross-Examination In Camera by Ms. Hightower

1 A Gehle.

2 Q Gehle, I apologize. Dr. Gehle's report -- did you
3 do your own independent diagnosis each time you review him?

4 A I did.

5 Q Okay. I just wanted to make sure. I was clear
6 about that.

7 A And I have had cases where I did not necessarily
8 agree with the treatment or diagnosis and in this case I do
9 believe she got it right.

10 Q It just wasn't clear in your reports that I read.
11 I just wanted to make sure that your diagnosis is what
12 we're discussing on the paraphilia biastophilia.

13 THE COURT: Let me just ask you this, Doctor.
14 First it was France Allen or Frances last name, I'm just
15 reading their conclusion and it says Paraphilia NOS,
16 nonconsent is not a legitimate mental disorder diagnosis
17 and seems more an excuse for keeping dangerous sex
18 offenders locked up. Have you had an opportunity to read
19 his.

20 THE WITNESS: I have not read that recently, but
21 I've seen it. My concern with things like that, Your
22 Honor, is you know, that's more in the area of opinion and
23 the fact that something is peer reviewed doesn't
24 necessarily mean that it's based more on scientific fact
25 than other articles might be. There are some very strong

1 opinions about that. I'll concede that.

2 THE COURT: But you do not concur with it.

3 THE WITNESS: I do not concur with it.

4 MS. HIGHTOWER: Your Honor, if I may, I would just
5 point out that Doctor Hallen (phonetic) certainly was one
6 of the chairs for the DSMN-4 he was one of the authors.

7 THE WITNESS: Uh-huh.

8 THE COURT: Well, obviously, Dr. Brown is being
9 very candid with me and with y'all that there is some,
10 obviously, like in a lot of areas law and medicine and
11 psychiatry, there are lots of people who disagree with each
12 other's opinions. I'm not so sure it goes to the
13 admissibility. It probably goes to the weight of his
14 opinion when he testifies, but obviously, you'll be in a
15 position to cross-examine him on all of the arguments that
16 you've had here.

17 But whether or not it rises to the level that it's
18 not scientifically reliable in some areas, notwithstanding
19 the fact that it is disagreed by others and I think the
20 courts are split around the country. There are some courts
21 that have not allowed it and there are several courts cited
22 in one of your cases even -- they had cited South Carolina,
23 but Mr. Morrow's pretty up to date on that and he said that
24 it was a non published opinion. I don't know if that's
25 what they're relying on it or not, but since in South

1 Carolina, it's recognizing it. But then they go into
2 criticism of courts never holding what we call it in South
3 Carolina a State v. Council type hearing to determine
4 reliability, they call it an offer.

5 And apparently there haven't been some in those
6 types -- were used in those areas.

7 But anyway, it's an area that's -- there's a lot of
8 disagreement in. But does that mean it's not -- as the
9 gate keeper, that I completely keep it out or do I allow it
10 in and let the jury give it any weight it deems it should
11 give it or none at all. And I'll tell them they don't have
12 to give it any weight. And you'd be allowed to
13 cross-examine him extensively, as long as you want to, as
14 much as you want to, on the material that you've got.

15 But the rule that it is not scientifically reliable
16 just because we've got these few articles and other people
17 disagreeing, I don't think it's proper for me to do that.
18 So I'm going to allow it. But obviously, you have the
19 right the cross-examine and I would like for you, please
20 ma'am, Number one, I'm going to commend you on your
21 excellent motion and the material that you've got attached
22 to it. So I don't have a trial that's going to end up --
23 if it ends up adverse for Mr. Ridley, I would like for us
24 to make this motion and the attached articles and pieces,
25 et cetera, as part of the record so if it's appealed,

1 you'll have all that in the record to get the appellate
2 courts to look at it.

3 MS. HIGHTOWER: Yes, sir, I appreciate it. I would
4 like to admit it as an exhibit.

5 THE COURT: Make sure you give it to Ms. Brenda and
6 she'll take care of it for you.

7 All right. Anything else before we start back?

8 (Court's Exhibit Number 1 was marked for evidence.)

9 MR. MORROW: No Your Honor.

10 MS. HIGHTOWER: No, Your Honor. I don't believe
11 so.

12 THE COURT: Let's -- I think the jury is coming
13 back at 2:15. All right. We've got a few minutes we'll
14 stretch our legs and get ready to go.

15 Thank you, Doctor. You may step down.

16 THE WITNESS: Yes, sir.

17 THE COURT: Appreciate your candidness with me.

18 (A brief recess was observed.)

19 THE COURT: All right. Anything for the record
20 before we start back?

21 MS. HIGHTOWER: Nothing, Your Honor.

22 MR. MORROW: Nothing from the State.

23 (The jury entered the courtroom at 2:13 p.m.)

24 THE COURT: Some of the jurors changed shirts
25 during the break.

1 THE JUROR: Sir, I had a kind of an accident at
2 Taco Bell.

3 THE COURT: Thinking outside of the box.

4 THE JUROR: Outside the shell, too.

5 THE COURT: All right. First thing we have to do
6 to get started, is you have to stand once again and raise
7 your right hand and the clerk will administer an oath for
8 this particular case.

9 (The jury was sworn at 2:15 p.m.)

10 **OPENING REMARKS BY THE COURT**

11 THE COURT: Ladies and gentlemen of the jury panel,
12 as I said when we selected you this morning, this is a
13 little different type of case than we normally try in the
14 courtroom. Normally in civil cases people are suing for
15 monetary damages or injuries they sustained in an
16 automobile wreck or the doctor committed malpractice or a
17 lawyer committed malpractice or somebody breached a
18 contract or -- and the only way they can resolve it is to
19 ask for monetary damages.

20 In general sessions, criminal court that Judge
21 Keesley's got, that's a criminal situation where someone's
22 accused, like I had last week a burglary first, armed
23 robbery, kidnapping, et cetera. And if they're found
24 guilty in that, the remedy of the situation is that I have
25 to impose a sentence on them. If they're found not guilty,

1 obviously, they go home.

2 Well, the other -- this is sort of a different type
3 case than we normally try. We try them from time to time,
4 but this is a case that the State has brought under the
5 Code of Laws set out in South Carolina Code of Laws,
6 Chapter 48, Section 44-38-30 and those that follow. This
7 is what's commonly known as the Sexual Violent Predator
8 Act. And this is an act that the legislature passed years
9 ago which basically provides that if someone has been in
10 the past convicted of a sexually violent offense -- and
11 there are a number of crimes that are deemed to be sexually
12 violent crimes -- if the State can prove that to you beyond
13 a reasonable doubt that the respondent in this case,
14 Mr. Ridley, has been convicted of a sexual violent offense.
15 And if they also can prove to you beyond a reasonable doubt
16 that he suffers from a mental abnormality or personality
17 disorder that makes him likely or more likely to commit a
18 violent sex act if he is released from his confinement.

19 So what we have in this case is Mr. Ridley has --
20 there won't be any question that he's been convicted in the
21 past of a violent offense. So the main question that's
22 going to be asked in this case is you have to decide
23 whether the State can prove to you beyond a reasonable
24 doubt that he suffers from a mental abnormality or a
25 personality disorder that makes him more likely to commit a

1 violent sex act if he is released from his confinement.
2 And they have to prove that to you beyond a reasonable
3 doubt.

4 Now, we have two types of burden of proof in cases.
5 In all civil cases except for this type of case, under the
6 Sexual Violent Predator Act, the burden is what we call by
7 the preponderance or the greater weight of the evidence.
8 And that simply means that in a civil case that these are
9 the scales of justice, when the parties come into the
10 courtroom, the scales of justice are even. And for you to
11 be successful in getting awarded a monetary award for --
12 when that lawyer or doctor messed up when they treated you,
13 you have to prove the case by the preponderance, or the
14 greater weight, of the evidence; you have to make the
15 scales of justice tip ever so slightly, ever so slightly.
16 And if you're able to do that, you've met your burden of
17 proof by the preponderance or the greater weight of the
18 evidence. Some people say they started on the 50 yard line
19 and if you can push them over to the 51, you've met your
20 burden of proof. That's what we have in all civil cases.

21 In criminal cases, because a person is accused of a
22 crime, he has the constitutional presumption of the burden
23 of innocence or the presumption of innocence when he or she
24 comes into the courtroom, the scales are tipped way in his
25 favor or her favor. They're presumed to be innocent under

1 the constitution. For the State to prove them guilty, they
2 have to tip the scales in this manner because that burden
3 is beyond a reasonable doubt. It's the kind of doubt that
4 would cause a reasonable person to hesitate to act.

5 So the burden is much greater and the legislature,
6 when they enacted this Sexually Violent Predator Act,
7 instead of -- notwithstanding the fact that it's a civil
8 case, this is the only civil case as I know that the burden
9 of proof is beyond a reasonable doubt. So the burden of
10 proof is on the State and it's beyond a reasonable doubt,
11 greater than in normal civil cases. Okay?

12 And they have to prove to you those two things:
13 He's been convicted of a sexually violent offense and he
14 suffers from a mental abnormality or personality disorder
15 that makes him more likely than not to commit a violent
16 sexual act in the future. So that's what you're going to
17 be asked to decide.

18 Now, I think y'all have seen me enough to know that
19 I try to run things on time. I try to be efficient with
20 our time. So I like to start when we say we're going to
21 start and I like to keep the lawyers moving. This is a
22 relatively short case. I think we're going to have three
23 witnesses, two psychologist, psychiatrists and Mr. Ridley.
24 So I suspect we'll get way down the road this afternoon
25 with our presentation of evidence.

1 But the way it will work is this: In just a few
2 minutes, because the State has the burden of proof, they
3 will make an opening statement to you, followed by the
4 defendant or Mr. Ridley, the respondent in this case, his
5 lawyer. Opening statements are not evidence. It's simply
6 what the lawyers contend that the issues are. They'll give
7 you sort of a road map as to where they're going from point
8 A to point B; but that is not evidence in the case.

9 Once they conclude their opening remarks, we'll
10 take testimony. The State has one witness, the respondent
11 has two. When we conclude the testimony, the lawyers will
12 be able to give you final argument and once that is done, I
13 will charge or instruct you on the law and then you'll be
14 in a position to start your deliberations.

15 Notwithstanding the fact that I try to run
16 efficiently and keep it moving, I'm not up here trying to
17 run a race. So any time any of you need a break, you need
18 to use the bathroom, you want something to drink or stretch
19 your legs or just tired of listening to me, raise your
20 hand. If you get hot, cold, don't get uncomfortable, just
21 raise your hand and I'll make sure your needs are met.

22 We'll take a little short break, I don't know,
23 3:30, quarter to four, four o'clock, somewhere in that
24 neighborhood, so you can stretch your legs.

25 But if anything comes up that you need to call to

1 my attention, if you get uncomfortable, raise your hand. I
2 will ask you and instruct you each time we take a break,
3 don't start deliberating or talking about the case until
4 all the evidence has been presented, final arguments are
5 made and I've instructed you on the law and then you'll be
6 in a position to start your deliberations.

7 If we go to tomorrow, I will ask you not to do any
8 type of independent research tonight on any of these
9 alleged disorders or personality abnormalities, et cetera.
10 You're to decide the case based solely on what you hear in
11 the courtroom.

12 I'll tell you up front, you're going to probably
13 hear two very fine psychiatrists, psychologists, people in
14 the psychiatric world to be giving opinions in this case.
15 Probably, if I'm halfway right, their opinions are going to
16 be different and it's going to be up to you to listen to
17 everything and, and consider everything, and you have to
18 make a decision as to who and what the true facts are. You
19 judge the credibility, the believability. You determine
20 what the true facts are. You apply it to the law as I give
21 it to you and then you'll be in a position to render a
22 verdict which says whether or not the State has met its
23 burden of proving to you that this act applies to
24 Mr. Ridley beyond a reasonable doubt.

25 So I'm going to turn it over to the lawyers and let

1 them make their opening statements and then we'll start
2 taking testimony.

3 Anything I've left out? Need to add? You want the
4 discuss with me?

5 MR. MORROW: Just briefly, Your Honor.

6 (There was a bench conference out of the hearing of
7 the jury and the Court Reporter.)

8 THE COURT: Just so there's no misunderstanding, in
9 this particular law, I told you they have to prove to you
10 beyond a reasonable doubt that he suffers from a mental
11 abnormality or personality disorder at this present time.

12 MS. HIGHTOWER: Thank you, Your Honor. Appreciate
13 it, sir.

14 THE COURT: All right. Mr. Morrow?

15 MR. MORROW: Thank you, Your Honor.

16 **OPENING STATEMENTS**

17 MR. MORROW: Good afternoon, ladies and gentlemen.
18 My name is Christopher Morrow. You might hear people refer
19 to my as Cam from time to time. My full name the
20 Christopher Andrew Morrow. Cam is my initials and it's a
21 nickname that people who are familiar with me call me. I
22 work with the South Carolina Attorney General's Office.
23 That's located in Columbia, South Carolina. We do cases
24 all throughout the state and you may be wondering why am I
25 here and why isn't someone more local handling this case.

1 Well, there's a really simple explanation to that.
2 When the legislature passed the statute twenty years ago,
3 they assigned all of the sexually violent predator cases to
4 the South Carolina Attorney General's Office. We have a
5 section that deals with nothing but sexually violent
6 predator cases and I am part of that section. I have about
7 half the state, another guy has the other half of the
8 state.

9 The case today was brought under the South Carolina
10 Sexually Violent Predator Act. We are here because Richard
11 Ridley is currently committed to the South Carolina
12 Department of Mental Health's Sexually Violent Predator
13 Treatment Unit. The State is seeking to keep him committed
14 to the South Carolina Department of Mental Health's
15 Sexually Violent Predator's Treatment Unit. And don't
16 misunderstand, I'm not telling you that because -- to shift
17 burden of proof, it's still my responsibility or the
18 State's responsibility to prove that he is a sexually
19 violent predator and suffers from a mental abnormality or
20 personality disorder. However, this is an annual review
21 trial and you may be wondering why he's getting an annual
22 review, so I'm trying to explain that to you now.

23 Now, you might be asking what is a sexually violent
24 predator. The South Carolina General Assembly twenty years
25 ago passed the South Carolina Sexually Violent Predator Act

1 and they did that with two thoughts in mind. First, that
2 there are certain individuals in the state that suffer from
3 mental abnormalities or personality disorders that make
4 them likely to commit acts of sexual violence and that
5 these individuals need treatment in a secure facility or
6 setting to protect the public during the treatment process
7 because they're dangerous.

8 Now, Mr. Ridley is seeking release from his
9 treatment. He has challenged the opinion of the department
10 of mental health that he needs further treatment and is
11 seeking immediate release. The State is seeking to have
12 Mr. Ridley continue his treatment at the Sexually Violent
13 Predator Treatment Unit and the department -- that
14 Mr. Ridley and the department of mental health disagree
15 about whether he still needs to be there.

16 So what do I have to prove? I have to prove that
17 Mr. Ridley has been convicted of at least one sexually
18 violent offense. You're going to hear about his criminal
19 record as part of the basis of our expert's opinion and
20 he's going to talk about that. And you're also going to
21 see that he was convicted of a sexually violent offense.
22 You'll have the certified copy of one of these offenses to
23 look for -- look at.

24 The second thing that I have to prove is that
25 Mr. Ridley suffers from a mental abnormality or personality

1 disorder that makes him likely to commit future acts of
2 sexual violence if not confined for long term care,
3 control, and treatment.

4 Today you're going to hear that Mr. Ridley's been
5 diagnosed by the State's expert, Dr. Gordon Brown with
6 other specified paraphilic disorder, biastophilia and
7 antisocial personality disorder with narcissistic features.
8 You're going to hear the testimony of Dr. Brown. You'll
9 also hear testimony from which you can decide whether
10 Richard Ridley lacks control over his mental abnormality
11 and personality disorder and whether those disorders make
12 him likely to commit acts of sex -- future sexual violence.

13 Now, Dr. Brown, who is with the department of
14 mental health, has seen Mr. Ridley in each of his past four
15 annual reviews. He's conducted an annual review
16 evaluation, which included reviewing multiple files,
17 conducting an actuarial assessment of Mr. Richard Ridley's
18 risk to reoffend, and interviewing Mr. Ridley. Dr. Brown
19 will tell you how his mental abnormality and personality
20 disorder that he suffers from and he'll explain that to you
21 and how that relates to his future likelihood to commit a
22 sexual violent crime.

23 You're also going to hear from any witness the
24 defense may provide, including, I believe Dr. Selman
25 Watson, who was hired by the defense to conduct an

1 independent evaluation of Mr. Ridley. So the question that
2 will be presented to you, is after comparing the witnesses
3 that will testify in this trial and assessing their
4 credibility and thoroughness and the extent of their
5 evaluation and knowledge, whether Mr. Richard Ridley
6 suffers from the mental abnormality or personality disorder
7 which makes him likely to reoffend sexually if not confined
8 to a secure facility for treatment. In other words, is
9 Mr. Ridley safe to be out in the community on his own and
10 not commit another crime of sexual violence ever again.

11 Now, burden of proof in this case is on the State.
12 The State welcomes that burden. The judge will instruct
13 you that this is a civil case and not a criminal case. And
14 just like he told you a second ago that this case happens
15 to have a burden of beyond a reasonable doubt. It's a
16 higher burden. But keep in mind, it's not beyond all doubt
17 or every doubt or any conceivable doubt, but beyond a
18 reasonable doubt.

19 He'll tell you that proof beyond a reasonable doubt
20 is proof that leaves you firmly convinced or a doubt that
21 would cause you to hesitate to act. Now, these cases by
22 their very nature tend to contain very disturbing facts and
23 this case is certainly no different in that regard but I
24 ask you to do one thing throughout this case and that's to
25 listen to the evidence. As you listen to the evidence, I

1 believe this burden we carry will become clear, that
2 Richard Ridley is a sexually violent predator and he needs
3 to remain confined to the South Carolina Sexually Violent
4 Predator Treatment Unit for further treatment to protect
5 the public of the State of South Carolina during the
6 treatment process and to get him the treatment that he
7 needs. Thank you.

8 THE COURT: Yes, ma'am?

9 MS. HIGHTOWER: Thank you, Your Honor. If it
10 please the Court.

11 THE COURT: Yes, ma'am.

12 MS. HIGHTOWER: Good afternoon. I guess to begin,
13 we need to begin -- we're going to all talk to you about
14 the statute today apparently because in trying to think
15 about how I wanted to talk to y'all and how to present --
16 you know to present my opening statement to you, it just
17 made sense to me, as well as Mr. Morrow's remarks and
18 certainly the judge is giving you the law, the instruction
19 on the law, we are going to go over the statute. And so --
20 and the judge touched on, obviously, it is your job to
21 listen to the evidence and listen to the facts. And you're
22 going to take the instructions from the judge under the
23 law, under the statute; and you're going to apply that law
24 to what you determine to be is the evidence presented in
25 the case. That's -- as the judge said, you're the judge of

1 the evidence, certainly.

2 Now, back in the -- in the 1990's, the State
3 legislature, our South Carolina legislature passed the
4 Sexually Violent Predator Act. And as Mr. Morrow touched
5 on, the reasons for that act and the reasons behind the
6 policy for it are why it came about and it's in the very
7 first part of the statute under 44-48-20, is that the
8 legislature determined that there -- and I'll just read
9 from it. It's easier than trying to summarize for you.
10 But the general assembly, our legislature finds that
11 they're mentally abnormal and extremely dangerous groups of
12 people. Sexually violent, again, the key here, y'all, is
13 -- the key here y'all is about the sexual nature of the
14 crime. That's what the statute is written for. That's
15 what the statute is driven by. All right? It's not just
16 because that we have somebody who's committing crimes. All
17 right? But we have to focus on the sexual nature of the
18 crimes, because again, you go back to the policy why we're
19 here and why the South Carolina State legislature did this
20 is because in the very first statement of 44-48 is that
21 they, the general assembly, finds that there's mentally
22 abnormal and extremely dangerous group of sexually violent
23 predators. They exist. And because they exist, they
24 require involuntary commitment in a secure facility and
25 we're going to talk about what long term means.

1 But we're going to put that the reason why they're
2 committed is because they're committed for treatment. For
3 their care, because obviously, if you're going to civilly
4 commit somebody, you're going to have to care for them. So
5 -- and then obviously, for their control because again,
6 that's what the legislature is talking about is their
7 control, their control over the person; confine them, and
8 again because as you go on, with the policy and why we have
9 it is because this group of people, the legislature
10 determined that they are dangerous and that we need to
11 civilly confine them because of the likelihood that they're
12 going to reoffend.

13 That's the bottom line. That's why they're
14 dangerous. That's why there's -- it's, it's, in the
15 statute, the legislature's policy, going again, thinking
16 about why do we have this out here. Why does this even
17 exist is because of the likelihood that they're going to
18 reoffend. The likelihood. And again, the statute defines
19 likelihood to reoffend. That there's this group of --
20 subgroup of people convicted of sexually violent or have
21 sexually violent offenses in their past, convicted of at
22 least one, that they are likely to reoffend. So the
23 likeliness is defined as they present a menace. They're a
24 menace to society.

25 So we need to confine them, we need to care for

1 them. And most importantly, again, we need to treat them.

2 My client, Mr. Ridley, he's a 47-year-old man and
3 there is absolutely no question that he has committed
4 sexually violent crimes. That's fact. We don't need -- we
5 don't need to ask y'all to make that determination. That
6 -- as Judge Early touched on, that's already been decided.
7 He has been convicted. He walked into this courtroom. It
8 was in Aiken County, that's why we're here today. His
9 crime for which he was committed and for which he walked
10 into this courtroom and pled guilty to, was here in Aiken
11 County. That's why we're here.

12 And, obviously, you're going to hear about that
13 charge, we heard the prosecutor talked about it, the judge
14 talked about it, I'm talking about it. But let me just
15 make sure I say this clearly for myself, is that the bottom
16 line is that Mr. Ridley, in 2001 came into this courtroom
17 and he spoke the truth. He admitted guilt, he pled guilty
18 to criminal sexual conduct in the third degree. He pled
19 guilty to assault and battery of high and aggravated
20 nature, that's -- we sometimes refer to it as an acronym of
21 ABHAN, but the facts under that case were sexual in nature,
22 just because it's called assault and battery of a high and
23 aggravated nature, that's still, the underlying facts were
24 sexual in nature. It was a sexual crime. And he did -- he
25 was sentenced. He was sentenced to the department of

1 corrections and he did -- he was sentenced to ten years for
2 the criminal sexual conduct charge. He was sentenced to a
3 second consecutive ten year sentence for the assault and
4 battery of a high and aggravated nature. He went to the
5 department of corrections and he did his time on those
6 sentences.

7 He also was found to have violated a sexual -- the
8 sex offender registry act as well and he was sentenced to
9 an additional time frame under that, I believe it was 90
10 days.

11 Because Mr. Ridley's not from Columbia -- is not
12 from Aiken, South Carolina. He's from New York, born and
13 raised. He has relatives that live here in Aiken that he
14 came to get away from what was going on in New York. He
15 came down here and he -- when he was here, like I said,
16 bottom line, that's not a -- that's not something we're
17 asking that you -- he pled guilty, he spoke the truth. He
18 admitted what he did. And he has other past convictions as
19 well from New York where he was raised.

20 But let me turn back to the statute for a minute.
21 The State brought this action when he was almost done with
22 his time frame because that's what the statute says. You
23 identify somebody that has a sexually violent offense on
24 their record; clearly Mr. Ridley does. And then -- the
25 State has to identify that person and then they do a

1 petition and they ask that the person's committed to this
2 sexually violent program. All right. Now, remember it's a
3 civil commit. It's not about criminal. He's done his
4 criminal time. This is how you qualify for this program,
5 the policy, what the legislature created in a civil
6 setting, civil commitment and he's trying to get -- this is
7 how we got here. This is what the evidence is going to
8 show.

9 He pled guilty. He did his time. Because he pled
10 guilty to a qualifying offense, a sexually violent offense,
11 then he was looked at about through this statute and then
12 this is where the attorney general comes into play because
13 like Mr. Morrow says, the statute says that the attorney
14 general has the responsibility for bringing these cases; so
15 they did their job. They brought this case. And let me
16 just tell you what happened. And when I say this case, the
17 beginning of this case, because he went onto the Sexually
18 Violent Predator Act in 2014. He went into the program
19 then.

20 So the petition was brought, the attorney generals
21 did their job and my client, by order of this Court, walked
22 into this courtroom and he admitted, he stood in this
23 courtroom in September of 2014 -- I'm sorry -- in August of
24 2014 and he admitted that he needed treatment. And he
25 voluntarily waived himself into this program. He

1 voluntarily had himself civilly committed under this
2 statutory structure. That was in August of 2014 and then
3 of course, they processed him in and he actually started in
4 September of 2014.

5 So that brings us -- that brings us to why we're
6 here today. That is why we are here today. That was 2014,
7 it's 2018. You heard about my client had an annual review,
8 annual -- it's obviously annual, it happens every year and
9 again that's by the statute and is under 44-48-110, we have
10 once a year a person who's committed under this statute, my
11 client voluntarily waived into, has the right to be
12 re-examined, looked at again; right to a probable cause
13 hearing. And at that probable cause hearing, a decisions
14 made to believe whether the person's mental abnormality or
15 their personality disorder has so changed that the person's
16 now safe to be at large.

17 So under this statute, you've got an annual review,
18 look at the treatment and you have the right to come in,
19 you have a hearing and if you can demonstrate probable
20 cause under the statute that you are so changed, you have
21 the right to have a hearing -- a trial, I'm sorry, a trial.

22 Mr. Ridley did that. He had a probable cause
23 hearing and he demonstrated that he had the right to have a
24 jury, he had the right to bring his case before y'all. So
25 that's why we're here. And the determination and what

1 y'all, you know, the facts, the judge of the facts, you're
2 to determine, but what we are asking is to decide whether
3 this mental abnormality, personality disorder, Mr. Ridley,
4 himself, through his treatment program, is so changed that
5 he's safe. Mr. Morrow mentioned it. Is he safe to be at
6 large. That's the bottom line. Look at the treatment,
7 look what he did. And again, safe means or under the
8 statute means, if he's released he is not likely to commit
9 acts of sexual violence. Not likely to commit sexual --
10 and then the statute defines what not likely to commit
11 means: A person's propensity to act is at such a degree
12 that he poses a menace to the health and safety of us in
13 society.

14 That's the bottom line. Y'all decide whether or
15 not Mr. Ridley is safe to reenter. Obviously my job is, I
16 represent Mr. Ridley. I was appointed to represent him.
17 My job is to stand up here in my opening as the judge told
18 you, what's the evidence going to show.

19 You're going to hear and what I believe the
20 evidence is going to show, but obviously, that's why y'all
21 are here -- what's the evidence going to show y'all sitting
22 here. Y'all talk about it, y'all decide. It's the
23 greatest system in the world. We've got the disagreement
24 here. But you're going to hear from the two expert
25 witnesses in this case. We're going to put both of them up

1 and that's -- the statute provides for that too by the way.
2 It -- it's that the State has the right to have a qualified
3 expert and the -- and the committed person, Mr. Ridley, he
4 has a right to have a qualified expert. It's written. The
5 legislature put it back in there. That's why we have two
6 experts to come up here to tell y'all what they see and
7 what they determine. Okay. It's part of the statute.

8 You heard about the State's burden of proof. I
9 don't think I need to go into that. It's self-explanatory.
10 Certainly y'all heard about it. Definition about what's a
11 mental abnormality. We're going the get into that. Y'all
12 will be listening for that. What's a personality disorder.
13 But again, here is whether or not he remains a menace,
14 whether he is safe to be released.

15 And that's the decision that you have. And I --
16 based upon all of the evidence. Again, I'm -- y'all seem
17 or will understand your roles here. I just ask you we've
18 got two witnesses and we've got my client as well to
19 testify. So just I'd ask certainly we want to make sure
20 all of the evidence is in. As the judge told you you're
21 not to do any research, you're not to talk to each other
22 ahead of time, but you go back there at the end and you
23 will do it. You will talk about what the case shows or
24 what the case has demonstrated to you.

25 I believe that the evidence is going to show that

1 my client's worked on his treatment. I believe that this
2 evidence will show that he, he has entered into the
3 sexually violent predator program, SVP or however you want
4 to set it out, SVPP Sexually Violent Predator Program.
5 There's a master plan. You're going to hear about how they
6 treat; you're going to hear about the master plans they
7 come up with. They're going to talk you about, they
8 actually provide this treatment for these group of
9 individuals that the legislature has created this civil
10 commitment. You're going to hear about those factors that
11 they have to work on in treatment, insights as to why he's
12 there. Insights into what was your behavior -- not
13 behavior, what was your thinking patterns when the behavior
14 occurred.

15 The evidence will show that my client attends his
16 group sessions. That he attends his treatment plan. It's
17 going to show that he's helped others in his group. I'm
18 interested also to hearing more about the program itself.

19 This is my first case in terms of representing
20 somebody in a jury trial with the sexually violent
21 predators program. I'm interested in knowing exactly how
22 this treatment progresses. I'm interested in knowing how
23 they actually do it because certainly there's a lot of
24 group sessions from the reports. But the evidence is going
25 to show through those reports and through what the

1 witnesses say and who certainly from somebody from the SVP
2 program can tell us how they do. And then these sessions
3 they have is going to show about how he relates his own
4 crimes, his own offenses and, and how he released that to
5 then and to where he is now, again, the treatment, the
6 effectiveness of the treatment because that's the decision
7 y'all have to make. Is he safe or does he still pose a
8 menace. And in order to look at Mr. Ridley, certainly, is
9 evidence we're going to have to get into, is we're going to
10 have to get into his past because they, they -- that's part
11 of their treatment plan. You've got to look at what your
12 offending behavior -- who you were or what was happening
13 during your offending period. And I'm going to tell you
14 the evidence is going to show is that in the 90's and in
15 2001, Mr. Ridley, he was a drug dealer when he committed
16 these crimes and his past crimes.

17 You're going to hear -- he talks about it in his
18 treatment plan -- but you're going to hear about he was
19 selfish, he was self-centered, he looked at his victims,
20 not as people, but as objects. And like I said, the bottom
21 line, 18 years ago, Mr. Ridley came into this courtroom and
22 he -- that was when he pled; 18 years ago he came into this
23 courtroom and he spoke the truth about his actions and he
24 pled guilty to sexual assault, to criminal sexual assault,
25 criminal sexual conduct in this third degree, to ABHAN and

1 he received his sentence for those. And then as he came
2 through the system, as he came through what the attorney
3 general brought, he voluntarily waived into the treatment.
4 So you're going to hear about his background because we
5 have to go the back to get to here. We've got to go to the
6 back to get to the beginning.

7 Also, the very first sentence that Mr. Ridley was
8 committed for, like I said, he's from New York. There's
9 New York, there's New York offenses, there's New York
10 sexual offenses as well. But the evidence is going to
11 show, is that seven years before his very first New York
12 criminal sexual conduct offense happened, the evidence is
13 going to show that's when he began his drug dealing
14 situation, that he's raised by a single mom. Loves him.
15 Loves him now. She tried her best when she had Mr. Ridley.
16 But he's a teenager in New York.

17 He had -- the evidence is going to show he had, he
18 had older cousins. He had family members who were drug
19 dealers too. And they recruited him with the money, with
20 the lifestyle. And as a teenager running this life where
21 he began in the 1980's early 90's. He's arrested himself
22 at 17 years old.

23 He was taken to Riker's Island. The evidence is
24 going to show that where we began, where my client began,
25 as he was being detained in Riker's Island, pretrial

1 detention, he was gang raped. Other inmates, other people
2 waiting -- other 17-year-olds jumped him. It's fact. The
3 evidence is going to show that.

4 And this is -- like I said seven years before any
5 of the first sexual offenses ever, he ever committed
6 begins, the drugs. This is the drug lifestyle that
7 permeates through the whole history. You'll hear about
8 that. But he was gang raped at Riker's Island at the age
9 of 17 and the only thing that was left at that point was
10 his anger. And the evidence is going to show that he never
11 received any treatment for this ever. Never did.

12 And that anger coupled with the lifestyle that
13 keeps going on with the drug dealing, with the cousins,
14 with where he was continued, so I submit to you is that the
15 evidence is going to show in this case is that this case is
16 about -- what it's really about, it's not about mental
17 abnormalities. It's not about personality disorders. It's
18 about plain old anger.

19 So that brings us back to 2014 and he looked at the
20 situation and he looked at the petition to put him in the
21 sexually violent program, predator program, and he waived
22 himself in. And the evidence is going to show that he
23 finally, in his treatment program, he addressed that rape.
24 That assault on him all those years ago. And it's going --
25 the evidence is going to show that he entered the SVP plan,

1 he's worked on his treatment plan. But there's also one
2 more thing out there, y'all, that the evidence is going to
3 show, is that something else that Mr. Ridley has had to
4 work on in his treatment plan. See Mr. Ridley is a
5 bisexual man, and for many years that created not only
6 anger in himself, but he was uncomfortable about it. It
7 wasn't accepted in the 80's and the 90's as it is today.
8 It wasn't something that, that, you know, you could legally
9 get married. It wasn't -- it was not something -- it was
10 something he was ashamed of. It was something that was
11 hard for him to talk about. In fact, in his treatment
12 program, it's going to tell him -- it took him the
13 treatment plan to talk about it.

14 He's the father of three children. He's had a
15 sexual relationship with women. He's had a girlfriend
16 before. But he had to keep the boyfriend secret and he was
17 ashamed of that secret. And the evidence is going to show
18 that he comes to -- comes to -- he comes to treatment with
19 that and he comes to peace with that part of himself. The
20 evidence is going to show that Mr. Ridley's worked hard on
21 the person who he is today. And he's standing here,
22 sitting here and he's going to -- he's asking you to look
23 at him. He's asking you to look at him. Look at what he's
24 done. Look at the work he's done. Look at what he's
25 worked through this program that your legislative created,

1 created for care, for treatment.

2 The evidence is also going to show he's got plans
3 for the future. He does. He does. It's kind of hard to
4 believe, right, when you think about all this and throwing
5 all this at you, but there's -- there's something that they
6 work on as well on the unit, what they call in the unit, is
7 your discharge plan. He's got a discharge plan. He's got
8 an idea about where he can go. His adult sons want to know
9 him. He's in contact with them. You'll hear about his
10 concrete plans about where he's going to live. There's a
11 community. There's a faith community, and he has faith,
12 that he's already spoken with that he's worked with his
13 caseworkers. They're called Band of Brothers. It's not
14 fancy. I mean, it's -- the housing and what they provide,
15 it's, it's not fancy, but it's a place for him to develop
16 it's a ministry, I believe of the Baptist church, but, but
17 there's a job at the chicken plant up in Greenville.
18 There's housing there. There's a start. There's a
19 support. There's a way to address the situation.

20 So anyway the evidence is going to show that he's
21 worked hard to address his situation. The facts are
22 y'all's to determine. Certainly the statute says whether
23 or not your determination is whether or not he's likely to
24 commit unwelcome sexual acts in the future, likely to
25 commit by definition, is he is a menace to society. Our

1 position or at my closing, I'm going to stand up here and
2 I'll summarize what I believe the evidence shows and he's
3 -- and I believe that the evidence is going to show that
4 he's not a menace. He's a 40-year-old man who's safe to
5 reenter. He's safe. He's done his time. He's paid --
6 he's waived himself into the program. He's worked on his
7 treatment plan.

8 At the end of the case, I'm going to ask y'all to
9 return a verdict that speaks the truth and that my client
10 is safe.

11 My name is Bea Hightower. I'm an attorney, I work
12 out of Columbia. I practice law with my husband. It's my
13 privilege to stand before y'all and represent Mr. Ridley.
14 And I thank you for your time today and tomorrow.

15 THE COURT: Mr. Morrow, you may call your first
16 witness.

17 MR. MORROW: Your Honor, the State calls Dr. Gordon
18 Brown to the stand.

19 THE COURT: Dr. Brown if you'd come around please.

20 DR. GORDON BROWN,

21 having been duly sworn, testified as follows:

22 THE CLERK: Please have a seat in the witness box
23 and state your full name for the Court.

24 THE WITNESS: My name the Gordon Degar Brown Jr.,
25 B-R-O-W-N.

Dr. Gordon Brown - Direct Examination by Mr. Morrow

DIRECT EXAMINATION

BY MR. MORROW:

Q Dr. Brown, what is your occupation?

A Actuarial measures forensic psychologist.

Q And who do you work for?

A I work for the South Carolina Department of Mental Health for Forensic Evaluation Service.

Q And how long have you worked in that capacity?

A I've been there for four years now.

Q Okay. What advanced degrees do you possess?

A I have a PhD in clinical and community psychology from the University of South Carolina.

Q And what states are you licensed to practice in?

A I'm licensed in Georgia and South Carolina.

Q And what is psychology?

A Psychology is basically the study of human behavior.

Q What is forensic psychology?

A Forensic psychology is basically the application of what we know about clinical psychology in a legal context.

Q Can you tell us about your career as a psychologist following your graduation from graduate school?

A Well, I finished graduate school in December of 1983. At the same time I finished my clinical internship which was done at Eisenhower Medical Center at Fort Gordon.

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 Immediately after that I went to Germany for three years
2 where I served as the third army division psychologist.

3 After that I spent about a year at Fort Sam Houston
4 in Houston, Texas where I went through the army officers
5 medical advance course, was briefly on the faculty of the
6 army health sciences there teaching in the behavior science
7 specialist branch.

8 I left the army at that point I moved to Anderson
9 South Carolina, worked for three years at the Harris
10 Psychiatric Hospital with the department of mental health
11 working on the child adolescent unit where I got inpatient
12 experience, family experience, such experience working with
13 children and adolescents. And I went there specifically
14 for that experience, but after three years decided to move
15 on became the director of psychological services at the
16 Medical College of Georgia in their student health service.
17 Did that for about five years and then they went through
18 some downsizing and reorganizing, so I went to work for the
19 Georgia Department of Corrections thinking at the time that
20 I would do that until I found something better to do, but
21 found that I liked it. Ended up spending four years
22 working in a women's prison in Davisboro, Georgia doing a
23 lot of supervision of mental health counselors, kind of
24 overseeing the treatment of the mental health inmates there
25 in that prison. And also doing a number of mental health

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 evaluations, including what we called at the time
2 competency and responsibility evaluations when they were in
3 trouble for disciplinary infractions, did some parole and
4 probation evaluations.

5 After about four years of doing that, I moved to
6 the Augusta Medical Prison where I was the clinical
7 director for the mental health and mental retardation
8 program, again, for about four years in capacity,
9 supervised about 15 masters level mental health counselors,
10 helped to run a seven-bed crisis stabilization unit that
11 served all of the prisons in Georgia. A 100 bed supported
12 living unit for inmates that had mental health needs rising
13 to the level of inpatient care and anywhere from 50 to 300
14 inmates that received outpatient mental health services
15 within the general population.

16 While I was there I began doing some more specific
17 forensic training and then I moved over to the Eastern
18 Central Region Hospital in Augusta and spent two years
19 there as a forensic program director overseeing a
20 outpatient forensic evaluation service and also working on
21 the inpatient forensic unit where we dealt with people who
22 had been found not competent to stand trial either to
23 restore them to competency to stand trial, or those who
24 have been found not guilty by reason of insanity.

25 And after that, I really decided I didn't want to

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 be an administrator after all so I moved back to South
2 Carolina to be an evaluator with the department of
3 disabilities and special needs. I was there for about
4 eight-and-a-half years. For the first half of that time,
5 did primarily evaluations of competency to stand trial and
6 then for the last half I started doing evaluations in death
7 penalty cases looking at questions involving intellectual
8 disability because if someone is intellectually disabled in
9 South Carolina, that disqualifies him from the death
10 penalty. So I did a number of those evaluations. And as I
11 got closer to retirement time decided to move over to the
12 department of mental health about four years ago to work
13 with the --

14 THE COURT: How long ago?

15 THE WITNESS: About four years ago.

16 THE COURT: Thank you.

17 THE WITNESS: To the department of mental health
18 and began working with the sexually violent predator's
19 program. And at that point DMH was still managing the
20 treatment program, so I was running one of three treatment
21 teams, supervised four masters level counselors that were
22 the case managers, did the actual treatment rounds and
23 groups and things like that. And I also was doing some
24 annual reviews. Now that the treatment part has been
25 privatized, I'm just doing evaluations, annual reviews, as

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 well as doing some pre-commitment evaluations.

2 Q Dr. Brown, have you had any additional specialized
3 training or experience within the field of forensic
4 psychology beyond your doctorate degree?

5 A I have. When I was in Georgia, we had regular
6 ongoing training that was done through what was then the
7 Georgia Department of Human Resources. I've been to at
8 least 180 hours of forensic training specifically with the
9 American Academy of Forensic Psychology. They put on
10 workshops around the country, typically a full day at a
11 time and I'll go for three or four of those days. And
12 recently through an organization called Global Institute
13 for Forensic Research have done, gosh, about 40 hours of
14 training and looking at specific risk assessment
15 instruments.

16 Q And Dr. Brown, do you have any memberships in any
17 professional organizations?

18 A I do. The American Psychological Association and
19 Division 41, which is also called the American
20 Psychological of Law Society, a group of attorneys and
21 psychologists working together on forensic issues;
22 Southeastern Psychological Association, Georgia
23 Psychological Association; Augusta Area Psychological
24 Association; probably the two that are most relevant here
25 would be the, the Association for the Treatment of Sexual

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 Abusers and SOCCPN, Sexual Offenders Civil Commitment

2 Program Network which is a -- basically involves employees
3 from all of the different sex offender programs from around
4 the country. And then one that's not related, IMAGO
5 Relationships International which is a group that deals
6 with couples therapy.

7 Q Dr. Brown, does your work and has your work in your
8 career allowed to conduct forensic evaluations of
9 individuals?

10 A It's does.

11 Q Do you have any experience working with sex
12 offenders?

13 A I do.

14 Q And how -- can you -- how long was that -- what was
15 that experience?

16 A As far as working just with sex offenders, that's
17 been the last four years with the department of mental
18 health. The first two-and-a-half years involving both
19 treatment and evaluations. And more recently just doing
20 the evaluations.

21 Q And how many sex offenders have you evaluated
22 during that time?

23 A Approximately 70 different residents, yes.

24 Q And what types of evaluations have you conducted in
25 relation to sex offenders.

Dr. Gordon Brown - Direct Examination by Mr. Morrow

1 A Primarily the annual reviews, but also more
2 recently, I've been doing a few of the pre-commitment
3 evaluations.

4 Q Can you briefly talk about your -- I'm sorry, I've
5 already asked that.

6 Can you briefly describe your background in
7 relation to sexually violent predator cases?

8 A When I first started working there, the program
9 only had two psychologists and another one and I came in
10 about the same time. At this point, we developed a rather
11 comprehensive training program for our master's level
12 counselors. So a lot of it has been what we would call
13 on-the-job training in terms of learning from people in the
14 program, also learning from people in similar programs
15 around the country about how the evaluations are done, how
16 the treatment's done. And then learning as we go along. A
17 lot of the principal reports apply from general psychology,
18 general mental health practice. We've done a great deal of
19 training in-house to be able to try to do a good job with
20 them.

21 Q Have you ever been previously recognized as an
22 expert witness in the field of forensic psychology?

23 A I have.

24 Q About how many times?

25 A I would estimate about fifty times between South

Dr. Gordon Brown - Voir Dire Examination by Ms. Hightower

1 Carolina and Georgia.

2 Q And have you been qualified as an expert in
3 sexually violent predator cases?

4 A I have.

5 Q How many times?

6 A I would estimate about 15 times.

7 MR. MORROW: At this time, Your Honor, the State
8 would move that Dr. Brown be recognized as an expert in the
9 field of forensic psychology.

10 THE COURT: Any cross-examination as to his
11 qualifications?

12 MS. HIGHTOWER: Yes, please, Your Honor.

13 THE COURT: Yes, ma'am.

14 MS. HIGHTOWER: Thank you, may it please the Court.

15 VOIR DIRE EXAMINATION

16 BY MS. HIGHTOWER:

17 Q I was trying to follow through, Dr. Brown -- good
18 afternoon?

19 A Good afternoon.

20 Q I'm Bea Hightower. Nice to see you.

21 Dr. Brown, I was going through your testimony. Am
22 I correct in saying that it was -- it was within the last
23 four years that you came to the sexually violent predator
24 program, the SVP program?

25 A That's correct.

Dr. Gordon Brown - Voir Dire Examination by Ms. Hightower

1 Q Okay. And you indicated that -- so that would have
2 been 2014, correct?

3 A That's correct.

4 Q So you and Mr. Ridley arrived at the program at the
5 exact same time?

6 A That's correct.

7 Q You indicated that your job description while at
8 the -- while at the SVP program when you came there, you
9 did -- wore a couple of different hats. What were those?

10 A I ran one of the three treatment teams as a part of
11 the treatment program and then also did annual review
12 evaluations.

13 Q Okay. Did you treat my client? Did you treat
14 Mr. Ridley?

15 A No, ma'am.

16 Q Okay. You indicated that there's been a change in
17 the program, a privatization, when did that occur?

18 A That's correct. That was, I think, October 2016
19 that Correct Care Recovery Systems took over the treatment
20 aspect of the program.

21 Q So this program was created, the department of
22 mental health's supposed to run it --

23 THE COURT: Ma'am, this is as to his
24 qualifications, not general cross-examination.

25 MS. HIGHTOWER: Yes, sir, Your Honor.

Dr. Gordon Brown - Voir Dire Examination by Ms. Hightower

1 THE COURT: You'll have full leeway on cross.

2 MR. MORROW: Yes, sir, Your Honor.

3 BY MS. HIGHTOWER:

4 Q Let me ask it this way, sir, Your Honor, that -- so
5 in 2016 when they came into privatize the program, what
6 were your duties then? Did you stop with the SVP
7 treatments, did you -- what happened then?

8 A That's correct. I stayed with the department of
9 mental health and became a full time evaluator.

10 Q Okay. Full time evaluator.

11 And I understand you said you developed the
12 training programs that were used at the SVP program when
13 you first got there and going forward?

14 A Well, the group of psychologists together developed
15 it. I was a part of that process.

16 Q Prior to 2014, did you have any -- did you have any
17 SVP training or specialized knowledge?

18 A Not as far as SVP specific. I -- certain within
19 the department of corrections in Georgia worked with sex
20 offenders, but Georgia does not have an SVP program, so not
21 specifically with SVP's.

22 Q Right. So you were working with the general prison
23 population?

24 A Correct.

25 Q In Georgia?

Dr. Gordon Brown - Voir Dire Examination by Ms. Hightower

1 A Correct.

2 Q Of course, some of those are the people that have
3 committed sexual crimes and so you --

4 A Correct.

5 Q Okay. But nothing targeted to the sexually violent
6 program, nothing targeted to the -- the specific paraphilic
7 type -- the sexual urges, the reason why the statute was
8 created for those people that have that specific problem?

9 A That's correct.

10 Q To put it another way, your work in the department
11 of corrections in Georgia, you were there doing competency
12 evaluations, I believe you said and dealing with just the
13 general prison population and their needs from a mental
14 health standpoint?

15 A That's correct. Yes, ma'am.

16 MS. HIGHTOWER: Your Honor, if it please the Court.
17 I mean, I do have some concerns having Dr. Brown -- with --
18 with this testimony on cross, having him admitted as an
19 expert. It doesn't seem that he has a background, the
20 detailed background, in the sexually violent predator
21 arena. Certainly not two years of treatment with them and
22 then two years forward doing simple -- not simple, but his
23 job description being the evaluator, so we do have some
24 discrepancy.

25 THE COURT: Thank you, I appreciate your concern,

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 but I will qualify him as an expert in the field of
2 forensic psychology.

3 MS. HIGHTOWER: Yes, Your Honor. Thank you.

4 THE COURT: Ladies and gentlemen of the jury, what
5 that simply means is that, normally our rules of evidence
6 do not allow someone to give opinion testimony. This's an
7 exception for someone who by way of training, education and
8 experiences become an expert in some field, sort of beyond
9 the scope of the ordinary person such as you and I, like
10 psychiatry, psychology, they're allowed to give opinion
11 testimony and at the conclusion of the case, I'll instruct
12 you on how you handle someone that I've qualified as an
13 expert and how -- what you can do with those opinions and
14 how you handle those.

15 So he'll be allowed to give opinions and obviously,
16 he can be cross-examined about how he came about his
17 opinions and directly be examined on his opinions, et
18 cetera.

19 He will be allowed to give opinion testimony.

20 MR. MORROW: Thank you, Your Honor.

21 DIRECT EXAMINATION

22 BY MR. MORROW:

23 Q Dr. Brown, how did you become involved in
24 Mr. Ridley's case?

25 A I was assigned to see him for his annual review, as

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 has already been forded out, there is an annual review
2 process and the clinical chief psychologist assigns those
3 to the various staff members.

4 Q And were you paid to conduct your evaluation in the
5 case?

6 A I'm paid a salary by the department of mental
7 health and this was a part of my normal responsibilities.

8 Q Would you have been paid any differently if you did
9 not recommend Mr. Ridley to stay committed?

10 A No, sir. It's the same.

11 Q Dr. Brown, what type of evaluation did you perform
12 in the case?

13 A This was an annual review evaluation.

14 Q Okay. And when you're assigned an annual review
15 evaluation, what is it that you're asked to do?

16 A What we're asked to do is to identify whether or
17 not a person has a relevant mental abnormality or
18 personality disorder and to determine if while they've been
19 in the program they have so changed that they're now safe
20 to be released to the community without significant risk of
21 re-offending.

22 Q Dr. Brown, could you describe the method by which
23 you conduct an annual review evaluation under the Sexually
24 Violent Predator Act?

25 A Sure. First, we look at all the available records.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 We look at the legal file, which will typically include
2 documentation related to all of the offenses. We look at
3 all the prospects all the way through the time that they
4 were committed to the program. We read the pre-commitment
5 evaluation that was typically written by another mental
6 health professional to see what they had to say and if
7 there's a dissenting opinion, we'll typically read that
8 opinion to see what the other expert had to say.

9 After doing all of that, we'll look at all of the
10 treatment records during the review period, which is
11 typically a year's time. And then we'll meet with the
12 resident himself to have an interview with him to complete
13 the process.

14 Q And, Dr. Brown, how is an annual review evaluation
15 different from a recommitment evaluation?

16 A The pre-commitment evaluation, well, first of all,
17 has established there's a sexually violent offense in the
18 record. Does this person have a mental abnormality or a
19 personality that predisposed them to continue committing
20 sexually violent offenses if they're not confined for
21 long-term care, control, and treatment.

22 And in the annual review process, the idea is, have
23 they now so changed that they're safe to be released.

24 Q Dr. Brown, as part of your evaluation, did you meet
25 with and interview Mr. Ridley?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A I did.

2 Q And how long did you interview Mr. Ridley?

3 A I've seen him three different times for annual
4 reviews, plus two other shorter times to get ready for a
5 prior hearing and then for this trial, so a total of almost
6 ten hours altogether.

7 Q And Dr. Brown, is Mr. Ridley in the courtroom
8 today?

9 A He is.

10 Q Could you describe or could you point him out?

11 A He's in the yellow jumpsuit there.

12 Q Okay. Did you explain the purpose of the
13 evaluation to Mr. Ridley?

14 A I did.

15 Q Did he consent to the evaluation?

16 A He did.

17 Q And Dr. Brown, in addition to meeting with and
18 interviewing Mr. Ridley, what information did you receive
19 to aid you in conducting your evaluation?

20 A Well, again, all of the legal files, including his
21 offense history. And each year, we get a packet of
22 treatment records earlier from department of mental health
23 and then from one of -- from both department of mental
24 health and Correct Care and more recently, of course, from
25 Correct Care. So all of the treatment records then that

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 are associated with his treatment in this program.

2 Q And how did you obtain that information?

3 A The legal file is put together when he's first
4 referred for evaluation and that basically stays at the
5 department, so our paralegal gives that to us. And at this
6 point, we request treatment records from Correct Care and
7 they send them over to us.

8 Q And is this the type of information that is
9 typically and reasonably relied upon by experts in your
10 field?

11 A It is.

12 Q Did you consider and rely on that information that
13 you listed for the jury a moment ago and upon your
14 interview in rendering your opinion in this matter?

15 A I did.

16 Q Dr. Brown, can you explain to the jury how an
17 individual's past sexual offense behavior relates to his
18 future sexual offense behavior?

19 A Any time we're trying to predict how someone's
20 going to act in the future, the first thing that we want to
21 do is look at their past behavior and specifically look at
22 patterns of behavior. What does this person keep doing
23 over and over again. What has he done in the past that
24 makes it likely he'll do those same kinds of things in the
25 future. And with sexual offense behavior in particular, we

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 know that people with a higher number of sexual offenses
2 are more likely to commit future sexual offenses than
3 people who don't have that higher number. So it's
4 important to look at not only the quantity but also the
5 nature of the offenses.

6 Q Dr. Brown, based on your interview with Richard
7 Ridley and your review of his file, could you tell if he'd
8 been convicted of a sexually violent offense?

9 A Yes.

10 Q In fact, you found he'd been convicted of nine
11 sexual offenses, correct?

12 A That's correct.

13 Q Two counts of sodomy in the third degree and one
14 count of sexual abuse third degree; subject a person to
15 sexual conduct without consent from 1996 in New York State?

16 A That's correct.

17 Q One count of sodomy third degree; deviant
18 intercourse with a person under 17 in New York State in
19 1997?

20 A That's correct.

21 Q Four counts of sodomy third degree child under 17
22 in New York State?

23 A That's correct.

24 Q And one count of criminal sexual conduct in the
25 third degree in 2001 in South Carolina?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A That's correct.

2 Q Did you review the 1996 offenses and documents as
3 part of your evaluation?

4 A I did.

5 Q And are those the type of documents that are
6 commonly and reasonably relied upon by experts in your
7 field?

8 A They are.

9 Q Dr. Brown, why is it necessary to review the
10 details of the underlying facts of the offenses or the
11 details of the offense when doing these types of
12 evaluations?

13 A Well, again, we're looking for patterns of
14 behavior, does this person keep doing the same kinds of
15 things over and over and sometimes you can't tell just from
16 the -- could I have some water, please.

17 (The witness was given a cup of water.)

18 THE WITNESS: Sometimes you can't tell just from
19 the name of the offense whether or not it is, in fact, a
20 sexual offense. So it's important to look at the nature of
21 the offenses to see exactly what it did involve and to see
22 if there's a pattern there.

23 BY MR. MORROW:

24 Q Could you describe the facts and circumstances
25 regarding Mr. Ridley's 1996 third degree, two counts and

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 sexual abuse third degree, an act in a minor injurious to a
2 child under 17?

3 A Unfortunately, we don't have specific investigative
4 records from the State of New York. Those were requested
5 in the pre-commitment process, got back a letter saying
6 that those records aren't available. So basically all we
7 have regarding those are the names as they were recorded on
8 the legal documents that we did get.

9 The sodomy third degree, he was 21 or older and he
10 did intercourse under the age of 17 and there were two
11 counts of that. And then the sexual abuse second involved
12 sexual contact with a person less than 14 years old and
13 that one, I think was amended to sexual abuse third,
14 subjecting another person to sexual contact without
15 consent. So I don't have the underlying details from the
16 investigative reports from that.

17 Q Did you also review the 1997 conviction for sodomy
18 third degree deviant intercourse with a person under 17 as
19 part of your evaluation?

20 A I did.

21 Q And were they -- was that part of the basis of your
22 expert opinion?

23 A It was.

24 Q Are the documents, or what you relied upon commonly
25 relied upon by experts in your field?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A They are.

2 Q And why is it necessary to review the facts of that
3 offense?

4 A Well, again, we're looking for patterns here and
5 with the 1996, 1997, we're seeing sodomy come up a lot
6 where he's more than 21 and the victim is less than 17. So
7 we're seeing a pattern in the behavior with that.

8 Q What, if anything, did Mr. Ridley have to say about
9 these offenses during your interview?

10 A The New York records seem to indicate three
11 different cycles of offenses and he has basically said
12 there were only two. Now, in the first one, he said they
13 were attempts and not actual completion of the sex acts.
14 And with the last one, he did say, I think that involved
15 him forcing the victim to give him oral sex.

16 Q And that last one you're talking about is the 1997
17 -- or, I'm sorry, did you review documents concerning the
18 1997 conviction for four counts of sodomy third degree, a
19 child under 17, acting in a manner injurious to a child
20 under 17 as part of your evaluation?

21 A Yes, that's correct.

22 Q Were they part of the basis for your expert
23 opinion?

24 A They were.

25 MS. HIGHTOWER: Your Honor, if I could just

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 interrupt for a moment.

2 THE COURT: You got an objection?

3 MS. HIGHTOWER: I just wanted a clarification. I
4 don't understand. Is Mr. Morrow saying there's four counts
5 from -- and from when? I'm trying to follow along with the
6 records I have. I just wanted to make sure I was
7 understanding that correctly, sir.

8 THE COURT: All right. Restate your question.
9 Where are you there were two of them in 1997, the first one
10 or the second one?

11 MR. MORROW: Well, there -- yes, this is the second
12 set of charges from November of 1997.

13 THE COURT: And those charges are what?

14 MR. MORROW: Four counts of sodomy in the third
15 degree child under 17, one count of acting in a manner
16 injurious to a child under 17.

17 THE COURT: Five separate offenses?

18 MR. MORROW: That's correct, Your Honor.

19 THE COURT: You with us, ma'am?

20 MS. HIGHTOWER: I do not have that -- I mean I have
21 the 1997.

22 THE COURT: Hold on, hold on. Show it to her,
23 please.

24 MS. HIGHTOWER: I do not have that reflected, if I
25 could speak with Mr. Morrow for a moment. If I could see

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 the underlying document --

2 THE COURT: Ma'am, walk right over there and he'll
3 show it to you -- or he'll walk to you.

4 MS. HIGHTOWER: Thank you. Beg the Court's
5 indulgence.

6 THE COURT: Yes, ma'am.

7 (There was a pause in the proceedings.)

8 THE COURT: Everybody square?

9 MS. HIGHTOWER: Thank you, Your Honor.

10 THE COURT: You okay?

11 MS. HIGHTOWER: He's going to amend his question.
12 Thank you, sir.

13 THE COURT: Ladies and gentlemen of the jury panel,
14 nobody's trying to hide anything from anybody else, it's
15 just when these cases come about and the lawyers take on
16 the responsibility, all the records are sent. Nobody's
17 trying to hoodwink anything. Under our rules today,
18 everybody has to know everybody about everything.

19 So you've got -- you got your finger on it, ma'am?
20 You good?

21 MS. HIGHTOWER: I think so, yes, Your Honor. He's
22 -- we've talked about it and he's going to amend his
23 question. Thank you.

24 BY MR. MORROW:

25 Q I'm sorry, Dr. Brown, the third conviction from

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 1997, November 5th of 1997 appears in the record to be two
2 counts of sexual -- sexual criminal act, sodomy in the
3 third degree and did you review those for your evaluation?

4 A I'm sorry, I've lost you now.

5 Q That third -- the third conviction or the third
6 cycle of convictions from New York appears to be two counts
7 of criminal sexual act in a manner injurious to a child --
8 or two counts of sodomy in the third degree, a child under
9 17.

10 A I'm sorry, one more time.

11 Q Did you review the 1997 offenses?

12 A I did.

13 Q And what did you find when you reviewed the 1997
14 convictions?

15 A There were convictions for sodomy third degree,
16 deviant intercourse with a person under 17 incapable of
17 consent. And then later four counts of sodomy third degree
18 after 21 or more as deviant intercourse with a person under
19 17. There were four counts -- no -- yes, four counts of
20 that. And then act in a manner injurious to a child less
21 than 17.

22 MS. HIGHTOWER: Your Honor, I'd object. I -- I.

23 MR. MORROW: She'd have plenty of time to
24 cross-examine the witness.

25 MS. HIGHTOWER: Can I see what the witness is

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 reading from?

2 THE COURT: Well, you can cross-examine him. You
3 know what the rules are.

4 MS. HIGHTOWER: Yes, sir.

5 THE COURT: What are you reading from?

6 THE WITNESS: What I have is a summary list and
7 I've gone through the NCIC report and --

8 THE COURT: Let's take our afternoon break and let
9 me get square with these lawyers.

10 I tell you what I do need. How about select me a
11 foreperson from the twelve of y'all. That's the person who
12 sort of acts as a spokesman and asks -- advises me of any
13 concerns you have when you're conducting your
14 deliberations. So -- or you can select the lady sitting in
15 the foreperson seat. However y'all want.

16 Don't discuss the case, we'll be back in just a few
17 minutes.

18 (The jury left the courtroom at 3:28 p.m.)

19 THE COURT: All right. Let me go on the record,
20 please, lady and gentleman. Y'all, please while we're
21 taking the break see if you can't resolve confusion. The
22 doctor has an abstract up here. You're welcome to look at
23 that.

24 You don't have any personal notes on it, do you
25 sir?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 THE WITNESS: I just have some numbers I've written
2 trying to figure out the number of payouts -- no notes, no.

3 THE COURT: And we'll take about a ten minute break
4 for our afternoon and then come back and go to five.

5 MS. HIGHTOWER: Thank you, sir.

6 THE COURT: Doctor, obviously, you can take a break
7 and step down, just don't discuss your testimony.

8 THE WITNESS: Thanks.

9 (A brief recess was observed.)

10 THE COURT: Were y'all able to get reconciled?

11 Ma'am?

12 MS. HIGHTOWER: Well, I think where we ended, Your
13 Honor, with I can cross-examine him on what I think is a
14 mistake in the record. His summary sheet is -- is -- it's
15 his summary sheet. I don't know where he got those numbers
16 from, but it -- did Mr. Morrow get you everything he had
17 and do you have everything she had.

18 He's pointed out in the rap sheet from New York
19 that he had. When I went through everything, I also had
20 the New York arrest records. So...

21 THE COURT: All I can tell you is if there's any
22 discrepancies, you can certainly cross-examine him on it.

23 MS. HIGHTOWER: And that, like I said, Your Honor,
24 that's kind of where we ended up because I couldn't
25 convince Mr. Morrow that two turning into four counts is

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 impossible.

2 THE COURT: No, it's not impossible. He's sticking
3 to his guns and you're sticking to his guns.

4 MS. HIGHTOWER: Advocacy.

5 THE COURT: Ma'am?

6 MS. HIGHTOWER: Advocacy.

7 THE COURT: Also known as impossible sometimes.

8 MS. HIGHTOWER: I know. I appreciate the break,
9 Your Honor, and I appreciate Mr. Morrow -- we tried.

10 THE COURT: I understand.

11 MS. HIGHTOWER: Thank you.

12 (The jury entered the courtroom at 3:51 p.m.)

13 THE COURT: So did y'all select a foreperson?

14 THE FOREPERSON: Yes, sir. I'm good with not doing
15 this. I voted for this fellow here.

16 THE COURT: He can't be a foreperson, he can't even
17 eat a Taco. (Laughter)

18 You'll do a wonderful job, ma'am.

19 BY MR. MORROW:

20 Q Dr. Brown, you found that on three different
21 occasions -- I'm sorry, one occasion in 1996 and two
22 occasions in 1997, Mr. Ridley was convicted of a count --
23 of sodomy third degree, correct?

24 A That's correct.

25 Q And all of his offenses were against males under 17

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 years of age?

2 A That's correct.

3 Q And did you review the documents concerning his
4 2001 criminal sexual conduct in the third degree conviction
5 from the State of South Carolina as part of your
6 evaluation?

7 A I did.

8 Q And were they part of the basis of your expert
9 opinion?

10 A They were.

11 Q Are these the type of documents that are reasonably
12 and typically relied upon by other experts in your field?

13 A They are.

14 (State's Exhibit Number 1 was marked for
15 identification.)

16 BY MR. MORROW:

17 Q Dr. Brown, I'm going to show you what's been
18 premarked for identification purposes only, as State's
19 Exhibit 1. If you'd take a moment to look at these
20 documents and see if you recognize them?

21 A Okay.

22 MR. MORROW: Your Honor, may I approach?

23 THE COURT: Do you know what they are?

24 MS. HIGHTOWER: Thank you, Your Honor, I've
25 reviewed them.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 BY MR. MORROW:

2 Q Okay. Do you recognize those documents?

3 A I do.

4 Q And were they part of the basis of your expert
5 opinion?

6 A They were.

7 Q Is there anything on that document indicating it's
8 authenticity?

9 A I'm sorry?

10 Q Is there anything on that document to indicate it's
11 authenticity? In other words, is it sealed by the clerk of
12 court?

13 A Oh, yes, yes, I'm sorry. I didn't hear your
14 question. I'm a little bit hard of hearing sometimes.

15 There is. There is a seal from the clerk.

16 MR. MORROW: At this time, Your Honor, the State
17 would admit State's Exhibit 1 into evidence.

18 MS. HIGHTOWER: Without objection.

19 (State's Exhibit Number 1 was entered into
20 evidence.)

21 BY MR. MORROW:

22 Q Dr. Brown, did you review the facts and
23 circumstances around that criminal sexual conduct in the
24 third degree offense?

25 A I did.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 Q And what were the facts and circumstances around
2 that offense?

3 A This was a case where Mr. Ridley was working at a
4 fast food restaurant as a manager and ended up giving a new
5 employee a ride home. And after doing so threatening the
6 employee, forced him to perform oral sex, anally raped him.
7 Those are the basic facts.

8 Q And what, if anything, did Mr. Ridley have to say
9 about those offenses during your interview?

10 A Mr. Ridley told me that the victim had stolen some
11 money from him and that he, Mr. Ridley, basically tricked
12 him into having sex because of that.

13 Q And Dr. Brown, did you review documents concerning
14 -- concerning Mr. Ridley's 2002 conviction for assault and
15 battery of a high and aggravated nature?

16 A I did.

17 Q And were they part of the basis of your expert
18 opinion?

19 A They were.

20 Q Are these the type of documents that are commonly
21 relied upon and typically relied upon by other experts in
22 your field?

23 A They are.

24 Q And was Mr. Ridley originally charged with a
25 sexually violent offense in relation to that conviction?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A He was.

2 Q And could you describe the facts and circumstances
3 underlying this assault and battery of a high and
4 aggravated nature conviction from 2002?

5 A Okay. In this case, he forced the victim to
6 masturbate and perform oral sex. Threatened to rape and to
7 kill the victim. This is one that occurred in the Aiken
8 County Detention Center while he was facing charges for the
9 earlier charges we just talked about.

10 Q And that happened while he was in the Aiken County
11 Detention Center?

12 A That's correct.

13 Q And what sentence did he receive for that
14 conviction?

15 A That was ten years.

16 Q And did you also review his charges and conviction
17 for failure to register as a sex offender from 2002?

18 A I did.

19 Q And was it part of the basis of your expert
20 opinion?

21 A Part of the basis, not as strongly as the sexually
22 violent offenses were, but, yes.

23 Q And are these the type of documents that are
24 commonly and reasonably relied upon by other experts in
25 your field?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A They are.

2 Q Why is it necessary to review the underlying facts?

3 A Because, again, we're looking for patterns of
4 behavior and is this a consistent part of the person's
5 behavior and something he's likely to keep doing.

6 Q And what did you find about -- how did he -- how
7 was it discovered that he failed to register as a sex
8 offender?

9 A I don't know how it was discovered. The charges
10 related to the fact that when he moved to South Carolina
11 from New York, he failed to register with the sheriff's
12 office as is required when you change residences.

13 Q Dr. Brown, as part of your evaluation and part of
14 evaluations in these type of proceedings, is it important
15 that you review sexual offenses that resulted in charges,
16 but were ultimately dismissed?

17 A It is.

18 Q And why is that?

19 A Well, probably the biggest reason is when we're
20 looking at the risk of re offending, we know that it's not
21 just a number of convictions, it's the number of charges a
22 person has faced before as a part of the likelihood of re
23 offending. And it's also, again, a part of the pattern of
24 behaviors that we look at.

25 Q And, Dr. Brown, did you review -- or what if

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 anything, did you find charges-wise that were dismissed?

2 A November of 2001, there was a criminal sexual
3 conduct in the third degree charge, also November of 2001,
4 criminal sexual conduct with a minor and then in March of
5 2002, assault with intent to commit criminal sexual conduct
6 second degree. And intimidation of witness.

7 Q And what, if any of that, did you consider relevant
8 for your ultimate opinion?

9 A Well, again, it's a part of the pattern of behavior
10 we see where Mr. Ridley's, in some cases convicted of, and
11 in other cases accused of, forcing other people to engage
12 in sexual activity.

13 Q Now, Dr. Brown, you evaluated Mr. Ridley in
14 relation to his progress and the treatment at the South
15 Carolina Sexually Violent Predator Treatment Unit, correct?

16 A I did.

17 Q And how long -- how often do evaluations of an
18 individual's progress and treatment take place?

19 A The statute requires an annual evaluation of their
20 progress.

21 Q And when was Mr. Ridley committed to the SVP
22 treatment program?

23 A August 25th of 2014.

24 Q And have you seen him in relation to his annual
25 review?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A I have.

2 Q Okay. And how many times have you seen him?

3 A I've seen him three times.

4 Q Okay. Has he ever been recommended for release
5 from the program?

6 A No.

7 Q Have you recommended others for release during that
8 time?

9 A I have.

10 Q But not Mr. Ridley?

11 A No, I have not.

12 Q And why is that?

13 THE COURT: The question is has he recommended or
14 has the department recommended.

15 BY MR. MORROW:

16 Q Has the department recommended for release?

17 THE COURT: Go ahead.

18 BY MR. MORROW:

19 Q Dr. Brown, have you personally recommended anyone
20 for release during that time period?

21 A Yes, I have.

22 Q But not Mr. Ridley?

23 A But not Mr. Ridley, correct.

24 Q Why -- and why not? Why?

25 A Well, again, we're looking at whether or not the

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 person has made enough progress so that they're safe to be
2 released in the community and those that I have recommended
3 I feel that they've made enough progress and they're at a
4 low enough of a risk that they are safe to be released into
5 the community. In Mr. Ridley's case, I don't believe he's
6 made sufficient progress.

7 Q How much progress would you say Mr. Ridley has made
8 in his treatment?

9 A I would say very little.

10 Q And why would you say he's only minimal progress or
11 little progress?

12 THE COURT: He didn't say a little, he said
13 minimal.

14 BY MR. MORROW:

15 Q Minimal, I'm sorry.

16 A Mr. Ridley, in some ways participates. He goes to
17 group, he does the assignments. He does things like that.
18 But in group he's -- he's very good at giving feedback to
19 others, giving his opinion, you know, letting other people
20 know because the kinds of things they need to work on, the
21 consistent feed back I've gotten from his case managers is
22 that he's not so receptive to getting feedback. He
23 complains about things like having to redo is
24 autobiography, which is a big part of the early stages of
25 treatment. When there's actually very good clinical reason

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 for doing that.

2 So, in my perception, he spent more time fighting
3 the commitment and trying to argue that he doesn't need to
4 be there rather than actually engaging in treatment to try
5 to progress to the point where he can be recommended.

6 Q Dr. Brown, what source of information did you use
7 to form the basis of your opinion about his progress and
8 treatment?

9 A It's primarily the treatment records. What is said
10 in the group notes and the progress notes, in the treatment
11 plan, any other records that are available.

12 Q And then in addition to that, you met with
13 Mr. Ridley on several different occasions?

14 A That's correct.

15 Q And when did you meet with Mr. Ridley?

16 A In July -- July 31st of 2015, I met with him for
17 about two-and-a-half hours. August 24th, 2016 for about
18 two hours. June 1st, 2017 for about three hours and
19 there's one other time in preparation for a probable cause
20 hearing. I didn't record the date or time of that one.
21 And then last week in preparation for this trial for about
22 an hour and a half.

23 Q And so you've had an opportunity to observe
24 Mr. Ridley's progress over time?

25 A I have.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 Q And what was Mr. Ridley's diagnosis upon commitment
2 to the sexual violent predator treatment unit?

3 A He was committed with two diagnoses. One is other
4 specified paraphilic disorder, specifically biastophilia,
5 and the other antisocial personality disorder with
6 narcissistic traits.

7 Q And how was Mr. Ridley committed to the SVP
8 treatment unit?

9 A He went through the normal process of being
10 screened for evaluation for the program and then when he
11 came to court to face a jury trial, he voluntarily
12 committed to the program.

13 Q And is the diagnosis that you just went over the
14 same as your current diagnoses?

15 A They are.

16 Q Okay. Tell us about your current -- what if any
17 mental abnormality or personality disorder did you diagnose
18 Mr. Ridley with?

19 A Okay. The primary diagnosis that I would give him
20 at this point would be antisocial personality disorder.

21 THE COURT: Wait a minute. You were given that
22 diagnosis or you made the diagnosis.

23 THE WITNESS: I'm sorry?

24 THE COURT: You were given the diagnosis or you
25 made the diagnosis?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 THE WITNESS: That's the primary diagnosis I would
2 give at this point.

3 THE COURT: You would give?

4 THE WITNESS: Yes, yes, sir.

5 THE COURT: Okay. Your diagnosis.

6 THE WITNESS: Correct, Your Honor.

7 THE COURT: I'm sorry. I thought I heard something
8 else.

9 BY MR. MORROW:

10 Q You diagnosed him with antisocial personality
11 disorder and you also diagnosed him with other specified
12 paraphilic disorder, biastophilia; is that correct?

13 A That's correct, yes.

14 Q Tell us about the other specified paraphilic
15 disorder biastophilia. What is that?

16 A Okay. I want to read part of this from the
17 diagnostic manual, which is where we get it from. What
18 we're looking at here is what's called a paraphilia.

19 MS. HIGHTOWER: Your Honor, I'm going to object.
20 If we could identify what part of the manual he's reading
21 from because as we all know how it's broken down in terms
22 of.

23 THE COURT: Clarify where you're reading from.

24 THE WITNESS: Okay. This is the paraphilic
25 disorders on page 685.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 MS. HIGHTOWER: The identified paraphilic disorders
2 or just the general instruction into the --

3 THE WITNESS: This is just the general instruction.

4 MS. HIGHTOWER: Thank you.

5 THE COURT: Move along.

6 THE WITNESS: A paraphilia denotes any intense and
7 persistent sexual interest other than sexual interest in
8 genital stimulation or preparatory fondling with
9 phenotypically normal, physically mature, consenting human
10 partners.

11 So basically we're talking about strong persistent
12 sexual arousal to something other than a mature, consenting
13 partner. For it to rise to the level of a paraphilic
14 disorder, that's a paraphilia that's causing some kind of
15 distress or impairment to the individual himself or a
16 paraphilia that's causing harm, personal harm, or risk of
17 harm to someone else. And there are several specific
18 paraphilic disorders that are listed in the manual and
19 Mr. Ridley does not meet the criteria for any of those and
20 where I would put his diagnosis is under the category of
21 other specified paraphilic disorder. And for this, I'm
22 reading from page 705.

23 And this applies to presentations for the symptoms
24 of a paraphilic disorder are there. In other words, it's
25 persistence, long lasting, it's been there for at least six

Dr. Gordon Brown - Direct Examination Continued by Mr. Mor

1 months. It caused clinically significant distress or
2 impairment in social, occupational, or other important
3 areas of functioning. And then they go on to list several
4 examples and say that this is not limited to these specific
5 exams but can include other paraphilias as well.

6 And the specific paraphilic disorder that I've
7 diagnosed is called biastophilia. Others would call it
8 simply nonconsent or possibly rape. But the idea that his
9 sexual arousal comes because of the nonconsent of the other
10 person. So he's sexually aroused by the idea of having sex
11 with individuals who are not consenting.

12 Q Dr. Brown, how did you find that Mr. Ridley met the
13 criteria for other specified paraphilic disorder,
14 biastophilia?

15 A If you look at just what we have in the applicant's
16 history, all of his partners were either not able to give
17 consent because of their legal age or were clearly
18 nonconsenting in that he forced them to have sex against
19 their will. And we see a pattern that goes over several
20 years, not just a one-time rape incident.

21 Q You also -- you mentioned this a second ago: And
22 you also diagnosed him with a personality disorder,
23 antisocial personality disorder with narcissistic traits;
24 is that --

25 A That's correct.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 Q What is antisocial personality disorder with
2 narcissistic traits?

3 A And again, I want to be sure I read this from the
4 manual so we get it exactly right. And this is from the
5 section on antisocial personality disorders and specifically
6 antisocial personality disorder on page 659. What we're
7 looking at is a pervasive pattern of disregard of the
8 rights of others, violation of the rights of others
9 occurring since the age of 15 and having to meet at least
10 three of seven specific criteria. And those criteria are
11 failure to conform to social norms, which is to lawful
12 behaviors as indicated by repeatedly performing acts that
13 are grounds for arrest, deceitfulness as indicated by
14 repeated lying, use of aliases, conning others for personal
15 profit or pleasure, impulsivity, or failure to plan ahead,
16 irritability, or -- and aggressiveness indicated by
17 physical fights or assaults, reckless disregard for safety
18 of self or others, consistent irresponsibility, and lack of
19 remorse.

20 Q And how did you find that Mr. Ridley met the
21 criteria for antisocial personality disorder with
22 narcissistic traits?

23 A Well, his criminal history itself indicates the
24 failure to conform to social norms. He acknowledges having
25 conned some of the victims into having sex, so there's a

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 deceitfulness there. You know, the impulsivity, the
2 failure to plan ahead, the kind of lifestyle that he's had.
3 He's not a man who has had long term goals and works
4 steadily toward those goals. Consistent irresponsibility
5 in terms of the kind of lifestyle that he had on the
6 streets.

7 Q And how does -- how does treatment for an
8 individual with these types of diagnoses, how does it work?

9 A Well, it has to be long term treatment because
10 we're talking about ingrained personality characteristics
11 and just a part of the way that a person is. What takes
12 looking in a very intense situation, intense treatment
13 program and to what kind of person was I, why did I do the
14 kinds of things that I did. What do I need to change about
15 the way that I am, the way that I'm thinking in order to
16 not do those things in the future in order to make better
17 choices, better decisions in the future.

18 Q And what has Mr. Ridley been working on during his
19 treatment in the SVP unit?

20 A Specifically, he's spent a lot of time working on
21 the autobiography which is where they go through their
22 different phases of life, how they came to be the person
23 they are, you know, what kind of life experiences got them
24 to where they are. And then tying that in with the offense
25 history and part of that too is what we call disclosure,

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 where they talk specifically about their sexual offenses.

2 And then we also -- I would have them looking at things
3 like risk factors, coping skills for the future. So those
4 are the kinds of things that he's been working on in the
5 program.

6 Q Have you found that Mr. Ridley has participated in
7 treatment?

8 A Participated in terms of attending the groups, in
9 terms of participating in group and in terms of doing
10 assignments, yes.

11 Q And you started seeing Mr. Ridley, you first saw
12 him in 2015; is that correct?

13 A 2015.

14 Q In that report, you found that he had just begun
15 treatment?

16 A That's correct.

17 Q The -- and he participated in group therapy during
18 that time as well?

19 A That's correct.

20 Q What, if anything, did he struggle with at that
21 time?

22 A When I saw him in 2015, probably the most striking
23 thing to me was when I asked him what was deviant or
24 abnormal about his past behavior, you know, on the one
25 hand, he says that everything was deviant about it, but

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 when he refocuses on the fact that it was just -- it was
2 deviant to have sex with other men. And I think that's an
3 issue he struggles with -- not just in 2015, but since
4 then. So the very issue that it's not forcing people who
5 aren't willing to have sex, it's that -- the fact that I'm
6 having sex with other men that he found to be the deviant
7 part of it. And just really minimizing and not recognizing
8 how serious, how offensive his behavior really was.

9 Q So, I'm sorry. Could I get you to clarify just for
10 a moment. You're saying that his -- he was focused more on
11 his -- the nature of his home sexual relationships or
12 having sex with other men being deviant rather than the
13 fact that they were consenting?

14 A That's correct, yes.

15 Q You also said -- you also saw him in 2016, is that
16 correct?

17 A That's correct.

18 Q And you found in 2016 that he still remained in the
19 beginning stages of treatment?

20 A That's correct.

21 Q And why? Why -- he's been in for two years at that
22 -- at this point. Why did you find that he remained at the
23 beginning stages of treatment?

24 A Well, again, he's doing -- he's going through the
25 acts. He's doing the things that the program's requiring

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 him to do in terms of going to group, doing the
2 assignments, but the consistent feedback from case managers
3 is there's no depth there. It's like he wants to complete
4 the assignment and move onto the next one rather than
5 really getting the benefit from the assignment that he's
6 supposed to be getting.

7 Q And in 2016, you also found -- did you find that he
8 continued to minimize?

9 A I did.

10 Q And how is that relevant to your -- to your finding
11 that he still needs to continue treatment?

12 A He minimizes it in terms of trying to resent
13 victims as being more consenting than the record would
14 indicate that they were. I think it was the first time I
15 saw him when I asked him about why he was committed to the
16 program and he talked about the program being for people
17 who had committed violent, heinous crimes; and he says his
18 crimes were not violent, they weren't heinous. I don't
19 think he saw his own crimes as fitting the definition of
20 what kind of crimes that this program...

21 Q Dr. Brown, what, if anything about Mr. Ridley's
22 behavior on the unit did you find, or did you find anything
23 similar to his behavior that he had -- when he was
24 committing these offenses?

25 A One of Mr. Ridley's ongoing issues, and he's talked

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 about this himself, within the evaluations, the need for
2 power and control. You know, I've got to be the one in
3 charge. I've got to be the one directing what's happening.
4 And he's continued to do that in the program. He's spent a
5 great deal of time on those legal issues, trying to justify
6 his behavior, trying to explain why he shouldn't have been
7 in the program instead of working towards getting out. But
8 also, some of the things in terms of just feeling like the
9 rules of the program don't apply to him. He doesn't have
10 much of a disciplinary history within the program, but
11 because of things that did come up are the kinds of things
12 that he was doing on the street.

13 One is he goes to medical without his shirt on.
14 Not a big deal, except that's a part of the patterned
15 behavior, the rule about having to wear a shirt in this
16 situation shouldn't apply to me. It's a silly rule. I
17 don't have to follow it.

18 There was a disagreement with a mail clerk in the
19 process of trying to mail something out and he gets angry
20 about that. Probably the most flagrant, which, again, it's
21 not an extremely serious thing, but a part of the process.
22 He reached level, I guess blue level under the DMH program
23 where he was at the highest privilege level and that level
24 could order a television. But there's a policy and
25 procedure in place for doing that and he had requested

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 permission to order a television, had been told what he
2 would need to do and the staff member that responded was
3 very clear, do not order a television until I give you
4 permission to do so. Mr. Ridley proceeded right away to
5 order a television and then later it was, well, I
6 misunderstood the memo. Having seen the memo, I don't see
7 any way to misunderstand that.

8 A fairly recent group note, another resident
9 mentioned that Mr. Ridley was trying to persuade him to get
10 him a pair of shoes in exchange for canteen goods. So
11 again, trying to be conniving and dishonest and making
12 things happen the way that he thinks that they should
13 happen.

14 Q Dr. Brown, you also looked at him in 2017, his
15 current evaluation that we're in. What progress, if any,
16 had he shown from the 2016 evaluation to the 2017
17 evaluation?

18 A Again, I would say very little progress.

19 Q And why? What reasons would you give for that?

20 A He's still focusing more on the legal issues. He's
21 complaining at that point, you know, this is about the time
22 that Correct Care had taken over the treatment. A lot of
23 complaints about how the department, how they ran the
24 program, a lot of complaints about some of the issues that
25 came up in the transition. And each time you have a

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 transition like that they're are going to be some problems
2 and he comes in just assuming that Correct Care is going to
3 do horrible job and they're not going to do it well,
4 they're not going to get it right. So you're spending more
5 time trying to complain about the things and make it right
6 through the legal process or the grievance process than
7 focusing on the treatment.

8 Q And did you consider this as continued evidence of
9 his antisocial personality?

10 A I did.

11 Q You also saw Mr. Ridley again last week; is that
12 correct?

13 A I did.

14 Q What, if anything, did you find?

15 A About the same. You know, I will say Mr. Ridley
16 interviews very well, so he's very easy to interview. He's
17 very convincing in interview. And you know, like the
18 previous times when I'm leading the interview with
19 Mr. Ridley, I'm thinking, well, maybe he has made progress,
20 maybe he has changed. He's very convincing in that way.
21 But when I go back and look at the record, I just don't see
22 a treatment record that reflects other people saying about
23 him what he's saying about himself in the interview.

24 THE COURT: So are you making this assessment based
25 on what you read in the records or are you directly

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 observing him doing what you say he's doing or not doing.

2 THE WITNESS: Well, I'm not in the treatment
3 program, so this isn't something that I can directly
4 observe. This is based on the records that I've seen about
5 the treatment.

6 THE COURT: Somebody's writing that up and you're
7 reading the reports, you haven't seen him doing any thing
8 which you described.

9 THE WITNESS: That's correct.

10 THE COURT: Okay.

11 BY MR. MORROW:

12 Q Dr. Brown, was there a recent progress note that
13 involved offensive parallel behavior?

14 A There was.

15 Q And what, if anything, did you find in that
16 progress note?

17 A This was from the 22nd of this month, so this is
18 just a few days ago -- I'm sorry, the group note was from
19 the 15th of this month, just a few days ago.

20 Mr. Ridley wasn't focused during that time and he
21 was described as minimization, jumping to conclusions,
22 manipulations, deceitfulness, problem solving,
23 dysfunctional coping. He became angry, basically saying he
24 wasn't going to help anyone because of that. But a large
25 part of the focus was that he has been helping one of the

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 younger male residents in the program, more or less
2 mentoring the resident and in addition training that
3 resident to take over his job when he leaves the program.
4 Again, which is in violation of the policy because he can't
5 choose his successor. Whoever get it is job would have to
6 apply for it and go through the formal process. The
7 problem is, and this resident, I think he's like 26 years
8 old; he's very much in that category of people that
9 Mr. Ridley has found himself attracted to in the past.

10 So what he's calling mentoring behavior on the unit
11 is very similar to what we see in his offense history as
12 grooming behavior where he befriends these younger men and
13 at least in the past has raped them. And he may have the
14 best of intentions, but what they have to look at at a
15 treatment program like this is how is this like behavior
16 that you've demonstrated in the past.

17 And during that same group, there was talk of some
18 attraction to one of the younger male staff members that's
19 also within that mid 20's age category. And you know, my
20 concern is Mr. Ridley's not recognizing this as a part of
21 his -- and you know, just a few weeks ago is still dealing
22 with these issues and not aware of the finds of risky
23 situations that he's going to be dealing with for the
24 entire rest of his life.

25 Q Did you find in your most recent evaluations that

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 he acted in a manner that was similar to his -- the way he
2 was acting during his offending history on the outside?

3 A Sure.

4 Q And could you give examples of that?

5 A Well, that's part of what I was just talking about.
6 But, again, a part of it is the need to be in charge, the
7 need to be in control. I'm going to pick the person who's
8 going to take my job and I'm going to train that person to
9 do the job so he can do it when I leave; wanting to be sure
10 that he's running the show.

11 Q And what does Mr. Ridley need to do to continue to
12 work on in treatment? What does he need to work on in
13 order to make progress to the point where he's ready to be
14 released?

15 A I think the first thing he needs to do is to
16 acknowledge that he is someone who really does meet the
17 criteria to be in a program like this to recognize that he
18 does have some very serious violent offenses in his past
19 and then basically Correct Care at this point has a phase
20 program in place where he just needs to go through the
21 phases in order and take care of all of the treatment goals
22 as they come along. I don't know that there's anything
23 outside of solid treatment program's going to offer. He
24 needs to look at his past as he has been doing and be able
25 to specifically tie that into his offense history and then

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 moving, going into the next phase, begin to look at, okay,
2 this is who I was in the past. Who do I want to be in the
3 future and what do I need to do to get there.

4 Q Dr. Brown, did you guys -- did you discuss with
5 Mr. Ridley during your evaluation what his plans were if he
6 were released?

7 A I did.

8 Q And what were those plans?

9 A Those have changed somewhat over time as I have
10 seen him. I think the first time I saw him he was talking
11 about being a baker and then he eventually getting into a
12 brick mason and then eventually getting into a tree removal
13 service. The more specific thing he's talking about at
14 this point is going to live at Band of Brothers which is in
15 Greenville County. It's a transitional faith-based housing
16 program, primarily for people coming out of prison to get
17 them reoriented to the community.

18 While he's doing that, he says he plans to work in
19 a chicken plant to be able to have some income and be able
20 to support himself; meanwhile taking a truck driving
21 training course that I think he already has set up so he
22 that he can get his CDL and eventually become a truck
23 driver and then further on down the road maybe have a tree
24 removal service.

25 Q Did you find his release plan realistic?

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 A I do not.

2 Q Why not?

3 A Well, there are several problems there. One is
4 that DMH has quit using Band of Brothers because we've not
5 gotten good reports about it, so I'd be concerned about
6 that as a place for him to live. You know, having met with
7 Mr. Ridley over the years now, I just have a hard time
8 seeing him working in a chicken plant and then being
9 satisfied working in that environment even very short term.
10 But the biggest concern that I would have would be that as
11 a truck driver, here's someone who didn't register when he
12 moved from New York to South Carolina and as a predator
13 he'd be required to register every 90 days and, you know,
14 driving a truck around the country, it's going to be
15 difficult to manage to do that.

16 He has talked about wanting to be in ongoing
17 outpatient treatment, but that's not the kind of thing
18 that's easily done when you're driving a truck. So I don't
19 see that as being a viable plan.

20 Q When you do these type of evaluations, Dr. Brown,
21 how do you measure a person's risk to reoffend?

22 A Well, part of it is what I've already been talking
23 about in terms of the owe looking for the patterns of
24 behavior, what kind of things this person has done in the
25 past and how does that relate to what they might like to do

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 in the future. But then we also use some actuarial
2 measures, specifically the Static 99 and the Static 99R and
3 the Static 2002R?

4 Q And what is a Static -- I'm sorry. What is the
5 Static 99R and the Static 2002R?

6 A These are what we call actuarial measures. It's
7 not a test that I give to Mr. Ridley. It's where I sit
8 down and look at the record. Some of the information comes
9 from interview, but we know that there are certain
10 characteristics that correspond with a person's likelihood
11 of reoffending. People with these characteristics, with
12 these types of history are more likely to reoffend than
13 people who don't have these. So the Static 99R, the Static
14 2002R give us a way of looking at history and putting a
15 number on it.

16 We psychologists love numbers. We like to stick a
17 number on everything. So we can give that history a number
18 and then compare that with other offenders and basically
19 put them at a relative risk level compared with other sex
20 offenders.

21 Q And so you mentioned the Static 99R why was that
22 relevant to your evaluation?

23 A This is the most widely used actuarial measure. So
24 this is what most people doing these types of evaluations
25 is going to look at to help to assess a person's risk.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 Q So the Static 99R is an actuarial assessment used
2 by other experts in your field?

3 A Right.

4 Q And was it part of the basis of your expert
5 opinion?

6 A It was.

7 Q And what, if anything, did you find -- what was
8 Mr. Ridley's score on the Static 99R?

9 A The scores on the Static 99R range from minus 3 to
10 3 to 12 and his score was 9.

11 Q And what does a score of 9 mean?

12 A Well, let me talk about that in a few different
13 ways here. Within the correctional system, they've started
14 using a level system. We used to say average, medium,
15 high, but that's somewhat subjective. So within the
16 correctional systems, they've started talking about levels
17 of risk and those range -- there are five levels ranging
18 from 1, 2, 3, then 4A and 4B with 4B being the highest
19 level, 4A being the lowest level. His risk level of the
20 Static 99R is a 4B, which we say is well above average.

21 THE COURT: It says what?

22 THE WITNESS: Level 4B, well above average.

23 THE COURT: Thank you.

24 BY MR. MORROW:

25 Q And this is a static -- now the Static 99R, Dr.

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 Brown is an actuarial score that is compared to his risk to
2 reoffend to other convicted sex offenders, correct?

3 A That's correct.

4 Q And --

5 A Well, other sex offenders.

6 Q And so what, if anything, did it indicate about
7 Mr. Ridley's risk to reoffend when compared to other sex
8 offenders?

9 A Well, if we look at people with a score of 9, and
10 the research -- have done between 38 and 50 percent of
11 those between 38 and 50 out of 100 would reoffend within
12 five years.

13 THE COURT: 28 to 50 --

14 THE WITNESS: 38 to 50 out of 100 would reoffend
15 within five years.

16 THE COURT: Okay.

17 THE WITNESS: And another way of looking at that is
18 to look at what we call the relative risk. On the Static
19 99R a score of 2 is considered the average sex offender.
20 People with a score of 9 are over 7 times as likely to
21 reoffend as someone with a score of two.

22 BY MR. MORROW:

23 Q How many -- what percentile of people scored higher
24 than Mr. Ridley on the Static 99R?

25 A It was about three tenths of one percent that

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 scored higher.

2 Q So he scored in the 99th percentile?

3 A 99 percentile, correct.

4 Q So it's fair to say that based on his Static 99R,
5 Mr. Ridley is more likely to reoffend or more dangerous
6 than 99 percent of other sex offenders? Is this an
7 accurate assessment of that tool?

8 A Well, we're looking at group data here. So I can't
9 say that Mr. Ridley's 99 percent more dangerous than other
10 sex offenders. But he's certainly achieving a score out of
11 the 99 percentile. And we know that people with a score of
12 9 are far more likely to reoffend than people with a score
13 of 2.

14 Q Okay. And in addition to the Static 99R, you also
15 mentioned the Static 2002R?

16 A Correct.

17 Q What is that and how is it different than the
18 Static 99R?

19 A There are a lot of similarities. They include some
20 of the same elements for the Static 99 -- I'm sorry, what
21 the Static 2002R includes and the Static 99R does not
22 include is some emphasis on deviant sexual interest,
23 persistence in sexual offending, and also just general
24 criminal history. They are recommending at this point that
25 you look at both of them, you know, look at both scores and

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 use those together rather than using one of them alone.

2 Q And what -- what did you find Mr. Ridley's score to
3 be on the Static 2002R?

4 A On the 2002R, and the scoring's similar but a
5 little bit different, these scores range from minus 2 to
6 13. His score was an 8.

7 Q And what, if anything, did a score of 8 indicate
8 about his risk to reoffend?

9 A Well, like the Static 99R, that's also the level 4B
10 or well above average range and if we look at the five year
11 re-offense rate on this item, it's between 29 and 40
12 percent with that score that reoffend within five years.
13 And people with a score of 8 are 5 times as likely as the
14 average sex offender to reoffend or not people with a score
15 or that group with that score were five times as likely to
16 reoffend.

17 Q The 2000 -- so the scores on both the Static 99R
18 and the Static 2002R indicated that Mr. Ridley was in the
19 higher percentile to reoffend?

20 A That's correct.

21 Q When you're doing these evaluations, you're asking
22 to determine whether he's likely to ever reoffend sexually,
23 correct?

24 A I'm sorry?

25 Q When you're doing these evaluations, you're

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 assessing his likelihood to reoffend ever again, correct?

2 In his lifetime?

3 A Yes.

4 Q Okay. And the 99R and the 2002R really can only
5 tell you within the next five to ten years; is that
6 correct?

7 A Well, we're saying at this point five years. Some
8 of the older manuals will include a ten year projection.
9 So basically we're looking at within five years.

10 Q And --

11 A And if a person's in the community for five years
12 and doesn't reoffend, then the risk of re-offending after
13 that would go down.

14 Q Dr. Brown, you also mentioned in addition to these
15 static risk factors to reoffend the factors of the Static
16 99 and the Static 2002R are based on, are there other types
17 of risk factors for re-offense?

18 A There are. The other type we talk about at this
19 point in the evaluation process is dynamic risk factors.

20 Q And what kind of dynamic risk factors did you find
21 Mr. Ridley had?

22 A And again, when we talk about risk factors, we're
23 looking at not just things that we think might correlate,
24 but we know the people that have these risk factors are
25 more likely to reoffend than people that don't have those

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 risk factors. It's not just a list we're pulling out of
2 the air. We're looking at these in large groups of
3 individuals. You know, these are the people who are most
4 likely to reoffend. And one is sexual preoccupation. And
5 Mr. Ridley's history indicates regular sexual
6 preoccupation. I will say there's not much in -- or I
7 don't see anything in the correction records or in our
8 records that would indicate that that's been necessarily an
9 issue at this point.

10 There is a preference for pubescent males, to a
11 preference for adolescent males. And I would say that's an
12 ongoing issue because we don't have adolescent males on the
13 unit, but he is sexually attracted toward those who are
14 closest in age to that of those available.

15 Offensive support attitudes, it's the idea that,
16 you know, this guy stole money from me. He owes me. You
17 know, I'm entitled to get sex from these people. Those
18 attitudes in support of sex offenses are important.

19 Lack of emotionally intimate relationships with
20 adults, people who don't have those stable intimate
21 relationships with other adults tend to be more likely to
22 reoffend and that's been a part of Mr. Ridley's history.

23 Lifestyle impulsiveness and, you know, this is
24 probably best exemplified right now by his discharge plan.
25 You know, that's a fairly short term goal. I don't really

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 see a long term goal there that he's working toward that's
2 realistic and I think being a truck driver in many ways
3 increases the possibility of those impulsive kinds of
4 things.

5 THE COURT: Hold on a second. Being a truck driver
6 increases the probability? Is that what you're saying.

7 THE WITNESS: Correct. In the sense of not having
8 a stable place to live. Mr. Ridley says while I'm driving
9 the truck, I won't need to pay rent. I won't need a car.
10 I can live in the truck, I can drive it; and if you're just
11 driving around the country with no set residence -- and I'm
12 not saying this is how most truck driver's live -- I'm
13 saying for Mr. Ridley, I don't think this is a realistic
14 plan. But if you're just going from truck stop to truck
15 stop, you know, that is an impulsive kind of way of getting
16 around.

17 BY MR. MORROW:

18 Q And Dr. Brown you're basing that off of what
19 Mr. Ridley told you in his interview; is that correct?

20 A Correct. That's correct.

21 Q Okay.

22 A And then poor problem solving. Again, looking at
23 his approach to the program, rather than as many people do
24 come in and say, okay. What do I need to do to get out of
25 this program and sitting down and focusing on treatment and

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 getting the job done. He's finding fault with the program
2 and fighting the program and trying to argue that I don't
3 need to be there. So he's not looking at the problem and
4 coming up with a realistic solution to getting there. And
5 again, I would say that the discharge plan is probably not
6 a solid one in terms of demonstrating good problem solving
7 skills and saying, okay, this is what I want to do and this
8 is how I'm going to get there.

9 Resistance to rules and supervision. This was a
10 major issue in the community. There was some
11 disciplinary's while he was in prison. But we see it more
12 in the subtle things and the little things, not that
13 there's anything big, but if someone's really looking at
14 doing well and proving they don't need to be somewhere
15 they're going to follow the rules and do what they need to
16 do to follow those. I think all of these things together
17 present a picture of someone who has enough dynamic risk
18 factors, that he's not likely to be successful.

19 Q Dr. Brown, why is it important to look at both
20 static and dynamic risk factors for these evaluations?

21 A Well, part of it is, assuming that Mr. Ridley
22 doesn't commit any other sex offenses, his static score
23 will be 9 until he turns 60. So he could be sitting here
24 13 years from now and that score's just not going to
25 change. So there's absolutely nothing he can do about that

Dr. Gordon Brown - Direct Examination Continued by Mr. Mo

1 score. The dynamics on the other hand are things and are
2 by definition changeable. Those are things he can work on
3 and those are areas where he can make improvement and
4 hopefully through treatment be able to change in a positive
5 way.

6 Q Dr. Brown, to be clear, is it your expert opinion
7 that Mr. Ridley suffers from a mental abnormality or a
8 personality disorder?

9 A It is.

10 Q And that mental abnormality is other specified
11 paraphilic disorder biastophilia?

12 A That's correct.

13 Q And in addition to that is your expert opinion that
14 he suffers from antisocial personality disorder with
15 narcissistic features?

16 A That's correct.

17 Q Dr. Brown, do you have an opinion as to whether
18 Mr. Ridley's other specified paraphilic disorder,
19 biastophilia and antisocial personality disorder also give
20 him serious difficulty in controlling his behavior?

21 A I believe it does.

22 Q Do you have an opinion as to whether Mr. Ridley is
23 likely to commit future acts of sexual violence?

24 A I do.

25 Q And what is that opinion?

Dr. Gordon Brown - Direct Examination Continued by Mr.

1 A I believe based on all the information I have t
2 he is likely to continue to commit sexual violent offenses.

3 Q Dr. Brown, in your opinion to a reasonable degree
4 of psychological certainty, do you have an opinion as to
5 whether his other specified paraphilic disorder
6 biastophilia and antisocial personality disorder make him
7 likely to engage in acts of sexual violence if not confined
8 to a secure facility for long-term control, care, and
9 treatment?

10 A I do.

11 Q And, Dr. Brown, do you have an opinion to a
12 reasonable degree of psychological certainty as to whether
13 Mr. Ridley meets the criteria of a sexually violent
14 predator?

15 A I believe that he does.

16 Q And all of these things are based on a reasonable
17 degree of psychological certainty?

18 A They are.

19 Q Thank you, please answer any questions that the
20 defense may have.

21 THE COURT: Ladies and gentlemen of the jury, I
22 suspect that her cross-examination will be more than 20
23 minutes. Y'all want to get 20 minutes out of the way and
24 stop at five or do you want to wait and let's go and start
25 back at 9:30 in the morning with fresh coffee and sausage

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 biscuits and tacos for one person.

2 No, seriously, we can stop now and we can -- we're
3 going to start at 9:30 in the morning notwithstanding, and
4 I will have hot coffee and -- would y'all rather have
5 sausage biscuits or fruit, or donuts, whatever you prefer.
6 We'll make sure we have those here before 8:30 so you can
7 have that. And more than likely I will buy your lunch
8 tomorrow. We'll just order in. We can bring it in so we
9 can keep going.

10 So what's your pleasure.

11 A JUROR: I do have one question, Your Honor.

12 THE COURT: Well, what is it about? Time or --

13 A JUROR: Time frames tomorrow, stopping where we
14 are now as opposed to what we have left.

15 THE COURT: Well, what we've got left is his
16 cross-examination. We've got Mr. Ridley. And we've got
17 one other doctor. So it's going a little longer than I
18 thought.

19 A JUROR: But it shouldn't be past five o'clock
20 tomorrow?

21 THE COURT: Well, if it is, you need to stop?

22 A JUROR: Probably, but --

23 THE COURT: I always put my jurors before
24 everything else. If we have to come back Wednesday, we
25 will. But let's just see how far we get. Lots of times

Dr. Gordon Brown - Direct Examination Continued by Mr. Morrow

1 we'll get to three o'clock and a lot of time jurors will
2 want to go ahead and hear the arguments and the charge so
3 they can deliberate. I give them that option and that's --
4 you got something you need to do at five.

5 A JUROR: Five o'clock is more of a benchmark so --
6 I work nights so I will -- if I can't get a certain amount
7 of sleep before midnight --

8 THE COURT: I understand. I understand.

9 A JUROR: -- I would like to let my boss know this
10 is going to run a little bit longer.

11 THE COURT: Well, let's do this. We'll assess
12 everything tomorrow at lunchtime and see how we're running
13 and I'll obviously take that into consideration as --
14 anybody's having any problems, I try to let my jurors tell
15 me what they want to do by way of time. Some jurors like
16 to keep trucking and get it over with and some jurors like
17 to come back fresh in the morning. We'll just do what is
18 best for y'all. Not best for me.

19 So you want to go on tonight until 5 or you want to
20 take a break and come back in the morning.

21 A JUROR: Tonight's not a /PRAB.

22 THE COURT: I know it's not, I'm just asking what
23 you want to do.

24 A JUROR: Let's keep going.

25 THE COURT: All right. Let's go to five.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 All right. Ma'am, you may start your
2 cross-examination.

3 MS. HIGHTOWER: Thank you, if it please the Court.

4 THE COURT: With the understanding now, when we
5 come back in the morning, we're not going to go over what
6 you went over from 4:40 to five o'clock.

7 MS. HIGHTOWER: Yes, sir. I understand.

8 THE COURT: I learned long ago when you give lawyer
9 a whole night, they get all rejuvenated.

10 MS. HIGHTOWER: Yes, sir, thank you very much, Your
11 Honor:

12 THE COURT: You're welcome.

13 MS. HIGHTOWER: If it please the Court.

14 THE COURT: Yes, ma'am.

15 **CROSS-EXAMINATION**

16 BY MS. HIGHTOWER:

17 Q Dr. Brown, let me just start with one thing that
18 jumped out at me on your direct examination. You indicated
19 that his discharge plan, Mr. Ridley's discharge plan was
20 that -- let's me -- let me get my question out. Was that
21 -- my understanding, and correct me if I'm wrong, wasn't
22 that developed with Correct Care?

23 A Well, again, I don't work with Correct Care, but
24 that's my understanding, that yes, it would be.

25 Q Okay. And you testified on direct examination that

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 that's no longer -- the Band of Brothers, that's no longer
2 an approved place at Correct Care?

3 A Well, again, Correct Care is not department of
4 mental health. It's not a place that has been approved by
5 the department of mental health for discharge.

6 Q All right. Well, let's --

7 THE COURT: Hold on.

8 THE WITNESS: I don't know the answer to that. I'm
9 sorry.

10 BY MS. HIGHTOWER:

11 Q Well, you testified that the Band of Brothers, the
12 place that he is -- his discharge plan says that that's his
13 step down, that's where he's stepping down first to go,
14 right?

15 A Correct.

16 Q You testified that that's no longer an approved
17 placement, correct?

18 A Well, maybe I can clarify that. If I were
19 recommending Mr. Ridley and we were going before the DMH
20 Discharge Review Board and the discharge plan was to go to
21 Band of Brothers, that would not be approved by the
22 discharge review board.

23 Q Okay. But it has been approved by Correct Care,
24 correct?

25 A I don't --

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 THE COURT: Hold on. Hold on. Who is Correct
2 Care.

3 MS. HIGHTOWER: I agree, Your Honor. And let me
4 just back up and start all over.

5 BY MS. HIGHTOWER:

6 Q Let's provide a foundation for those two -- these
7 two entities that we're talking about, Dr. Brown.

8 Four years ago when you started this program, who
9 ran the sexually violent predator program?

10 A I'm sorry?

11 Q Who ran the program four years ago, the sexually
12 violent predator program?

13 A Four years ago it was the department of mental
14 health.

15 Q Okay. And did the department of mental health stop
16 running the SVP program at some point in time?

17 A The treatment part of the program was contracted
18 out.

19 Q Okay. The treatment part of the program was
20 contracted out to whom?

21 A To Correct Care Recovery Systems.

22 Q And what is Correct Care Recovery Systems?

23 A That's a private company that -- and I'm not a
24 Correct Care employee, but they do run at least a couple of
25 the sexually violent predator programs around the country

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 and I understand they also run some other mental health
2 types of operations in correctional settings.

3 THE COURT: But do they run it for South Carolina
4 Department of Corrections or for the South Carolina
5 Department of Mental Health.

6 THE WITNESS: It's under a contract with the
7 department of mental health.

8 THE COURT: For South Carolina?

9 THE WITNESS: That's correct.

10 THE COURT: Well, that's what we're talking about.
11 Are they still doing it?

12 THE WITNESS: Correct Care?

13 THE COURT: Yeah.

14 THE WITNESS: Yes, sir.

15 THE COURT: So if they recommend something and
16 y'all have contracted out to them you don't necessarily
17 follow what they recommend? That is a question.

18 THE WITNESS: Well, again, this would only become
19 an issue if he's -- if the State evaluators is recommending
20 him and the discharge review board says no, we're not going
21 to approve that. Since the State's not recommending him,
22 Mr. Ridley can go wherever he wants to go when he's
23 released.

24 THE COURT: I'm sorry. I won't interrupt again.

25 MS. HIGHTOWER: No, sir, I agree. What?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 THE COURT: Ask the question again.

2 BY MS. HIGHTOWER:

3 Q Correct Care, if they recommend a placement program
4 or a placement discharge strategy, in my client Mr. Ridley,
5 they're working his treatment discharge plan, correct?

6 That's who's doing the treatment, right?

7 A Correct.

8 Q And if they recommend for Mr. Ridley in his
9 treatment plan, in his discharge plan that he can go to
10 Band of Brothers, that's within Correct Care's purview,
11 correct?

12 A I don't know that Correct Care would be
13 recommending a placement. They put together the discharge
14 plan based on what Mr. Ridley wants to do, where he wants
15 to go. Sometimes a discharge plan is they go home with a
16 mother.

17 THE COURT: Wait a minute. What if he wants to go
18 out and rob banks and what if he wants to go sell dope on
19 the streets. They 're going -- whatever he wants to do
20 they're going to go along with it?

21 THE WITNESS: Well, they're not going to put that
22 in their discharge plan, no, sir.

23 THE COURT: Go ahead. I'm sorry.

24 BY MS. HIGHTOWER:

25 Q So you testified that the department of mental

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 health wouldn't approve the Band of Brothers?

2 A That's correct.

3 Q Okay. And -- but are -- is your testimony that
4 you're not real sure what Correct Care is doing about
5 discharge plans? Because they're doing the treatment and
6 all you do is something different for department of mental
7 health?

8 A Well, again, this is not through the normal
9 department process of recommending someone for release.

10 Q What do you mean?

11 A Mr. Ridley --

12 Q What is the normal process for the department of
13 mental health to recommend release? I guess we should
14 start there.

15 A The usual process is the state evaluator recommends
16 a person for release. When we do that, we go before the
17 department of mental health discharge review board. We
18 present our case to them. The case manager may speak, the
19 resident may speak and the discharge review board will say
20 yes they approve and along with that, they approve the
21 discharge plan, say it's okay for this person to go to this
22 place. We've checked it out, it's a solid placement.

23 Q Okay.

24 A Given that there's not a state evaluator
25 recommending Mr. Ridley, he's not been through that process

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 and there is no state approved discharge plan.

2 Q The process we're in right now is a jury trial,
3 right?

4 A Right.

5 Q Right. Okay.

6 And in this jury trial the department of mental
7 health is not involved in the release of Mr. Ridley,
8 correct?

9 A The department of mental health is not recommending
10 Mr. Ridley be released; that's correct.

11 Q How would he go about being recommended for release
12 from the department of mental health? How do we get into
13 that -- that -- that hallway?

14 A That's what --

15 Q We're obviously in this hallway, how do we get to
16 that one?

17 A That's what the annual review process is.

18 Q Oh. Okay. So that's -- okay. Please.

19 A When I'm assigned to review a resident for our
20 annual review, you know, the question I have to ask is am I
21 going to recommend this person or not. And most often when
22 I know someone is recommended for release, they go through
23 that whole process with the department of mental health.
24 This is a fairly unusual situation in that Mr. Ridley is
25 petitioning the Court for release without having gone

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 through that process, without having a state evaluator say
2 yes, he's ready to go.

3 Q So Mr. Ridley hasn't gone through your process in
4 the department of mental health, correct?

5 A Through --

6 Q Your -- who you work for, not your personally. But
7 Mr. Ridley has not gone through the department of mental
8 health's process for recommendation for release and then
9 going in front of the department of mental health release
10 board is that what you're referring to?

11 A That's correct.

12 Q Okay. So he's not gone through your release
13 division, he's following the statute, correct?

14 A Yes, ma'am.

15 Q All right. He's following South Carolina Code of
16 Laws statute, 44-48-110, correct?

17 A Yes, ma'am.

18 Q He's been before -- he's followed every provision
19 in that statute, right?

20 A As far as I know, yes, ma'am.

21 Q Okay. And well, since we're talking about the
22 statute, when Mr. Ridley was first looked at for the
23 sexually violent program that's -- the statute says that
24 this attorney general shall bring the petition for somebody
25 whose charged number one with a -- has been convicted of a

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 sexually violent crime, correct? That's a qualifying
2 charge?

3 A Correct.

4 Q Right. Okay.

5 And so the statute then says if -- and there's a
6 second part of the definition, was the second part of the
7 definition you got a conviction for the crime and then you
8 suffer from some mental abnormality or personality disorder
9 that makes you likely to -- let me just read it -- suffers
10 from a mental abnormality or personality disorder that
11 makes the person likely to engage in acts of sexual
12 violence if not confined in a secure facility for long-term
13 controlled care, and treatment, right?

14 A Correct.

15 Q All right. So you have somebody, the process
16 begins. They meet that definition. Mr. Ridley followed
17 that process at the very beginning of this case, correct,
18 back in 2014, right?

19 A Correct.

20 Q And he voluntarily waived into the sexually violent
21 predator program, correct?

22 A Correct.

23 Q All right. And then what I hear you saying is that
24 the department of mental health -- well, the department of
25 mental health no longer has any control over his treatment?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A The department of mental health has an oversight.
2 I mean it's not that we turned it over to Correct Care.
3 There is an oversight committee that makes sure that
4 Correct Care is following the rules and complying with the
5 contract that they have with department of mental health.

6 Q How much oversight do they provide for the
7 individual treatment for the individual residents?

8 A Well, the individual treatment would be up to
9 Correct Care. They come up with the -- what they call the
10 integrated care plans, the treatment plans.

11 Q And the discharge plans?

12 A And the discharge plan.

13 Q Okay. Excuse me?

14 (There was a pause in the proceedings.)

15 BY MS. HIGHTOWER:

16 Q You said you -- in preparation for your opinion
17 testimony today, you reviewed documents, all of
18 Mr. Ridley's documents, correct?

19 A Yes, ma'am.

20 MS. HIGHTOWER: Your Honor, may I approach?

21 THE COURT: Yes.

22 BY MS. HIGHTOWER:

23 Q I'm going to hand you this document. Please tell
24 me if you recognize it.

25 A I do.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q And what is it?

2 A It's the discharge plan.

3 Q Discharge plan. And who developed the discharge
4 plan?

5 A Well, it's done between Correct Care and
6 Mr. Ridley.

7 Q Again, and Correct Care -- I'm sorry. I just want
8 to make sure I have this right. So Correct Care is
9 providing the treatment but the department of mental
10 health, who you work for doesn't -- they don't have
11 oversight over the program in general? Or did you say they
12 have oversight in this in particular?

13 A They would have no oversight over this because
14 they've not approved this discharge. They're not
15 recommending his discharge.

16 Q Well, let me ask you this question: Why is the DMH
17 or why would Correct Care be recommending a placement for
18 my client that he worked on in treatment with his treatment
19 provider, Correct Care, why would they be recommending
20 something that you say the department of mental health has
21 said to disregard?

22 A I don't know the answer to that.

23 Q Well, okay. Are you sure ha the department of
24 mental health disregards Band of Brothers as not being an
25 appropriate placement?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A That's what my supervisor told me last week.

2 Q Okay. Well, I should have objected to hearsay,
3 but --

4 THE COURT: Do you know of your own personal
5 knowledge the answer to that question?

6 THE WITNESS: No, sir. I'm not in a position where
7 I would.

8 THE COURT: Okay. Thank you.

9 Go ahead.

10 BY MS. HIGHTOWER:

11 Q All right. So you're not in a position to actually
12 know --

13 A No, ma'am.

14 Q -- what you just testified.

15 And I'm sorry. I handed you this document. You
16 identified it for me. Would you please, Dr. Brown, for me,
17 for the record, would you please read into the record what
18 the site assessment that was performed by Correct Care and
19 Mr. Ridley's discharge plan. Would you please read that
20 into the record?

21 THE COURT: And what date is that please, ma'am.

22 MS. HIGHTOWER: I apologize, Your Honor, it is
23 dated it doesn't -- hold on, one moment if I could beg the
24 Court's indulgence a moment, please. Your Honor.

25 (There was a pause in the proceedings.)

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 MS. HIGHTOWER: If I may approach again, Your
2 Honor? The witness?

3 THE COURT: I just asked him what the date was.

4 BY MS. HIGHTOWER:

5 Q Yeah, Dr. Brown, if you would look on page 4 of the
6 discharge plan.

7 A Okay.

8 Q You have it? Okay.

9 A I'm assuming this is the same copy.

10 Q Okay. At the bottom of page 3 -- at the bottom of
11 page 3 where it says Dr. Paul Stewart, you were right, Dr.
12 Paul Stewart, and he's marriage therapist, family
13 therapist, of course, the part of -- this part of the
14 aftercare plan is they were trying to look for sex offender
15 specific treatment should he, when Mr. Ridley's released,
16 they're looking in this section for after care for follow
17 up treatment on the outside, correct?

18 A Correct.

19 Q Okay.

20 And if you turn the page, it says that -- if you
21 could read that into the record. Per Dr. Gunter and Dr.
22 Gunter, for the record, would be the person who's providing
23 the follow up treatment care?

24 A Per Dr. Gunter he provides group sex offender
25 therapy weekly for \$30 per session. He reported that all

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 group members will be required to have a psychosexual
2 evaluation and basic assessment for sexual interest
3 completed before they begin group sessions. This
4 information is provided by Dr. Gunter via phone on February
5 7, 2018.

6 Q All right. There's a date, Your Honor?

7 THE COURT: February what?

8 MS. HIGHTOWER: 7th, 2018.

9 Correct, Dr. Brown.

10 THE WITNESS: Correct.

11 THE COURT: So recent.

12 BY MS. HIGHTOWER:

13 Q So --

14 THE COURT: And you were going to have him publish
15 something else when I interrupted you.

16 MS. HIGHTOWER: That's fine, sir.

17 BY MS. HIGHTOWER:

18 Q So again to continue on with the discharge plan. I
19 was going to -- if you would go to page 1 and read the
20 first paragraph on the release placement in there on
21 Correct Care's discharge plan that they worked on together
22 in the treatment plan for which they reached out to
23 community members like Dr. Gunter to provide sexual
24 offender follow up treatment.

25 A Okay. Mr. Ridley plans to reside at Band of

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Brothers transitional house in Greenville County. This
2 organization's goal is to provide men with true and
3 rehabilitation before sending them out into an environment
4 that would be difficult to adapt to or to conform to
5 without proper assistance, information and guidance. They
6 believe that with proper guidance and training these men
7 will be productive citizens and leaders in their respective
8 communities, Dr. Silvester Savage, II and Band of Brothers
9 ministries provide residents transport to work, community
10 programs, and various appointments, probation, parole,
11 doctors, social service agents, interviews, counseling
12 programs at various agencies, et cetera.

13 They also partnership with chaplains in one-on-one
14 counseling sessions, case management and religious
15 services. The program housing fees are \$125 per week with
16 \$150 dollars. Housing fees must be paid each Friday in
17 advance for the upcoming week.

18 Mr. Ridley completed a phone interview with Darryl
19 Riles, General Manager and is tentatively approved for
20 placement.

21 Q Okay. And if you will continue on into the next
22 segment and if you would go to the site assessment?

23 A Okay. A previous site assessment was completed by
24 the therapist and it was concluded and placement was
25 appropriate for resident.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q So the therapists were referencing in the Correct
2 Care Recovery Solutions, who runs the treatment plan and
3 his discharge plan for Mr. Ridley as of February 2018 they
4 found that a previous site assessment was completed by the
5 therapist and concluded that this placement was appropriate
6 for residence?

7 A I don't know when that previous site visit was. I
8 know this was one would have had to have been around 2014
9 when they decided it wasn't appropriate.

10 Q All right. 2014, who's running the treatment plan
11 then?

12 A Who's running the treatment plan?

13 Q Correct.

14 A Correct Care at this point is.

15 Q 2014.

16 A Oh, 2014, DMH was running it.

17 Q The DMH was running it?

18 A So it was approved in 2014. It's my understanding
19 that it is now not approved.

20 Q And you don't have any independent knowledge of
21 that?

22 A No, I don't.

23 Q All right. But -- but this document prepared by
24 Correct Care references the therapist, correct?

25 A Correct.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q And Correct Care is providing the therapy, correct?

2 A Correct.

3 Q So it would be the therapist that would confirm
4 that Band of Brothers is an appropriate site?

5 A I would hope so.

6 MS. HIGHTOWER: Your Honor.

7 THE COURT: All right, ma'am. You need to mark
8 that.

9 MS. HIGHTOWER: Yes, sir. I apologize.

10 THE COURT: No.

11 (Defendant's Exhibit Number 1 was marked for
12 identification.)

13 THE COURT REPORTER: It's Defense 1.

14 MS. HIGHTOWER: Okay. And I'll go ahead and move
15 it into evidence.

16 THE COURT: Any objection? It's probably -- it
17 part of the record any way, but that's the defense or
18 Ridley's one.

19 MR. MORROW: No objection from the State, Your
20 Honor.

21 (Defendant's Exhibit Number 1 was entered into
22 evidence.)

23 THE COURT: Okay. Y'all want to go to six.

24 MS. HIGHTOWER: Yeah, no.

25 THE COURT: Wait a minute, you don't --

1 MS. HIGHTOWER: I'll stand over here.

2 A JUROR: I have children to get.

3 THE COURT: I understand.

4 All right. We're going to break right here at five
5 as I earlier represented and please don't do any
6 independent research on the computer or let anybody talk to
7 you about the case. I'll see y'all -- we're going to start
8 at 9:30. Did you make the decision on -- y'all want
9 biscuits or fruit or yogurt? (Laughter)

10 All right. We'll do sausage biscuits in this
11 morning and then we'll reassess for lunch tomorrow. Have a
12 pleasant evening be here before 9:30, to get your biscuit
13 and your hot coffee. Thank you.

14 Everybody else remain seated, please.

15 (The jury left the courtroom at 5:08 p.m.)

16 THE COURT: All right. Doctor, you're in the
17 middle of your testimony. Enjoy your evening, don't
18 discuss it with anyone, please.

19 THE WITNESS: Yes, sir.

20 THE COURT: And we'll see you back in the morning
21 at 9:30. You can leave all the exhibits here and
22 everything. The courtroom will be locked. Let me see the
23 lawyers in chambers.

24 Y'all have him back at 9:30. Where you coming
25 from?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 THE OFFICER: Columbia.

2 THE COURT: All right. Don't be late.

3 You want a biscuit?

4 THE OFFICER: Yes, sir.

5 (Court was adjourned for the day.)

6 **TUESDAY, FEBRUARY 27, 2018**

7 THE COURT: All right. Anything for the record
8 before we start, Mr. Morrow?

9 MR. MORROW: Nothing from the State, Your Honor.

10 THE COURT: Ma'am?

11 MS. HIGHTOWER: Nothing, Your Honor.

12 THE COURT: All right. Bring the jury in, please.

13 (The jury entered the courtroom at 9:30 a.m.)

14 Where's the witness?

15 Dr. Brown, if you would come around and have a
16 seat, please.

17 You may continue, ma'am.

18 MS. HIGHTOWER: Thank you, Your Honor, if it please
19 the Court.

20 THE COURT: Yes, ma'am.

21 **CROSS-EXAMINATION**

22 BY MS. HIGHTOWER:

23 Q Good morning, Dr. Brown.

24 A Good morning.

25 Q You indicated that you're a psychologist working

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 for the South Carolina Department of Mental Health; is that
2 correct?

3 A That's correct.

4 Q Okay. And that you have been working at the
5 department of mental health in the area since 2014,
6 correct?

7 A That's correct.

8 Q And you've indicated that at this time your work is
9 limited to producing or issuing annual psychological
10 reviews for the patients that are on the SVP unit, correct?

11 A That, and I'm also beginning to do some
12 pre-commitment evaluations.

13 Q I apologize. You did say that. You're doing
14 pre-commitment documentation as well. That's when
15 somebody's in the department of corrections and they're
16 being reviewed for placement on the program?

17 A That's correct.

18 Q So prior to being committed, correct?

19 A That's correct.

20 Q And also involves the same exact kind of
21 circumstances that you're doing review of their history,
22 correct?

23 A Looking at their past crimes, correct.

24 Q Correct.

25 Looking at any type of work that was available in

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 the department of corrections, correct?

2 A Yes, ma'am.

3 Q Now, so am I correct -- and I just want to be clear
4 about this, you're not providing any treatment to any of
5 these inmates or patients, are you?

6 A Not at this time, no, ma'am.

7 Q Okay. And you haven't been since you took on that
8 duty of doing the annual reviews and pre-commitment reviews
9 and issuing these reports as to...

10 A When I first started working in the job, I did do
11 some evaluations as well as some treatment.

12 Q Some treatment?

13 A So for the first two-and-a-half years, there was
14 some of both.

15 Q And that was when the department of mental health
16 actually ran the program?

17 A That's correct.

18 Q And they're no longer running the program as we
19 talked about yesterday, correct?

20 A The treatment part of the program, that's correct,
21 yes, ma'am.

22 Q And we'll get onto that a little more in a minute.

23 Well, let's go ahead and get into it now. Who runs
24 the treatment program now? Correct Care Recovery
25 Solutions, correct?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A Correct.

2 Q And that's a for-profit corporation that's been
3 contracted out, correct?

4 A Correct.

5 Q And the department of mental health is contracted,
6 they pay their bills, and they run the program.

7 A Yes, ma'am.

8 Q And again, it's a for-profit corporation, correct?

9 A That's correct.

10 Q They're not a charitable organization, right?

11 A That's correct.

12 Q All right. Are you familiar with any of the
13 background about Correct Care Recovery Solutions, how they
14 came about, where they came from or any type of how they
15 run their stuff?

16 A I can't say that I am, no, ma'am.

17 Q Thank you.

18 I want to talk a bit about your work with providing
19 -- or your knowledge about sexually violent predators and
20 your education in this field in particular. And providing
21 your expert opinions.

22 What -- what forensic training have you had in this
23 area of sexual violent predator program?

24 A That's very difficult training to get, specifically
25 related to sexually violent predators. That's something we

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 actively look for. There is some specific training related
2 to the assessments. I've participated in a number of
3 webinars with the Global Institute of Forensic Psychology
4 in terms of the background scores use of the Static 99R the
5 Static 2002R, the bars 2002, which is a part of those two
6 instruments. The PCLR which diagnoses psychopathy, those
7 kinds of things. And as I indicated yesterday, when I
8 began working there, we did a great deal of training within
9 the program itself as to evaluators ourselves, as well as
10 training the case managers involving treatment and dealing
11 with the SVP's.

12 Q Yes, I believe your testimony yesterday indicated
13 that you were learning as you went along?

14 A Well, that's part of any new job.

15 Q Any new job.

16 A Yes.

17 Q Correct. And you just said that it's difficult to
18 get this kind of training. Is that because it's a unique
19 and specialized field dealing with a specialized and unique
20 group of individuals?

21 A It is.

22 Q Okay. You talked about your -- what you just
23 talked about, about your training with the Global Institute
24 of Health?

25 A Global Institute of Forensic Research.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q Forensic research.

2 Okay. Again, and you also talked about the --
3 you've taken classes through the American Academy of
4 Psychology or Psychiatry?

5 A American Academy of Forensic Psychology.

6 Q Okay. Specifically what courses did you take?

7 THE COURT: You mean as to this or anything?

8 MS. HIGHTOWER: As to special -- I apologize.

9 Thank you, Your Honor.

10 BY MS. HIGHTOWER:

11 Q As to the sexual violent predator program.

12 A There was one and I don't remember the name of it
13 through GFR that talked specifically about the approach to
14 working with this population. I've also been to the
15 University of Virginia Institute of -- its ILPP and I can't
16 remember right now what that stands for, where there were
17 people from several different programs and we talked about
18 the assessment and treatment of the dynamic risk factors.

19 Q And that's a class you sit in?

20 A Yes, that was, I think, a two day class.

21 Q So those are the two classes you've taken?

22 A Dealing specific -- well, more than two. There
23 were at least three, four different webinars through GFIR.
24 The class --

25 Q What's the webinar involve?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A I'm sorry?

2 Q What's the webinar involve? Watching --

3 A That's an interactive thing where there's an expert
4 who either helped to develop the instrument or who has been
5 specifically trained to train others to use the instrument
6 so that we actually go through the Static 99s and difficult
7 case material. We would practice scoring them, we'd get
8 feedback. It's a very intensive learning experience.

9 Q Okay. And you did that when?

10 A There were at least three different ones dealing
11 with Static 99, Static 2002R.

12 Q In providing the actual treatment, the ongoing
13 treatment, now, that's being provided by Correct Care
14 Solutions -- we talked about that yesterday, correct?

15 A That's correct.

16 Q So you're not actually providing the actual
17 treatment, applying what you learned in these four classes
18 to Mr. Ridley, correct?

19 A Well, those were classes dealing more specifically
20 with assessments. Those were not dealing specifically with
21 treatment.

22 Q So they're not dealing with treatment at all.
23 They're just, again, assessments. Is that what your
24 testimony is?

25 A Right.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q So back to the treatment issue. Your specific
2 history as to treating people with mental health issues, as
3 I read your resume and what you testified to yesterday, you
4 dealt with special needs disabilities?

5 A That's correct.

6 Q You worked for the Department of -- DDSN --
7 Disabilities and Special Needs, am I getting that correct?

8 A Correct.

9 Q I'm close?

10 A Correct.

11 Q Okay. And you worked there and you worked with
12 adolescent children -- and children, adolescents and
13 children?

14 A At DDSN?

15 Q Uh-huh.

16 A No, that was -- we did evaluations of competency to
17 stand trial. And early in that process, sometimes criminal
18 responsibility as well. It was primarily adults, but there
19 were some juvenile evaluations involved.

20 Q I apologize, just tell me. You have -- I thought I
21 read on your resume that you worked with children as well
22 as students and those kind of circumstances?

23 A I did spend three years at Harris Psychiatric
24 Hospital on the child and adolescent inpatient unit working
25 with children, adolescents in that setting.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q Okay. So in the -- you've been doing this for how
2 long?

3 A Oh, 34 years now, altogether.

4 Q Right. So the -- majority of your treatment and
5 more -- the majority of your clinical work has been in
6 those kind of fields, correct?

7 A Correct.

8 MS. HIGHTOWER: One moment, please, Your Honor.

9 (There was a pause in the proceedings.)

10 MS. HIGHTOWER: Thank you, Your Honor.

11 THE COURT: Hold on a second, ma'am.

12 MS. HIGHTOWER: Yes, sir.

13 (There was a pause in the proceedings.)

14 THE COURT: All right. Let's move along, now.

15 MS. HIGHTOWER: Yes, sir. I apologize.

16 BY MS. HIGHTOWER:

17 Q Now, you've diagnosed my client per your testimony
18 -- isn't it correct that you've diagnosed my client with
19 other specified paraphilic disorder, nonconsent or
20 biastophilia?

21 A That's correct.

22 Q And antisocial personality disorder, correct?

23 A That's correct.

24 Q And that remains your diagnosis today, correct?

25 A It is.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q Okay. All right. Now, we talked about the
2 diagnostic statistical manual, mental disorder, correct?
3 The DSM-5?

4 A Correct.

5 Q All right. What is this book?

6 A That's the official publication of the American
7 Psychiatric Association that includes all of the relevant
8 psychiatric and mental illness diagnoses.

9 Q That includes all of the mental, mental disorders,
10 mental diagnoses, correct?

11 A That's correct.

12 Q And the criteria that you in your field and Dr.
13 Watson and psychiatrists and psychologists throughout --
14 throughout the United States use to diagnose, correct?

15 A That's correct.

16 Q All right. Could I call it the bible?

17 A I think that would be a fair analogy.

18 Q All right. In this book, we list the bipolar
19 disorders, the neuro development disorders, the
20 schizophrenic disorders, depressive disorders, all the
21 mental illness disorders, correct?

22 A That's correct.

23 Q All right. And they've got recognized criteria and
24 what we diagnose with, right?

25 A That's correct.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q Okay. You have a copy with you --

2 A I do.

3 Q -- correct, sir?

4 Thank you.

5 And you looked at it yesterday and comment -- now
6 in the paraphilic, there's a chapter on paraphilic
7 disorders in this bible?

8 A That's correct.

9 Q Right. All right.

10 And in this chapter, it specifically lists out
11 specific paraphilic disorders, such as -- well, let's just
12 go with one that's most familiar to most of us, is the
13 pedophilic disorder?

14 A That's correct.

15 Q Right. And that's on page 697. And there's
16 criteria listed and it's about the uncontrolled sexual
17 arousal, right?

18 A That's correct.

19 Q And again, let's just be clear what we're talking
20 about here in this statute, what we're talking about here
21 in the paraphilic disorders --

22 THE COURT: Ma'am, please ask a question.

23 BY MS. HIGHTOWER:

24 Q Isn't it clear or isn't it true that what we're
25 talking about is the sexual arousal? That's the

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 paraphilia, right?

2 A That's correct.

3 Q All right. That's the attraction like, for example
4 voyeurism disorder; that's specifically listed. Isn't it
5 true that voyeuristic disorders is an intense recurrent
6 sexual arousal from observing an unsuspecting person who's
7 naked or disrobing, correct?

8 A That's correct.

9 Q All right. An exhibitionist on page 689, that's
10 specifically listed. Isn't it true that it's a recurrent
11 interest in sexual arousal from exhibitionist is the
12 exposure of one's genitals -- right?

13 A That's correct.

14 Q -- to others. Either in public or unsuspecting
15 persons, right?

16 A Yes, ma'am.

17 Q Again, that's the section -- the paraphilia is the
18 sexual arousal, correct?

19 A That's correct.

20 Q Your diagnosis of biastophilia nonconsent, it's not
21 listed in this book?

22 A It's not listed specifically in the manual, no,
23 ma'am.

24 Q All right.

25 THE COURT: Well is it generally listed?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 THE WITNESS: It is generally listed. It is
2 included as a possibility within the manual.

3 BY MS. HIGHTOWER:

4 Q Where?

5 A There are several categories including the
6 paraphilic disorders that have further unspecified and even
7 an unspecified category. We can talk about depressive
8 disorder not otherwise specified, and this is using older
9 terminology, or anxiety disorder not otherwise specified
10 and there's a similar category in the paraphilic disorders
11 and in the DSM-5 on --

12 Q Not otherwise specified?

13 A That was terminology used in DSM-4, the previous
14 manual.

15 Q So that's DSM-5 and 4 --

16 A So they both include that as an additional type of
17 category.

18 Q It includes that catchall, that waist basket?

19 A It's not a waist basket, it's not a catchall.

20 Q It's not a catchall?

21 A No.

22 Q Okay. Let me just ask --

23 THE COURT: Hold on a second, ma'am, let's lay the
24 ground work. Please let him finish his response before you
25 ask a question.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Let her finish her question before you respond.

2 My court reporter's having some trouble with y'all
3 talking over each other. So please.

4 MS. HIGHTOWER: Yes, sir.

5 THE COURT: Ask your question.

6 BY MS. HIGHTOWER:

7 Q The catchall, not otherwise specified. Where does
8 it say biastophilia?

9 A I'm sorry.

10 Q Where does it say biastophilia?

11 A It doesn't include the actual terminology --

12 Q It doesn't. And --

13 A -- but it does allow it.

14 Q I'm sorry, are you finished answering that
15 question? I don't want to --

16 Okay. Isn't it true that in this do you believe
17 that the psychologists and psychiatrists that wrote this
18 book -- and my understanding is they do extensive work on
19 this. They ask for peer review journals. They ask for --
20 isn't it true they bring everybody in from y'all's
21 community across the United States when they redo these
22 books?

23 A That's correct.

24 Q All right. And there's an extensive review period?

25 A That's correct.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

- 1 Q All right. Comment period, people --
- 2 A Yes, ma'am.
- 3 Q -- there's committees. There was a specific
- 4 committee about paraphilic disorders, that chapter you read
- 5 from, correct?
- 6 A That's correct.
- 7 Q All right. And isn't it true that in their review,
- 8 in their committees, isn't it true that they specifically
- 9 rejected the biastophilia diagnosis?
- 10 A That's correct.
- 11 Q That's true? They rejected it?
- 12 A In terms of not including it.
- 13 Q Right. It's not included. It's not listed as a
- 14 disorder, a mental disorder. It's not listed?
- 15 A That's correct.
- 16 Q They considered it, right? They looked at it,
- 17 right?
- 18 A They did.
- 19 Q And they looked at it in the D -- okay. Why is it
- 20 a Number 5?
- 21 A I'm sorry.
- 22 Q Why is it the DSM-5?
- 23 A This is the fourth edition. The first diagnostic
- 24 manual was published, I want to say before 1950 --
- 25 Q It was like after World War II, I believe, right?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A Right.

2 Q Right. You guys gathered -- wanted to have
3 specific criteria about how to diagnose, how to treat;
4 isn't that correct?

5 A Not with the earlier DSM's. They weren't so
6 specific. The DSM-3 began to get into the more specific
7 criteria for diagnoses.

8 Q Right. Because we want to, as a professional
9 community, correct? They want to do that?

10 A That's correct.

11 Q All right. And starting with DSM-3, was
12 biastophilia included then? Was it? It was specifically
13 rejected then, correct?

14 A I don't know about the history of DSM-3.

15 Q All right. It wasn't included in 4 either, they --

16 A Right.

17 Q -- specifically rejected it in Number 4. They did.
18 Dr. Allen Frances --

19 MR. MORROW: Objection, Your Honor. Is there a
20 question here?

21 THE COURT: Stand up when you object.

22 I don't know if there's a question or not.

23 BY MS. HIGHTOWER:

24 Q Isn't it true that Dr. Allen Frances, chair of the
25 DSM-4 Task Force for the paraphilic work group, isn't it

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 true that he -- he and others who rejected it, isn't it
2 true they rejected it because rape is not a mental
3 disorder?

4 A That was part of their rationale, yes, ma'am.

5 Q Okay. And then part of the other concern was -- is
6 that through -- isn't it true that part of the other
7 concern is that this biastophilia, which is not included in
8 the bible, it's being used in cases just like this to enter
9 people in the SVP program as a mental -- a mental disorder,
10 even though it's not recognized as a mental disorder; isn't
11 that true?

12 A I would not say that it's not recognized as a
13 mental disorder. It's not recognized as a mental illness
14 within the diagnostic manual.

15 Q It's not --

16 A The manual does allow for it and in my opinion, it
17 does meet the criteria of mental abnormality as it's set
18 forth in the statute.

19 Q All right. But the chair of the DMS-5 (verbatim),
20 in the paraphilic chapter that we've been reading from, the
21 chair does not recognize it, correct?

22 A That's correct.

23 Q Are you familiar with a paper entitled Inventing
24 Diagnosis for Civil Commitment to Rapists?

25 THE COURT: Written by whom?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 MS. HIGHTOWER: It was written by Arthur Zander.

2 THE WITNESS: That sounds familiar. I can't say
3 right offhand that I've seen that one.

4 BY MS. HIGHTOWER:

5 Q Are you -- well, are you familiar about the fact
6 that Arthur Thomas Zander in this --

7 MR. MORROW: Your Honor, the witness has answered
8 that he does not -- is not specifically aware of that
9 paper.

10 THE COURT: You might want to show it to him and
11 see if he references it.

12 You have a copy of it?

13 MS. HIGHTOWER: I do, sir. I can hand it to him.

14 I was kind of asking about a specific part of
15 the --

16 THE COURT: Well, the rules say if he recognizes as
17 an authoritative source you can publish it to the jury. If
18 he doesn't recognize it, it's hard to say he used pursuant
19 to the rules. You can show it to him to see if he
20 recognizes it.

21 MS. HIGHTOWER: May I approach, Your Honor.

22 THE COURT: Certainly, ma'am.

23 MS. HIGHTOWER: Thank you, sir.

24 BY MS. HIGHTOWER:

25 Q Dr. Brown, I probably touched on this yesterday,

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 but let me just show you this article entitled Commentary,
2 colon, Inventing Diagnosis for Civil Commitment of Rapists.

3 A Okay.

4 THE COURT: The question is: Are you familiar with
5 that.

6 THE WITNESS: I have read this, but it has been
7 some time. I didn't say I'm familiar with it at this
8 moment in terms of the specifics.

9 BY MS. HIGHTOWER:

10 Q But you have read it?

11 A Yes, ma'am.

12 Q And in that paper, isn't it true --

13 MR. MORROW: Your Honor --

14 THE COURT: Sustained.

15 You have to ask it, do you consider it as an
16 authoritative source in this particular area.

17 BY MS. HIGHTOWER:

18 Q Is it, sir?

19 A The journal -- the Journal of the American Academy
20 of Psychiatry and the Law certainly is an authoritative
21 source, but this is a commentary. This is not a peer
22 reviewed research article. That's a commentary, meaning
23 it's someone's opinion.

24 Q Correct. But then it's from the Journal of the
25 American Psychiatry and the Law, correct?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A That's correct.

2 Q Okay. So that is a -- that is recognized?

3 MR. MORROW: Your Honor, I would object to this
4 line of testimony. The witness has testified that this
5 particular article is an opinion article included in a peer
6 article and not a peer reviewed source.

7 THE COURT: Well, he's playing with words now.
8 He's saying it's an authoritative source, the journal is,
9 and this part of the journal, so I'm going to allow her to
10 use it as the rules provide, which is, you may publish the
11 part you're asking and ask him if it's a reasonable
12 opinion.

13 BY MS. HIGHTOWER:

14 Q Do you agree with the statement by this author
15 where he states, Forensic psychology, using the diagnosis
16 of paraphilia not otherwise specified as a proxy for the
17 rejected diagnosis of paraphilia coercive disorder -- and
18 if I may interject, paraphilic coercive disorder, that's
19 biastophilia, correct?

20 A That's correct.

21 Q ...may be violating at least two standards of the
22 American Psychological Associations Ethical Principals of
23 Psychology and Code of Conduct, correct?

24 A I would not agree with that.

25 Q You would not?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A I would not.

2 THE COURT REPORTER: Judge, I'm having a hard time
3 hearing them with them turned away from me. I'm sorry.

4 MS. HIGHTOWER: No, no, I apologize.

5 THE COURT: Restate your answer, please.

6 THE WITNESS: I would not agree with that
7 statement.

8 MS. HIGHTOWER: Do you need me to reread --

9 THE COURT REPORTER: I got what you said, just him.

10 BY MS. HIGHTOWER:

11 Q So you do not agree that it's an ethical violation?

12 A I do not.

13 Q All right. Talk about the antisocial personality
14 disorder, what was the definition per the manual, and I
15 believe you read from it, the antisocial personality
16 disorder, the second part of your diagnosis of my client,
17 what is that?

18 A That's a pervasive pattern of disregard for and the
19 violation of the rights of others occurring since age of 15
20 years, as indicated by at least three of the following
21 criteria.

22 Q Let's start at age 15?

23 A Occurring since age 15.

24 Q And the specific criteria, failure to conform to
25 social norms; is that right?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

- 1 A Yes, ma'am.
- 2 Q Lack of remorse; is that one of the criteria?
- 3 A That is one of the criteria.
- 4 Q And onset of age 15, correct?
- 5 A Well, beyond the age of 15.
- 6 Q Beyond the age of 15.
- 7 A It's someone who demonstrates that after the age of
- 8 15. We couldn't make this diagnosis before the age of 15.
- 9 Q All right. And in terms of -- now, you've been
- 10 doing Mr. Ridley's annual reviews since 2015, right?
- 11 A That's correct.
- 12 Q And so you've spent time with my client,
- 13 Mr. Ridley, correct?
- 14 A That's correct.
- 15 Q All right. And I believe you gave some hours about
- 16 when you interviewed. Could you tell us how many hours
- 17 you've interviewed my client?
- 18 A It's been about ten hours altogether.
- 19 Q About ten hours altogether since 2015?
- 20 A Correct.
- 21 Q So all these taken together, you've sat down and
- 22 spoken to my client for ten hours?
- 23 A I would say that's a pretty close estimate.
- 24 Q And how you come at your opinion here today,
- 25 doctor, is you review all of these records, correct?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A That's correct.

2 Q And you interview my client?

3 A That's correct.

4 Q Now, you're not his treating physician, we
5 certainly have established that.

6 Who is his treating psychologist?

7 A The psychologist that oversees the program is Dr.
8 Chris -- but he would have a specific case manager.

9 Q Is that a psychologist?

10 A It's not a psychologist. It's a licensed mental
11 health care provider.

12 Q All right. So there's one psychologist over the
13 entire unit -- when I say unit, I mean the entire program?

14 A That's my understanding as of at this point.

15 Q All right. Who's his psychiatrist? Who treats him
16 on a one on one level?

17 A I don't know that there is a psychiatrist that
18 would treat most of the residents on a one-on-one basis.
19 There is one available when there is need for a
20 psychiatrist.

21 Q So there's no one-on-one treatment in the sexually
22 violent predator program?

23 A As far as individual therapy, no, ma'am.

24 Q So the only therapy they're getting is in their
25 group sessions?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A That's what's recommended in those type of
2 programs. We find group therapy to be far more effective
3 than individual therapy.

4 Q We don't provide individual therapy?

5 A No, ma'am.

6 Q Has he ever been prescribed medications to help
7 with any mood disorders or anything or is --

8 A Not that I recall. I don't think he has.

9 Q So what's a support team member? You reviewed the
10 records of Correct Care and they list a support team member
11 as somebody working with Mr. Ridley. Who is that?

12 A I'm not sure what you're referring to.

13 Q Okay. What is a clinical counselor or case
14 manager?

15 A The clinical counselor, case manager, would be the
16 assigned person that works with Mr. Ridley and then you
17 have individual check-ins. I would say the -- not for the
18 individual treatment, but at least it's on a weekly basis,
19 Mr. Ridley and the other residents would check in with
20 their case manager and then beyond that in group time, of
21 course.

22 Q And are they a psychologist?

23 A No, it's a licensed mental health provider.

24 Q Are they trained in this field of paraphilic
25 disorders or sexually violent predator?

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 A I don't know the current case managers with Correct
2 Care, so I -- I can't answer that.

3 Q So do -- the general assembly puts forth its
4 concerns, creates this program, but is it -- is it not
5 staffed with people that are trained to do this particular
6 work?

7 A It is and that would be a part of DMH's oversight
8 of that and I'm not a part of that process.

9 Q Okay. It is DMH oversight?

10 A There is a DMH committee that looks at, you know,
11 what they do in their program, how the program is run; what
12 the various staffing is. So that is monitored by DMH.

13 Q And by monitored, do we mean working with the
14 residents?

15 A No, they are monitoring, overseeing the work that
16 Correct Care is doing.

17 Q So they're monitoring the case managers and the
18 group leaders that are doing the group facilitation?

19 A I -- I really can't talk about the details of how
20 they do it because again, I'm not a part of that process.

21 Q You're not part of that process. So you're limited
22 in your actual, just review of the document that is they
23 give you and your interview with my client?

24 A I can review the documents and then I have
25 available to me and interview Mr. Ridley. And that's --

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 that's what I have to work with.

2 Q My understanding that --

3 MS. HIGHTOWER: May I beg the Court's indulgence
4 for just one moment.

5 (There was a pause in the proceedings.)

6 MS. HIGHTOWER: Thank you.

7 BY MS. HIGHTOWER:

8 Q Let me -- in your interview -- let's get to my
9 client. In your interviews with my client, he disclosed to
10 you about what happened to him at Riker's Island, right?

11 A That's correct.

12 Q All right. And he talked about his -- his anger at
13 being sexually violated in such a violent way, didn't he?

14 A That's correct.

15 Q And he talked about how -- how did he explain about
16 his control issues, about having that -- having that
17 experience, coming forward during his offense time frame --
18 offense cycle as we all refer to it; but during the five
19 years that he committed his sexual offenses, what did he --
20 what was his talk about?

21 A He makes a --

22 Q How he related back to his sexual violation as a
23 17-year-old at Riker's?

24 A He make a connection between the fact that he was
25 violated by 16 or 17 year old males and then relates that

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1 to the fact that that's the age group that he chose to
2 later violate against.

3 Q Right. And then also that he didn't receive any
4 treatment about that violation, correct?

5 A That's correct.

6 Q All right. And that he also talked about -- and
7 you touched on this in your direct examination yesterday --
8 that he talked about, he felt like his attraction to males
9 was what was deviant about him, correct?

10 A Correct.

11 Q I mean he clearly indicated that he had trouble
12 talking about, in group sessions, which is what the
13 treatment program is, obviously, in his group sessions, he
14 didn't -- didn't he tell you or did he tell you about how
15 difficult it was for him to talk about his attraction to
16 males?

17 A He has talked about that, yes.

18 Q And then certainly given the fact that he was
19 victimized and violated, himself, at Riker's Island, that
20 was a difficult thing for him to address?

21 A That's correct.

22 Q All right. And you mentioned it in your prior
23 reviews that he's talking about his attraction or his, his,
24 his attraction to males as being uncomfortable and deviant
25 in his mind, correct?

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1 A That's correct.

2 Q And then in your review, this annual review, isn't
3 it true that my client talked to you about -- he's dealt
4 with that and he came -- he had -- I'm calling it a
5 breakthrough -- I don't think that's how y'all talked about
6 it -- but in his work in group in June of 2017, he talked
7 about -- he talked with you about how he understood that it
8 was okay to be sexually attracted to males, correct?

9 A That's correct.

10 Q And that he recognized that his -- that wasn't the
11 problem, the problem was actually the rape?

12 A That's correct.

13 Q All right. And he recognized that and y'all talked
14 about it?

15 A That's correct.

16 Q And did he also tell you that he was able to talk
17 about it, finally, in group?

18 A He did.

19 Q All right. And in all of these reports that you're
20 reading about from the 2017 treatment plans and the group
21 case managers and I say group because that's the treatment
22 he 's getting, he actually brings that up and talks about
23 that?

24 A Yes, ma'am.

25 Q Okay. Let's talk about this, doctor: In your

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1 annual review of 2015, you said Mr. Ridley had just started
2 the program, correct?

3 A That's correct.

4 Q Just begun treatment.

5 And you also in your direct, you talked about
6 Mr. Ridley's difficulty with coping skills and problem
7 solving because he was frustrated about his work in the
8 treatment program, correct?

9 A That's correct.

10 Q And you mentioned the fact that he had to redo his
11 autobiography, right?

12 A Yes, ma'am.

13 Q And he had to redo -- I don't know, the beginning
14 of his treatment plan over, correct?

15 A That he complained about that or --

16 Q Well, yeah, he complained about it --

17 A Yes, ma'am.

18 Q He complained about it because he had to do it?

19 A That's correct.

20 Q Is he the only resident at the SVP program that had
21 to redo his autobiography?

22 A Oh, no. Almost all of them do.

23 Q Everybody did. Why is that? Why did everybody
24 have to start over?

25 A Well, I think we're talking about two different

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1 things here. One of the most common complaints I got when
2 I ran the treatment team was, I've already done my
3 autobiography, they're asking me to redo it. So redoing
4 it, adding new information, looking at it in different ways
5 is a part of the treatment process.

6 Q I get that. But specifically Mr. Ridley and all
7 the other residents had to redo their autobiography because
8 Correct Care came in, correct? Brought their own people.
9 Brought their own group therapists or group leaders; isn't
10 that true?

11 A I think this's a reasonable assumption. I don't
12 know that in fact. I can't say for sure that is what
13 happened.

14 Q Well, it's true that DMH contracted out all of it's
15 treatment from to Correct Care Recovery Solutions, right?

16 A I'm sorry?

17 Q It is true that the department of mental health
18 contracted out to Correct Care to take over the program,
19 correct?

20 A That's correct.

21 Q And when did that happen?

22 A I think that was October 2016.

23 Q 2016. And isn't this the same period of time that
24 he's expressing frustration about having to redo his
25 autobiography and start again?

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1 A Yes, ma'am.

2 Q Y'all talked about that?

3 A Yes, ma'am.

4 Q Okay.

5 MS. HIGHTOWER: A moment, please, Your Honor?

6 (There was a pause in the proceedings.)

7 BY MS. HIGHTOWER:

8 Q You talked about negatives that you saw, and we'll
9 get into those in little -- in a minute, about the
10 difficulty with the TV and those issues.

11 But you didn't mention any positives in terms of
12 specific instances of positive behavior demonstrated by my
13 client while in this program. I apologize if I'm wrong
14 about that, but I do want -- in my review of the records
15 there were -- there have been instances where my client has
16 been confronted by another person on the unit and he's had
17 racial slurs thrown at him; isn't that correct?

18 A That's correct.

19 Q And you've talked about how he handled that
20 confrontation, correct?

21 A And he did handle that well. I think I addressed
22 that in one of the annual reviews.

23 Q Yeah, but I don't think you talked about it
24 yesterday. So let's -- how did he handle that? How did he
25 use his coping skills to deal with that situation where

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1 he's confronted by another inmate? How did he deal with
2 that?

3 A My memory is that he was able to just walk away
4 from it. I'd have to look at my report to see specifically
5 what I said about time, but he did not get -- he did not
6 make an issue of it.

7 Q And then -- do you recall telling him or him
8 telling you that he actually told the other inmates that if
9 you're going to speak that way to me, then we have nothing
10 to talk about. And he walked.

11 A Yes, I recall that.

12 Q Does that refresh your memory?

13 A That's correct.

14 Q And so he was able to talk through -- not only just
15 walk away, he was able to talk through the person that was
16 confronting him and then walk away?

17 A That's correct.

18 Q And your -- in the most recent review, let's just
19 get to that one, the overall behavior in 2017, part of your
20 report is -- it indicates that he -- let's talk about, He's
21 attained the highest level of behavior. You touched on
22 that. He's a blue level; is that right?

23 A Well, that's what department of mental health
24 called it in our behavior privilege program.

25 Q You talked about that. Let's talk about -- what's

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1 the privilege system and how is it coded. What do you do
2 in each level? What do you have to demonstrate?

3 A Okay. And again, I'm not that familiar with
4 Correct Care's system. They have a similar thing where
5 they have five -- I think they call it care levels. But
6 it's basically behavior privilege level. If a person
7 managed to stay out of trouble, when we worked with the
8 program at DMH, they had to attend group close to 100
9 percent of the time; they had to actively participate in
10 group; they couldn't have any negative write-ups, so
11 basically as they did better and better; they would
12 progress from red level, which was very restrictive, to a
13 green level, which is where most of the residents were,
14 with an average number of privileges, to blue level, where
15 they could have a television; they could participate in a
16 dining out program, they have food brought in from outside
17 sources and had other privileges; they could stay up later
18 at night and things like that.

19 Q So when you were supervising it through DMH, he had
20 attained the blue level?

21 A That's correct.

22 Q In that he was able to order the TV and order food
23 like you said, you can order food in from outside. He had
24 attained that level. And that was --

25 A That's correct.

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1 Q If I recall, that was in 2016 is when you were
2 still overseeing at DMH, correct?

3 A Correct.

4 Q So he had -- he had attained that level to --

5 A Yes, ma'am.

6 Q -- and fulfilled those requirements?

7 A That's correct.

8 Q And to your knowledge and based upon your review of
9 the records from Correct Care and your interviews with my
10 client, he's maintained that level?

11 A Yes, ma'am.

12 Q To your knowledge?

13 THE COURT: What percentage of people in treatment
14 attain this blue level? Do you know? Very few or --

15 THE WITNESS: With DMH, there were very few that
16 made it to blue level. That was not that common.

17 THE COURT: Go ahead.

18 BY MS. HIGHTOWER:

19 Q It was eight people, does that sound about right?

20 A I don't know.

21 Q Very few -- how many people are on the sexually
22 violent predator program?

23 A The last number I heard about the time we were
24 going through the transition, it was 180. So I would think
25 at this point it's somewhere between 180 and 200.

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1 Q Okay. So when you were last -- when you were last
2 overseeing and involved in the treatment part when DMH ran
3 it, there was about, approximately, 180 residents?

4 A That's correct.

5 Q Okay. And only about approximately eight attained
6 that level; is that about right?

7 A That sounds right.

8 Q You talked about risk factors and my client. Isn't
9 it true he identified one of his risk factors was the fact
10 his history, his drug dealer lifestyle, correct?

11 A That's correct.

12 Q And he talked about that throughout his treatment
13 while DMH ran it and he talks about it now, as --

14 A That's correct.

15 Q All right. Again, and in coping skills and healthy
16 relationships, isn't it true that he has worked on,
17 demonstrated -- I think it's page 9 of your report of
18 dynamic risk factors that he, in coping -- how he keeps
19 with confrontation -- isn't it true that he now gives
20 himself more time to think, correct?

21 A Correct. That's when he's -- how he does things.

22 Q So the impulsivity, the entitlement, his prior
23 lifestyle, he's worked on that?

24 A That's correct.

25 Q All right. You talked about his discharge plan.

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1 MS. HIGHTOWER: A moment, please, Your Honor.

2 (There was a pause in the proceedings.)

3 BY MS. HIGHTOWER:

4 Q Page 5 of your report indicates that Mr. -- isn't
5 it true that Mr. Ridley's former DMH case manager described
6 him as an active participant in group, indicated that he
7 promptly submitted his assignments and appropriately
8 discussed them in group, correct?

9 A That's correct.

10 Q All right. Isn't it also true that it's noted that
11 he's able to assist other group members in understanding
12 their treatment and related treatment concepts?

13 A That's correct.

14 Q Okay. And you also indicate -- isn't it true that
15 you also indicate that Mr. Ridley adds to the group
16 discussions by providing his own insight into topics and
17 frequently relates the discussions with his own offenses?

18 A That's correct.

19 Q So he's examined his offense history. He's able to
20 -- and this is your most recent report, correct?

21 A Yes, ma'am.

22 Q Okay. And he's able to have insight into topics
23 and the work that they're doing in these group sessions,
24 correct?

25 A I would say limited insight, but some, yes.

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1 Q Providing -- it says, isn't it true, he adds to the
2 group discussions by providing his own insight into topics
3 and frequently relates the discussion with his own
4 offenses, correct?

5 A That's correct.

6 Q We talked about during the transition he indicated
7 that he was upset that he had to start over. We talked
8 about that. We can move on.

9 Oh, I did want to mention this fact, because you
10 know that that's part of his -- one of his -- that's one of
11 his negatives, right? Is that he was upset and frustrated
12 with the program and that he needed to be able to deal with
13 that, correct?

14 A That's correct.

15 Q All right. But also, you go on into page 6 of your
16 report: I'm sorry, page 13 of your report, when you
17 interview him, he talks to you about treatments better than
18 expected with CC, with Correct Care, and that he's worked
19 through the difficulties of having to start over.

20 A I'm sorry?

21 Q It was -- I have it on page 13.

22 A In this part he was referring to there was -- like
23 a lot of people were skeptical when Correct Care came in
24 and he said that looking back, he did think that the
25 transition had gone more smoothly and that it was going

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1 better than he expected it.

2 Q So in retrospection, looking at it, he's thinking
3 it's better, correct?

4 A Well, better than he thought it was going to be.

5 Q Yeah. Right.

6 And part of the specific, -- isn't it through that
7 part of his specific criticism is -- if you can answer
8 this, I don't know if you can or not. But my
9 understanding, isn't it true that part of his specific
10 criticisms is they reworked the group therapy. They worked
11 the -- they reworked who the participants were. And
12 meaning, they took the group of men that worked together,
13 talked through their program, talked through their group
14 sessions, right? That's the model? That's the model that
15 happened under DMH, right?

16 A That's correct.

17 Q And they stayed together, right? The group? They
18 don't -- they don't --

19 A They -- well, they changed over time as people came
20 and left.

21 Q Correct.

22 A But basically the group stayed together, yes,
23 ma'am.

24 Q Right. And that's part of the treatment model.
25 That's part of what you do, you build trust and rapport?

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1 A That's correct.

2 Q That's what they're working on, right?

3 A That's correct.

4 Q All right. Now, when Correct Care came in, part of
5 the frustration is that they mixed up the groups, right?

6 A That's correct.

7 Q You're fam -- you're familiar with that?

8 A Yes.

9 Q Okay. All right. So -- so they go through the
10 transition and he talks to you about that. He says it's
11 better that he suspected, right?

12 A That's correct.

13 Q So they've worked through it in hindsight.

14 In your interview with Mr. Ridley, he says --
15 Mr. Ridley, himself, says that he does not believe that he
16 has deviant sexuality. Y'all talked about that. He
17 doesn't believe he has deviant sexuality?

18 A That's correct.

19 Q And specifically, he's talked with you in your
20 interview about the fact that he recognizes that it's okay
21 to be attracted to men, that he can have a homosexual
22 relationship with another male, correct?

23 A Yes, ma'am, that's, that's correct.

24 Q So -- and as that relates back to his offense
25 history, back during the period of time from the '96 to

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1 2001, approximately, that five and a half period of time
2 where he offended, as he relates back to that, certainly,
3 he recognizes that that violent behavior, that rape, y'all
4 talked about that; and isn't it true he recognizes that the
5 power and control that he was seeking, he recognizes that
6 that's the deviance, correct?

7 A He says that he does recognize that, yes, ma'am.

8 Q All right. That -- he brought that up to you in
9 the 2017 review, right?

10 A That's correct.

11 Q And that's different than what he brought up to you
12 in say his 2015 review?

13 A That's correct.

14 Q So obviously, we have change from 2015 to 2017;
15 isn't that correct? In that respect?

16 A I can't say that that demonstrates change. He's
17 changing what he's saying. Whether or not that reflects
18 real change or getting different answers, it's hard to say.

19 Q It's hard to say.

20 As I understand, in this program, everything you're
21 doing with these patients, is -- is about what they say. I
22 mean -- okay.

23 Let me ask it this way: Isn't it true that there
24 are -- there are different type of tests that you can --
25 and maybe you can't speak to this, I don't know, maybe it's

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1 not in your background, but are you aware that there are
2 specific tests that can be administered to sexually violent
3 people to register their arousal rate to specific types of
4 stimuli, correct? Are you aware of that?

5 A Yes, ma'am, yes, ma'am.

6 Q Okay. And describe what that is. Describe that
7 process.

8 A Well, the most common is the PPG, the Penile
9 Plethysmograph where they actually measure how much the
10 penis is aroused in response to specific stimuli.

11 Q And let's just -- let's just talk about what it is.
12 So you actually attach an instrument, correct?

13 A Correct.

14 Q And then you show the patients specific pictures,
15 correct?

16 A Yes, ma'am.

17 Q And you can go through every diagnosis in the
18 paraphilic bible and you can go through the exhibitionism,
19 so you can show pictures of that, correct?

20 A Well --

21 Q Well, all right. I guess, let me use pedophilia.
22 I apologize, it's a better example. Pedophilia, so --
23 right, he would use that? Isn't it true that that's --

24 A That's correct.

25 Q All right. Do you give this test -- or did you

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1 give it in the department of mental health when y'all ran
2 it?

3 A We were not able to give it when we had the
4 program.

5 Q Okay. So -- and is it being given as a measure of
6 progress or measure of work on whatever treatment -- is it
7 being given while Correct Care runs it?

8 A It's a part of the plan to give it after phase 2.2
9 where they go through the PPG and actually will measure
10 arousal and they start working on arousal management. So
11 that's not something that's been given at this point, but
12 it is a part of the plan going forward.

13 Q Part of the plan going forward or is it being done?

14 A Well, it's not being done now because no one is at
15 the phase where it would be done.

16 Q Okay. So what's the -- what's a Abel testing?
17 What's that?

18 A The Abel is an assessment of sexual interests.

19 Q Okay. And he has -- Abel testing, is that being
20 used on the treatment plan? Is that being used in the
21 treatment?

22 A No, ma'am, it's not.

23 Q Okay. Okay. So back to what you are doing, what
24 we are talking about; isn't it true that what he told you
25 in 2015 about what he was uncomfortable with, what he

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1 considered a deviant, attraction being a homosexual, has
2 changed? He told you something different in 2017, correct?

3 A That's correct.

4 Q All right. Mr. Morrow talked with you yesterday
5 about --

6 Oh, let me ask you this: Are you aware that a part
7 of our examination and my preparation in this case today
8 that we did have Mr. Ridley submit to a PPG exam?

9 A Yes, ma'am.

10 Q You're aware of that?

11 A I am.

12 Q And you've had the results of that for --

13 A I've seen Dr. Watson's summary of the results.
14 I've not seen the test results themselves.

15 Q Okay. Mr. Morrow asked you yesterday about the
16 Static 99R score sheets. Do you have those?

17 A I do.

18 Q Okay.

19 MS. HIGHTOWER: May I approach the witness, Your
20 Honor?

21 THE COURT: You may.

22 MS. HIGHTOWER: Thank you.

23 BY MS. HIGHTOWER:

24 Q All right. And the Static 99R that's a risk factor
25 for static factors, correct?

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1 A That's correct.

2 Q All right. And what does static mean?

3 A Static factors are factors that are part of the
4 person's history. We know how these factors in their
5 background, in their history are more likely to reoffend
6 than those who do not have them.

7 Q Okay. Do static factors change?

8 A They can change, if those diagnoses change, but
9 typically, no, they do not. A person who commits a new
10 sexual offense, it could change the score.

11 Q Certainly if you reoffend it's going to offend -- I
12 mean it's going to affect how many offenses they have,
13 correct?

14 A Correct.

15 Q Okay. Let's just go through it. So the first
16 static factor is the age, correct?

17 A That's correct.

18 Q All right. Of the person. Right?

19 A Of the person at the date they're released from
20 total confinement for that offense.

21 Q Okay. So it doesn't look at the date -- at the age
22 they were at the time of the offense, it looks at the time
23 that they're released from their confinement from where
24 they've done their time?

25 A That's correct.

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- 1 Q Okay. So those ages -- ages 18 to 34, they've got
2 a score of one, correct?
- 3 A Correct.
- 4 Q And then ages 35 to 39, they have a score of 0,
5 correct?
- 6 A Correct.
- 7 Q And then ages 40 to 59, they got a score of
8 negative 1?
- 9 A That's correct.
- 10 Q All right. And then age 60 and over, that's a
11 negative 3, correct?
- 12 A Correct.
- 13 Q All right. So what's going on there?
- 14 A Well, we do know that the risk of recidivism
15 typically goes down as a person ages.
- 16 Q Okay.
- 17 A So they get credit for aging in using this
18 instrument.
- 19 Q And that would be the one factor that changes?
- 20 A Right.
- 21 Q Then again, everything else looks at their past,
22 their static past?
- 23 A Correct.
- 24 Q All right. Number two is one of the questions,
25 Have you ever lived with a lover. And this one is marked

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1 no, correct?

2 A That's correct.

3 Q And you've recognized that he has explained that he
4 has lived with his mother of his children, correct?

5 A That's correct.

6 Q And so this is scored as a no, so --

7 A And I can explain why it's scored at a no.

8 Q Sure, go ahead.

9 A One thing we look at is what a person reports over
10 time. Now, when Mr. Ridley had the pre-commitment
11 evaluation with Dr. Gehle, she scored it at a 0. So after
12 I saw Mr. Ridley, I actually talked to Dr. Gehle and she
13 showed me in her notes where he said they only lived
14 together for a year and a half. So because I would trust
15 the information he gave her in the pre-commitment process
16 more than what he tells evaluators when he knows how this
17 thing is scored, I would tend to go with Dr. Gehle's score.

18 Q You said Dr. Gehle gave him a 0?

19 A Dr. Gehle gave him 1 on that.

20 Q Okay. All right. All right. So --

21 But you're familiar that he, he, he reports that he
22 has lived with the mother of his children?

23 A Yes, ma'am.

24 Q All right. Was the problem was that he didn't live
25 with her long enough?

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1 A Well, there's nothing arbitrary, but if you look at
2 the data, people who do have that relationship of living
3 with someone for two years, he would be less likely to
4 commit than those who don't haven't lived together for two
5 years relationship.

6 Q So there is a factor about in -- you've got to look
7 at how long -- y'all were looking at how long they were
8 living together?

9 A Correct.

10 Q Okay.

11 A And I will say that that's one item that can be
12 omitted. So that's not one that's going to make a huge
13 difference one way or the other.

14 Q And again, the whole process behind this Static 99,
15 how was it developed?

16 A It was developed by someone called Karl Hansen.
17 The initial instrument he used was something called the R
18 Razor which would be an early static measure. And I think
19 he went up to a score of 6 looking at some of these
20 specific kinds of criteria. David Thorne, at the same time
21 was working on a similar measure. I think it was in
22 England. And the two of them got together and came up with
23 this as a better instrument than either one of those two
24 alone.

25 Q And how did they go about collecting the data? How

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1 did they come up with these factors? How does it even -- I
2 think put together this table? This algorithm, this plug
3 in some numbers and come out with a score? How did they do
4 that?

5 A Well, that's a matter of looking at the research
6 and looking at people who have offended and what is
7 different about their background and their history than
8 from those who haven't offended. And specifically those
9 who are re-offending.

10 Q So am I right in saying that they took a group of
11 people that -- known sex offenders, correct?

12 A Correct.

13 Q Right. And they studied or they brought the known
14 sex offenders in that had done their time and came back and
15 were out in the community and you interviewed them -- they
16 took the data --

17 A Correct.

18 Q -- they created some kind of questionnaire about
19 these static factors, right?

20 A That's correct.

21 Q Okay. And then they looked at that specific group
22 of sex -- known sex offenders and they ex -- they looked at
23 who re-offended from that group?

24 A Correct.

25 Q Right. Okay. And then from that data, then they

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1 extrapolated risk levels, right?

2 A That's correct.

3 Q Okay. Based upon those people and their
4 extrapolation?

5 A That's correct.

6 Q And that they could use the analogy that it's like
7 an insurance. It's like the field of insurance, where you
8 -- you know, we, we -- my daughter has a fender bender in
9 the Target parking lot. She's 17 years old. My insurance
10 goes up, right? And that's based upon the fact that she's
11 now had a fender bender, right?

12 A Correct.

13 Q All right. But in that same algorithm that the
14 insurance uses to up my rates because she's had a fender
15 bender, this -- what the insurance company can't know about
16 my daughter is that now she looks four times at every
17 mirror and she backs up at less than a mile -- she creeps
18 out behind, right?

19 A Uh-huh.

20 Q So, so, so the difficulty with using that -- I mean
21 -- using that analogy to this analogy, the difficulty about
22 those type of scoring, is you can't predict individual
23 behavior, correct?

24 A That's correct.

25 Q I mean that's clear in this literature that that is

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1 not to be said. This is not to be used as -- it's a --
2 it's limited I guess I should say it that way. It's of
3 limited use, I guess I should say it. Is that a fair
4 enough statement? It's of limited use as to an
5 individual's risk of re-offending?

6 A Well --

7 Q Whether or not they would?

8 A Well, we can't use it to say that Mr. Ridley's risk
9 of reoffending is this percentage or this X number of times
10 more likely. What we can say is in research, people with
11 that score have re-offended at this rate.

12 Q Right.

13 A It's absolutely not about a particular individual.

14 Q Right. Nothing about that particular individual.

15 Thank you.

16 Well, let me ask you this way, I mean, because, I
17 guess my question would be, what would be the point of
18 treating him if he's going to spit out that score based
19 upon those static factors and it's history, so it's not
20 going to change until of course he gets age 60?

21 A Well, this is one part of the assessment. And only
22 one part.

23 Q One part.

24 A And that's why I said yesterday we also have to
25 look at dynamic risk factors and look at those things that

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 a person can change.

2 Q And let's look at those. I'm sorry, I did want to
3 make this other point because I was confused about it.

4 What was the -- based upon that Static 99 risk of
5 re-offending within 5 years, y'all talked about something
6 about there's a window, there's a time limit of five years.
7 Did I misunderstand that?

8 A The --

9 Q Explain that to me.

10 A And one thing I like about the Static 99, they
11 update the norms, they update the data as they do more
12 research and things change. And probably in some of my
13 earlier reports, I've talked about five year re-offense
14 rates and ten year re-offense rates.

15 Q Right.

16 A And now we're saying is reliable to predict out for
17 about five years.

18 Q Okay.

19 A If someone hasn't re-offended in five years, then
20 the risk of re-offending does go down significantly. And
21 then once they're in the community, there are other
22 measures we can look at as well to see how some of those
23 dynamic risk factors are changing and then further look at,
24 is the risk going down as they're being successful in the
25 community.

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 Q Okay. And the data that they use to create the
2 Static 99, they looked at known sex offenders and their
3 re-offense rates, correct?

4 A That's correct.

5 Q Okay. And we're saying it's like -- it should be
6 within a five year window? Is that -- am I understanding
7 that right?

8 A That's correct. Well, we're saying these offenders
9 re-offended at this rate within a five year period.

10 Q All right. So Mr. Ridley pled -- pled guilty to
11 his crimes in 2001. He's been in the department of
12 corrections serving 20 years. You're familiar with his
13 department of corrections record, right? That's part of
14 what you reviewed?

15 A Correct.

16 Q Right. Is there anything in his department of
17 corrections records for the past 14 years that indicated
18 that he re-offended sexually?

19 A No, ma'am.

20 Q Okay. Is there any indication that he re-offended
21 in the last four years on the sexually violent predator
22 program?

23 A None.

24 MS. HIGHTOWER: A moment, please, Your Honor.

25 (There was a pause in the proceedings.)

Dr. Gordon Brown - Cross-Examination by Ms. Hightower

1 BY MS. HIGHTOWER:

2 Q One thing Mr. Ridley would like for me to point out
3 is that in -- in the offenses that he pled to and then went
4 to the South Carolina Department of Corrections for, isn't
5 it true that that -- that victim was in his 20's, correct?

6 A I'm sorry --

7 Q That that victim was in his 20's correct? 20 years
8 old?

9 A That's correct, yes, ma'am.

10 Q 20 was all?

11 A Yes.

12 Q In your review of the records, and I just want to
13 make sure this is clear.

14 In your review of the records in terms of the
15 offenses, I'm referring to them as sexually violent crimes,
16 but there -- but that's because of the definition, the
17 statute defines them as sexually violent crimes, correct?

18 A That's correct.

19 Q All right. So there is nothing in the record that
20 indicates that he ever used a gun, correct?

21 A That's correct.

22 Q And he never used a knife, correct?

23 A That's correct.

24 Q His offense history and his conversations with you
25 and his conversations with the treatment teams and his

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

1 disclosures, they indicate that his offense history was
2 through force, verbal force?

3 A That's correct.

4 MS. HIGHTOWER: A moment, please, Your Honor.

5 (There was a pause in the proceedings.)

6 MS. HIGHTOWER: Thank you, Your Honor, that's all I
7 have.

8 THE COURT: Mr. Morrow?

9 MR. MORROW: Briefly, Your Honor.

10 **REDIRECT EXAMINATION**

11 BY MR. MORROW:

12 Q Dr. Brown, let's talk about Correct Care real
13 quick. It's a private company, right?

14 A That's correct.

15 Q And they have contracted with the department of
16 mental health to provide the staffing and run the
17 day-to-day operations of the SVP unit?

18 A That's correct.

19 Q Okay. They do this in several other states?

20 A I know they do it in Florida. I'm not sure which
21 other ones.

22 Q And the department of mental health exercises
23 oversight over the treatment process, correct?

24 A That's correct.

25 Q All right. There is a team that does that?

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

1 A That's correct.

2 Q All right. And it makes sure -- that team makes
3 sure that the treatment complies with the requirements of
4 our statute, correct?

5 A That's correct.

6 Q Okay. And as part of DMH's role in this process,
7 DMH conducted pre-commitment evaluations and annual review
8 evaluations, correct?

9 A That's correct.

10 Q And you did this by consulting with Correct Care
11 staff, which we talked about.

12 A That's correct.

13 Q And by reviewing their progress notes and that kind
14 of treatment notes?

15 A That's correct.

16 Q And reviewing Mr. Ridley's records?

17 A That's correct.

18 Q And you found during Mr. Ridley's treatment that
19 there were his case manager and progress notes indicated a
20 number of problems with treatment?

21 A I did.

22 Q Is that correct?

23 A Yes.

24 Q And one of those is that he minimized the aspects
25 of his crime; is that correct?

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

- 1 A That's correct.
- 2 Q And that he was resistant to rules and supervision?
- 3 A That's correct.
- 4 Q Essentially he doesn't like hearing the word no?
- 5 A I think that's a fair statement.
- 6 Q And when he was in the community, that manifested
- 7 itself in his sexual offending; is this correct?
- 8 A That's correct.
- 9 Q And particularly, this is of concern to you because
- 10 he trained one of the -- he was observed in, engaged in,
- 11 offensive parallel behavior including younger looking
- 12 residents on the unit; is that correct?
- 13 A That's correct.
- 14 Q Even though that was against the rules?
- 15 A That is against the rules, yes, sir.
- 16 Q Okay. And he also failed to follow rules in other
- 17 situations?
- 18 A That's correct.
- 19 Q And what were some of the examples of those?
- 20 A One was a situation where he bought the television
- 21 after being specifically told not to. Not wearing a shirt
- 22 to the medical section, those are the two that come to mind
- 23 right away.
- 24 Q He also -- on your Static 99 score sheet, he got a
- 25 score of 9; correct?

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

1 A That's correct.

2 Q That's in the 99th percentile?

3 A That's correct.

4 Q On the Static 2002R, he got a score of an 8?

5 A That's correct.

6 Q That's also in the 99th percentile?

7 A That's correct.

8 Q What's the highest score you've ever seen?

9 A The highest -- well, we just started using the
10 Static 2002R, so I really can't address that in terms of
11 what the highest score would be. The highest I've seen in
12 the program was actually a 10, but that's one whose score
13 ran between 8 and 10, depending on --

14 MS. HIGHTOWER: Your Honor, I'm going to object.

15 THE COURT: Sustained. That's not relevant in this
16 case. We're talking about Mr. Ridley. Not anybody else.

17 MS. HIGHTOWER: Thank you.

18 BY MR. MORROW:

19 Q Dr. Brown, is other specified paraphilic disorder
20 in the DSM-5?

21 A Not by that name.

22 Q I'm sorry. Other specified paraphilic disorder --

23 A Other specified -- yes, yes it is.

24 Q Okay. And that appears on page 705?

25 A I think that's correct.

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

1 Q And other categories in the DSM-5 include other
2 specified -- other specified disorders as well; is that
3 correct?

4 A That's correct.

5 Q And the other specified depressive disorder,
6 correct?

7 A That's correct.

8 Q Other specified anxiety disorder; is that correct?

9 A That's correct.

10 Q Other specified personality disorder; is that also
11 correct?

12 A Correct.

13 Q Okay. And in the section that talks about other
14 specified paraphilic disorders, on page 705, it specifically
15 states examples of presentations that can be specified
16 using the other specified designations include, but are not
17 limited to and it has a delineated list of --

18 A That's correct.

19 Q Okay. Are not limited to, correct?

20 A That's correct.

21 Q All right. And the research you've -- in the
22 research you've reviewed, biastophilia is a legitimate
23 diagnosis.

24 A There are some experts who would say that it's not,
25 but there are other experts who say very strongly yes it

Dr. Gordon Brown - Redirect Examination by Mr. Morrow

1 is.

2 Q And in your opinion, you agree with those who say
3 that it is?

4 A I agree with those who say that it is.

5 Q And that biastophilia is the arousal with
6 nonconsent?

7 A That's correct.

8 Q Okay. Now, we went over -- Counsel went over a
9 question about Mr. Ridley being a victim; is that correct?

10 A That's correct.

11 Q And he was very angry about that; is that correct?

12 A At the time he was, yes.

13 Q And so he knew what the impact of victimizing
14 someone would be?

15 A That's correct.

16 Q Yet he still decided to do that to others?

17 A That's correct.

18 MR. MORROW: Thank you, no further questions.

19 THE COURT: You may step down. You may step down.

20 Redirect -- recross examination is discretionary to
21 the Court and I do not allow it.

22 MS. HIGHTOWER: Thank you, Your Honor.

23 THE COURT: Next witness.

24 MR. MORROW: Your Honor, at this time the State
25 would rest its case.

1 THE COURT: All right. Madame Forelady, ladies and
2 gentlemen, we're -- I need to spend a few minutes with the
3 lawyers. I'm going to let you go back to the jury room.
4 Don't discuss the case, don't start any deliberations. The
5 bailiff will have a menu for you, we'll order you some
6 lunch. With special arrangements with Taco Bell --
7 (laughter).

8 (The jury left the courtroom at 10:41 a.m.)

9 THE COURT: Anything from the State before we
10 proceed with a break?

11 MR. MORROW: Nothing from the State.

12 THE COURT: Ma'am, anything?

13 MS. HIGHTOWER: No, Your Honor. I'm ready to make
14 my motion before our break.

15 THE COURT: Go ahead.

16 MS. HIGHTOWER: At this time I would make a motion
17 for a directed verdict in the case. I relied on my motion
18 in limine, what I've already submitted in court as to the
19 unrecognized diagnosis of biastophilia. Also in addition
20 to my motion and the law and the peer review journals that
21 I've submitted already, I would also --

22 THE COURT: Well, let's assume you're right, but
23 doesn't he have the other diagnosis that is recognized?

24 MS. HIGHTOWER: He has the other diagnosis -- or
25 the testimony is that he has the other diagnosis,

1 antisocial personality disorder. But under the statute,
2 Your Honor, I would argue that the State's burden of proof
3 beyond a reasonable doubt to prove its case, not beyond a
4 reasonable doubt because obviously it's not that standard
5 in the directed verdict motion, but there's not evidence
6 under the statute that they have tied the antisocial
7 personality to sexual dangerousness.

8 I have, obviously, my theory of my case, Your
9 Honor, it's clear that under the statute, under the
10 principles and policies and why we have to, it has to be
11 sexual in nature. What the -- what the law is looking at
12 is the dangerousness of this person in terms of their
13 sexual re-offense. As I have looked at the testimony and I
14 have looked at what the State's put forth, they've not in
15 any way whatsoever linked antisocial personality to sexual
16 dangerousness. I --

17 THE COURT: I tend to agree with you on that.

18 The problem is -- not the problem -- the reality
19 is, is that this specific diagnosis that Dr. Brown has
20 opined to as being a valid diagnosis, obviously, from your
21 presentation and the motion in limine and the material that
22 you have presented in support of your motion, it's a split
23 authority throughout the -- throughout the country. Some
24 states, they recognize it, some courts recognize it, some
25 don't. And I don't know that South Carolina has -- I don't

1 think South Carolina in a published opinion has addressed
2 that specific issue. Obviously, you can argue that it is
3 not a recognized diagnosis. We'll assume, make very good
4 use of Rule 803(18) but I think there's evidence in the
5 record from Dr. Brown, who is well qualified, that in his
6 opinion that there is an appropriate diagnosis and his
7 interpretation of the DSM is that it allows it.

8 You've got representation available in
9 cross-examination that perhaps it is not. But I don't
10 think I can, as a matter of law, the way it exists now,
11 rule that that is not a proper diagnosis that would not
12 support a verdict under the sexual violent predator. It's
13 a question for the jury. The jury can well believe your
14 side of the story that it is not a recognized diagnosis and
15 you can argue that. But they can find that they haven't
16 proved their case beyond a reasonable doubt.

17 But at this stage of the game, viewing this in the
18 light most favorable to the State, I have to respectfully
19 deny your motion. I think you're well protected. I have
20 allowed you to put your entire motion, all the supplements
21 in with attachments in and you've made a good record. I
22 can't direct a verdict at this stage.

23 MS. HIGHTOWER: Your Honor, may I ask the Court to
24 please consider a second ground for my directed verdict
25 motion?

1 THE COURT: Absolutely.

2 MS. HIGHTOWER: In terms of the evidence presented
3 by the State and taking it in the light most favorable to
4 them, our -- what we're here about is demonstration of
5 change or lack of change so that he, Mr. Ridley remains
6 such that he is a danger to society, that he is likely to
7 reoffend.

8 THE COURT: That would be the lack of change.

9 MS. HIGHTOWER: Correct.

10 But -- it's confusing. I'm conflicted in my head
11 because it says one way about the probable cause hearing
12 and then it flips it where I have to show that he's still a
13 danger or...

14 THE COURT: Well, they've still got the prove
15 beyond a reasonable doubt that he remains a danger to the
16 community as far as re-offending in a sexually violent way
17 and I assume you're taking the position that his treatment
18 has changed such and they haven't proved because it's
19 changed and now he's safe.

20 MS. HIGHTOWER: Yes, and my grounds for -- my
21 second grounds for the motion or directed verdict is that
22 the State has not met its burden at the directed verdict
23 stage that they have demonstrated that he is not so changed
24 that he is still a danger to the community.

25 THE COURT: There's evidence in the record from Dr.

1 Brown, who opines that he is likely to reoffend in a
2 sexually violent manner based on his review of the records,
3 i.e. his treatment records, his interview, his application
4 of various tests. So I have to respectfully deny that.

5 MS. HIGHTOWER: Thank you, Your Honor.

6 And I think -- I think I've already done this but
7 Mr. Ridley has handed me a piece of paper as well and just
8 wants to highlight the fact that we're talking about a
9 limited subclass of dangerous persons under the SVP act and
10 in re Thomas, he indicates that likeliness to engage in
11 acts of sexual violence within the definition of SVP, if
12 it's propensity to commit acts of sexual violence is of
13 such a degree as to pose a menace, and I think Mr. Ridley's
14 intention here is to ask me to please argue that under that
15 -- under that South Carolina case in re Thomas, which is
16 402 South Carolina 373, 2013 opinion, that the -- certainly
17 the State has failed to meet its burden as under in re
18 Thomas.

19 THE COURT: Do you have a copy of that case?

20 MS. HIGHTOWER: I do not believe I do.

21 THE COURT: Give me the site again. Ma'am, give me
22 the site again.

23 MS. HIGHTOWER: It is site 402 South Carolina 373.

24 THE COURT: We'll make a copy when we take a break.

25 MS. HIGHTOWER: Thank you, Your Honor.

1 THE COURT: All right. We're going to take a short
2 break and come back and start with your testimony.

3 MS. HIGHTOWER: I have -- I actually do have a copy
4 of Thomas.

5 THE COURT: I can take that one. I'm going to go
6 -- let's take about a ten minute break.

7 (A brief recess was observed.)

8 THE COURT: All right. I've read the Matter of the
9 Care and Treatment of Thomas, petitioner. I do not find
10 that applicable to this case. That's a case where the
11 nonexpert witness gave an opinion and they reversed on that
12 opinion by that particular lady that was allowed to give an
13 opinion notwithstanding the fact that she was not an expert
14 in that field. I don't see where that's applicable to this
15 case. Thank you.

16 MS. HIGHTOWER: Thank you, Your Honor.

17 THE COURT: All right. You ready to proceed,
18 ma'am?

19 MS. HIGHTOWER: Yes, Your Honor.

20 (The jury entered the courtroom at 10:59 a.m.)

21 THE COURT: Everybody get their order placed?

22 (No one responded.)

23 THE COURT: Call your first witness.

24 MS. HIGHTOWER: Thank you, Your Honor. Mr. Ridley
25 would call Dr. Selman, E. Selman Watson to the stand.

E. Selman Watson - Direct Examination by Ms. Hightower

1 THE COURT: Come around, Doctor.

2 E. SELMAN WATSON,

3 having been duly sworn, testified as follows:

4 THE CLERK: Please take a seat in the witness box.

5 State your full name for the Court.

6 THE WITNESS: My full name is Edwin Selman,

7 S-E-L-M-A-N, Watson, W-A-T-S-O-N.

8 DIRECT EXAMINATION

9 BY MS. HIGHTOWER:

10 Q Dr. Watson, what do you do?

11 A I'm a forensic psychologist.

12 Q And do you also practice clinical psychology as
13 well?

14 A I do.

15 Q Okay. And where's your office? Where is it?

16 A The office is located at 1720 Main Street in
17 Columbia.

18 Q And so you provide clinical and forensic psychology
19 from that location?

20 A I do, yes. Most of my practice is strictly
21 evaluation.

22 Q Strictly -- all right. And give me -- where did
23 you go to school?

24 A I got a PhD degree from the University of South
25 Carolina in the clinical psych program. Since receiving

E. Selman Watson - Direct Examination by Ms. Hightower

1 that degree, I've earned 500 hours of forensic training
2 through the American Academy of Forensic Psychology.

3 Q Five hundred hours of forensic --

4 A Forensic psychology training, yes.

5 Q And what do we mean by forensic? Just to make sure
6 we're clear on that.

7 A That's the interface of psychology and the law. So
8 it has to do with legal principles.

9 Q Legal principles, combined with behavior?

10 A It looks at behavior, criminal responsibility,
11 competency, risk assessments, things such as that.

12 Q Okay. What is your -- so you have that training of
13 the 500 hours or the 500 hours of that training, what else
14 -- what other classes or what other training have you
15 received?

16 A I spent 27 years in the Department of Mental
17 Health. I worked at Brian Psychiatric Hospital. That's a
18 280 bed acute care inpatient facility. I attended
19 thousands of probate court hearings as relating to patients
20 that were mentally ill, or not ill, making determinations
21 as to whether they needed additional treatment.

22 Q Have -- have you -- do you have any specialized
23 knowledge in the sexually violent predator area?

24 A Yes, I ran the program from January of '03 to
25 January of '07. I was the acting director of the SVP

E. Selman Watson - Direct Examination by Ms. Hightower

1 program.

2 Q And what were those dates again?

3 A January of '03 to January of '07.

4 THE COURT: You were what now?

5 THE WITNESS: I was the acting director of the
6 sexually violent predator program.

7 THE COURT: In what state?

8 THE WITNESS: South Carolina.

9 BY MS. HIGHTOWER:

10 Q So you ran the South Carolina program?

11 A I ran the program for four years, yes.

12 Q For four years.

13 Any other specialized training in sexually violent
14 predator in addition to that experience?

15 A I've attended numerous academy workshops, one by
16 Phillip Wicka (phonetic) that was very extensive in terms
17 of evaluating sex offenders, how to evaluate, what
18 methodologies used, things such as this. So, yes, I've had
19 several academy workshops related to sex offender training.

20 Q Dr. Watson, have you ever been qualified to testify
21 as an expert in this area before?

22 A Yes, I did most of the annual reviews when I was
23 running the program as the acting director. I probably
24 attended 40 to 50 reviews at that time.

25 Q Were you -- have you testified in sexually violent

E. Selman Watson - Direct Examination by Ms. Hightower

1 predator cases such as these before?

2 A Yes, I have.

3 Q And have you been declared to be an expert in that
4 testimony?

5 A Yes, I have.

6 MS. HIGHTOWER: Your Honor, at this time I would
7 proffer Dr. E Selman Watson as an expert in clinical and
8 also forensic psychology.

9 THE COURT: Any cross-examination on his
10 qualifications?

11 MR. MORROW: No, Your Honor.

12 THE COURT: Thank you.

13 All right. Madame Forelady, ladies and gentlemen,
14 Dr. Watson, likewise, will be allowed to give opinion
15 testimony in his field of expertise, i.e. psychology and/or
16 forensic psychology.

17 MS. HIGHTOWER: Your Honor, I'd also ask that Dr.
18 Watson be qualified as an expert in the field of sexually
19 violent predator practice.

20 MR. MORROW: I would object to that, Your Honor.

21 THE COURT: I'm going to allow him to testify to
22 psychology. I don't know there's a specialty in sexually
23 violent predator.

24 MS. HIGHTOWER: I wasn't sure either, Your Honor,
25 but given the experience.

E. Selman Watson - Direct Examination by Ms. Hightower

1 THE COURT: I think that covers -- he'll be allowed
2 to give opinion in that field, but I'm not sure I can
3 qualify anybody specifically to that one narrow area.

4 MS. HIGHTOWER: Thank you, Your Honor.

5 THE COURT: It's a wide range what he's qualified
6 to testify to.

7 MS. HIGHTOWER: Certainly.

8 BY MS. HIGHTOWER:

9 Q Dr. Watson, in preparation for your report and your
10 testimony today, give the jury a background of what you
11 did?

12 A I spent approximately ten hours interviewing
13 Mr. Ridley. I met him on three or four different
14 occasions. I heard about his history. I made observations
15 of his behavior and I looked at all of the DMH and SCDC
16 records that were available at the time.

17 Q So --

18 A I also set him up with a PPG examination through
19 Dr. Brooks' lab in Columbia. They collected some PPG data
20 on him and I also reviewed those results.

21 Q Okay. Now, in your qualifications as an expert in
22 the area of psychology, forensic psychology the
23 intersection between the law and behavior where we are
24 today, in your qualifications there, you indicated that you
25 have testified in SVP cases before. That's -- isn't it

E. Selman Watson - Direct Examination by Ms. Hightower

1 true that you testified in the very first SVP case that was
2 brought in South Carolina?

3 A Yes, I was one of the experts in the very first SVP
4 case coming out of Williamsburg County. Donna
5 Schwartz-Watts Maddox was the expert for the AG's office
6 and I was an expert for the defendant.

7 Q And what year was that?

8 A It was either 1998 or '99, but I think it was the
9 very first SVP case that went trial.

10 Q Because the actual statute was passed in '98, the
11 creation of the unit then?

12 A That's correct. This was a Williamsburg County
13 case.

14 Q And in your previous -- or in your -- how many
15 cases have you testified in SVP cases in particular? I
16 know you've testified in other areas, but...

17 A I've done dozens because I did all the annual
18 reviews when I was running the program for four years, so
19 I've been in court many, many times.

20 Q You mentioned that you testified as an expert
21 witness for the resident in that case, or the person that
22 was being looked at, correct?

23 A That's correct. He was trying to be civilly
24 committed.

25 Q And what happened in that case?

E. Selman Watson - Direct Examination by Ms. Hightower

1 A He was released.

2 Q Have you ever refused to testify for a defense
3 witness or a resident in the program before?

4 A Yes, I had an attorney call me to try and help him
5 with another inmate that was being civilly committed and I
6 looked at those records, evaluated the individual, and
7 decided I could not be of any help. I felt like he needed
8 treatment, so I politely declined.

9 Q When you ran the department and your training and
10 expertise in this area, sexually violent predator program,
11 tell us about what's going on in terms of treatment, the
12 models. What are we looking at when we're building -- when
13 we're trying to accomplish the goals that our general
14 assembly set out? What are these treatment programs like?

15 A Well, basically the goal is to try and change their
16 behavior and most of these programs involve helping them to
17 build a set of skills that will either help them manage
18 their urges or modify their behavior. There are different
19 models. There are different theoretical models that the
20 programs tend to emulate and one of the best models is the
21 Risk Needs Responsivity model that's promoted by a guy
22 named Bonta.

23 Q What's that entail?

24 A Well, everybody is not high risk when they come
25 into the program so they determine their level of risk and

E. Selman Watson - Direct Examination by Ms. Hightower

1 then they determine their criminogenic needs: What are the
2 psychodynamic factors that they need to address in
3 treatment. And then responsivity relates to cognitive
4 behavioral strategy that they use to try and address those
5 criminogenic needs.

6 Q Okay. Some of that went over my head. So you said
7 there are different models and they address the residents.
8 It sounds like you address the residents and individuals
9 when they come in?

10 A Well, when they come in with the Bonta model, they
11 look at -- they try to determine whether they're high risk
12 individuals or low risk individuals.

13 Q Uh-huh.

14 A And rather than having every resident go through
15 the entire program, they will tailor the treatment to
16 whether they're high risk or low risk.

17 Q Got you.

18 A So not everybody gets the same treatment. What
19 they'll focus on generally is dynamic risk factors that
20 they bring into the program and that will comprise most of
21 their treatment.

22 Q So the dynamic risk factors. And again by dynamic
23 risk factors, that's different than static, correct?

24 A The static risk factors will never change because
25 they are historical risk factors. For example on the

E. Selman Watson - Direct Examination by Ms. Hightower

1 Static 99R one of the questions is, do you have any
2 stranger victims. Well, if they have a history of having
3 offended against strangers, that fact will never change.
4 Those are historical factors.

5 Q So certainly in Mr. Ridley's case, his static
6 factors are never going to change; that is the Static 99.

7 A His Static 99R score will never change until he
8 gets older. He will lose points as he gets older because
9 there's an age-out pattern to offending. Older criminals
10 offend at a lower rate or reoffend at a lower rate because
11 they have less energy. Okay. So this is true of all
12 criminals, not just sex offenders. All criminals have an
13 age-out pattern. So as they get older, they offend at a
14 lower rate, reoffend at a lower rate.

15 Q Okay. And so this Bonta model that you're talking
16 about relates to what we do in South Carolina -- what model
17 are we following in South Carolina?

18 A I'm not sure what model we follow in South
19 Carolina. They didn't follow the Bonta model when I was
20 there.

21 Q All right.

22 A This is the predominant model of treatment across
23 the U.S.

24 Q Did you try to implement that when you were there?

25 A No, ma'am, I was there just to try and run the

E. Selman Watson - Direct Examination by Ms. Hightower

1 program and really didn't have time to implement a model.

2 One of the reasons I left the program was that DMH was not
3 properly funding the program. I could not hire qualified
4 staff to work with this particular population. So I spent
5 four years there and then I left. When I left Nick Dupase
6 (phonetic), the program manager left with me because we
7 just didn't feel like we had the control we needed to work
8 with this group.

9 Q To work with this group?

10 A That's right.

11 Q We'll get into that some more too during the
12 cross-examination, I mean examination. But -- but isn't it
13 -- isn't it true that -- or that certainly we want
14 qualified people dealing with this group -- with this group
15 of individuals?

16 A Well, I think it's the most critical population DMH
17 has to operate, and I think they should put the most highly
18 trained clinicians working with this population.

19 Q In your review of Mr. Ridley's records -- and
20 you've reviewed everything that Dr. Brown reviewed,
21 correct? Prepared today?

22 A I'm assuming I did, yes.

23 Q Okay. So you've reviewed all the Correct Care
24 notes, correct?

25 A All those were furnished, yes.

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1 Q Okay. And you've reviewed, certainly, the 2017 --
2 I'm sorry. You certainly reviewed his criminal history
3 from the department of corrections?

4 A I have, yes.

5 Q Okay. What else -- and maybe I just need to ask
6 this: What did you review to get ready for today?

7 A Well, I reviewed Dr. Gehle's report. I reviewed
8 Dr. --

9 Q That was the first pre-commitment evaluation,
10 right?

11 A First, yeah, first commitment evaluation.

12 I reviewed Dr. Brown's annual reviews, his reports
13 as well.

14 Q All the ones he did since 2015?

15 A That's correct.

16 The DMH notes; all the group therapy notes; spoke
17 extensively with Mr. Ridley.

18 Q How many hours did you spend with Mr. Ridley? Did
19 you meet with him one time or did you follow up as well?

20 A No, I think we met about four times for a total of
21 probably ten hours.

22 Q Ten hours.

23 A The last time I was with him, I was also with you.

24 Q Uh-huh.

25 A And I think that was probably a two-and-a-half to

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1 three-hour session.

2 Q Exactly. So in your work and preparation for
3 coming to this trial today, you've spent approximately ten
4 hours with Mr. Ridley, in addition to all the documents and
5 everything you read, right?

6 THE COURT: Ms. Hightower, I'll remind you that
7 this is your witness. Rules do not allow leading. Please
8 ask direct questions.

9 MS. HIGHTOWER: Yes, Your Honor.

10 BY MS. HIGHTOWER:

11 Q I think we've covered it anyway. I'll move on
12 about what you reviewed.

13 In looking at my client in particular and the
14 treatment he received at the sexually violent predator
15 program, what could they have done in terms of objective
16 measures?

17 A I'm not aware of any objective measures that are
18 used in the program. Most of their progress is based on
19 the subjective judgment of the statute.

20 Q Did --

21 A I'm not aware of any objective instruments that can
22 chart their progress over time.

23 Q So when you say subjective, you're looking at
24 subjective work of the -- of the treatment staff. What do
25 you mean by that?

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1 A Just their judgment, just their clinical judgment
2 in terms of where they stand in the program.

3 Q And what they wrote in their notes?

4 A That's correct.

5 Q What objective measures are there that could be
6 imposed?

7 A Well, there are various instruments where you can
8 chart a person's progress. One is called the acronym is
9 SOTIPE, S-O-T-I-P-E. It's a sex offender treatment
10 intervention program. So there are commercial instruments
11 where you can chart a person's progress.

12 Q And to your knowledge were any of those done in
13 this case?

14 A No, ma'am.

15 Q The diagnosis itself, Dr. Watson, you heard the
16 testimony about other specified paraphilic disorder
17 biastophilia, what is your -- and, of course, as it relates
18 to the bible, the DSM-5, what is your opinion about the
19 fact that -- is it there? and why is it not there? and is
20 that important in this case?

21 A Biastophilia is the course of paraphilia disorder.
22 It's the equivalent of the course of paraphilic disorder.
23 It's my understanding from looking at the literature that
24 the DSM-5 rejected this as a valid diagnosis. What they
25 did with biastophilia, is that put it in the index. It

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1 deserved further study, but they did not legitimize it as a
2 diagnosis, so it's not in the DSM-5. It shouldn't be
3 considered a specified paraphilic disorder; in my opinion.

4 Q It should -- it shouldn't be considered?

5 A No, no.

6 Q And why not?

7 A Because rape is not the result of a mental
8 abnormality. Rape is a result of criminal behavior. With
9 pedophiles, they have sexual urges they can't control.
10 That's a mental abnormality. Rape is a criminal act. It
11 does not arise from a mental abnormality. It's certainly
12 associated with personality disorders, certain personality
13 disorders, but you can also have someone be a rapist
14 without any kind of personality disorder. Your next door
15 neighbor could be a rapist and not have a personality
16 disorder. So rape itself is not generated or a product of
17 a mental abnormality.

18 Q And that's important because the statute itself
19 requires a finding -- isn't it -- is that our
20 understanding?

21 A That's correct.

22 Q In your work in this area, where do you look? What
23 do you do in terms of the statute and what it's asking you
24 to do in terms of a mental abnormality or a personality
25 disorder?

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1 A Well, you look for a paraphilic disorder.

2 Paraphilia is the intense interest, sexual interest. In
3 paraphilic disorder is the harm component, having the
4 interest and then harming someone else, or having enough
5 psychological distress to where, you know, you harm
6 yourself.

7 Q So again in the analogy of the sexual urges of the
8 pedophile, that's a mental disorder?

9 A The urges they can't control is a product of a
10 mental abnormality.

11 Q Right. And you're in agreement? Or what is your
12 opinion as to Dr. Alan Frances, the chair of the DMS Task
13 Force on the paraphilic work group? What is your opinion
14 about his conclusion that rape is not a mental abnormality?

15 MR. MORROW: Objection. Leading.

16 THE COURT: Well, she is leading. That's correct.
17 Sustained.

18 Rephrase your question.

19 BY MS. HIGHTOWER:

20 Q As to Dr. France -- Alan Frances's work, what is
21 your opinion?

22 A Rape is not a mental abnormality, it's a criminal
23 act. It's criminal behavior.

24 Q Under the statute of sexual danger, dangerousness
25 as it relates to antisocial personalities, you touched on

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1 this, could you explain some -- could you explain about the
2 relation between the antisocial personality? I think you
3 touched on about the neighbor and that kind of thing.

4 Could you explain that a little bit more?

5 A Well, to be diagnosed with APD or antisocial
6 personality disorder, you have to meet certain criteria.
7 And as Dr. Brown noted on the stand, this involves a
8 violation of societal norms. These people tend to be
9 angry; they tend to be impulsive; they tend to engage in a
10 lot of self-gratifying behavior that might include criminal
11 acts. They don't show much empathy for the victims and
12 there's oftentimes a significant lack of remorse. So it's
13 a very -- it's 7 or 8 criteria that defined that particular
14 personality disorder.

15 Q And did that actually describe the majority of
16 people incarcerated in the department of corrections?

17 A Probably 90, 95 percent.

18 Q 90 --

19 A Everybody in SCDC where I -- that I come in contact
20 with have a Axis 2 or form of Axis 2 diagnosis like a
21 personality disorder, yes.

22 Q All right. And Axis 2 diagnosis, could you explain
23 what that means?

24 A Axis 2 is the old number in DSM-4. They did away
25 with the axes when they came out with DSM-5. But Axis 2

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1 was reserved for personality disorders. And so an
2 antisocial personality disorder would be on a treatment
3 plan described under Axis 2.

4 Q And again, what's important for our take away here
5 is someone within -- that has an antisocial personality
6 disorder as it relates to their sexual propensity, how does
7 that work?

8 A That's a criminal act. That's a criminal act and
9 they engage in sensation seeking behavior. Actually when
10 it comes to the term of rape, rape is not crime of passion.
11 Rape is a crime of aggression, power, and control over the
12 victim. And this is what's really evidenced in looking at
13 Mr. Ridley's history. He talks about the power and control
14 he had over his victims. There's very little in his
15 records about uncontrolled sexual urges. I could find
16 only, maybe one or two references. So I think power and
17 control was the motivating force for him offending against
18 these teenage victims.

19 Q So there was very little in his treatment records
20 involve about -- what was it?

21 A Sexual urges. I found very few references to him
22 having talked about fantasies, sexual urges, things like
23 this that would relate to a mental abnormality.

24 Q A mental abnormality involving sexual
25 dangerousness?

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1 A That's right.

2 Q Okay. Would you expect to see this type of -- in
3 his treatment record if he -- would you expect to see it if
4 it were there?

5 A That's what I was looking for, yes, when I went
6 through the records. And it's only -- I can only think of
7 one reference where they talk about any kind of urges.

8 Q In your work, in your expert opinion, you expect,
9 you went looking for it because you expected to see it
10 because that's what's predominant in people that have this
11 sexual abnormality, mental abnormality?

12 A If it's a mental abnormality, that's the number one
13 feature that I would look for, yes.

14 Q And you looked for it and it's not here?

15 A It's -- I think -- I only found one reference that
16 related to him talking about any kind of sexual urges.

17 Q We talked about the Static 99R, that algorithm,
18 that scoring mechanism?

19 A Yes.

20 Q What is your opinion about the Static 99 as
21 evidence in cases in general and then evidence in this case
22 in particular?

23 A Well, it's the best actuary instrument we've got.
24 It's universally used. The Static 99R has probably been
25 through ten revisions in the last twelve years. They've

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1 come up with different likelihood ratios, different rates
2 of offender. So they've had to update the Static 99R
3 continuously. I was at the ATSA conference two years ago
4 in Orlando and Dr. Helma, who is one of the developers of
5 the Static 99R was presenting the new coding rules,
6 different rules for coding and different tally sheets. So
7 it's undergone a number of different revisions based on
8 research that's ongoing.

9 Q What is the information that's used in the Static
10 99R?

11 A There are different factors. Factors like were
12 there any male victims? were there any stranger victims?
13 have you ever lived with them for a year, two and a half
14 years? Things such as this.

15 Q You mentioned the relationship or living with a
16 lover. In your opinion of the Static 99 that was done on
17 my client, what's your opinion about the fact that whether
18 or not he had a relationship or living with a lover or --
19 how do you look at that?

20 A He told me that he lived with his girlfriend in
21 Washington state for three years. They produced children
22 together. So I was kind of concerned that Dr. Gehle kind
23 of dinged him on that and gave him a point when his report
24 to me was that he certainly met that requirement.

25 Q Okay. Basically, it's a fill in the table, it's

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1 based upon the history and it doesn't change except for the
2 age, right?

3 A The static factors will never change. The Static
4 99 score will be the same 50 years from now except for the
5 fact that he'll be getting older. So it really doesn't
6 look at change. It looks at offense history. He could be
7 in the treatment program for ten years and his Static 99R
8 score is going to be pretty much the same except for the
9 age-out effect.

10 Q And what's the concern about how the Static 99 data
11 in general as it applies to a particular person in the --
12 in the likelihood to reoffend?

13 A Well, again, it doesn't look at the dynamic risk
14 factors that have been addressed in treatment. Okay? So
15 it considers none of the dynamic risk factors associated
16 with treatment.

17 Q Okay. Let's look -- and you've reviewed my
18 client's dynamic risk factors, correct?

19 A Correct.

20 Q All right. And let's just go through them: Sexual
21 preoccupation. What dynamic -- and by dynamic, what you
22 mean that?

23 A It's just the different dynamic risk factors:
24 Emotional, connectiveness to children, impulsivity,
25 negative emotionality, cognitive distortions, there are

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1 several dynamic risk factors.

2 Q And these things can change over time with
3 treatment, correct?

4 A They can with treatment, yes.

5 Q And is that where the treatment focuses?

6 A That's where the treatment should focus on, yes.

7 Q Okay. Thank you. And so in focusing on
8 Mr. Ridley's treatment, did you -- did you see where he --
9 you indicated he doesn't -- well, let me just ask you --
10 you looked for sexual preoccupation as a dynamic risk
11 factor. Did you see any of that in these reports?

12 A No. Mr. Ridley has experienced no sexual acting
13 out in corrections over a 14 year term. Mr. Ridley
14 reported to me that there's been no sexual acting out on
15 his part during his three and a half years in the SVP
16 program. So, I mean, that's one behavior that you can say,
17 obviously, in my opinion, has improved when you compare it
18 to his history.

19 Q Compared to his history when he did offend and went
20 into the department of corrections?

21 A That's correct.

22 Q And if he had uncontrollable sexual urges, what
23 would you expect to see?

24 A You'd expect -- I would expect to see some sexual
25 acting out. There's ample opportunity in prison for all

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1 kinds of sexual exchanges. And when I was in the SVP
2 program, there was ample opportunities for sexual
3 exchanges.

4 Q So it --

5 A Just the nature of the environment, yes.

6 Q And then -- and it's reported and it's found out,
7 correct?

8 A Oh, absolutely. If it's discovered, it's found
9 out, there's a PREA Act SCDC.

10 Q What's that?

11 A That's the Prison Rape Elimination Act. So it's
12 taken very seriously by SCDC officials. If we find an
13 inmate has been assaulted then there are charges levied.
14 So we try too stay on top of that.

15 Q And in fact, that PREA Act is posted in the
16 majority of the institutions and the pre-detention areas,
17 correct?

18 A It is. I've worked contracting with corrections
19 for ten years. I work out there with Dr. Billy Wood, treat
20 the mentally ill inmates within the department of SCDC.

21 Q So in the past 18 years, you haven't seen any
22 acting out from Mr. Ridley in his record?

23 A I see nothing in the records that reflect that, no.

24 Q And it's certainly happening, going on in the
25 department of corrections?

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1 A Oh, absolutely. Absolutely. It's very prevalent.

2 Q All right. In terms of preference, sexual
3 preference, dynamic risk factor, is that one -- I believe
4 this sexual preference for -- I guess in pedophilia there's
5 a sexual preference for prepubescent adolescent children?

6 A That's correct.

7 Q And certainly Mr. Ridley's diagnosis is no way
8 touching on pedophilia?

9 A He hasn't offended against any prepubescent
10 children that I'm aware of, no.

11 Q All right. And what I'm getting at is the persons
12 that he offended against, what's your opinion about that in
13 terms of his attraction? During his offense cycle?

14 A I think there was some attraction to teenage males.
15 But again, I think the dynamics in a lot of this activity
16 was that he was trying to give a lot of power and control
17 over his victims.

18 Q Again you addressed the nature of rape.

19 A That's right; that's correct.

20 Q Another dynamic risk factor is offensive supportive
21 attitudes. What is that? What does that mean in the
22 literature?

23 A Offense supported attitudes are beliefs that he
24 held in his mind, thoughts that he held in his mind that
25 would support his offending. For example, thinking of the

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1 victim, I didn't really hurt that person, you know.

2 Thinking thoughts to where it would sort of minimize his
3 crime, minimize that activity. Allow that kind of
4 offending to continue. So it's errors in his thinking.
5 It's distorted beliefs.

6 Q So --

7 A And I think that's what he's addressed in the
8 program.

9 Q He's addressed that in the program?

10 A I think that's what he spent the most time on, yes.

11 Q Okay. And -- because -- for example in one of his
12 descriptions in conversation with you about the victim
13 didn't fight back or didn't resist. In his mind, what is
14 your opinion about that? Is that going to his offense
15 supportive attitude, what he thinks that means?

16 A With errors in his thinking, he might have
17 interpreted that to mean that the person wanted to have the
18 exchange.

19 Q And --

20 A And that's an offense supportive belief, yes.

21 Q And this's what he's worked on?

22 A Yes, that's what he's worked on, those kinds of
23 thoughts.

24 Q Another dynamic factor, again, not in this case,
25 emotional concurrence with children. What is meant by

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1 that?

2 A Don't see any of that with Mr. Ridley because he's
3 not a pedophile.

4 Q Okay.

5 A He's not the kind of offender that were he a
6 pedophile that would play a lot of games with children, go
7 the movies with children, just show a lot of inclination
8 towards child like activities. That's really not in his
9 offense history.

10 Q Okay.

11 A And he's not a pedophile.

12 Q And his offense history, the people that he was
13 attracted to or the people that he victimized, those are
14 teenagers, prepubescent, looking like adults; is that
15 right?

16 A Yes. I'm sure some of them probably looked like
17 adults, but they were -- there were two or three that were
18 under the age of 18.

19 Q Okay. Emotionally intimate relationships with
20 adults, that's another dynamic factor, what are your
21 thoughts on that?

22 A Well, he's had an intimate relationship with an
23 adult. He's got children he produced with Crystal, his
24 girlfriend that he lived in Washington State with for three
25 years. So he's, he's shown some capacity for intimate

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1 relationships. He was also living with a lady named Carrie
2 in New York State and they were together for quite a while.
3 So he's shown some capacity for intimate relationships.

4 Q And I want to ask you about, you read the treatment
5 plans and you understand -- or I understand that they work
6 on their treatment therapy and in their groups. How is Mr.
7 -- based upon the record, how is Mr. Ridley viewed by his
8 other group mates? The other people on the unit that he's
9 in treatment with?

10 A The group therapy notes that I reviewed are pretty
11 glowing about his participation. I've seen some group
12 notes that said he's participated 100 percent of the time.
13 So it sounds to me as if he's been actively involved in his
14 treatment.

15 Q And in terms of his relationship to the other
16 members in his group, what have you reviewed about his
17 inter -- his relationship is what I want to ask you about,
18 his relationships with these people in the group?

19 A I think he's tried to be helpful, I think he's
20 tried to explain terms to them that they might not
21 understand. You have to understand that people -- there's
22 some mentally retarded offenders on the unit, so they're
23 not all of the same ability level. Mr. Ridley's a bright
24 individual. He's at least average IQ. He's got good
25 insight. I think he's tried to help others in the program

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1 progress as he's tried to do. So he seems to have been
2 very active and involved and engaged. I think the word
3 they use on the group therapy notes is he's very engaged.

4 Q Very engaged.

5 In any of the relationships or friendships that
6 he's built would that qualify -- I mean we're talking about
7 intimate stuff here. It's not just what he's relaying
8 about his offense history, they go through it with every
9 person in the group. Could that give rise to an emotional
10 relationship or -- that we're talking about in this dynamic
11 risks?

12 A I think what you would describe is he has the
13 capacity to develop prosocial relationships, appropriate
14 interpersonal relationships.

15 Q Well, certainly empathy as well. I mean, is that
16 --

17 A Yes, I think he's certainly more empathetic than he
18 was when he entered corrections and I suspect far more
19 empathetic since he's been in the program for three and a
20 half years.

21 Q All right. And going back to his offense history,
22 another dynamic risk factor is lifestyle impulsiveness.
23 What do you see in your expert opinion about Mr. Ridley's
24 lifestyle impulsiveness?

25 A Clearly if you look at his offense history, it was

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1 very impulsive. I think there was a lot of impulsivity
2 when he -- during his early years in corrections. I think
3 he received probably 18 to 20 charges. His last four years
4 in corrections I think were pretty much offense free. He
5 didn't receive any charges. So it seems as if he's
6 progressed over time.

7 Clearly looking at his offense history, he was a
8 very impulsive individual at that point in time and was
9 seeking a lot of self-gratification.

10 Q And certainly the drug dealer, the criminality,
11 what do you see in those -- in a person like that in their
12 lifestyle impulsivity; is that common?

13 A That goes with that lifestyle. Impulsivity goes
14 with the criminal lifestyle.

15 Q And in his work with you what did he relate to you
16 about what was going on when he offended? What was he
17 doing at that time?

18 A Well, before he came into corrections, he was in
19 the drug dealer lifestyle. So he was engaged in a lot of
20 criminal conduct prior to coming to prison.

21 Q And you -- give you us your impression about his
22 disclosure to you about where he is and where he came from
23 and what he did. What's your opinion about that?

24 A Well, he feels like he's benefitted a lot from the
25 program. So do I. I don't think he's the same person that

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1 came into corrections. And I doubt if he's the same person
2 that entered the SVP program. I think he's in good control
3 of his behavior now and the fact that he's engaged in no
4 sexual acting out would indicate that he's got some
5 control.

6 Q All right. Dr. Brown and Mr. Morrow, they talked
7 about some resistance to rules and supervisions and
8 grievance and hostility about -- what is your opinion about
9 that? You were here for the testimony. You've heard that.
10 What is your opinion about resistance to rules. They
11 mentioned that he --

12 A Well, I questioned Mr. Ridley about that and he
13 said he's never had a BON or a behavior observation note.
14 He said he's never been before the behavior review board.
15 He's in a confined facility, so, you know, obviously, there
16 are rules to follow. But over a four year period of time,
17 I wouldn't see those kinds of complaints as being overly
18 significant.

19 Q So you're --

20 A I --

21 Q -- I'm sorry.

22 A Again, over a three and a half, four year period of
23 time, I'm sure that there are residents in the program that
24 have created a lot more trouble than Mr. Ridley.

25 Q Certainly. In your experience in these cases, if

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1 they're actually grievances, if they're actually resistant
2 to rules and supervisions and acts out you would expect a
3 behavioral observation note or a BON, right?

4 A I didn't see any BON's in his record. No.

5 Q Certainly didn't get one for the TV infraction,
6 correct?

7 A No, that could have been a misunderstanding. I
8 don't know what the rules are out there, but three and a
9 half years got to have rules. They've got a huge
10 population out there. When I was out there, there were
11 lots of infractions. People were being called down and
12 charges discussed, for all kind of behavioral infractions,
13 but if you look at Mr. Ridley's records, it seems like he's
14 almost been a model resident out there.

15 Q And again, you'd expect to see it if there was any
16 pulsivity and infractions and grievance; is that right?

17 A Sure. And again, grievance is -- some of the
18 grievances might have been legitimate. I mean, you're
19 dealing with a staff that, you know, might not have the
20 best skills in terms of handling certain grievances, so it
21 might have been a grievance that had some degree of
22 legitimacy to it.

23 Q Thank you for mentioning that because there was one
24 grievance that's mentioned in the records, I don't know if
25 you recall or not, about his pay discrepancy, correct?

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1 A I think so, yes.

2 Q Right. And the fact that he was called on, raising
3 that pay discrepancy as being resistant to the rules,
4 correct?

5 A That's correct.

6 Q And what happened with that pay discrepancy? What
7 happened with that?

8 A I don't know, but it sounds to me as if he was
9 inquiring about the discrepancy and trying to work it out.

10 Q Okay. Another dynamic risk factor, negative social
11 influences. I mean, in my mind that goes back to the
12 offense. But please explain.

13 A Clearly he had strong negative sexual influences
14 when he -- prior to coming to corrections. I mean he was
15 in the drug dealer lifestyle. He had uncles that were also
16 participating in that kind of criminal activity. He had
17 very negative role models. Most of his uncles he looked up
18 to. And so there were some really significant negative
19 social influences early on in his life.

20 Q And again, in Mr. Ridley's disclosure with you, in
21 his reports of his history and in all of the ten hours you
22 worked with him, how did he appear to you? How did he
23 present himself? What -- what did you think?

24 A Well, he understands now he made some very poor
25 choices back then. I mean certainly he was young. He was

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1 a lot younger then. He's more mature now. He's more
2 insightful now. But clearly he recognizes that with poor
3 choices come consequences and those consequences tend to be
4 negative.

5 Q In any time with your work with Mr. Ridley, were
6 you ever concerned about his credibility or his
7 truthfulness or?

8 A I think that's probably always an issue on
9 reliability with this particular population. I mean it's
10 not unusual to see inconsistencies in terms of what they
11 might self-report and what might be reflected in the
12 record. I think even those people that have been released
13 from the program, you could probably fault them on this
14 particular trait. So I've always had some, some problems
15 or issues if I see a lot of inconsistencies.

16 Q You just don't accept everything on face value in
17 the record? Or how do you deal with that? How do you deal
18 with the fact that you've got --

19 A If I've got a lot of inconsistencies, I would
20 confront them with it. I would discuss it.

21 Q What is your opinion about what -- that
22 circumstance with Mr. Ridley?

23 A Well, there's some inconsistencies and I certainly
24 didn't have time to talk to him about all of them. I guess
25 the biggest inconsistency in my mind was reading the victim

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1 impact statement that I put in my report about the
2 individual that was raped in 2001, his employee at Burger
3 King. He tried to indicate to me that it was a consensual
4 act. Reading the victim impact statement, it was clear to
5 me it was not consensual. So any inconsistencies like
6 that, I'd like to try and review and explore.

7 Q And the -- did you discover some actual incorrect
8 information as you read those reports?

9 A Yes, his self-report differed at times from Dr.
10 Gehle's report. Sometimes from Dr. Brown's report. So
11 there were some inconsistencies between different sources
12 of information.

13 MS. HIGHTOWER: May I approach the witness, Your
14 Honor?

15 THE COURT: Yes, ma'am.

16 BY MS. HIGHTOWER:

17 Q I'm going to show you this document and ask, did
18 you review this document in preparation for your testimony
19 today?

20 A I'm sure I did if this is part of the SVP records.

21 Q Right. And were there concerns about the record
22 that was presented to you to review in that instance?

23 Well, first off when was that record written?

24 A This was written August of 2014. It's a treatment
25 plan.

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1 Q A treatment plan.

2 And so Dr. Gehle would have used this report,
3 correct?

4 A I'm not sure when she did her evaluation of
5 Mr. Ridley. This was a report that was developed, I think,
6 shortly after he was civilly committed. And looking at
7 this report, it mentions that he was charged with 17 sexual
8 offenses against 16 females and one male. And I could not
9 find that information in any of his history. So I was
10 wondering if this was information that applied to
11 Mr. Ridley's history or whether it had gotten confused with
12 some other resident's history.

13 Q Right. And that's in the record, correct?

14 A That's in the record and I asked Mr. Ridley about
15 this 16 females that were targets of his offense and he
16 said that's just not true.

17 Q That's just not --

18 A Yeah, he said it's not true.

19 Q Okay. And in your review of the record, is --

20 THE COURT: Please mark that, ma'am, into evidence.

21 (Defendant's Exhibit Number 2 was marked for
22 identification.)

23 THE COURT REPORTER: It's Defense Number 2, Your
24 Honor.

25 MS. HIGHTOWER: Thank you.

E. Selman Watson - Direct Examination by Ms. Hightower

1 BY MS. HIGHTOWER:

2 Q In your review of the entire record, was he ever
3 charged with that many offenses against a woman?

4 A Well, I didn't count the offenses, but just talking
5 with Mr. Ridley, nothing like that came out of our
6 interactions. He did not mention having offended against
7 16 female victims and I could not really find it in the
8 other records.

9 Q 17 offenses against 16 females and one male?

10 A Yeah, it just didn't jive with what I heard from
11 him.

12 Q All right. Because clearly everything that you
13 reviewed in his offense history involves attraction to
14 males, right?

15 A That's correct.

16 Q The dynamic risk factor about hostility towards
17 women, do you see that?

18 A Yes, he has some hostility towards women. I know
19 he had problems with his girlfriend in Washington State.
20 Her name was Crystal. There's some indications in the
21 records that that was one reason he left Washington State
22 was because they were having some issues between them.

23 Q All right. So that relationship broke up, so --

24 A Broke up because of that, yes.

25 Q All right. Any other dynamic risk factor that I

E. Selman Watson - Direct Examination by Ms. Hightower

1 failed to go over that you think is important for the jury
2 to know? That I haven't touched on?

3 A I believe the big one is cognitive distortions,
4 which he spent most of his time working on.

5 Q Please explain what you mean by cognitive
6 distortion and how it relates.

7 A Errors in thinking, having thoughts that supported
8 his offending. Minimizing what he'd done offensively. Any
9 kind of error in thinking that would be beneficial to him,
10 but it certainly wouldn't be beneficial to the victim and
11 wouldn't necessarily be beneficial to reality of
12 circumstance of the situation he was in.

13 Q What insights do you believe in your expert opinion
14 that he's gained from this program and gained from working
15 on those various factors that we went through?

16 A Well, they now can look at that behavior more
17 realistically. I think he understands the harm he did to
18 his victims. He can shift role perspective and understand
19 the feelings of what it might have been like for his
20 victims to experience when that offending was taking place.
21 I think he's more empathetic. I think he's aware of the
22 errors in his thinking. I think he's in better control of
23 his behavior and so I think he's benefitted from some of
24 the treatment.

25 Q And in terms of risk of re-offense or risk of, or

E. Selman Watson - Direct Examination by Ms. Hightower

1 likelihood to engage in future sexual violence, what is
2 your opinion as to that?

3 A Well, I think he's safe to be at large as a result
4 of his treatment, but with any of these individuals in this
5 particular program, I would personally want him to be
6 followed in outpatient care. He could benefit from some
7 more treatment as an outpatient. He would probably learn
8 some more skills as an outpatient. So I would want to get
9 some sort of monitoring him for the adjustment to the
10 community and some degree of what his compliance is with
11 outpatient care. I understand the statute doesn't allow
12 that. I mean, I understand the statute. I can't comply --
13 or encourage him to do any kind of outpatient follow up,
14 but outpatient care is critical for psychiatric
15 individuals.

16 Q Have you and Mr. Ridley talked about this aspect of
17 your opinion?

18 A Yes, I've talked about this with him extensively
19 and he has indicated that he will get follow up care. The
20 time -- the four year period I was running the SVP program,
21 I only recommended one person's release. And that person
22 went in with Dr. Berl Burke who was conducting or holding
23 groups in Columbia. His office was two doors down from
24 mine. His was at 1728 Main Street. And I can tell you the
25 person that -- the one person I released or recommended be

E. Selman Watson - Direct Examination by Ms. Hightower

1 released, three to five years after he left the program, he
2 was still attending those groups because I would see him in
3 the parking lot. He would be waiting for Dr. Burke in the
4 parking lot.

5 So some people do get the outpatient care. Some
6 people elect to do that and they follow through with that.
7 I don't think I would ever recommend anybody being released
8 from the program without some follow up care.

9 Q All right. You're familiar with Mr. Ridley's
10 discharge plan, correct?

11 A I'm familiar with the name Band of Brothers, but
12 I'm not aware of the program up there.

13 Q Well, I'm referring to Defendant's Exhibit 1 in
14 terms of Mr. Ridley's discharge plan and does it address
15 what you are -- what you're talking about? What -- a
16 component of what's needed?

17 A Yes, because it talks about some follow up sex
18 offender treatment and identifies a provider who could help
19 him with that, Dr. Gunter. Usually when you get any kind
20 of outpatient treatment for sex offenders, as part of that
21 treatment are periodic polygraph exams. So they go through
22 periodic polygraph exams every six months to make sure what
23 they're activities might involve. And this is true of any
24 good sex offender outpatient program. And so I would
25 expect him to submit to those kinds of examinations as

E. Selman Watson - Direct Examination by Ms. Hightower

1 well.

2 Q And have y'all discussed it? And what is your
3 opinion about Mr. Ridley?

4 A I think he'll comply. He indicated he will follow
5 up with some treatment.

6 Q You think he's going to follow up with treatment.

7 Oh, the work with Dr. Burke, in this case, did you
8 work with Dr. Burke as well?

9 A We got a PPG exam on Mr. Ridley, I believe, in
10 October of last year. He was sent to the PPG lab on
11 Barnwell Street in Columbia. Tim Stevenson is a retired
12 Calhoun County sheriff's deputy. He's the lab operator and
13 we put him through the limestone of the PPG, yes.

14 Q Okay. And what does that entail?

15 A They look at slides, of various aged victims,
16 prepubescent boys, teenage boys, men, and women, adult men,
17 adult women. And we measure their level of sexual arousal
18 with mercury string gauge. So we can determine what is
19 their greatest level of arousal. Is it to adult men and
20 women, teenage girls and boys, or prepubescent children.
21 And his PPG data indicated that his greatest level of
22 arousal was to male adults in a persuasive context. That's
23 normal homosexual contact. So he prefers adult men when it
24 comes to sexual tendencies.

25 Q All right. And that's what this objective measure,

E. Selman Watson - Direct Examination by Ms. Hightower

1 not subjective you talked about, but we've got a subjective
2 level --

3 A Yes, his level of arousal to adult men was twice as
4 high as his level of arousal to any other slide or
5 subgroup.

6 Q In a consensual context, correct?

7 A In a consensual relationship, yes.

8 Q In reviewing your records, do you have concerns
9 about doctor's reports -- Dr. Brown's reports and his
10 testimony and his findings? Did you note concerns about
11 what you have heard of Dr. Brown's report?

12 THE COURT: You can't pit one witness against the
13 other. Come on. That's not allowed under the rules.

14 Go ahead.

15 MS. HIGHTOWER: Thank you, Your Honor.

16 BY MS. HIGHTOWER:

17 Q The treatment providers, are they listed anywhere
18 whose providing treatment for Mr. Ridley?

19 A I'm not aware of any listing, no.

20 Q And is that a concern for you?

21 A The only concern I would have is what their
22 qualifications and training might be in serving in that
23 capacity. I don't know if any of these case managers have
24 had any specific sex offender training.

25 Q All right. And Mr. Ridley completed his

E. Selman Watson - Direct Examination by Ms. Hightower

1 autobiography in doing his treatment, in working his
2 treatment plan. Are your -- do you have concerns about
3 this program in terms of where he goes from there? I mean
4 what does he have to do next?

5 A I don't think he's aware of where he really stands
6 in the program. I think the fact that he's written his
7 autobiography several times is engendered a good bit of
8 frustration on his part. But there's no objective measures
9 that have been utilized to chart his progress, so I think
10 he has some confusion or uncertainty in terms of exactly
11 what else he needs to do, what else he might need to learn.

12 Q There was some criticism about Mr. Ridley's
13 specific behavior in a group session and in particular
14 about his defense of the -- of the treatment provider, the
15 group leader. Can you speak to -- speak to that incident
16 and what do you think that shows about Mr. Ridley and where
17 he's come?

18 A Mr. Ridley was in one group process and apparently
19 one of the residents became rather threatening towards the
20 group leader and I think was starting to approach the group
21 leader on foot and Mr. Ridley intervened to try and offer
22 her some protection, which I would see as a very adaptive
23 response on his part. He was trying to be of some help to
24 a staff member.

25 Q Okay.

E. Selman Watson - Direct Examination by Ms. Hightower

1 A So I certainly wouldn't be critical of him for
2 that.

3 Q Did we -- did you mention about the Stable 07 and
4 what is it here in this case?

5 A Usually when you civilly commit sex offenders, you
6 want to get a Static 99R, which was done. You want to get
7 a Static 02, which was done, but it's also recommended that
8 you get a Stable 07 to look at dynamic risk factors. The
9 Stable 07 has never been done on Mr. Ridley. I've never
10 seen one scored and I've looked through all the records
11 that were made available to me.

12 Q And why is that important?

13 A To look at those dynamic risk factors in terms of
14 what you might identify as treatment needs.

15 Q Okay. And you can chart change in progress?

16 A You can with certain instruments, yes.

17 Q In looking at Mr. Ridley in your expert opinion,
18 specifically what happened to him at Riker's Island and
19 coming forward, are there any mood problems? What in your
20 expert opinion -- what do you think is going on in dealing
21 with that?

22 A Would you repeat the question?

23 Q In going through what happened with him in Riker's
24 Island and the antisocial or -- what needs to be addressed
25 in treatment, what concerns do you have there as it relates

E. Selman Watson - Direct Examination by Ms. Hightower

1 to any other explanation? PTSD for example, or...

2 A Well, when he was sexually assaulted at Riker's
3 Island, he clearly had some equalized symptoms of PTSD.
4 When he left detention he was socially withdrawn. He
5 dropped out of any kind of meaningful activities. He
6 indicated to me that he had nightmares for two years. So I
7 think that this was probably a pretty traumatic experience
8 for him. He did not get any help. I don't think he went
9 to the mental health center and got on any medication, so
10 he tried to deal with these symptoms on his own. I think
11 it left him extremely angry that he was violated this way
12 at Riker's Island and I think that anger motivated some of
13 these assaults that took place in his future.

14 Q And again, he's addressed those in treatment?

15 A Yes, I think he's talked about that extensively in
16 treatment.

17 Q What's your opinion in terms of, has he benefitted
18 from the treatment?

19 A I think he has benefitted from the treatment, yes.

20 Q What's your opinion as to a reasonable degree of
21 medical certainty in terms of whether or not he's safe?

22 A I think he's safe to be at large, but again, I
23 would want to get some follow up care for him, as I would
24 any offender coming out of this population.

25 Q Not just Mr. Ridley, any --

E. Selman Watson - Cross-Examination by Mr. Morrow

1 A Any offender leaving this program would need some
2 follow up care in my opinion, yes.

3 Q And y'all talked about that, correct?

4 A We did.

5 Q And it's in his discharge plan, correct?

6 A That's correct.

7 Q Thank you.

8 MS. HIGHTOWER: That's all I have, Your Honor.

9 THE COURT: Everybody okay? Need a break?

10 (No one responded.)

11 MR. MORROW: Thank you, Your Honor.

12 **CROSS-EXAMINATION**

13 BY MR. MORROW:

14 Q Dr. Watson, you wrote a report based on your
15 evaluation of Mr. Ridley, correct?

16 A That's correct.

17 Q And going in that report, you state that you're
18 reading from a referral section that Mr. Ridley is of the
19 opinion that he is so changed; is that correct?

20 A My reason for referral is listed on page 1.

21 Q Okay.

22 A I simply said this he was referred by Ms.
23 Hightower, he was a sexually violent predator in the SVP
24 program. He spent four years in the treatment and he was
25 of the opinion that he was safe to be at large, yes.

E. Selman Watson - Cross-Examination by Mr. Morrow

1 Q You were asked to opine about the statute whether
2 Mr. Ridley's mental abnormality or personality disorder
3 remained such that he's safe to be at large and if released
4 he's likely to engage in acts of sexual violence?

5 A That's correct.

6 Q Okay. In your report, Mr. Ridley told you that his
7 life underwent a change around the age of 16 as he began
8 socializing with several cousins and those cousins were a
9 poor influence; is that correct?

10 A Very poor influence, that's correct.

11 Q Okay. Now, as part of your evaluation, Dr. Watson,
12 you would have reviewed prior evaluation reports in
13 Mr. Ridley's case, correct?

14 A I reviewed Dr. Gehle's report and the annual
15 reviews of Dr. Brown, yes.

16 Q And Dr. Gehle's report, the one that you're
17 referring to is from February 21st of 2014, it's a
18 pre-commitment report, correct?

19 A That's correct, yes.

20 Q And in that report, Mr. Ridley told Dr. Gehle that
21 he was 13 when he began doing these acts and -- 13 and on,
22 I believe, he's quoted, I became a terrorist?

23 A He became a what?

24 Q At 13 -- before 13, I was a model. From 13 on I
25 became a terrorist. Is that --

E. Selman Watson - Cross-Examination by Mr. Morrow

1 A I don't remember the exact terminology he used, no.

2 Q Okay. You would agree that 13 is younger than 16,
3 correct?

4 A Certainly.

5 Q And that would be an inconsistency between your
6 report and Dr. Gehle's report?

7 A I'd have to look Dr. Gehle's report.

8 Q Would it help to refresh your memory if you could
9 see the report?

10 A Sure.

11 MR. MORROW: Your Honor, may I approach?

12 THE COURT: Yes, sir.

13 (The report was given to the witness.)

14 THE WITNESS: It's kind of contradictory. It says
15 that 13 and before I was a mama's boy; 13 and on, I became
16 a terrorist.

17 Well, it's either one way or the other. You know,
18 unless it happened six months into his 13th birthday.

19 BY MR. MORROW:

20 Q But you would agree that that is different -- that
21 is a different age than what he told you; is that correct?

22 A That's correct. Yes, that's an inconsistency.

23 Q Okay. So also if your report under relevant
24 history, you write that the respondent -- or that he -- he
25 spent three years residing in the State of Washington with

E. Selman Watson - Cross-Examination by Mr. Morrow

1 with a woman named Crystal; is that correct?

2 A That's what he related to me, yes.

3 Q Right. Yet, in 2014, in Dr. Gehle's report and
4 also in subsequent reports by Dr. Brown, he stated that he
5 lived with Crystal for only about a year and a half?

6 A Again, I don't know what he reported to Dr. Gehle,
7 but I can just relate what he reported to me. I'm sure
8 there's inconsistencies in these particular evaluations.

9 Q But you did review those evaluations as part of
10 your report, correct?

11 A Yes, I mentioned there are inconsistencies in these
12 different sources of information.

13 Q Now, the amount of time Mr. Ridley lived with a
14 partner would be particularly relevant to his score on the
15 Static 99R; is that correct?

16 A It would, yes.

17 Q In fact, his score would go down a point if he
18 lived with a partner for more than two years, correct?

19 A That's correct.

20 Q And Mr. Ridley would have had access to his reports
21 and evaluations as part of this process; is that correct?

22 A I'm not sure what access he would have to Dr.
23 Gehle's report.

24 Q Dr. Watson, you spoke about Mr. Ridley's behavior
25 while at the department of corrections noting that he had

E. Selman Watson - Cross-Examination by Mr. Morrow

1 no sexual acting out, correct?

2 A That's what he worded to me and I didn't see any
3 charges to that effect.

4 Q But he did have 26 infractions involving variation
5 breaking department of corrections rules?

6 A Yes, most of that, we discussed, involved
7 contraband that came his way early on during his stay.

8 Q Okay. However, he -- in addition to that, while he
9 was incarcerated at the Aiken County jail in 2002, he was
10 arrest -- he was charged with criminal sexual conduct;
11 isn't that correct?

12 A That's correct.

13 Q And that involved -- that involved an incident with
14 a cellmate; is that correct?

15 A That's correct, yes.

16 Q And he eventually pled guilty to that offense?

17 A That's my understanding, yes.

18 Q Okay. Now, Dr. Watson, you would agree that
19 antisocial personality disorder is in the DSM-5, correct?

20 A Absolutely, yes.

21 Q And you would further agree that one of the
22 features of antisocial personality disorder listed in the
23 DSM-5 is failure to conform to social norms with respect to
24 lawful behavior as indicated by repeatedly performing acts
25 that are grounds for arrest?

E. Selman Watson - Cross-Examination by Mr. Morrow

1 A That's correct, yes.

2 Q Okay. While serving a ten-year sentence for his
3 conviction for criminal sexual conduct in the third degree,
4 Mr. Ridley committed 26 separate infractions while in the
5 department of corrections?

6 A Yes..

7 Q Is that --

8 Okay. Two of those infractions were assaultive in
9 nature but not sexual in nature; is that correct?

10 A Okay.

11 Q Those included possession of a weapon and fighting
12 without a weapon; is that correct?

13 A Yes.

14 Q Okay. In addition while out in the community
15 between 1996 and 2002, a period of six years, Mr. Ridley
16 was charged with 17 sexually or sexually re/HRAEULTed
17 offenses and convicted of 7 of those offenses; is that
18 correct?

19 A I don't know, I haven't seen those records.

20 Q You've not seen the records of his convictions?

21 A No, not those convictions that you just mentioned,
22 no.

23 Q Have you seen the records of his convictions from
24 New York?

25 A No, those records were not available according to

E. Selman Watson - Cross-Examination by Mr. Morrow

1 Dr. Gehle. She said she tried to get those records and
2 they were not made available.

3 Q But you did have access to the criminal history on
4 Mr. Ridley; is that correct?

5 A I'm not even sure if I had that available. I was
6 looking for the records from New York and I saw under Dr.
7 Gehle's report that she never managed to get those criminal
8 records.

9 Q Okay. Dr. Watson, are you familiar with a criminal
10 history report or NCIC report? Are you familiar with
11 those? Have you seen those as a part of your --

12 A No, I don't recall looking at those documents.

13 Q Okay. You're aware that in South Carolina he was
14 convicted of criminal sexual conduct in the third degree,
15 correct?

16 A That's correct, yes.

17 Q You're aware that he was also charged with four
18 other offenses at that time, correct?

19 A Yes.

20 Q And those charges were dismissed?

21 A I'm aware of other charges. I'm not sure which
22 ones were dismissed. I'm aware of the offenses that took
23 place in '97 in New York, and I'm aware of the two offenses
24 in Aiken County. I think he mentioned one case to me that
25 in Aiken County was not prosecuted, but we didn't get into any

E. Selman Watson - Cross-Examination by Mr. Morrow

1 discussion as to that incident.

2 Q So they were not a part of your report or your
3 evaluation?

4 A No, sir.

5 Q You would have had access to those records,
6 correct?

7 A I just reviewed what was sent to me. I mainly
8 reviewed the treatment records and the SCDC records.

9 Q Dr. Brown -- were you aware of an incident
10 involving -- while he was at the --

11 THE COURT: You mean Dr. Watson?

12 MR. MORROW: I'm sorry.

13 BY MR. MORROW:

14 Q Dr. Watson, are you aware of an incident involved
15 in May of 2017 in a progress note which validate purchase
16 order from Burger Smoke House that Mr. Ridley made?

17 A No, sir.

18 Q Okay. In that process -- did you review all the
19 progress notes that were available?

20 A I reviewed everything that was sent to me, yes.

21 Q Okay. Do you recall -- do you recall Mr. Ridley's
22 attitude upon being told that he could not order that?

23 A No, sir, I don't.

24 Q Okay. You also -- you also reviewed -- you
25 reviewed a February 15, 2018 progress note about offensive

E. Selman Watson - Cross-Examination by Mr. Morrow

1 parallel behavior?

2 A I reviewed a February 2018 progress note that came
3 to me like a day or two ago. And what struck me about this
4 progress note was it was four and a half pages long, four
5 to five pages long. It was a huge narrative and it
6 differed from other progress notes which were only maybe a
7 quarter of a page long. So it seemed as if there was an
8 agenda here to sort of paint Mr. Ridley in a very negative
9 light.

10 Q You would agree that that progress note indicated
11 that Mr. Ridley was engaging in offensive parallel
12 behavior?

13 A I don't recall exactly the progress note. I just
14 recall it was a very negative in regards to Mr. Ridley.
15 All the other progress notes have been fairly glowing of
16 his progress in the program.

17 MR. MORROW: Beg the Court's indulgence.

18 (There was a pause in the proceedings.)

19 BY MR. MORROW:

20 Q Would it refresh your recollection to see this
21 progress note again?

22 A I'll be glad to look at it, yes.

23 MR. MORROW: May I approach, Your Honor?

24 THE COURT: You may.

25 THE WITNESS: Yeah.

E. Selman Watson - Cross-Examination by Mr. Morrow

1 BY MR. MORROW:

2 Q Have you seen that report?

3 A I saw it a couple of days ago, yes.

4 Q And would you read the highlighted portions of that
5 report?

6 A The group session revolved around addressing and
7 processing boundary issues and appropriate behaviors,
8 relationships, and parallel offender behaviors. Mr. Ridley
9 was the resident in focus during today's discussion.
10 During check in, Mr. Ridley's disclosure demonstrated
11 minimization, jumping to conclusions, manipulation,
12 deceitfulness, poor problem solving, and dysfunctional
13 coping.

14 The other highlighted section says, as he is
15 continuously observed spending an excessive amount of time
16 with a resident who appears to be in his arousal window --
17 I'm not sure what an arousal window is -- Mr. Ridley
18 continued to demonstrate like behaviors throughout the
19 group discussion. As he continued addressing this topic,
20 when asked about his attraction to the resident that there
21 are concerns about, he stated I'm attracted to them
22 physically, but not mentally and emotional.

23 You want me to continue?

24 Q No, that's perfectly fine. You would agree that a
25 -- that Mr. Ridley's victims were younger males, teenage

E. Selman Watson - Cross-Examination by Mr. Morrow

1 males, and a male in his 20's; is that correct?

2 A That's correct.

3 Q You would agree that Mr. Ridley engaged in grooming
4 behavior with those individuals?

5 A No, I wouldn't call them grooming behaviors. I
6 would -- he would be trying to manipulate them and exchange
7 sex for money or drugs or something like that. So was
8 clearly acting in an antisocial manner, but I wouldn't
9 describe those as grooming behaviors.

10 Q Dr. Watson, regarding Mr. Ridley's conviction for
11 criminal sexual conduct in the third degree in South
12 Carolina, you would agree that that victim did not consent
13 to sexual intercourse with Mr. Ridley?

14 A Could you repeat that?

15 Q You would agree that that victim did not consent to
16 intercourse with Mr. Ridley?

17 A I would, yes.

18 Q Yeah, and yet he told you that it was consensual?

19 A He did.

20 Q Okay. And do you have an incident report from the
21 Aiken Department of Public Safety from September 13th,
22 2001? And did you review that as part of your records?

23 A I may have if it's in this material. I'm not sure
24 you want me to go through it. I remember looking at some
25 documents from the Aiken County Sheriff's Office.

E. Selman Watson - Cross-Examination by Mr. Morrow

1 Q Would it refresh your recollection to see that
2 report?

3 A Sure.

4 MR. MORROW: Your Honor, may I approach?

5 THE COURT: You may.

6 THE WITNESS: No, I've not seen this document.

7 MR. MORROW: All right. Thank you.

8 MS. HIGHTOWER: I apologize, Your Honor, if I may
9 -- what document was he referring to.

10 THE COURT: I don't know, he said he hadn't seen
11 it. It was something from the Aiken Police Department.

12 All right. Move along.

13 BY MR. MORROW:

14 Q Let's move along. Dr. Watson, you had him sent for
15 a PPG with Dr. Burke; is that correct?

16 A Excuse me?

17 Q You had him sent for a PPG with Dr. Burke?

18 A Dr. Burke's lab in Columbia, yes.

19 Q And that report was issued on, I believe, in
20 October of 2017?

21 A That's correct, yes.

22 Q And in October of 2017, it indicated that his
23 greatest level of arousal was adult male, persuasive
24 context; is that correct?

25 A Persuasive context, that's correct.

E. Selman Watson - Cross-Examination by Mr. Morrow

1 Q And additionally he had significant responses to
2 teen female persuasive presentations; is that correct?

3 A That's correct.

4 Q And teen male persuasive presentation; is that
5 correct?

6 A That's correct.

7 Q And he also had teen male coercive situations; is
8 that correct?

9 A He did, yes, sir.

10 Q What are teen male coercive situations?

11 A The teen male level of arousal was far below the
12 normal male relations. But the coercive exchange and
13 coercive context involves some use of force. It sort of
14 can be a rape scenario.

15 Q Okay. And in Dr. Burke's report, he indicates that
16 a 10 percent increase in humetic -- I'm sorry is that the
17 proper way to pronounce it, humetic?

18 A Yes, it's an increase in circumference.

19 Q Is considered worthy of further --

20 A That's correct.

21 Q And he indicated that Mr. Ridley's response to teen
22 male coercive was 17.34 percent?

23 A I'd have to look at the report again.

24 Q Certainly.

25 MR. MORROW: Your Honor, may I approach?

E. Selman Watson - Cross-Examination by Mr. Morrow

1 THE COURT: You may.

2 THE WITNESS: Thank you, sir.

3 The teen male coercive score was 815. The adult
4 male persuasive score was 14.39, that's more than two --
5 deviations difference. The teen female persuasive was 6.80
6 and the teen male persuasive was 6.28. And there was no
7 indication of response interference. So in other words
8 when he was taking this test, he was not trying to use his
9 breathing pattern to suppress his arousal. There was no
10 response interference that measures in the PPG process
11 itself. It looks for a response and appearance to try and
12 suppress arousal. He did not engage in any of that.

13 BY MR. MORROW:

14 Q Dr. Watson, there are these percentages indicated
15 on this record, correct? Indicate a specific number of
16 increase, but also indicates percentage, correct?

17 A Yes.

18 Q Okay. And that percentage is what Dr. Burke's
19 talking about with 10 percent increase; is that correct?

20 A No, the 10 percent increase is the baseline over
21 baseline. So he gets a baseline circumfrentry and he went
22 10 percent over that is an indication of arousal.

23 Q Dr. Watson, just to be sure, so I make sure I
24 understand this. In the teen male coercive presentation,
25 he had an 8.55 millimeter change and it indicates a 17.34

E. Selman Watson - Redirect Examination by Ms. Hightower

1 percent right next to that; is that correct?

2 A Teen male coercive or persuasive?

3 Q Coercive. In the narrative paragraph following
4 that.

5 A Oh the narrative. There's no percentages in the
6 readouts.

7 Yes, 27.24, yes.

8 Q Thank you.

9 MR. MORROW: No further questions for Dr. Watson.

10 THE COURT: Anything on redirect, ma'am?

11 MS. HIGHTOWER: Yes, Your Honor, if it please the
12 Court.

13 **REDIRECT EXAMINATION**

14 **BY MS. HIGHTOWER:**

15 Q I want to touch on the weekly progress note that
16 was sent to me and I forwarded to you from February 22nd,
17 2018 that Mr. Morrow asked you about. In that progress
18 report, there was some concern or there's concern in this
19 report, I think he called it offense parallel behavior; is
20 that...

21 A That's what it seems, yes.

22 Q Okay. And it involved a 26 year old male resident,
23 correct?

24 A I'd have to look at the note.

25 MS. HIGHTOWER: May I approach?

E. Selman Watson - Redirect Examination by Ms. Hightower

1 THE COURT: You may.

2 BY MS. HIGHTOWER:

3 Q Well, I guess, let me put it this way: Nothing in
4 this note reflects any type of rape, correct?

5 A Not from my recollection of the note, no.

6 Q You recall if there was any report about any sexual
7 acting out, correct?

8 A I would have -- if it had been there, I don't think
9 there's any sexual acting out, no.

10 MS. HIGHTOWER: One other thing, Your Honor.

11 BY MS. HIGHTOWER:

12 Q When we were discussing cognitive distortion and
13 what that means in terms of what they work on in treatment
14 it's a dynamic risk factor; is that correct?

15 A Yes.

16 Q Okay. And in the cognitive distortion as I
17 understand it, that's where you view -- my understanding is
18 that's where you're viewing the victims from your
19 perception -- your messed up thinking, your cognition?

20 A If you look it's where you look at the errors in
21 your thinking, correct.

22 Q And your addressing the fact that when he said
23 consensual sex, is that a cognitive distortion of what
24 happened? Can it be interpreted that way?

25 A Well, I think it's probably an unreliable report.

E. Selman Watson - Redirect Examination by Ms. Hightower

1 Q Okay.

2 A I wouldn't look at that for distortion. I think
3 it's more of an unreliable report.

4 Q Okay. So then as you go forward and you move in
5 terms of treatment for cognitive distortions and the work
6 that he's done on the treatment, what -- what's your expert
7 opinion about that?

8 A Well, you would think that the errors in his
9 thinking would decrease.

10 Q Uh-huh.

11 A And he would start thinking more prosocial ways.

12 Q Okay.

13 A More adaptive ways, more ways to have normal
14 interactions with people.

15 Q And again, given control of these sexual urges, you
16 would expect to see reports of that, correct? In his
17 interpersonal relationship?

18 A If he couldn't control his sexual urges, I would
19 expect to see a lot more sexual acting out, yes.

20 Q Thank you. That's all I have.

21 THE COURT: Thank you, sir.

22 Madame Forelady, ladies and gentlemen, let's take
23 about a ten or fifteen minute break. What I'd like to do
24 is come back after you take a short break and let's go
25 until the food comes. We've got one witness let. We'll

1 get started with that witness, go until the food comes, and
2 we'll decide how long we want to take to eat and then come
3 back and finish up the testimony and then we'll have a
4 discussion about where we go. Is that fair enough?

5 Don't discuss the case and don't deliberate. Take
6 about a ten minute break, not long. There trying for one,
7 that means 1:15, probably. I don't have any control over
8 that.

9 (The jury left the courtroom at 12:23 p.m.)

10 THE COURT: All right. Let's break for about ten
11 minutes. Let me see y'all quickly back here and talk about
12 logistics.

13 (A brief recess was observed.)

14 THE COURT: All right. Anything for the record
15 before we start back?

16 MS. HIGHTOWER: No, Your Honor.

17 MR. MORROW: No, Your Honor.

18 THE COURT: All right. Mr. Whittle.

19 (The jury entered the courtroom at 12:40 p.m.)

20 THE COURT: You may call your next witness.

21 MS. HIGHTOWER: Thank you, Your Honor. If it
22 please the Court, I'd like to call Mr. Ridley, Richard D.
23 Ridley to the stand.

24 THE COURT: Mr. Ridley come around, please.

25 RICHARD D. RIDLEY,

Richard D. Ridley - Direct Examination by Ms. Hightower

1 having been duly sworn, testified as follows:

2 THE CLERK: Please take a seat in the witness box
3 and state your full name for the Court.

4 THE WITNESS: Richard David Ridley.

5 THE COURT: Mr. Ridley, pull that microphone a
6 little closer and speak into it. Thank you.

7 **DIRECT EXAMINATION**

8 BY MS. HIGHTOWER:

9 Q Mr. Ridley, please tell the jury about where you're
10 from.

11 A I'm from Jamaica Queens, New York. Basically I was
12 raised in Jamaica Queens, New York. I came down here when
13 I was 29 years old.

14 Q And whose -- I'm going to say the name wrong.
15 Who's your mama? What's her name?

16 A Gurlia Ridley.

17 Q Gurlia Ridley?

18 A Yes, ma'am.

19 Q Okay. And tell me about being raised by Gurlia
20 Ridley?

21 A Well, my mother raised me, my brother, and two of
22 my -- two of her sister's sons. Jamar and Isha (phonetic).
23 So there was four boys and my mother would cook like -- on
24 the weekend, she would cook the meals for us. Throughout
25 the week -- and she -- she worked two jobs, so a lot

Richard D. Ridley - Direct Examination by Ms. Hightower

1 throughout the week she would cook the -- well, on the
2 weekends, Saturday and Sunday, she would cook the meals for
3 the week as far as Monday through Thursday. And then
4 Friday, she had -- she had one job she didn't have to work
5 at, so she would take us out to eat on Friday. And this
6 went on for most of my life.

7 Q All right. And are you -- where are you in your
8 sibling lineup and your cousins that your mama raised as
9 well?

10 A Well, I'm the oldest, one.

11 Q You're the oldest?

12 A Then my brother's a year and like two months
13 younger than me and then Jamar and Isha, they're like four
14 years younger than me and six years younger than me,
15 respectively.

16 Q Okay. And so when growing up with your mama
17 working the two jobs, describe about what that entailed.
18 What was that like?

19 A I mean basically we -- I mean you just didn't have
20 no real structure as far as family type of -- I mean she
21 tried to do her best, but, you know, I mean, she wasn't
22 around, so we didn't have that, you know, that real family
23 structure like that.

24 Q You had other family members that lived in Jamaica
25 Queens, other uncles, cousins?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Yeah, I had -- well, most of them my mother tried
2 to keep me away from.

3 Q Why is that?

4 A Because they was mostly into the street like and
5 drug dealers type stuff when I was younger.

6 Q Did you listen to your mama?

7 A I listened for a while. And -- I mean we had
8 curfew and stuff like that as far as -- when Archie Bunker
9 went off -- until I was about nine years old, when Archie
10 bunker went off, that's when I had to go to bed, 8:30. You
11 know, that was how it was. Until I was about 10 or 11.

12 Q Your brother, let's just touch on him. Where is
13 he?

14 A My brother right now is out -- he just retired as
15 far as from the military. He's in Pennsylvania State.

16 Q And where was he stationed when he did his military
17 service?

18 A Fort Louis McCord, most of his time.

19 Q Okay. And that's Washington State?

20 A Yes, ma'am.

21 Q Is he married?

22 A Currently, he's divorced. He was married. He's
23 divorced now.

24 Q All right. And did you have an occasion to go out
25 to Washington State?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A It was to actually make sure he was doing the right
2 thing towards marriage. My mother had sent me out there
3 when I was like 20 -- I want to say 21, 22, something like
4 that. Plus she wanted to get me out of New York. That was
5 the other reason.

6 Q Uh-huh.

7 A I was really heavy into selling drugs and stuff
8 like that and that gave her a way to get me out of New York
9 and keep me alive, basically.

10 Q All right. Because what was going on in Jamaica
11 New York -- obviously, at some point in time, you stopped
12 listening to your mama, right?

13 A Yes, ma'am.

14 Q What happened?

15 A I was going back and forth and getting locked up
16 and stuff like that. When I was 16, the first time I was
17 ever arrested, I had went to Riker's Island and was
18 assaulted on Riker's Island.

19 Q Okay. And I want us to talk about what happened
20 then. But before we get into that, I want to just finish
21 filling in your background for the jury.

22 So in Washington State, did you have a relationship
23 with a woman named Crystal?

24 A Yes, that's my baby mother. I have three sons by
25 her.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q Okay.

2 A My oldest right now is 25. My two twins just
3 turned 21.

4 Q And what are their names?

5 A Aterakatere, Normi (phonetic), those are the twins.
6 And Miguel is the oldest one.

7 Q Okay. All right. And do they all live out in
8 Washington State as well?

9 A Yes, ma'am.

10 Q And your relationship there -- there was a question
11 about your relationship with Crystal. How long did it last
12 and did y'all live together? What type of relationship --
13 was it a romantic relationship? Did y'all live together?

14 A Yeah, I mean, I worked -- legally, I wasn't selling
15 drugs when I was in Washington State and stuff like that.
16 I stayed with Crystal for about three years, a little bit
17 over three years. But I would travel back and forth as far
18 as from Fort Huachuca in Arizona to New York, stuff like
19 that. I mean, where my brother went, a lot of times I
20 would go, you know, but mainly, I lived in Washington State
21 for that amount of time.

22 Q So your mom sent you from New York to be with your
23 brother, get you away from the uncles and the cousins and
24 the drug life, right?

25 A Yes, ma'am.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q All right. And you followed your brother around a
2 bit?

3 A Yes, ma'am.

4 Q Okay. You met Crystal, y'all were together and
5 y'all have three sons by her?

6 A Yes, ma'am.

7 Q Okay. How old were you when you started selling
8 drugs for your cousins and for your uncles?

9 A Probably about 16. 15, 16, somewhere around there.
10 About 16.

11 Q What was it like?

12 A I mean, it was --

13 Q How was the money?

14 A It was good. I mean to me, you know, I mean at
15 first, all I used to have to do was just go open up the
16 little -- it was like a cab stand. I would just go open
17 the cab stand and throw its shutters up and there would be
18 a car waiting to take me to school and I would go straight
19 to school from there. I mean all I had to do was just open
20 up a little -- because there, you open up the store front.
21 That's what it's called store fronts. And it's not like
22 the doors are locked or anything like that. But it's a
23 front for a cab stand, but they would sell drugs out of it.
24 Q So that's what's really going on behind the cab
25 stand?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Yeah. Yes, ma'am.

2 Q So you opened the cab stand and that would be part
3 of your responsibility?

4 A Yes, ma'am.

5 Q In this family enterprise?

6 A Yes, ma'am.

7 Q Did your mama take money from you for the drugs,
8 the drug money?

9 A No, ma'am. No.

10 Q What did your mama say about that?

11 A My mother, she was very explicit. One time I even
12 tried to pay her electric bills because she wouldn't take
13 money from me an stuff and she went and found out about it
14 and gave me the money back and she was just like, you know,
15 I'll never take any of that dirty money and this and that
16 and this.

17 Q So you were -- let's talk about Riker's Island.
18 You were arrested during this time, correct?

19 A Yes, ma'am.

20 Q For the drug running?

21 A Yes, ma'am.

22 Q All right. And your mama didn't bail you out, did
23 she?

24 A No, ma'am, my mother didn't know I was on Riker's
25 Island at the time.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q Oh, okay. Wasn't trying to teach you a lesson?

2 A Yeah, and then when she did find out, to her it was
3 like, well, I'd used the excuse that I was staying over at
4 my cousin's house.

5 Q Oh, okay.

6 A For the weekend. And the reality was that I was
7 actually with my cousin Trugar (phonetic) who was a drug
8 dealer and I got arrested on that Saturday. So my mother
9 didn't know I was arrested at all.

10 Q All right. So at 17 years old, you were arrested
11 for this drug activity. You go to Riker's Island and what
12 happened?

13 A Yeah. I was in Mod 9 and I was going to the
14 bathroom and like two guys that ran up on me with razor
15 blades to my throat and walked me to the back of the
16 bathroom. I was sexually assaulted in the back of the
17 bathroom. There was other guys back there too.

18 Q You receive any treatment for that assault?

19 A No, ma'am.

20 Q In terms of the sentence or in terms of the charge
21 that is you were charged with, what happened with those
22 after it was discovered what happened to you?

23 A Well, the officer in the dorm found out about it)
24 and basically they took me out that day, I mean like within
25 30 minutes they had the captain down there and I was

Richard D. Ridley - Direct Examination by Ms. Hightower

1 basically released and the charges were dismissed and
2 stuff. I never heard about the charges again.

3 Q And you spent a lot of time, certainly, you've
4 admitted to your sexual offenses, correct?

5 A Yes, ma'am.

6 Q And that you spent -- you spent a significant
7 amount of time in the department of corrections from a CSC
8 third offense here in Aiken County, correct?

9 A Yes, ma'am.

10 Q Okay. And during the connection or during that
11 whole period of time, have you thought about or connected
12 your history together?

13 A Yes, ma'am. At one point in time, I was believing
14 that, you know, I had to hide everything that had happened
15 to me and stuff like that. So I turned around and I
16 regressed into myself, really. And even from the treatment
17 program I was able to see a lot of the -- connect a lot of
18 the -- lots as far as that's concerned. I hid a lot of
19 stuff from my family and stuff like that. Instead of me
20 embracing the people that really cared about me at that
21 point in time when I was sexually assaulted, I ran away
22 from them and I embraced the streets more. To me that was
23 my defense mechanism. It was. It was the way I could deal
24 with it. I couldn't cope with it. I didn't know what
25 coping was, first of all, I didn't know, you know what I'm

Richard D. Ridley - Direct Examination by Ms. Hightower

1 saying, that somebody was wrong.

2 Q Right.

3 A To me, it was like, I was asking myself why did it
4 happen to myself -- why did it happen to me. But at the
5 same time, I didn't question it passed that.

6 Q Uh-huh.

7 A It was something I had to keep secret to everybody
8 around me and instead of me, like I said, bringing it to
9 someone's attention and ask for help, I regressed more to
10 myself and I became really un-empathetic to people, I did.
11 I embraced the streets more, sold more drugs.

12 Q What's the mentality of a person that was in your
13 position at this point in your life? What's that
14 mentality? What -- what are you thinking?

15 A I mean, it's about me. It's not about anybody
16 else. I mean it was nothing as far as -- I didn't care
17 about the next person. I didn't. Because I didn't care
18 about myself. It wasn't just I didn't care about the next
19 person, I didn't care about myself. I didn't see myself as
20 being, you know what I'm saying, my self-esteem was tore
21 down from the experience. But I didn't even know what
22 self-esteem was back then. I mean there was a lot of stuff
23 that I'm able to connect now that I wasn't able to connect
24 with back then.

25 Q Well, let's talk about that because, you know,

Richard D. Ridley - Direct Examination by Ms. Hightower

1 prior to entering the SVP unit, you've heard about Dr.

2 Gehle's report, correct? She did the presentence report,
3 right?

4 A Yes, ma'am.

5 Q And you met with her. And in that report you
6 talked about you couldn't empathize with others, that it
7 wasn't about that for you?

8 A No, ma'am.

9 Q Okay. And since being on -- and you voluntarily
10 waived into the program?

11 A Yes, ma'am.

12 Q You remember doing that in this courtroom, correct?

13 A Yes, ma'am.

14 Q All right. And since waiving into the program and
15 the treatment that you've had over the past four years,
16 what are you thinking now?

17 A I mean, now, I know I can be empathetic. I know
18 that we're all part of each other. I know that, you know
19 what I'm saying, the stuff that I was doing to people out
20 there, I was acting out, out of anger in a lot of ways.
21 You know what I'm saying, instead of me regressing or
22 repression, the anger that was in, that's what I was doing
23 back then.

24 Now, I can turn around and actually use some of the
25 coping skills that I've learned. I can look at the next

Richard D. Ridley - Direct Examination by Ms. Hightower

1 person and actually look at them on my level, whereas back
2 then I couldn't. I couldn't see the next person as being
3 on my level. I couldn't see anybody else as being --
4 because I felt like I was beneath everybody else. Even
5 though I was selling drugs, I still felt like I was beneath
6 everybody else.

7 Now, I know that I am just like the next person,
8 you know what I'm saying? We're all connected? Some kind
9 of way. I have a better respect for myself. But I
10 couldn't respect you unless I could respect myself, you
11 know what I'm saying? And that's where I've come. I've
12 come a long way as far as being able to understand myself
13 and the things I did. I knew back then that I was doing
14 wrong. I did. There's no doubt about that, you know what
15 I'm saying. But I didn't know how to actually find myself.
16 I didn't know what I needed to do to be able to, you know
17 what I'm saying, actually be a person that could respect
18 the next person because I didn't know how to respect
19 myself.

20 Now, I mean -- even before I came to the treatment
21 program, I have to say, you know what I'm saying, because
22 first I had to admit to my mother what happened to me at
23 Riker's Island. And that happened in 2004. I mean,
24 there's a lot of stuff I had to go through.

25 Q Let me stop you right there for a second. So your

Richard D. Ridley - Direct Examination by Ms. Hightower

1 ready mother never found out about what happened to you, a
2 17-year-old, you were gang raped at Riker's Island until
3 the 2000's?

4 A No, ma'am.

5 Q Why not?

6 A I was ashamed. Well, I am. I had to be able to
7 tell my mother about it and even today there's still some
8 of that -- it's hard for me. But I had to tell my mother
9 about it and she felt that she failed. Even to this day
10 she still feels that. And that doesn't make me feel good.
11 I mean, I should have been able to actually ask for help
12 and I didn't. I started sexually offending people based on
13 that anger. And that anger, I can't use it as a crutch,
14 you know what I'm saying. I can't use it as, okay, this
15 happened to me so I did this. No, I can't, you know what
16 I'm saying? But I didn't turn around and try to get an
17 understanding of anything within myself. I didn't.

18 Q When did you come to this -- when did you come to
19 this?

20 A In 2004, I turned around and started going to the
21 church and embracing the church more. And there was a
22 preacher that came in and he told me, he said --

23 Q Where are you in 2004?

24 A I'm in McCormick Correctional facility and I was at
25 Kairos --

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q What's Kairos?

2 A Kairos is a religious organization that does
3 retreats with, basically prisoners. And for four days
4 you're there with nothing but clergy type people and it's
5 like a brotherhood. It really is. And they do their best
6 to get you to be able to understand yourself more. And it
7 doesn't matter what religion you are, you know. And that
8 was something that attracted me right there.

9 Q The first part of treatment?

10 A Yes, ma'am. And that was admitting that I had a
11 problem. And it really was. You know what I'm saying? I
12 mean, the reverend, he had turned around -- and he's also a
13 dentist. He had turned around and he said, he said, I can
14 see you're in a lot of pain. I can see that you're going
15 through something, Brother.

16 And I was just like, I broke down for some reason,
17 you know. And I had talked to him and I was able to
18 actually talk to him, you know.

19 And he was just like, Man, no one's better than
20 you, you're not less than the rest of us. I mean, you have
21 to forgive yourself first and foremost, you know. And it
22 started making sense to me, you know. And he had me write
23 an apology letter to all the victims that I victimized and
24 stuff. And --

25 Q And did you?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Yes, ma'am. And at the end of Kairos, all the
2 letters was collected and we would go out into a backyard.
3 It's like a big courtyard and we would burn the letters,
4 you know. And he was like, Now, forgive yourself, you
5 know. And after that I wrote my mother a letter. That
6 weekend, I wrote my mother a letter and I explained to her
7 what happened to me on Riker's Island and stuff like that.
8 And, you know, my mother, she didn't -- she couldn't
9 understand why I couldn't come to her a long time ago. And
10 even -- I mean, I'm an adult now, and I still couldn't. I
11 mean, really.

12 So she didn't have an understanding, how is it that
13 you're grown and you didn't tell me what happened back
14 then? I'm trying to figure out why you were sexually
15 acting out, you know. And now, I get some kind of
16 comprehension. Don't you see when you were 16 and this
17 happened to you.

18 Q That's your mama --

19 A That's my mother.

20 Q -- struggling with it --

21 A This is my mother, yes. And she was like when you
22 were 16, this happened to you. She started sending me all
23 kind of self-help books. Because I was even -- even back
24 then I mean, I still had the anger, you know. And that's
25 why I had caught the charges I did in SCDC and stuff.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Fighting, I had two fighting charges, I think.

2 Q And when you say conflict, let's talk about this.
3 Let's talk about, you had other SCDC violations for
4 contraband, is that -- that's not drugs or anything like
5 that?

6 A No, ma'am. I had 20 something books. My mother --
7 this is -- my mother had sent me so many books. And you
8 can only have 10 books in your cell at the time. And I had
9 20 something books. And at the time, I'm trying to learn
10 as much as I possibly can about change, growth,
11 development. I mean, I'm reading books from, you know,
12 Mantak Chia, dealing the fusion of the five elements, stuff
13 like that; Joyce Meyers. I'm reading all kind of books and
14 I'm finding, I can understand. I can relate to a lot of
15 them. And those were the contraband charges, some of them.

16 Q Well, there was one marijuana?

17 A Yes.

18 Q I mean there was one contraband when you think
19 about it. There was.

20 A Yes, ma'am. But outside of that --

21 Q You admitted that in front of the -- you know they
22 had their own disciplinary board in SCDC; right?

23 A Yes, ma'am.

24 Q And you didn't fight it?

25 A No, ma'am.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q Okay. So you were starting to address it in the
2 department of corrections coming forward on the SVP unit,
3 you've been on the unit for four years, correct?

4 A Yes, ma'am.

5 Q And talk about your treatment and your work through
6 the plan.

7 A I mean, at first when I got here, I mean -- when I
8 first got to the SVP program, I was of the understanding,
9 I'm going to learn as much as I possibly can to get out of
10 the program as soon as I possibly can. Judge Early was the
11 person that, you know, signed my civil commitment order and
12 he, he -- something stood out to me that he said and I saw
13 the passion in what he said. That made a difference to me.
14 He was like, young man, take it and do the best you can in
15 there and we may be able to release you soon.

16 When he said that to me, that's what I did. And
17 when I seen Judge Early in 2016, that's exactly what I
18 through at him as far as I said, Judge Early, you did tell
19 me to do the best I possibly can. I done that, you know.

20 Q You also, in terms of the treatment that you
21 received in 2015, and let's touch on the devient nature of
22 what -- the work that you said and the discourse that you
23 had with Dr. Brown in his reports and that the devient
24 nature in your mind, you're still thinking this because of
25 your attraction?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Yes, ma'am.

2 Q Let's talk about that.

3 A Yes, ma'am, in 2015, I mean, I'm seeing Dr. Brown
4 for the first time. Dr. Brown, from my understanding, he,
5 he, you know what I'm saying, during the evaluation, they
6 ask you a lot of questions.

7 Q Uh-huh.

8 A And you try to give the best answer that you
9 possibly can from your understanding at the time. That's
10 why I say even in treatment, I've still grown, no matter
11 what -- it's not like I'm saying I haven't grown in
12 treatment because I have.

13 Q As to your sexual orientation, is that something
14 you've struggled with?

15 A Exactly. And even in 2015, I was still struggling
16 with it. To me it was still something -- I mean, I'm
17 coming out of SCDC. It's not like I'm vocal that I have an
18 attraction for males. It's not. You know, and I'm not
19 doing anything with males because it's illegal anyway, but
20 regardless, I'm just not going to go through that in SCDC.

21 Q As you pushed your anger down from when you were
22 16, 17, at Riker's Island same kind of -- is it the same
23 kind of thing?

24 A Yes, to a point it was.

25 Q All right.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A And it was still me trying to hide certain aspects
2 of myself.

3 Q And when you talked to Dr. Brown, and it's
4 reflected in his 2016 annual report or '17 annual report,
5 you said, or you reflected on a date, June 2016, I believe,
6 that you told him you made -- you made a breakthrough?

7 A Yeah. I told him that I had made a breakthrough as
8 far as I know now that it's not so much that it's the
9 attraction of males that was the deviant nature, it's was
10 the actual nonconsenting. It was me turned around and
11 trying to coerce, you know what I'm saying, that was the
12 deviant nature of my actions, my offenses.

13 Q Why was it so difficult to talk about the -- the
14 homosexuality in group?

15 A At first it was difficult because I'm coming to a
16 group, I don't know these guys. I mean, these are intimate
17 details of my life that it took me forever to tell my
18 mother about.

19 Q Uh-huh.

20 A So how much harder is it going to be for me to tell
21 a bunch of strangers. And there's eight people in my group
22 and then even -- like Correct Care, when they turn -- when
23 they turned around and switched up all the groups, we never
24 had more than eight people in the group under DMH. Now
25 it's 14 people in my group. So when they made it 14 people

Richard D. Ridley - Direct Examination by Ms. Hightower

1 in my Correct Care group, I'm like -- and I expressed that
2 to Dr. Brown, I was like it's 14 people, how are you
3 supposed to be able to turn around and be able to relate to
4 14 people and just tell them your business as far as your
5 intimate details of your life, you know --

6 Q It's difficult?

7 A Exactly. And just do it like that. And I
8 expressed that to Dr. Brown. I said it's going to be
9 something I'm going to have to work on. I wasn't saying
10 I'm not going to do it. I did it before. It's just
11 something I have to work on because these are 14 people I
12 don't know. I -- you know.

13 Q You talked -- we've learned a lot about the dynamic
14 risk factors and those -- what do you think in terms of
15 those risk factors that you've been working on in group are
16 important for the jury to know about you? What did you
17 take away from what you've done, those risk factors and
18 what you're working on?

19 A Well, my -- the biggest risk factor I had at one
20 point in time was poor impulse control. That was. And
21 that was related more to my drug dealer lifestyle more than
22 me just doing things without thinking, you know what I'm
23 saying. And that was something that also related to my
24 sexual offender too because of the fact that I was doing a
25 lot of stuff out of anger and without thought. I was just

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1 doing things just because. You know what I'm saying? And
2 that was the biggest thing I worked on as far as that
3 because it deals with your actual thinking pattern. You
4 know what I'm saying? That's something that, like I said,
5 I did learn in treatment, being able to turn around and
6 say, you know what I'm saying, give yourself a chance to
7 think before you act on something. I didn't do that when I
8 was on the streets. I didn't do that when -- before my sex
9 offending. I didn't do that before I got incarcerated by
10 South Carolina. I didn't do that. You know what I'm
11 saying? I was just doing, doing, doing whatever came to my
12 mind, I just did, you know what I'm saying? You know there
13 was no thought there.

14 Now, I actually do know that I can give myself a
15 chance to think. Now I know that I don't have to turn
16 around and look at myself as less than the next person. I
17 don't have to turn around and -- and sexually offend the
18 next person. I can be with a guy and it's all right. You
19 know what I'm saying? I know that now, you know what I'm
20 saying? I didn't know that before. You know what I'm
21 saying? To me I just had to hide that, you know? And I
22 don't have to coerce the next person. If the next person
23 doesn't want to be with me, then I don't need to be with
24 them any way. You know what I'm saying? I mean -- but I
25 didn't have that understanding then.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q Prevention, relapse strategy, I think that's a
2 formal psychological speak about, what are you doing or
3 what are you going to do in the future to make yourself as
4 safe as possible?

5 A Well, it's relapse prevention plan.

6 Q Okay. All right. A strategy you use to implement
7 the plan?

8 A Yes, ma'am.

9 Q Okay.

10 A My relapse presence plan is first of all, on my
11 own, first line of defense as far as offending in any kind
12 of nature. It doesn't mean just sexual offending it can be
13 criminal offending as well, you know what I'm saying? I'm
14 my own line of defense. I have to be able to think about
15 the situation. I have to be able to stay out of high risk
16 situations. I mean I have to be able to notice when I'm
17 starting to slide into a high risk situation; or being
18 placed in a high risk situation, you know what I'm saying.
19 I mean, if I already know that I'm starting to lie to
20 people; if I already know I'm starting to deceive people,
21 if I already know that I'm starting to be conniving towards
22 others, I already know that that's something that slides me
23 right back into where I was in the first place, sexually
24 offending. And that's not something that I'm happy with.

25 Q Dr. Brown -- I mean Dr. Watson talked about follow

Richard D. Ridley - Direct Examination by Ms. Hightower

1 up and treatment plan and going on the outside. What's
2 your plan there?

3 A I definitely -- I definitely will invest in myself
4 as far as treatment. You know what I'm saying? I mean, I
5 want to get the best understanding of myself, but I also
6 want to make sure that I'm not going to turn around and get
7 other people at jeopardy in any kind of way, shape, form,
8 or fashion. But that also is something as far as, what's
9 wrong with treatment? I mean, what's wrong with --
10 everybody has some kind of issue that they may be dealing
11 with, you know what I'm saying? With me, what's wrong with
12 going to a person that can actually speak to you on the
13 level of this is what you're going through right now.

14 Q And you and Dr. Watson talked about that?

15 A Yes, ma'am. Yeah.

16 Q Part of your treatment -- part of your discharge
17 plan?

18 A It's part of my relapse prevention plan and my
19 discharge plan.

20 Q Why is it in your discharge plan?

21 A Because I'm definitely going out there to get it.

22 Q And who insisted it be in there?

23 A Oh, me. I mean, I actively pursued it. I had
24 asked Ms. Goodwin, which is my case manager, I -- well, she
25 was my team leader at the time. I had asked Ms. Goodwin to

Richard D. Ridley - Direct Examination by Ms. Hightower

1 turn around and see about getting me a treatment provider
2 and stuff and she was like, well, it depends on where your
3 going because I was going to go with Dr. Burke at first,
4 which was, except for Dr. Selman Watson, but Dr. Burke is
5 too far down. I'd rather be, you know --

6 Q Because he's in the low country and --

7 A Yeah, and I'm going to be in Greenville, so -- or
8 towards Greenville so that was going to be too far to
9 travel for me, so it was better for me to go to Dr. Gunter.

10 Q So you're actively pursuing people in the Upstate,
11 correct?

12 A Yes, ma'am.

13 Q For treatment and follow up?

14 A I already called them and everything, yeah.

15 Q All right. And -- and the Band of Brothers, why do
16 you think that's a good after care plan for you?

17 A Because it's a ministry, number one; and number two
18 it was also that a job is already there. And negative
19 social influences, that was something that was prevalent in
20 my life. I need to be able to go out -- even though I was
21 able to keep a job and get a job and all that stuff when I
22 was out there. I need to be able to turn around and go out
23 to a positive environment as far as having a job, having a
24 place the stay, stuff like that. I don't want to go back
25 to New York. I mean, I want to turn around and actually,

Richard D. Ridley - Direct Examination by Ms. Hightower

1 you know, get my own CDL, truck drive's license and stuff
2 like that. I mean it would save me money as far as
3 housing. It would save me money as far as cars, stuff like
4 that. So I could take and actually start my own business
5 eventually. I would like to.

6 Q So certainly working at the chicken plant isn't
7 you're long-term plan?

8 A No, no.

9 Q But certainly to step down from where you are, your
10 discharge plan with the Band of Brothers, does it --
11 doesn't it also -- what else does it include in terms of
12 counseling from a spiritual level?

13 A Yes, ma'am, they give you counseling there. They
14 also give you vocational training if you need it or
15 whatever the case may be, they will aid you with that.

16 Q Uh-huh.

17 A There's -- I'm in contact with Sage Truck Driving
18 and they -- Ms. Tara Elam, I've spoken to her, she's
19 supposed to be helping me with my CDL as far as voc rehab
20 is going to help me with the tuition as far as getting my
21 CDL license and stuff, so...

22 Q So a supportive environment, church based.

23 Now, is there any concern about the fact that the
24 other men that participate and live on -- in this program,
25 live in the Band of Brothers that they're also ex cons? Is

Richard D. Ridley - Direct Examination by Ms. Hightower

1 that a concern for you?

2 A No, ma'am. I mean, I never did drugs away, or
3 nothing like that as far as using drugs.

4 Q Uh-huh.

5 A And at the same time, there are probably some
6 people from the SVP program that came from the SVP program
7 that's there. I mean, but that doesn't mean whatever
8 they're doing, if it's negative or whatever, I have to also
9 do. You know what I'm saying? I'm not going to follow
10 their lead. I'm going to do my best to go in the right
11 direction with my life.

12 Q And certainly Band of Brothers was identified and
13 facilitated through Correct Care, your treatment manager?

14 A Yes, ma'am. Once again, Ms. Goodwin, who is my
15 team leader and my case manager.

16 Q Team leader.

17 A Yes. And my case manager. She was both at one
18 point in time. She turned around and she talked to Dr. --
19 I mean Reverend Savage and she had got everything situated
20 as far as how much the fees was. As a matter of fact, we
21 was going to put a down payment on it and everything as far
22 as the apartment or whatever living expenses was.

23 Q Mr. Morrow touched on some problems or difficulties
24 about not following rules and regulations on the unit,
25 involved the TV and some other infractions. Dr. Watson

Richard D. Ridley - Direct Examination by Ms. Hightower

1 talked about there are behavior observation notes, there's
2 procedures where you got oversight and review, if you
3 offend, if you violate rules. What happens at SVP if you
4 violate -- if you don't follow the rules, what happens?

5 A You violate any rule, you're going to be punished
6 for it. I mean, I reached what they call blue level. I've
7 never had a BON, a negative BON. The BON that I did get
8 for the TV, that was a negative BON.

9 Q So that's one?

10 A Yes, ma'am.

11 Q In four years?

12 A But it was dismissed. It was dismissed.

13 Q Because of a tech --

14 A Yes, ma'am.

15 Q I'm sorry. You've had one behavioral observation
16 note that was negative.

17 A Yes, ma'am.

18 Q And for the TV?

19 A Yes, ma'am.

20 Q Okay. All right. Behavioral observation notes
21 that are positive, have you had those?

22 A I've had five of those, ma'am.

23 Q Okay. And those are official recognitions in the
24 program, right?

25 A Yes, ma'am.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q All right. Another incident that happened was the
2 pay dispute, correct? You challenged Correct Care on your
3 pay?

4 A Yes, ma'am.

5 Q All right. What do you do? What do you do while
6 your there. Everybody works. And so you have to have a
7 job, right?

8 A Yes, ma'am. I was working in the clothing room at
9 the time.

10 Q Uh-huh.

11 A And the director of the program from Correct Care,
12 Mr. Buzz, had came to me and he was -- it was like four of
13 us and he had said, you know, I want y'all to stay working,
14 you know, because there's like key spots.

15 Q And this was during the transition?

16 A Yes, ma'am. It was during the transition. He
17 said, I want y'all to still work and y'all going to get
18 paid. And so I was like all right. No problem, you know,
19 because there was like -- there's certain key jobs that you
20 know, you really do need to keep working like laundry,
21 clothing, stuff like that because they, like the clothing
22 room does everything as far as admissions, releases, stuff
23 like that, clothes throughout the --

24 Q They want you to keep this job and your pay was
25 supposed to be?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Compensated. I was supposed to be paid for it. So
2 a month and a half goes by --

3 Q Because you've saved some money, right?

4 A Yes, ma'am.

5 Q And you've got money in your bank account?

6 A Yes, ma'am.

7 Q And let's be clear, when you're released on your
8 discharge plan, that's on you?

9 A Yes, ma'am.

10 Q That \$150 a week for your house, that's on you?

11 A Yes, ma'am.

12 Q And so you're -- you're using your money that
13 you've saved for these four years on this. Okay.

14 Ultimately the pay dispute, which was cited as
15 something that you were challenging authority, but how was
16 it resolved? That pay dispute?

17 A I had spoke to -- at first, I went to the -- first
18 I went to my case manager and I explained to her what was
19 going on as far as, you know, Mr. Buzz told me to keep on
20 working.

21 Q Uh-huh.

22 A You know, and that he was going to pay me for
23 working for those two weeks or -- I think it was like a
24 month.

25 Q During the transition?

Richard D. Ridley - Direct Examination by Ms. Hightower

1 A Yes, ma'am. That I wasn't paid, period. And so I
2 kept on working and I went to my case manager about it.
3 She told me to go to the resident advisor. I went to the
4 resident advisor. She said that there was nothing she
5 could do about it and to go to another person in the step.
6 And I went to that person.

7 Q So you're getting frustrated.

8 A No, it wasn't so much that I was getting
9 frustrated. I didn't get frustrated until when I went to
10 Mr. Buzz who actually told me to keep on working.

11 Q Uh -- huh.

12 A That he was just like, you know, just dismissive.
13 He was like, Well, I don't want to hear it, you know, and
14 just kept walking. And I was like, well, Mr. Buzz, I'm
15 just talking about what you had told me to do. You told me
16 to keep on working, you was going to pay for me keeping on
17 working. And he was like, I don't want to hear it. I
18 mean, it's a new program now and -- so I mean, I went
19 through all the chains of command as far as that. And I
20 then I went to DMH.

21 Q Okay. And what ultimately happened?

22 A They paid me.

23 Q They paid you for the work you had done?

24 A Yes, ma'am. Yes, ma'am.

25 Q Okay. Your discharge plan, you know it's going to

Richard D. Ridley - Direct Examination by Ms. Hightower

1 -- you're going to have to register as a sex offender,
2 correct?

3 A Yes, ma'am.

4 Q Why didn't you register when you first moved to
5 South Carolina?

6 A I didn't know the procedure of it. I thought that,
7 you know, you just register with New York, you don't
8 register down here. I don't know.

9 Q What year was that?

10 A This was 2001, ma'am.

11 Q Okay. Now, you're familiar with the fact that the
12 Adam Walsh Child Protection Act, a federal law, if you fail
13 to register, you're looking at ten years in federal prison;
14 is that right?

15 A Yes, ma'am.

16 Q And in fact, in the records, and -- you've already
17 had to sign a three page document and initial every
18 different line about what you have to do under the sex
19 offender registry?

20 A Yes, ma'am.

21 Q Briefly just explain to the jury what you're going
22 to have to do to register and then keep that registration?

23 A Every 90 days I have to take it and register as far
24 as with the local police department and as an SVP. And at
25 the same time if I do not register, that one missing time,

Richard D. Ridley - Direct Examination by Ms. Hightower

1 I am subject to the sexual act under that. But I will also
2 be violating the SVP act again.

3 Q Uh-huh.

4 A So I will be subject to -- but that's -- that is
5 still supervision and that's still good because, like I
6 said, like even Dr. Watson was talking about that
7 supervision should still be there especially when you're
8 first coming out and stuff like that. So that is
9 considered to be a form of supervision.

10 Q Okay. And it's lifetime, correct?

11 A Yes, ma'am.

12 Q And you have to go to get your picture taken and
13 checked in every --

14 A 90 days, ma'am.

15 Q 90 days. Okay.

16 Also, as part of your incarceration, you submitted
17 DNA. Your DNA is on file with the FBI, right?

18 A Yes, ma'am.

19 Q Okay. And again, you acknowledge -- again you
20 recognize that you have to have some supervision --

21 THE COURT REPORTER: Can you say that again, I did
22 not hear you well. I'm sorry.

23 BY MS. HIGHTOWER:

24 Q Just again, you recognize that you have -- you have
25 some supervision and absolute things for the rest of your

Richard D. Ridley - Direct Examination by Ms. Hightower

1 life that you're going to have to comply with?

2 A Yes, ma'am.

3 Q Under that -- under the Adam Walsh, under sex
4 offender registry?

5 A Yes, ma'am.

6 Q You know you're -- that's going to follow you.
7 Your DNA's on record and you've got a discharge plan to get
8 you started, correct?

9 A Yes, ma'am.

10 Q Mr. Ridley, if -- are you safe?

11 A I believe so, ma'am.

12 Q You believe so?

13 A Yes, ma'am.

14 Q If you had to title or title your story about where
15 you are today in front of these people, what would be
16 important to know about you? What would your title be?

17 A I mean, I came a long way. I mean, I came from not
18 knowing myself, not caring about myself, not caring about
19 you, you know what I'm saying, but that came from me also
20 not caring about myself. I think I've come a long way as
21 far as understanding myself now. I mean, I've learned as
22 much as I possibly can about myself to be able to be a
23 better person. You know, I mean true indeed, I committed
24 sex acts. I committed sexual crimes. I did. And I paid
25 for each one of those crimes. You know. To turn around

Richard D. Ridley - Direct Examination by Ms. Hightower

1 and just have me do a program over and over again and then
2 say it's just based on, I haven't explored this enough or I
3 haven't explored this enough that's wrong. And that's what
4 I expressed to Dr. Brown, because I even asked him myself,
5 in, what do I need to do to actually show you that I'm
6 ready and I'm safe to be at large.

7 And I'm -- because my aspect of it with Dr. Brown
8 was, Well, Dr. Brown, the people that I sexually offended
9 against was between the age of 16 and 20. And between
10 those ages, I've been around in SCDC. I've been around in
11 the program as well. And I haven't had any of that, 17,
12 going on 18 years now. I haven't had a sexual offense or a
13 sexual anything, you know. And about my thing with Dr.
14 Brown, I asked him, I said, So what do I need to do to show
15 you that I actually am safe to be at large? I mean, if I
16 haven't done anything in 17 years and I've been around -- I
17 mean I've had 18 year old roommates, you know. I haven't
18 sexually offended against anyone. You know, and his thing
19 was to tell me that just we don't look at people until like
20 four or five years. Okay. Well this is my fourth year.
21 It wasn't about what I learned, it's the amount of time
22 that I've been sitting in there.

23 Q That was your impression of what Dr. Brown was
24 telling you?

25 A That's what he told me.

Richard D. Ridley - Direct Examination by Ms. Hightower

1 Q And Dr. Watson, you worked with Dr. Watson?

2 A Yes, ma'am.

3 Q Thank you, Mr. Ridley. Please answer any questions
4 for Mr. Morrow or whoever, Your Honor.

5 THE COURT: Thank you, Mr. Ridley. I'll let you
6 step down, please.

7 THE WITNESS: Thank you, sir.

8 THE COURT: Madame Forelady, ladies and gentlemen
9 of the jury, the food is back there. I'll do it however
10 you want to. Give you 30 minutes to eat, come back, and
11 let's finish up. If you want to take an hour and go out
12 and stroll around the street, go to North Augusta, I'm not
13 going to give you that option -- let's do about 30 minutes.
14 I've got about a 15 minute hearing, that gives me 15
15 minutes to eat and we'll -- let's shoot for -- that clock
16 is wrong. About ten till two, how about that? We'll
17 finish up with Mr. Ridley and then we'll keep on and I'll
18 talk to y'all then and see where you want to go.

19 Don't discuss the case. Enjoy your lunch and if
20 you get through in five minutes and you want to go -- I
21 don't know what it's like outside if you want to go outside
22 and get some fresh air. Let's start back at about ten till
23 according to my clock, about quarter till according to that
24 clock. Thank you.

25 Everybody else remain seated.

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 (The jury left the courtroom at 1:21 p.m.)

2 (A recess for lunch was observed.)

3 THE COURT: Is the State ready?

4 MR. MORROW: Yes, Your Honor.

5 THE COURT: Ready?

6 MS. HIGHTOWER: Yes, sir.

7 THE COURT: Mr. Ridley, you may come back up.

8 (The jury entered the courtroom at 1:50 p.m.)

9 THE COURT: Mr. Morrow.

10 MR. MORROW: Yes, Your Honor.

11 **CROSS-EXAMINATION**

12 BY MR. MORROW:

13 Q Mr. Ridley, you've been committed to the SVP
14 treatment program for four years; is that correct?

15 A Going on four years, yes, sir.

16 Q And you would agree that in New York State you were
17 convicted on three separate occasions of sodomy third
18 degree; is that correct?

19 A Yes, sir.

20 Q And that your victim in that case was under 17
21 years of age?

22 A Yes, sir.

23 Q You would agree that in November of 2001, you pled
24 guilty to failure to register as a sex offender; is that
25 correct?

Richard D. Ridley - Cross-Examination by Mr. Morrow

- 1 A Yes, sir.
- 2 Q And that was upon moving to South Carolina?
- 3 A Yes, sir.
- 4 Q You agree that you were also charged on November
- 5 27th, 2001 with criminal sexual conduct in the first
- 6 degree?
- 7 A No, sir.
- 8 Q I'm sorry, third degree. You pled to that charge?
- 9 A Yes, sir.
- 10 Q On December 20th, 2001, while in the Aiken County
- 11 jail, you were charged with assault with intent commit
- 12 criminal sexual conduct in the second degree; is that
- 13 correct?
- 14 A Yes, sir.
- 15 Q And you ultimately pled guilty to assault and
- 16 battery of a high and aggravated nature?
- 17 A Yes, sir.
- 18 Q The victim in that case was another inmate?
- 19 A Yes, sir.
- 20 Q Okay. Now the victim in your criminal sexual
- 21 conduct third degree case, that was an employee that worked
- 22 for you at a fast food restaurant; is that correct?
- 23 A Yes, sir. Uh-huh.
- 24 Q While you were at the department of corrections,
- 25 did you participate in any sex offender treatment?

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 A No, no, sir.

2 Q Mr. Ridley, you told Dr. Watson that your life went
3 about a change around the age of 16 because you became
4 socializing with others; is that correct?

5 A It wasn't just about me socializing with others. I
6 mean, there was more freedom I was given at the time.

7 Q Right. But in your interview in 2014 with Dr.
8 Gehle, you told her it was around age 13; is that correct?

9 A Age of 13, my mother was more or less looser with
10 the rules and stuff as far as me getting in the house and
11 stuff.

12 Q You also reported to Dr. Watson that you lived with
13 a woman by the name of Crystal Norman for three years; is
14 that correct?

15 A Around three years. I mean on and off type stuff.

16 Q But you told Dr. Gehle in 2014 and then also Dr.
17 Brown that you had lived with her for only a year and a
18 half; is that correct?

19 A I mean at one point in time it was a year and a
20 half stay and then -- I mean, but I had three kids with
21 her, so it was over a time, sir.

22 Q Now, you would agree that as part of -- you're
23 entitled to see your reports and that kind of thing as far
24 as your evaluations in these cases; is that correct?

25 A Yes, sir.

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 Q Okay. You would agree that you'd seen your prior
2 reports; is that correct?

3 A I haven't seen all of them, sir.

4 Q You would agree that you knew that living with a
5 partner for less than two years was one of the reasons they
6 gave you a point on the Static 99?

7 A Actually, I didn't know that until this year, sir.

8 Q When did you see Dr. Watson?

9 A I want to say October..

10 Q 2017?

11 A Yes, I believe so, sir.

12 THE COURT: Speak up for me, please.

13 THE WITNESS: Yes, I believe so, sir.

14 BY MR. MORROW:

15 Q You also got a behavior observation note in October
16 of 2016 for ordering a television without permission in the
17 SVP unit; is that correct?

18 A Yes, sir.

19 Q And you were informed of what the ordering process
20 was at that point; is that correct?

21 A No, sir. I was already told to order the TV,
22 actually, from the same person that wrote me up for
23 ordering it ahead of time. And the reason I never went to
24 the DMC committee for it is because of the fact that they
25 found that she had already gave me permission in writing.

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 So they had dismissed it.

2 Q In May of 2017, you also had a problem where you
3 ordered some food from Burger's Smoke House; is that
4 correct?

5 A No, I didn't have a problem.

6 Q Well, in your -- in your notes there where you
7 talked to your case manager, you expressed complaints about
8 that and she actually writes that you continued to complain
9 after she explained the process to you about what you
10 needed to inform the security director; is that correct?

11 A Actually, what happened was she said that she was
12 going to speak to the security director to make sure that
13 he knew that we can get certain meats from Burgers Smoke
14 House and certain meats we couldn't. Like we can't get
15 like ribs. We can't get ribs because it has the bone in
16 it. So he wanted -- she wanted to make sure that the
17 security director understood because she had stopped my
18 order in the first place. And that was the issue. She had
19 stopped my order and I had said it was without bones. This
20 is the same stuff I ordered under DMH and now that Correct
21 Care has it, she just had stopped my order, but she worked
22 for DMH. So she should have known what we could have and
23 what we couldn't have. And Burger's Smoke House won't send
24 us anything with bones in it any way, under DMH's old
25 contract that they had with them.

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 Q On February 15th, 2018, you participated in the
2 group session about processing boundary issues; is that
3 correct?

4 A Say that again, sir?

5 Q February 15, 2018, you participated in group
6 session about processing boundary issues; is that correct?

7 A Yes, sir.

8 Q Okay. In that section, you were actually the
9 subject of this group, or the focus of the group session;
10 is that correct?

11 A True, sir.

12 Q Okay. And that was because you had been observed
13 spending a considerable amount of time with a younger
14 resident there and the staff was concerned about offense
15 parallel behaviors; is that correct?

16 A I can't speak on what they was concerned with. I
17 do know what had happened. Okay. If you want me to
18 explain what happened in that particular situation.

19 The day before that group, my case manager had came
20 to me. Mr. Atkinson had came to me. He said we got a
21 resident dropping a letter on you saying that -- dropping a
22 kite -- it's called a kite. Dropping a kite on you saying
23 that you're teaching Mr. Such and Such how to beat an
24 evaluation. That's what he said. And I was like, Well,
25 that doesn't make sense. I don't -- how do you beat an

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 evaluation. But why even more, why are you bringing that
2 to my attention. I can't do anything about somebody else
3 writing something up on me.

4 And Mr. Atkinson was like, well, the major -- the
5 real concern is maybe you're spending too much time. I
6 said, okay, Mr. Atkinson, I tell you what, I will no longer
7 -- and this is exactly what I told him -- I said I will no
8 longer speak to that particular resident or any other
9 resident about anything as far as their treatment or -- or
10 -- because they had asked me to be a mentor at one point in
11 time and I told them no. So when I told him that he was
12 just like, Well, that's not handling it appropriately. And
13 I said, Well, actually, I have to do what's right for me
14 because I don't want any kind of confusion.

15 See I had no problem with the mentor thing also.
16 And it was a resident that they told me to mentor, the case
17 manager came to me and asked me to mentor, had turned
18 around and submitted paperwork that was supposed to have
19 been notes that I made for him because he can't write. So
20 it was notes that I made for him, but he submitted it as
21 his own work.)

22 This happened in 2016 under DMH with Ms. Nance as
23 the case manager. She had came to me and she was like,
24 Well, I know you didn't do nothing wrong --

25 THE COURT: All right. Hold on a second. You

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 know, I don't know if anybody's going to object to all this
2 hearsay, but as the judge, I've got to put a stop to it.

3 THE WITNESS: But I had a problem with --

4 THE COURT: Don't talk about what other people told
5 you.

6 THE WITNESS: Okay.

7 THE COURT: Just answer his question.

8 THE WITNESS: Got you, sir.

9 I had a problem with the mentor problem, situation
10 before and that's why I responded the way I did to
11 Mr. Atkinson at the time.

12 BY MR. MORROW:

13 Q Mr. Ridley, did you respond to your case manager by
14 telling her that this was a blatant attack on you?

15 A It wasn't a her. It was Mr. Atkinson. That was
16 the first time I was speaking to him.

17 Q Did you tell him that people were being vindictive
18 against you.

19 A I said that that was just a form of vindictiveness.
20 I mean, you're coming to me without even checking out the
21 situation. And at least you should investigate it before
22 you come to me and tell me about something that somebody
23 else saying about me.

24 And that was my point that I was made with him. I
25 said that's just being vindictive. Someone being

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 vindictive. I can't do anything about somebody else trying
2 to attack me.

3 Q Did you also in that same group session tend to
4 justify and convince the group that you were not interested
5 in engaging in a relationship with a resident by attacking
6 the resident being emotionally immature?

7 A I didn't attempt to justify. I explained to them
8 that my most important focus was going home and I'm going
9 to do what's right for me to go home.

10 Q When you were talking to Dr. Watson, in his report,
11 he indicated that you minimized -- you said that the
12 criminal sexual conduct in the third degree was a
13 consensual situation; is that correct?

14 A Yes, sir.

15 Q And minimization is something that you've been --
16 you were supposed to be working on in treatment and have
17 been working on in treatment; is that correct?

18 A Yes, sir.

19 Q Okay. And yet, you still, in your most recent
20 interview with Mr. Watson are minimizing that criminal
21 sexual conduct conviction, is that correct?

22 A Yes, sir.

23 Q Okay. Mr. Ridley, is there anything that would
24 compel you to go to treatment when you leave if you are
25 released?

Richard D. Ridley - Cross-Examination by Mr. Morrow

1 A Yes, me.

2 Q Is there any agency, authority figure that would
3 make you or force you to go to treatment?

4 A There's not a legal entity that can force me to go
5 to treatment, no, sir.

6 Q Okay. Would you be monitored by any agency other
7 than having to register as a sex offender?

8 A I mean that is more monitoring than even probation,
9 I think.

10 Q So there's no one other than you to compel you to
11 go to treatment?

12 A No, sir.

13 Q If you were released today and you decide not to
14 move to Greenville, not to go to Band of Brothers and
15 follow your treatment program, what will happen to you?

16 A Repeat that, sir?

17 Q Will anything happen -- would there be any entity
18 that would enforce the fact that you comply with your
19 treatment, your release plan?

20 A I mean I would hope that I would follow my own
21 release plan as far as trying to establish my life again.

22 Q But there won't be any entity that will have --
23 will make you comply with that release plan?

24 A Ten years from now it will still be the same.

25 Q Thank you.

Richard D. Ridley - Redirect Examination by Ms. Hightower

1 MR. MORROW: No further questions, Your Honor.

2 THE COURT: Any questions on redirect, ma'am?

3 MS. HIGHTOWER: Just briefly.

4 **REDIRECT EXAMINATION**

5 BY MS. HIGHTOWER:

6 Q Mr. Morrow asked you about your New York
7 conviction, about sodomy with a minor under the age of 17.
8 How old were the minors?

9 A 16, ma'am.

10 Q And also, have you done everything, participated in
11 all aspects of the treatment plan that were offered to you?

12 A Yes, ma'am.

13 Q Is there anything you haven't done?

14 A I've done everything probably four times.

15 Q Nothing further.

16 MS. HIGHTOWER: Thank you, Your Honor.

17 THE COURT: All right. Mr. Ridley, you may step
18 down.

19 THE WITNESS: Thank you.

20 THE COURT: All right. Madame Forelady and ladies
21 and gentlemen, that concludes all the testimony. I need to
22 spend about three minutes with the lawyers, maybe five.
23 You'll come back out and get the final arguments, I'll
24 instruct you on the law and then we'll be in a position for
25 you to start your deliberations. I assume y'all want to

1 continue on today, it's just 2:15. So go straight one last
2 time, it won't be long. Thank you.

3 (The jury left the courtroom at 2:11 p.m.)

4 THE COURT: All right. Anything at the conclusion
5 of the testimony?

6 All right. Anything from either party?

7 MR. MORROW: Nothing from the State, Your Honor.

8 MS. HIGHTOWER: Nothing further, Your Honor.

9 THE COURT: All right. Ms. Hightower, have you
10 reviewed the verdict form that was submitted?

11 MS. HIGHTOWER: I saw it last week when he
12 submitted the packet. He copied me on it.

13 THE COURT: Any problem with it?

14 MS. HIGHTOWER: I -- I was just trying to rack my
15 brain about, if I could look at it one more time briefly,
16 please, sir. I apologize.

17 (There was discussion off-the-record concerning the
18 verdict form.)

19 THE COURT: Y'all okay with the verdict form or you
20 want me to change it.

21 MS. HIGHTOWER: It's at your discretion, Your
22 Honor.

23 THE COURT: Ma'am?

24 MS. HIGHTOWER: At your discretion, Your Honor.

25 (More off-the-record discussion on the verdict

1 form.)

2 THE COURT: I'll explain it to them.

3 MS. HIGHTOWER: Thank you, Your Honor.

4 THE COURT: Then I'm going the charge reasonable
5 doubt, credibility of witnesses. What else am I going to
6 charge.

7 MS. HIGHTOWER: Would you charge that they can
8 disregard one -- they can believe -- you know, they can
9 believe one --

10 THE COURT: I do charge that.

11 That's pretty much it, isn't it.

12 MS. HIGHTOWER: That's --

13 THE COURT: Anything else, Mr. Morrow?

14 MR. MORROW: Judge, do you use firmly convinced
15 language?

16 THE COURT: I do.

17 MR. MORROW: Thank you, Your Honor.

18 THE COURT: Y'all ready to argue? You need a
19 break?

20 MS. HIGHTOWER: I'm ready, Your Honor.

21 MR. MORROW: I'm ready, Your Honor.

22 THE COURT: All right. We'll take about three
23 minutes for my court reporter and the bailiffs.

24 (A brief recess was observed.)

25 THE COURT: All right. Mr. Morrow, you going to

1 open or you want to waive opening or how you want to do it.

2 MR. MORROW: I'm just going to go first all at
3 once.

4 THE COURT: All right. Bring the jury in, please.

5 (The jury entered the courtroom at 2:32 p.m.)

6 THE COURT: Madame Forelady, ladies and gentlemen,
7 as I told you earlier, the last thing we need to do is
8 final arguments. That is not evidence in the case. You've
9 heard all the evidence on which you will make your
10 decision. This is obviously, the lawyers argument in the
11 light most favorable to their position. It is not
12 evidence. So you've heard the evidence to make your
13 decision.

14 So then we'll do the arguments, then my charge is
15 not very long and then you'll be in a position to get the
16 case. So pay close attention. If at any time during the
17 arguments or my charge you need a break, raise your hand,
18 let me know.

19 Mr. Morrow.

20 **CLOSING ARGUMENTS**

21 MR. MORROW: Thank you, Your Honor. Ladies and
22 gentlemen, Richard Ridley is a predator. Predators both in
23 the human variety and those in the animal kingdom are most
24 dangerous when they conceal themselves with camouflage to
25 prevent potential prey from noticing them until the last

1 possible moment.

2 Think about it, if you see a tiger or a wolf or an
3 alligator sitting out in the open, you're likely to steer
4 clear of that animal. You know it's dangerous. You've
5 seen it, it's obvious. It looks like a predator. Similar
6 we are all familiar with the stereo type of the sexual
7 predator in our society, the stranger dressed in a long
8 trench coat, drives a windowless van --

9 MS. HIGHTOWER: Your Honor, I'm going to object.
10 This is -- I hesitated, I can't --

11 THE COURT: I know, that's rather inflammatory.
12 Just stick to the law and the facts in the case.
13 Talk about alligators and trench coats is not proper
14 argument in my opinion. Move along.

15 MR. MORROW: Most times dangerous types of predator
16 is those that are not obvious. Mr. Ridley is not an
17 obvious type of predator. He's --

18 MS. HIGHTOWER: Your Honor, I'm going to object.
19 That's assuming facts not in evidence.

20 THE COURT: Well, an argument is not facts, ladies
21 and gentlemen. So I'll give him some leeway. I'll let him
22 argue that, but what he's saying is not fact. It's his
23 argument, that's just his slant on what the argument --
24 what the facts say. You've heard all the facts, so that's
25 what you'll make your decision on, not anything other than

1 that.

2 MS. HIGHTOWER: Thank you, sir.

3 MR. MORROW: Mr. Ridley presents as charming. He
4 presents as very well spoken and very intelligent. He was
5 charming, well spoken and very intelligent when he was in
6 the community, when he was offending. Nothing about that
7 part of his personality has changed. However, under that
8 surface, while he was in the community, lie a predator.

9 Under the statute in South Carolina, the State has
10 to prove to you two things: First that Mr. Ridley has been
11 convicted of a sexually violent offense, at least one.

12 We've got his sexually violent convictions from the
13 State of South Carolina, criminal sexual conduct in the
14 third degree. It's been entered into evidence. You'll
15 have the conviction to look at while you're back there. In
16 addition to that -- the State has proven that element.

17 And in addition to that, the State has to prove
18 that he suffers from a mental abnormality or a personality
19 disorder that makes him likely to offend sexually if not
20 confined for treatment.

21 As that, the State has provided you with a
22 significant amount of information with regard to
23 Mr. Ridley's criminal offense history and the expert
24 opinion of Dr. Gordon Brown.

25 Let's talk about that history a little bit. In

1 1996, in 1997, Mr. Ridley was convicted in New York State
2 on three different occasions of sodomy in the third degree,
3 after 21 or more and the person was under 17. Next he
4 moved to South Carolina where he doesn't register as a sex
5 offender, even though he's required to by law. He then
6 seeks to get employment as a manager at Burger -- at a fast
7 food restaurant and offers an employee a ride home. And
8 then he takes advantage of that employee and forces him
9 into sex. He's convicted of that offense.

10 While he was at the Aiken County Detention Center
11 in jail, awaiting his day in court for that offense,
12 Mr. Ridley used express intimidation to force his cellmate
13 to perform oral sex on him. He was convicted of an assault
14 and battery of a high and aggravated nature for that
15 offense.

16 Between 1996 and 2001, Mr. Ridley had significant
17 history of offending sexually while in the community, even
18 offending while locked up in the Aiken County jail. In
19 2002, he was sentenced to 10 years in prison for his
20 offenses where his actions were monitored 24 hours a day, 7
21 days a week and he committed 26 separate rule infractions,
22 two of those were assaultive in nature.

23 Mr. Ridley was committed to the SVP treatment unit.
24 He's been there and there have been several instances where
25 he failed to follow the rules. He ordered a television

1 despite not getting authorization to do so. He was aware
2 of what the process was, he just chose to ignore it. When
3 he was prompted by his case manager about his behavior with
4 regards to younger residents, he replied that other people
5 were being vindictive against him. He was not willing to
6 take advice on that.

7 Now, you may be asking what do those nonsexual rule
8 violations have to do with Mr. Ridley's likelihood to
9 offend sexually. Well, it relates to his diagnosis. As to
10 that, you heard the testimony of Dr. Gordon Brown. He's a
11 psychologist with over 30 years experience. He was one of
12 three psychologist that was hired in the department of
13 mental health to oversee a treatment team and he led that
14 treatment team for two years. He's evaluated sex offenders
15 for the last four years under the South Carolina Sexually
16 Violent Predator Act. And he's done over 40 of those
17 evaluations. He's a member of the Association of the
18 Treatment of Sexual Abusers and the American Psychological
19 Association.

20 He diagnosed Mr. Ridley with other specified
21 paraphilic disorder, biastophilia. Dr. Brown told you that
22 he found that Mr. Ridley suffers from that diagnosis and he
23 explained that paraphilia is any intense and persistent
24 sexual or other than sexual interest in genital stimulation
25 or other preparatory fondling or what is normal

1 physiological mature consenting human partner.

2 He further explained that paraphilic disorder is a
3 paraphilia that is currently causing distress or impairment
4 to the individual or pedophilia that entails personal harm
5 or risk of personal harm to others. So Mr. Ridley meets
6 that definition because of his prior offenses where he's
7 caused harm to others. All of his victims have been
8 nonconsenting individuals and he has shown a repeated
9 pattern, repeating that behavior while out in the
10 community.

11 Now, Dr. Brown found that Mr. Ridley has a
12 significant criminal history. His victim -- all of his
13 victims could not either, one either could not legally
14 consent or did not, in fact, consent to such behavior.

15 Finally, he also diagnosed him with antisocial
16 personality disorder with narcissistic traits. Dr. Brown
17 explained antisocial personality disorder with narcissistic
18 traits means that a person has the pervasive pattern and
19 disregard for the rights of others, occurring since age 16;
20 a failure to conform to social norms with respect to the
21 law and behaviors as indicated by repeatedly performing
22 acts that are grounds for arrest; demonstrating a
23 deceitfulness as indicated by conning others for profit or
24 pleasure; demonstrating a impulsivity and a failure to plan
25 ahead; and demonstrating a reckless disregard for the

1 safety of himself or others; and demonstrated a lack of
2 remorse.

3 To show this, Dr. Brown offered Mr. Ridley's
4 criminal history, his numerous infractions while at the
5 department of corrections, coupled with his disregard or a
6 contempt for the rules in the SVP unit. His efforts to
7 circumvent the proper ordering procedures, his conflict
8 with staffing over these issues and his most recent offense
9 parallel behaviors in the unit all go to show this pattern
10 of behavior.

11 Dr. Brown discussed Mr. Ridley's progress and
12 treatment. He discussed the fact that he had performed
13 Mr. Ridley's last three annual review examinations and had
14 the opportunity to observe Mr. Ridley's performance over
15 time.

16 Dr. Brown noted that Mr. Ridley has consistently
17 focused on grievances in the court process rather than
18 focusing on treatment. He has consistently minimized his
19 offending behavior and the effect it had on his victims.
20 And he's still behaving in ways similar to what he did when
21 he was out in the community. He also told you that he
22 looked over Mr. Ridley's plan and discussed Mr. Ridley's
23 plan for release at the time Dr. Brown did his evaluation.
24 At that time he intended to be a truck driver. Persons who
25 fail to register as a sex offender, who move to South

1 Carolina, and now would like to take up an extremely
2 mobile profession where he would be traveling between
3 multiple states.

4 The static risk factors that we talked about were
5 the Static 99R scores. He used actuarial scores to
6 determine what his risk would be like compared to groups of
7 other sex offenders. On that score, Mr. Ridley had a 9.
8 He scored in the 99 percentile. His risk to reoffend was
9 in the well above average category and placed his five year
10 recidivism rate between 38 and 50 percent.

11 Dr. Brown also explained that he's seven times as
12 likely as the average sex offender, or that score makes him
13 likely as the average sex offender to reoffend. Further,
14 the Static 2002R score of an 8 placed him in a level of
15 above average risk category. He found that his risk to
16 reoffend was five times that of the average sex offender in
17 that category. Both of these actuarial measures indicate
18 he had a well above average or above average risk of
19 re-offending. He also talked about his dynamic risk
20 factors. His preoccupation with sex while he was in the
21 community. His threat for pubescent male victims. His
22 offense sieve attitude toward minimizing the violence of
23 his offenses, which he continued to do when he saw Dr.
24 Watson in his -- and Dr. Watson admitted to that on the
25 stand. Dr. Brown was of the opinion that Mr. Ridley needs

1 to continue confinement and treatment based on all of those
2 standards.

3 Now, let's talk about the defense's case. What you
4 heard from Dr. Watson, his expert is that Mr. Ridley made
5 several inconsistent statements to him that he lived with a
6 partner. He told Dr. Watson he lived with a partner for
7 three years after his report to Dr. Gehle that he only
8 lived with her for a year and a half. Now, Mr. Ridley had
9 access to his reports. He knew that was a point that went
10 against him earlier and he changed his story where it would
11 benefit him.

12 He also made several other inconsistent statements
13 including that he was 13 versus 16 when he started this
14 kind of conduct. And that has to do with -- just his
15 credibility and truthfulness now.

16 These also -- we also had a PPG examination that
17 was done by Dr. Watson or by the defense. In that PPG
18 examination, in the results, it identified that he was
19 aroused by, in addition to persuasive adult male
20 situations, persuasive teen male situations, and persuasive
21 teen female situations and coercive sexual situations.
22 Ladies and gentlemen, that's what he was convicted of. He
23 still shows that arousal today.

24 Further, Dr. Watson recommended follow up
25 treatment. Where the statute is concerned in this case

1 whether he is ready to be released today without any kind
2 of follow up treatment, whether he is ready to go out in
3 the community today.

4 Mr. Ridley took the stand. He admitted to all
5 these inconsistent statements. He talked about those on
6 the stand today in my cross-examination of him and he
7 further admitted that he minimized his violent offending
8 history in his most recent talk with Dr. Watson.

9 Now, the State's burden of proof in this case is
10 proof beyond a reasonable doubt. Proof beyond a reasonable
11 doubt is not a proof beyond all doubt or a proof beyond any
12 doubt or proof beyond any conceivable doubt. Proof beyond
13 a reasonable doubt is proof that leaves you firmly
14 convinced.

15 At the end of the day, ladies and gentlemen, if you
16 are firmly convinced that Mr. Ridley remains a sexually
17 violent predator and a danger to the community, that his
18 mental abnormality or personality disorder remains such
19 that he is likely to commit acts of sexual violence, then
20 you should find that he should remain in the sexually
21 violent predator program. Thank you.

22 MS. HIGHTOWER: Please the Court. Good afternoon.

23 As I told you in my opening, Mr. Ridley's a 47 year
24 old man. He's admitted the offenses, not an issue. He's
25 testified as to what happened; testified to what he pled

1 guilty to. He's testified, we've entered into evidence the
2 indictment, the sheet. Again, that's not a question, it's
3 not a fact. That's not what we're asking from you. All of
4 that is true. He's already spoke the truth about that when
5 he admitted his guilt. He spoke the truth about that when
6 he was sentenced. He spoke the truth about that when he
7 did his time. He did his time.

8 We're talking about the sexually violent predator
9 program and what we are asking y'all to decide and
10 certainly the judge will instruct you on the law of the
11 sexually violent predator program; you'll be asked to look
12 at the definitions and apply on that law, that legal
13 definition to the facts of the case. You're going to
14 specifically be asked to say what's the mental abnormality.
15 Mr. Morrow just admitted, he has to prove what's a mental
16 abnormality beyond a reasonable doubt. I submit to you,
17 certainly with the evidence in front of you, the testimony
18 of the witness, Dr. Watson, he testified as to what's a
19 mental abnormality and that rape is not a mental
20 abnormality.

21 The next -- certainly in going through the rest of
22 the law and what else you have to apply in terms of --
23 again, this is my closing, what I put before you now is my
24 opinion or my observations. Certainly y'all have been here
25 with us the whole time so y'all have your own opportunities

1 to talk about anything else you want. But in terms do you
2 have that definition that I submit to you has to be looked
3 at. You also have to look at the situation about the
4 definition of likely to commit -- excuse me, likely to
5 commit sexual acts of violence again, the menace, the
6 danger, the safety.

7 Is he safe. That's the next definition that I
8 submit to you that you must look to. Is he a menace, is he
9 safe. You decide. That is your judge -- you're the judge
10 of the facts. That is your ultimate decision under the law
11 and under the process that we're doing here today and
12 yesterday.

13 Certainly, I told you in my opening that the
14 evidence will show that Mr. Ridley's worked on his
15 treatment plan. He's worked on his treatment. Four years
16 since 19 -- since 2014 when he voluntarily waived himself
17 into the program. He's worked on that treatment. But --
18 and he talked about the insights that he gained. Certainly
19 Dr. Watson mentioned the insights that he gained; the
20 things that he looked at. What he worked on and also Dr.
21 Brown talked about the reports and what he's worked on in
22 his treatment, the insights he's gained. There were very
23 many positive -- positive aspects. I read it out loud and
24 asked Dr. Brown what, what he'd done. He helped others in
25 group. He's talked about his own offenses and related

1 those into what other members of the group were going
2 through; his own insight to it.

3 The testimony has been presented there.

4 And back to the mental abnormality, certainly both
5 experts talked about the diagnostic and statistical manual
6 of mental disorders, the bible, the DMS-5. It's been
7 through five different editions -- or four, here's our
8 fifth one. They both talked about this manual. They both
9 talked about the mental abnormality and biastophilia. We
10 discussed about that. Certainly you heard the evidence,
11 the biastophilia was considered, is not in there. It was
12 specifically rejected from 2003 to 2004 and it's not in
13 here today.

14 I told you in my opening and I bring forth to you in
15 my closing, this is about anger. This is old fashioned
16 anger, power, control from somebody with an aggressive
17 attitude, an aggressive lifestyle, the drug dealer. That's
18 who he was. People were objects for their own and insight
19 and care and compassion. 2001. That's why we have the
20 treatment plan. That's why the legislature put it into
21 place in terms of treatment. Mr. Ridley's earned the right
22 to be here today because he has worked on his treatment
23 plan for four years. He's earned the right to ask y'all to
24 consider his situation. To look at him. To look at what
25 he's done. And I ask that you consider and look at the

1 plans that he has for his future. Again, part of what
2 Correct Care put together -- who was the treating facility
3 by the way -- Correct Care, put together the treatment
4 plan. Where he's going to go. What's he going to do.
5 How's he going to have support. How he's going to have a
6 strategy to help him in his release, in his readjustment to
7 society.

8 He's got that in place. He's got that because he
9 knows he needs the support. He recognizes also in the care
10 plan, in the treatment plan, certainly, talking about the
11 follow up treatment. Follow up treatment with the help,
12 with the psychologist. Certainly he can -- and he told you
13 about it. I'll move on.

14 Certainly we ask you to consider everything here.
15 I ask you this: Consider what you don't hear. Consider
16 who didn't testify. Where's Mr. Atkinson?

17 MR. MORROW: Objection, Your Honor.

18 THE COURT: What's the objection?

19 MR. MORROW: How is this relevant to this case?

20 MS. HIGHTOWER: Mr. Atkinson was the one who was
21 specifically cited as writing that last report.

22 THE COURT: It's not evidence in the case, but
23 pursuant to the rules, she can site it.

24 MS. HIGHTOWER: Yes, they did.

25 THE COURT: Move along.

1 MS. HIGHTOWER: Thank you.

2 Yes. Exactly. According to the rules, you are
3 absolutely able to and have the right, common sense that's
4 why, you know, that common sense, that's what we ask in
5 addition to all this technical knowledge and everything.
6 Forget about that for a second. Let's just use our common
7 sense. Who didn't we hear from and why not? You can
8 consider that. Where is Mr. Atkinson? Where is the
9 Correct Care treating physician? Well, there's not a
10 physician, because they said there's not a physician, but
11 where's the counselor. I mean, is he such a menace and
12 such a danger and if he's not safe and they're that
13 concerned, why didn't we hear from those people. You can
14 consider it. I ask you to consider that.

15 Again, Mr. Ridley participated in the program. He
16 reached the highest level of behavior. You heard testimony
17 to that. Not only with DMH, but also under Correct Care.
18 And he is 8 of -- I can't remember over a hundred, but he
19 is 8 of 8 people that got highest level of behavior.

20 Active, participant through appropriately
21 discussing them in group, assists other group members in
22 understanding treatment related concepts. Those were
23 quotes from his progress notes. Quotes from the care
24 manager. From the reports. And remember, Dr. Brown said
25 that he bases his annual review upon the reports given. He

1 didn't say that he talked to anybody from Correct Care.

2 MR. MORROW: Objection. That's not in evidence.

3 THE COURT: Ladies and gentlemen, you heard all the
4 evidence. You determine what evidence convinces you of the
5 truth. This is argument. It's not evidence.

6 Please move along.

7 MS. HIGHTOWER: Yes, Your Honor.

8 I spoke to you in the opening about the
9 difficulties my hus -- my client coming to terms with his
10 own sexuality. It was an issue in his life. It was. It
11 was different back in the late 80's or the early 90's.
12 It's different today. There are certainly many healthy
13 relationships of same sex marriages, adoptions, date of
14 births. It's different today. You can have that. You can
15 have a life with those who you are attracted to. You don't
16 have to hide it. You don't have to suppress it.

17 And of course coupling that with what happened to
18 him in Riker's, again, we can certainly explain what
19 happened -- I'm not -- I don't mean to excuse it, y'all, I
20 don't mean to excuse it. I promise you, but just by way of
21 explanation, coupling the anger, coupling what happened,
22 coupling the lifestyle, coupling with what -- what -- what
23 went on, yeah, it happened. He admitted it. And he's not
24 that person as he was as a 20 something year old. He's not
25 that person. He's 47 years old. He's been there for 18

1 years. He's worked his treatment plan. He's come to terms
2 with who he is as a person. He's looked at it. He's
3 gained insight. He's shown control.

4 Remember, they said -- they said -- Dr. Watson said
5 he was looking for evidence of offense sexual re-offense,
6 looking for -- even their own witness with the Static 99
7 said that you should see some type of re-offense within
8 five years. Well, y'all, it's been since 2001 and not one,
9 nothing. Not one. The actuarial table, the life insurance
10 table, I submit that we're not insurance. We're not
11 tables. But even if you take their witness and what their
12 expert says, you should see re-offense in five years. We
13 don't see it. Reasons to doubt.

14 I'll just get to end. I'll just -- y'all have
15 heard the evidence. Finally, I think another reason to
16 consider as reasonable doubt in this case is that we had
17 two gentlemen come into this courtroom, both were qualified
18 as experts. Both of them read the reports, both of them
19 looked at Mr. Ridley and ironically, they both spent exact
20 same amount of time with Mr. Ridley, ten hours or roughly
21 the same amount of time. Dr. Watson told you how long he
22 kind of spends. And when you add up the years from 2000 --
23 however long Mr. Brown -- Dr. Brown has been writing his
24 annual reviews, he added up his hours. Over -- since 2015,
25 if you add it up, or when I added it up in my head, it was

1 ten. I think I asked him about it on cross: How many
2 hours did you spend with my client, Mr. Ridley. Ten. Dr.
3 Watson spent the same amount of hours with my client,
4 approximately ten. They read the same reports. They
5 looked at the same evaluations. Reason to doubt? They
6 both came to a different conclusions. That make you
7 hesitate? Reasons to doubt. Whether or not the State has
8 proved its case beyond a reasonable doubt. I submit that
9 to you.

10 Last thing I need -- I hesitate to bring this up,
11 but y'all can talk about it. Y'all heard everything. The
12 PPG, Dr. Watson testified that Mr. Ridley's arousal was to
13 adult consensual sex. That's quite -- Dr. Watson, he was
14 involved. He was the director of the SVP program. Dr.
15 Watson who testified in the very first SVP trial. Dr.
16 Watson who has had treatment experience with sexually
17 violent predators, who works in the department of
18 corrections as a psychologist, who this is his area. This
19 is his background. He's not learning it on the job. Dr.
20 Watson sat up here and I asked him is Mr. Ridley safe. His
21 expert opinion says yes.

22 Now my name is Bea Hightower. Thank you very much.
23 It's been my privilege to be in front of you.

24 THE COURT: Anything in reply?

25 MR. MORROW: Briefly, Your Honor. Dr. Watson got

1 up here on the stand and said Mr. Ridley is safe to be out
2 if he goes and attends outpatient treatment.

3 MS. HIGHTOWER: Your Honor, I object.

4 THE COURT: Hold on. What's the objection.

5 MS. HIGHTOWER: That is a mischaracterization of
6 what the statement -- what the evidence was. What the
7 statement was.

8 THE COURT: Well, they heard the evidence. I'm not
9 going to stop him over that. He did say something to that
10 effect.

11 MR. MORROW: Thank you, nothing further.

12 JURY CHARGE

13 THE COURT: All right. Ladies and gentlemen, my
14 instructions are not very, very long. First of all, as I
15 say, this is sort of a hybrid type case because it's a
16 civil proceeding, but the legislature, in writing this law
17 when they did used the end result is to determine whether
18 or not this man should be continued to be civilly committed
19 after he's done his -- all the time on his underlying
20 offenses. He's completed that sentence. So the
21 legislature under this statute allows the continued civil
22 commitment, if the State is able to prove their case to
23 you. And I'll go through all they have to prove. Because
24 it's a continued civil commitment, after somebody has done
25 all their time, they are -- they've raised the burden of

1 proof in this one civil proceeding. It is no longer the
2 preponderance or the greater weight of the evidence, it's
3 beyond a reasonable doubt. And I gave y'all that
4 illustration when we first started about the scales of
5 justice. So, in order to make a decision in this case,
6 obviously, the burden of proof at this trial is on the
7 State to prove beyond a reasonable doubt that Mr. Ridley's
8 mental abnormalities or personality disorder, if you find
9 that he has one, still remains such that he is not safe to
10 be at large and if released is likely to engage in acts of
11 sexual violence. So they have to prove that. It still
12 remains beyond a reasonable doubt.

13 So our courts have defined reasonable doubt, pretty
14 simple language and then they expand upon it. A reasonable
15 doubt is the kind of doubt that will cause a reasonable
16 person to hesitate to act. Hesitate to make a decision.
17 If you have reasonable doubt, if you don't have any
18 hesitancy, it's beyond a reasonable doubt.

19 It's the kind of doubt that would cause a
20 reasonable person to hesitate to act. It's also stated
21 that reasonable doubt is proof that leaves you firmly
22 convinced of the defendant's personality disorder remaining
23 the same.

24 There are very few things in this world that we
25 know with absolute certainty and in this type of case, the

1 law does not require proof that overcomes every possible
2 doubt. If based on your consideration of the evidence you
3 are firmly convinced that the personality disorder remains
4 the same, then it is your duty to find that he has
5 continued to be a sexual violent predator.

6 However, if you, on the other hand, think there's a
7 real possibility that he has made such improvement that
8 he's no longer a -- likely to be a danger to the community
9 in sexually violent acts, you must give him the benefit of
10 the doubt and release him.

11 Now, during this trial you and I have had certain
12 duties to perform. Obviously, my job is the -- I'm the
13 judge of the law in the case so you are -- have taken an
14 oath to accept the law as I give it to you. If you think
15 the law is something else or it should be something else
16 and it doesn't agree with what I say, please set that aside
17 and accept the law as I give it to you. And as I told you
18 earlier, more importantly, you're the judges of the facts
19 in the case. You've got the biggest job of anybody in the
20 courtroom.

21 So if at any time during the trial of the case you
22 looked up here and I shook my head or rolled my eyes or
23 smiled or frowned or you think I'm having some opinion
24 about the facts, I can't do it. I try these cases -- not
25 these kinds of cases, this is about my eighth case in the

1 Last four weeks. I can't have an opinion about the facts.
2 Sometimes I may be impatient up here but -- so if I've done
3 anything that you think I have an opinion about it, just
4 disregard that. You're the sole finders of the facts of
5 the case. You are the judges of the facts. And in being
6 the judges of the facts, you must necessarily determine the
7 credibility of the witnesses who have testified.

8 Credibility simply means believability. Who do you
9 believe. It becomes your duty as jurors to analyze and
10 evaluate the evidence and determine which evidence
11 convinces you of its truth. In exercising that duty of
12 finding the credibility or the believability of the
13 witnesses who have testified in the case, you have the
14 right to believe one witness over several, several over
15 one. You can disbelieve everything a witness says, you can
16 believe a little bit and disbelieve the other. You may
17 consider whether the witness has any -- exhibited to you
18 any interest, bias, or prejudice. And you also may
19 consider how the witness appeared on the witness stand.

20 Y'all are all adults. You've reached this stage in
21 life dealing with husbands, wives, children and employees,
22 and employers, friends. You know how to judge credibility.
23 Please don't leave that common sense when you go in the
24 jury room. Use your common sense in determining and
25 judging the credibility of the witnesses who have testified

1 in the case.

2 During the trial of the case, we had -- as I told
3 you, we had two gentleman, two doctors, PhD's that I
4 qualified as experts in the field of psychology. Normally,
5 our rules of evidence do not allow a witness to testify as
6 to opinions or conclusions. There is an exception with
7 witnesses we call expert witnesses, a witness who by
8 education and experience has become an expert in some art,
9 science, or profession may state an opinion as to relevant
10 and material matters in which the expert claims to be --
11 the witness claims to be an expert. And they may also
12 state the reasons for their opinion.

13 You should consider any expert opinion received in
14 this case like any other evidence. Give it the weight, if
15 any, you think it deserves. If you decide that the opinion
16 of an expert is not based on sufficient education and
17 experience, or if you conclude that the reasons given in
18 support of the opinion are not sound, or that the opinion
19 is outweighed by other evidence, you can disregard the
20 experts opinion entirely. An expert witness's testimony is
21 to be given no greater weight than that of any other
22 witness simply because I've classified him or designated
23 him as an expert.

24 Further, you are not required to accept an expert's
25 opinion even though it is not contradicted. So that's the

1 -- sort of general rule that we have in all cases.

2 Let's turn to, in this case, which is sexually
3 violent predator. This case is brought under the sexual --
4 Sexually Violent Predator Act. Normally with these cases,
5 we're trying to initially determine whether or not an
6 individual is a sexually violent predator. This case is a
7 little different in that Mr. Ridley has been in the
8 program. He didn't go through the traditional process. He
9 waived himself into the program. He agreed to go in the
10 program at the conclusion of his sentence. So when that
11 happens, we have these annual reviews. And Mr. Ridley has
12 the right to seek his release.

13 And in those types of cases such as this, where
14 you've been in the program, as I told you earlier, the
15 State has to prove beyond a reasonable doubt that
16 Mr. Ridley's mental abnormality or personality disorder
17 remains such that the person is not safe to be at large and
18 if released is likely to engage in acts of sexual violence.

19 Now, the State has that burden of proving to you
20 beyond a reasonable doubt that the personality disorder
21 remains the same. If they can't prove it beyond a
22 reasonable doubt then he's entitled to be released. So
23 going back to what a sexually violent predator is;
24 obviously the State must prove beyond a reasonable doubt
25 that the defendant has been convicted of a sexually violent

1 offense. And there's no question in this case that the
2 previous offenses that were committed way back in the late
3 1990's and the early 2000's, they were what is known as a
4 sexually violent offense under the law. They're classified
5 as that. So that is not an issue in this case.

6 In addition to that, the State must also prove
7 beyond a reasonable doubt that the defendant indeed -- in
8 fact, proved beyond a reasonable doubt, that he suffers
9 from a mental abnormality or personality disorder that
10 makes him likely to engage in acts of sexual violence if
11 not confined in a secure facility. In other words, he has
12 to continue to have that proven to you beyond a reasonable
13 doubt that he continues to have a mental abnormality or
14 personality disorder which makes him likely to engage in
15 sexual acts. They have to prove that to you beyond a
16 reasonable doubt.

17 The mental abnormality is defined -- means a mental
18 condition effecting a person's emotional capacity or
19 capacity to make conscious choices that makes a person
20 inclined to commit sexually violent offenses and likely to
21 engage in acts of sexual violence means this: It means the
22 person's tendency to commit acts of sexual violence is of
23 such a degree as to pose a menace to the health and safety
24 of others.

25 So you are charged with the responsibility in this

1 case to determine whether or not the State has proved
2 beyond a reasonable doubt that Mr. Ridley's mental
3 abnormality or personality disorder remains such that he is
4 not safe to be at large and if released is likely to commit
5 acts of violence.

6 If you find that they have proven that beyond a
7 reasonable doubt, then on the verdict form, Madame
8 Forelady, just mark yes. If you find that the State has
9 not proven beyond a reasonable doubt that his mental
10 abnormality, or he has one or a personality disorder, if he
11 has one, remains such that he is not safe to be at large,
12 if they have not proven that, then you hit no, mark no.
13 Sign it, read, it's self-explanatory.

14 Either they proved beyond a reasonable doubt or
15 they didn't. Yes or no. The verdict has to be unanimous.
16 All twelve of you must agree. As I tell all juries, you
17 don't have any friends to reward or enemies to punish.
18 Y'all have paid very close attention. This is an
19 interesting area of the law. The State does have that
20 burden beyond a reasonable doubt in this civil case.

21 So I ask you to deliberately and conscientiously
22 review the evidence and decide whether or not the State has
23 proven beyond a reasonable doubt he should remain in the
24 program after four years and after spending 18 some odd
25 years up there; or whether they have not done it and that

1 he should be released. That's your choice. That's your
2 decision.

3 I'm going to let you go back to the jury room.
4 Don't start quite yet your deliberation. I have to gather
5 up the evidence and send it back to you along with the
6 verdict form. It's an easy verdict form. It's got to be
7 unanimous. All twelve. Sign it when you get it.

8 If you have any questions during your deliberations
9 the protocol is to just write out the question on a piece
10 of paper, you'll have a pad back there; give it to the
11 bailiff, she'll give it to me. Sometimes I can answer it,
12 sometimes I can't. It depends on what the question is.
13 But I'll send you back a response.

14 Once you've reached a final verdict, a unanimous
15 verdict, sign it, knock, and we'll have you back in here.
16 Okay.

17 I'll let you go back to your jury room now, don't
18 quite start deliberating, let me ask if I've left anything
19 out.

20 Separate my alternate and then we'll go from there.

21 Thank you.

22 (The jury left the courtroom at 3:07 p.m.)

23 THE COURT: Any objections, requested additions, or
24 deletions to the charge as given by the State?

25 MR. MORROW: Nothing from the State, Your Honor.

1 THE COURT: Ma'am?

2 MS. HIGHTOWER: None, Your Honor.

3 THE COURT: All right. Please come review whatever
4 evidence if there's any and the verdict form, both out of
5 right here.

6 (The attorneys looked through the evidence and the
7 verdict form.)

8 THE COURT: Let the record reflect that both
9 lawyers have reviewed the exhibits and the verdict form and
10 both are in agreement. The case goes to the jury according
11 to my watch at 10 after -- it's a little after 3:10.

12 (The jury began deliberations at 3:17 p.m.)

13 THE COURT: Everyone ready to receive the verdict?

14 MS. HIGHTOWER: Yes, sir.

15 MR. MORROW: Yes, Your Honor.

16 THE COURT: All right. Bring the jury in, please.
17 Y'all remain seated, please.

18 (The jury entered the courtroom at 4:18 p.m.)

19 **VERDICT**

20 THE COURT: Madame Forelady, have y'all reached a
21 verdict?

22 THE FOREPERSON: Yes, sir.

23 THE COURT: If you would hand it to the bailiff,
24 please.

25 (The verdict form was handed to the bailiff and

1 then to the Court.)

2 THE COURT: Ma'am, you may publish it.

3 THE CLERK: Your Honor, in the case number
4 2013CP021005, we find the jury -- we, the jury unanimously
5 answer the question as follows: Yes, the State of South
6 Carolina has proven beyond a reasonable doubt that Richard
7 Ridley's mental abnormality and/or personality disorder
8 remains such that he is not safe to be at large if released
9 is likely to commit acts of sexual violence. And it's
10 signed by the foreperson.

11 THE COURT: Anything further for the jury before I
12 release them?

13 MS. HIGHTOWER: Nothing further, Your Honor, thank
14 you.

15 THE COURT: Thank you.

16 Madame Forelady, ladies and gentlemen, that will
17 conclude your service for this week. I appreciate it.
18 Y'all paid excellent attention having, tough case, but I
19 appreciate all you've done. The citizens of Aiken do as
20 well. Thank you.

21 If anyone needs a work excuse, go back to the jury
22 room, my bailiff will get one for you. If not we will be
23 sending you a huge check within the next few days.

24 Thank you very much. Have a pleasant evening.

25 (The jury left the courtroom at 4:20 p.m.)

1 THE COURT: Ms. Hightower, I will give you ten days
2 to make any post-trial motions.

3 MS. HIGHTOWER: All right. I certainly just can go
4 ahead and make a motion for judgment notwithstanding.

5 THE COURT: You don't want to have a few days to
6 think about it or you want to make it now? It's up to you.

7 POST-TRIAL MOTIONS

8 MS. HIGHTOWER: I'll just go ahead and make it now.
9 Based upon my motion in limine previously filed, the
10 arguments and what -- all the objections I /SERPL would ask
11 that you set aside the verdict of the jury and direct a
12 verdict in favor of my client.

13 THE COURT: Well, obviously, we had one expert
14 saying one thing and one saying another. It's obviously a
15 jury question and that's why we have jury trials and I
16 respectfully deny it.

17 Mr. Ridley, you and I have gotten to know each
18 other over the last few years. I know you're disappointed,
19 but I've seen a remarkable improvement in your situation
20 and I hope that you will maintain good attitude, as my mom
21 used to say, keep your chin up and, we get to review this
22 every year, so keep on making good progress and I'll pull
23 for you, okay?

24 MR. RIDLEY: Thank you, sir.

25 THE COURT: Thank y'all both very much. We stand

1 adjourned.

2 * * * * * END OF TRANSCRIPT * * * * *

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1 State of South Carolina)
2 County of Aiken) **Certificate of Reporter**

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I, Brenda J. Sigwald, Official Court Reporter for
the Second Judicial Circuit of the State of South Carolina,
do hereby certify that the foregoing is a true, accurate,
and complete Transcript of Record of the proceedings had
and evidence introduced in the trial of the captioned case,
relative to appeal, in the Court of Common Pleas in and for
the State of South Carolina on the 26th and 27th days of
February 2018.

14

15

I FURTHER CERTIFY that I am neither kin, counsel,
nor of interest to any party hereto.

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IN WITNESS WHEREOF, I have hereunto set my hand and
seal at Aiken County, this 27th day of August 2018.

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Brenda J. Sigwald
Brenda J. Sigwald,
Court Reporter and Notary Public
For the State of South Carolina
My commission expires
January 4, 2020

STATE OF SOUTH CAROLINA)
COUNTY OF AIKEN)

IN THE COURT OF COMMON PLEAS
SECOND JUDICIAL CIRCUIT
CASE #: 2013-CP-02-01005

IN THE MATTER OF THE)
CARE AND TREATMENT OF)
RICHARD D. RIDLEY,)

RESPONDENT.)

**MOTION IN LIMINE WITH
ANNEXED MEMORANDUM OF
LAW**

TO: ALL OTHER COUNSEL OF RECORD

The Respondent, Richard Ridley (Ridley), hereby moves, in accordance with Rules 104 and 702 SCRE, for an order of this Court excluding, in limine, all testimony and other evidence about the discredited diagnosis of other specified paraphilic disorder, non-consent or biastophilia. The grounds for this Motion are that the science underlying this discredited diagnosis is unreliable and that, therefore, this testimony and other evidence is inadmissible under State v. Jones, 273 S.C. 723, 259 S.E.2d 120 (1979), State v. Ford, 301 S.C. 485, 392 S.E.2d 781 (1990), and State v. Council, 335 S.C. 1, 515 S.E.2d 508 (1999).

WHEREFORE, Ridley prays that this Court enter and order in limine excluding all testimony and other evidence about the discredited diagnosis of other specified paraphilic disorder, non-consent or biastophilia.

MEMORANDUM OF LAW

STATEMENT OF THE CASE

This is a sexually violent predator (SVP) case. Ridley has moved for an order in limine excluding all testimony and other evidence about the discredited diagnosis of other specified paraphilic disorder, non-consent or biastophilia. Ridley submits the following Memorandum in support of that Motion.

FILED 2-26-18 9:30
Robert J. White
C.C.P. & C.S.
Deputy Clerk
Page 1 of 9

COURT'S
EXHIBIT NO. <u>1A</u>
IDENTIFICATION/EVIDENCE
DKT.# <u>Ridley</u>
DATE: <u>2-26-18</u>

STATEMENT OF THE FACTS

The State has classified Ridley as a sexually violent predator based on expert opinion that Ridley suffers from the mental abnormality of other specified paraphilic disorder, non-consent or biastophilia. The remainder of this Memorandum will demonstrate that the science underlying this diagnosis is unreliable.

ARGUMENT

I. THE LEGAL STANDARDS FOR ADMISSIBILITY OF SCIENTIFIC EVIDENCE.

"When admitting scientific evidence under rule 702 SCRE, the trial judge must find the evidence will assist the trier of fact, the expert witness is qualified, and the underlying science is reliable." State v. Council, 335 S.C. 1, 20, 515 S.E.2d 508, 516 (1999). In assessing the reliability of scientific evidence, the trial court must consider "the degree to which the trier of fact must accept, on faith, scientific hypotheses not capable of proof or disproof in court and not even generally accepted outside the courtroom." State v. Jones, 273 S.C. 723, 731, 259 S.E. 2d 120, 124 (1979). In applying the Jones standard, the trial court must look at several factors including:

- (1) the publications and peer review of the technique;
- (2) prior application of the method to the type of evidence involved in the case;
- (3) the quality control procedures used to ensure reliability;
- (4) the consistency of the method with recognized scientific laws and procedures.

Council, 335 S.C. at 19, 515 S.E.2d at 518; citing, State v. Ford, 301 S.C. 485, 392 S.E.2d 781 (1990).

II. THE PUBLICATIONS AND PEER REVIEWED STUDIES OF THE DIAGNOSIS OF OTHER SPECIFIED PARAPHILIC DISORDER, NON-CONSENT OR BLASTOPHILIA COUNSEL STRONGLY AGAINST ADMITTING EVIDENCE OF THIS DISCREDITED DIAGNOSIS.

A. DSM-5

DSM-5 is a remarkable feat of assembling and compiling a representation of those psychological disorders that are generally accepted by the psychiatric community. "After World War II, DSM evolved through four major editions into a diagnostic classification system for psychiatrists, other physicians, and other mental health professionals that describe the essential features of the full range of mental disorders." (DSM-5 at 6. App. p.1) Also see the section in the Introduction of the DSM-5 at page 6 on the DSM-5 Revision Process.

In 1999, the APA launched an evaluation of the strengths and weaknesses of DSM based on emerging research that did not support the boundaries established for some mental disorders. This effort was coordinated with the World Health Organization (WHO) Division of Mental Health the World Psychiatric Association (WPA) and the National Institute of Mental Health (NIMH) in the form of several conferences, the proceedings of which were published in a 2002 monograph entitled A Research Agenda for the DSM-5. Thereafter, the task force of 28 members was approved in 2007, and appointments of more 130 workgroup members were approved in 2008. More than 400 additional workgroup advisors with no voting authority were also approved to participate in the process. An intensive 6-year process involved conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 website for public comment, presenting preliminary findings at professional meetings, performing field trials, and revising criteria and text. (DSM-5 at 6-7, App. pp. 1 and 2)

Through this rigorous process, the relevant scientific community of psychiatrists, psychologists, other physicians, and other mental health professionals rejected other specified paraphilic disorder, non-consent or biastophilia as a valid mental health diagnosis. (App. p. 62)

B. The peer reviewed literature.

A review of the peer-reviewed literature shows that the diagnosis of other specified paraphilic disorder, non-consent or biastophilia is unreliable as having no reliable scientific basis. Summaries of the literature appear below:

“DSM-5 and Paraphilic Disorder” (First)

This article outlines issues which arose in adopting DSM-5's paraphilia section. The author notes that unlike other DSM sections, paraphilias are primarily diagnosed in forensic settings. There were three particularly contested DSM-5 paraphilia proposals: to add PCD and a new named paraphilia called “Hypersexual Disorder” and to broaden the pedophilia diagnosis to include pubescent as well as prepubescent children. None of these proposals were adopted. The DSM-4 and 4-TR, according to the author had a “forensically significant editing error... this error, a misplaced or, allow the diagnosis of a paraphilia to be based entirely on the presence of criminal sexual behavior, sidestepping the requirement that the behavior be a manifestation of a deviant sexual arousal pattern.” (195, App. p. 7) The DSM-

5 now generally has the deviant sexual arousal pattern as its centerpiece and places behaviors and fantasies in subsidiary roles.

Dr. First asserts the OSPD category is “intended to be used for presentations that do not meet the criteria for any specific DSM-5 disorder; for presentations of uncertain etiology with respect to whether the condition is substance induced, due to another medical condition, or primary; and for presentations where there is insufficient information to make a more specific diagnosis.” (198, App. p. 10) “By virtue of their residual and often idiosyncratic nature cases diagnosed as [OSPD] ... [including PCD] are, by definition, outside what is generally accepted by the field and thus should be used in forensic contexts only with great caution.” (199, App. p. 11).

“Commentary: Inventing Diagnosis for Civil Commitment of Rapists” (Zander)

[This article was written prior to the adoption of the DSM-V and thus in part analyze the NOS category under the DSM-4 and 4-TR]. Non-consent is not a diagnosis under the “International Statistical Classification of Diseases and Related Health Problems” or “ICD 10.” (App. p. 16) Attempts to provide a PCD diagnosis and DSM-3- TR from 1983 to 1986 resulted in “vigorous opposition” from multiple organizations. (461, App. p. 17) It was understood by the 1980’s that rape “is a violent assault motivated by the rapist’s desire for power and domination rather than by sexual arousal.” (461, App. p. 17) The APA board rejected the proposal in 1986

by vote of 10 to 4. (App. p. 17) Two new proposals were included at that time in the DSM Appendix as conditions warranting further study, but the non-consent diagnosis was not. (462, App. p. 18)

The DSM-4-TR assigned "V-codes" applicable to sexual abuse involving "sexual coercion rape." V-codes do not describe a mental disorder but rather problems which are "a focus of clinical attention." (463, App. p. 18) (citations omitted) This is further evidence the DSM did not intend PCD to be diagnosed in the "NOS" category. While the vague standards of the NOS category may be appropriate in clinical settings that category should not be used in forensic settings because NOS diagnoses are "ad hoc inventions of individual diagnosticians. (465, App. p. 20) The non-consent diagnosis is not generally accepted in the field because "it is based on a construct that was deliberately rejected as unsupported by research in the behavioral sciences when it was considered for inclusion in the manual of diagnosis that is based on professional consensus" (465, App. p. 21) The author asserts that psychologists who use the non-consent diagnosis may be in violation of APA ethical standards because the diagnosis is not supported by established scientific and professional knowledge. (App. pp. 20 and 21 Some men may rape because of a paraphilia but more research needs to be done to allow the non-consent diagnosis to be used in forensic settings.

"Paraphilia NOS, Nonconsent, Not Ready for the Courtroom (Frances and First)

This article states that the “DSM-5 rejection of paraphilia coercive disorder as an official category was necessary because the rationale and the supporting evidence were so thin.” (559, App. p. 31) The article also states that “there is no research to guide how a criteria set for paraphilia coercive disorder should be written and whether it could ever be reliably diagnosed.” (559, App. p. 31). “There was little interest (and very limited research) in the psychiatric status of rape until it became a convenient way to subject rapists to involuntary psychiatric commitment after their prison sentences had been served.” (560, App. p. 32). “Paraphilia NOS, non-consent, is not a legitimate mental disorder diagnosis and seems more an excuse for keeping dangerous sex offenders locked up.” (560, App. p. 32).

III. THE CASES DECIDED ON THE ADMISSIBILITY OF THE DIAGNOSIS OF OTHER SPECIFIED PARAPHILIC DISORDER, NON-CONSENT OR BIASTOPHILIA COUNSEL AGAINST ADMITTING IN EVIDENCE THAT DIAGNOSIS IN RIDLEY’S CASE.

In 2016, two Supreme Court Justices in New York in separate lengthy opinions excluded evidence of diagnoses of other specified paraphilic disorder, non-consent or biastophilia in SVP cases. State v. Jason C., 2016 N.Y. Slip Op. 26018, January 22, 2016 (App. pp. 34-48) and State v. Kareem M., 2016 N.Y. Slip Op. 50427, March 29, 2016. (App. pp. 49-850 While both cases discussed the admissibility of the evidence under the Frye v. U.S., 293 F. 1013 (D.C. Cir. 1923) criteria of general acceptance in the scientific community, which is different from

South Carolina's reliability standard, the analysis in these cases supports a finding of unreliability.

In Jason C., The New York Supreme Court, Kings County based its conclusion that the other specified paraphilic disorder, non-consent was inadmissible on several observations that go directly to the reliability of the science underlying this diagnosis. First, the court observed that there is no clear definition or criteria for this disorder. (p. 7, App. p. 40). Second, the court observed that the diagnosis cannot be reliably distinguished from other motivations for rape such as antisociality or sexual sadism. (p. 9, App. p. 42) Third, the psychological studies of the diagnosis do not reflect a wide, significant, well-rounded body of research that supports the validity of the diagnosis. (p. 11, App. p. 44) Fourth, the diagnosis has been repeatedly rejected for inclusion in the DSM. (pp. 14-15, App. pp. 47-48)

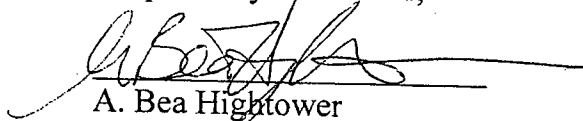
In Kareem M., the New York Supreme Court, New York County also based its conclusion excluding evidence of this disorder on points that support a finding of unreliability of the underlying science. This court also makes the points that this diagnosis was proposed for inclusion in the DSM and was rejected five times (p. 14, App. p. 62) and that there are no studies indicating that the diagnosis is predictive of future behavior. (p. 14, App. p. 62). The court also found that there had been no causal studies of why rape offenders offend and there have been no "field trials" that have examined how the disorder is diagnosed in practice. (p. 14, App. p. 62). Finally,

the court observed that rape has been historically considered a crime not a mental disorder. (p. 14, App. p. 62)

CONCLUSION

For the foregoing reasons, this Court should grant Ridley's Motion in Limine and exclude all evidence of other specified paraphilic disorder, non-consent or biastophilia.

Respectfully Submitted,



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Columbia, SC
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examination of the range of symptoms present, DSM can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. Although some mental disorders may have well-defined boundaries around symptom clusters, scientific evidence now places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors, and possibly shared neural substrates (perhaps most strongly established for a subset of anxiety disorders by neuroimaging and animal models). In short, we have come to recognize that the boundaries between disorders are more porous than originally perceived.

Many health profession and educational groups have been involved in the development and testing of DSM-5, including physicians, psychologists, social workers, nurses, counselors, epidemiologists, statisticians, neuroscientists, and neuropsychologists. Finally, patients, families, lawyers, consumer organizations, and advocacy groups have all participated in revising DSM-5 by providing feedback on the mental disorders described in this volume. Their monitoring of the descriptions and explanatory text is essential to improve understanding, reduce stigma, and advance the treatment and eventual cures for these conditions.

A Brief History

The APA first published a predecessor of DSM in 1844, as a statistical classification of institutionalized mental patients. It was designed to improve communication about the types of patients cared for in these hospitals. This forerunner to DSM also was used as a component of the full U.S. census. After World War II, DSM evolved through four major editions into a diagnostic classification system for psychiatrists, other physicians, and other mental health professionals that described the essential features of the full range of mental disorders. The current edition, DSM-5, builds on the goal of its predecessors (most recently, DSM-IV-TR, or Text Revision, published in 2000) of providing guidelines for diagnoses that can inform treatment and management decisions.

DSM-5 Revision Process

In 1999, the APA launched an evaluation of the strengths and weaknesses of DSM based on emerging research that did not support the boundaries established for some mental disorders. This effort was coordinated with the World Health Organization (WHO) Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health (NIMH) in the form of several conferences, the proceedings of which were published in 2002 in a monograph entitled *A Research Agenda for DSM-V*. Thereafter, from 2003 to 2008, a cooperative agreement with the APA and the WHO was supported by the NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) to convene 13 international DSM-5 research planning conferences, involving 400 participants from 39 countries, to review the world literature in specific diagnostic areas to prepare for revisions in developing both DSM-5 and the *International Classification of Diseases*, 11th Revision (ICD-11). Reports from these conferences formed the basis for future DSM-5 Task Force reviews and set the stage for the new edition of DSM.

In 2006, the APA named David J. Kupfer, M.D., as Chair and Darrel A. Regier, M.D., M.P.H., as Vice-Chair of the DSM-5 Task Force. They were charged with recommending chairs for the 13 diagnostic work groups and additional task force members with a multidisciplinary range of expertise who would oversee the development of DSM-5. An additional vetting process was initiated by the APA Board of Trustees to disclose sources of income and thus avoid conflicts of interest by task force and work group members. The full disclosure of all income and research grants from commercial sources, including the pharmaceutical industry, in the previous 3 years, the imposition of an income cap from all commercial sources, and the publication of disclosures on a Web site set a new standard for the

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field. Thereafter, the task force of 28 members was approved in 2007, and appointments of more than 130 work group members were approved in 2008. More than 400 additional work group advisors with no voting authority were also approved to participate in the process. A clear concept of the next evolutionary stage for the classification of mental disorders was central to the efforts of the task force and the work groups. This vision emerged as the task force and work groups recounted the history of DSM-IV's classification, its current strengths and limitations, and strategic directions for its revision. An intensive 6-year process involved conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 Web site for public comment, presenting preliminary findings at professional meetings, performing field trials, and revising criteria and text.

Proposals for Revisions

Proposals for the revision of DSM-5 diagnostic criteria were developed by members of the work groups on the basis of rationale, scope of change, expected impact on clinical management and public health, strength of the supporting research evidence, overall clarity, and clinical utility. Proposals encompassed changes to diagnostic criteria; the addition of new disorders, subtypes, and specifiers; and the deletion of existing disorders.

In the proposals for revisions, strengths and weaknesses in the current criteria and nomenclature were first identified. Novel scientific findings over the previous two decades were considered, leading to the creation of a research plan to assess potential changes through literature reviews and secondary data analyses. Four principles guided the draft revisions: 1) DSM-5 is primarily intended to be a manual to be used by clinicians, and revisions must be feasible for routine clinical practice; 2) recommendations for revisions should be guided by research evidence; 3) where possible, continuity should be maintained with previous editions of DSM; and 4) no a priori constraints should be placed on the degree of change between DSM-IV and DSM-5.

Building on the initial literature reviews, work groups identified key issues within their diagnostic areas. Work groups also examined broader methodological concerns, such as the presence of contradictory findings within the literature; development of a refined definition of mental disorder; cross-cutting issues relevant to all disorders; and the revision of disorders categorized in DSM-IV as "not otherwise specified." Inclusion of a proposal for revision in Section II was informed by consideration of its advantages and disadvantages for public health and clinical utility, the strength of the evidence, and the magnitude of the change. New diagnoses and disorder subtypes and specifiers were subject to additional stipulations, such as demonstration of reliability (i.e., the degree to which two clinicians could independently arrive at the same diagnosis for a given patient). Disorders with low clinical utility and weak validity were considered for deletion. Placement of conditions in "Conditions for Further Study" in Section III was contingent on the amount of empirical evidence generated on the diagnosis, diagnostic reliability or validity, presence of clear clinical need, and potential benefit in advancing research.

DSM-5 Field Trials

The use of field trials to empirically demonstrate reliability was a noteworthy improvement introduced in DSM-III. The design and implementation strategy of the DSM-5 Field Trials represent several changes over approaches used for DSM-III and DSM-IV, particularly in obtaining data on the precision of kappa reliability estimates (a statistical measure that assesses level of agreement between raters that corrects for chance agreement due to prevalence rates) in the context of clinical settings with high levels of diagnostic comorbidity. For DSM-5, field trials were extended by using two distinctive designs: one in large, diverse medical-academic settings, and the other in routine clinical practices. The former capitalized on the need for large sample sizes to test hypotheses on reliability and clinical utility of a range of diagnoses in a

DSM-5 and Paraphilic Disorders

O.S.P.D -

Michael B. First, MD

Given that paraphilic disorders are diagnosed largely in forensic settings, virtually every significant change in the criteria has forensic implications. Several controversial changes were considered during the DSM-5 revision process, but most were ultimately not included in the published text. However, any changes that make it easier to assign a paraphilic disorder diagnosis to an individual must be considered with caution. Criterion A for paraphilic disorders has been changed to reduce one potential risk that could result in false-positive diagnoses (i.e., allowing evaluators to diagnose a paraphilic disorder based entirely on the presence of sexual acts). In contrast, many of the other changes including some of those in the text, make it easier to diagnose a specific paraphilia and thus increase the risk of false-positive diagnoses. Since the assignment of a paraphilic disorder diagnosis can result in adverse legal consequences, the actual forensic impact of the changes will depend on how the legal system incorporates these new definitions into statutes and case law.

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The paraphilic disorders are unique in DSM-5,¹ in that forensic considerations played a central role in many of the proposed changes in the diagnostic criteria and accompanying text. In contrast to the disorders from almost every other DSM-5 diagnostic class, individuals with paraphilic disorders, especially in the United States, are mainly seen in forensic settings.² They may be persons who have been arrested for a sex-related crime, such as child molestation, rape, or other sexual assault or for charges involving child pornography, or they may be individuals involved in child custody evaluations to determine their fitness to be a parent. Thus, any significant changes made in the definitions or specifiers for the paraphilic disorders are likely to have forensic implications.

In 1990, Washington state passed a sexually violent predator (SVP) involuntary commitment statute, allowing sex offenders to be civilly committed to mental hospitals after completion of their mandatory prison sentences. Since then, 20 states and the federal government have enacted similar statutes.³ As a result, the scope and wording of the paraphilia criteria sets and text have come under intense scrutiny by forensic examiners and lawyers. The constitutional-

ity of SVP commitment statutes depends on the requirement that a violent sexual offender have a mental abnormality that predisposes him to commit sexual offenses, distinguishing him from dangerous sex offenders whose offenses are not the product of such abnormalities.⁴ Although the statutorily defined mental abnormality is not equivalent to any clinically defined mental disorder diagnosis, the presence of a DSM diagnosis, particularly a paraphilic disorder, is almost always key evidence in SVP civil commitment adjudications.⁵ Thus, any change in the wording of a diagnostic criterion or the addition of a new diagnostic category has important ramifications.

The determination of the presence (or absence) of a paraphilic disorder is also likely to have a significant impact on sentencing recommendations and the categorization of sex offenders into low, medium, or high risk under community-notification statutes (e.g., Megan's Law).⁶ For example, Federal sentencing guidelines require that the sentence take into account the need to "protect the public from further crimes of the defendant."⁷ Given that the presence of a paraphilic disorder is associated with an increased risk of recidivism⁸ and thus a risk of future harm to the public, a diagnosis of a paraphilic disorder is likely to result in the imposition of a longer sentence or the assignment of the individual to a higher risk category after being released into the community. Moreover, the diagnosis will determine the sex offender treatment that will be mandated during incarceration. Similarly, the determination that a parent

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undergoing a custody evaluation has a paraphilia diagnosis may have adverse consequences on that parent's custodial and visitation rights.⁹

Changes in the diagnostic criteria for the paraphilic disorders are relatively few. There are, however, several more extensive changes in the descriptive text. Forensic experts (and attorneys) often carefully scrutinize the text, as well as the diagnostic criteria, for information to bolster their opinions. However, although the DSM-5 diagnostic criteria went through many layers of review and scrutiny during the revision process, the text, by comparison, was subjected to a much more limited review and vetting process. In some cases, the lack of review resulted in the application of a more lax empirical standard, as will be discussed below. It is therefore advisable to examine statements critically in the text for their empirical backing before considering them in legal arguments.

Name Change from Paraphilia to Paraphilic Disorder

The term paraphilia was first introduced into DSM-III¹⁰ to replace the DSM-II¹¹ term sexual deviation "because it correctly emphasizes that the deviation (para-) lies in that to which the person is attracted (philia)" (Ref. 8, p 267). Although paraphilia has been used to refer to disorders of atypical sexual arousal up through DSM-IV-TR,¹² no term was available in DSM-IV-TR to indicate nonpathological, atypical sexual interests. In contrast, DSM-5 redefines the term paraphilia so that it now refers to a persistent, intense, atypical sexual arousal pattern, independent of whether it causes any distress or impairment, which, by itself, would not be considered disordered.

DSM-5 instead uses the term paraphilic disorder to refer to the disorder-worthy entities included in The Manual, which are defined as persistent and intense atypical sexual arousal patterns that are accompanied by clinically significant distress or impairment. Concomitant with this name change, DSM-5 also introduces the novel distinction between ascertaining a paraphilia and diagnosing a paraphilic disorder. According to DSM-5, "the term diagnosis should be reserved for individuals who meet both Criterion A and Criterion B (i.e., individuals who have a paraphilic disorder)" (Ref. 1, p 686). Examples of the difference between ascertaining a para-

philia and diagnosing a paraphilic disorder are provided throughout the text.

Although the intent of this change is to reduce stigma by clarifying that atypical sexual arousal patterns are not evidence of psychopathology, the decision to repurpose the existing term paraphilia, understood for the past 34 years to be indicative of psychopathology in both medical and legal circles, is likely to create much confusion.^{13,14} It is easy to imagine how the technical difference between a paraphilia and a paraphilic disorder might be lost on judges, juries, and others not well versed in the subtleties of the DSM and thus the redefinition of paraphilia is likely to blur rather than sharpen the distinction between a disorder and a nondisorder. Moreover, in the context of child custody evaluations, receiving an ascertained label of a paraphilia such as pedophilia is likely to be as damaging as being diagnosed as having a paraphilic disorder.¹⁵

Summary of Changes in the Paraphilic Disorders Criteria Sets

During the DSM-5 revision process, proposed changes in the DSM-IV¹⁶ paraphilias engendered a great deal of spirited debate in regard to their forensic implications. Particularly contested were proposals to add two new disorders (i.e., paraphilic coercive disorder and hypersexual disorder) and to broaden the pedophilic disorder diagnosis to include attraction to pubescent as well as prepubescent children. Other controversial proposals involved making significant changes to the criteria sets, including operationalizing the harm component by having it depend on the number of victims¹⁷ and including the use of child pornography.¹⁸ Ultimately, the proposals for adding paraphilic coercive disorder and hypersexual disorder and for expanding pedophilia to include hebephilia were rejected. Moreover, most of the other proposed criteria set changes were not implemented, so that the final criteria sets closely resemble their DSM-IV-TR counterparts.

Table 1 lists the DSM-5 criteria sets for the paraphilic disorders, with the DSM-IV-TR criteria sets provided for comparison. Conceptually, the diagnostic criteria are split into two constructs, both of which are required for the diagnosis of a paraphilic disorder. Criterion A is the paraphilia component of the disorder, which requires an atypical focus of sexual arousal and an arousal pattern that is recurrent, intense, and persists for at least six months. Criterion

APPENDIX 4

Table 1. DSM-IV-TR and DSM-5 Criterion Templates for the Paraphilic Disorders^{1,12}

DSM-5	DSM-IV-TR
✱ <u>Template for Paraphilic Disorders involving Nonconsenting Victims (i.e., Voyeuristic Disorder, Exhibitionistic Disorder, Frotteuristic Disorder, Sexual Sadism Disorder) except Pedophilic Disorder (see below).</u> A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity [Voyeuristic Disorder] from the exposure of one's genitals to an unsuspecting person [Exhibitionistic Disorder] from touching or rubbing against a nonconsenting person [Frotteuristic Disorder] from the physical or psychological suffering of another person [Sexual Sadism Disorder] ... as manifested by fantasies, urges, or behaviors. B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. (for Voyeuristic Disorder only): The individual experiencing the arousal and/or acting on the urges is at least 18 years of age. <u>For Exhibitionistic Disorder only:</u> Specify whether: 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 Specify if: <u>In a controlled environment:</u> this specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in paraphilic behavior are restricted. <u>In full remission:</u> The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.	Template for Paraphilias involving Nonconsenting Victims (i.e., Voyeurism, Exhibitionism, Frotteurism, Sexual Sadism) except Pedophilia (see below). A. Over a period of at least 6 months, recurrent intense sexually arousing fantasies, sexual urges, or behaviors ... involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity [Voyeurism]. involving the exposure of one's genitals to an unsuspecting person [Exhibitionism] involving touching or rubbing against a nonconsenting person [Frotteurism] involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person [Sexual Sadism]. B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulties.
✱ <u>Template for Paraphilic Disorders not involving nonconsenting victims (including Sexual Masochism, Fetishistic Disorder, and Transvestic Disorder)</u> A. Over a period of at least 6 months, recurrent and intense sexual arousal ... from the act of being humiliated, beaten, bound, or otherwise made to suffer ... [Sexual Masochistic Disorder] ... from the use of nonliving objects or a highly specific focus on nongenital body part(s) ... [Fetishistic Disorder] ... from cross-dressing [Transvestic Disorder] ... as manifested by fantasies, urges, or behaviors. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Template for Paraphilic Disorders not involving nonconsenting victims (including Sexual Masochism, Fetishistic Disorder, and Transvestic Disorder) A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors ... involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer [Sexual Masochism] ... involving the use of nonliving objects (e.g., female undergarments) [Fetishism] ... involving cross-dressing in a heterosexual male [Transvestic Fetishism]. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

B is the harm component, which requires the presence of distress, impairment in functioning, or involvement of nonconsenting victims. Three different wording templates for the diagnostic criteria have

been used: one for paraphilic disorders that may involve the participation of nonconsenting persons (i.e., voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, and sexual sadism disorder).

APPENDIX 5

DSM-5 and Paraphilic Disorders

Table 1. Continued

DSM-5	DSM-IV-TR
C. [For Fetishistic Disorder only:] The fetish objects are not limited to articles of clothing used in cross-dressing (as in Transvestic Disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator). <i>For Transvestic Disorder only:</i> Specify if: With fetishism: if sexually aroused by fabrics, materials, or garments. With autogynephilia: if sexually aroused by thoughts or images of self as female. <i>For Sexual Masochism Disorder only:</i> Specify if: With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing. <i>For Fetishistic Disorder only:</i> Specify: Body part(s) Nonliving object(s) Other Specify if: In a controlled environment: this specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in paraphilic behavior are restricted. In full remission: there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.	C. [For Fetishism only:] The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator). <i>For Transvestic Fetishism only:</i> Specify if: With Gender Dysphoria: if the person has persistent discomfort with gender role or identity
✱ <u>Template for Pedophilic Disorder</u> A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A. Note: do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. Specify whether: Exclusive type (attracted only to children) Nonexclusive type Specify if: Sexually attracted to males Sexually attracted to females Sexually attracted to both Specify if: Limited to incest	Template for Pedophilia A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A. Note: do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. Specify type: Exclusive type (attracted only to children) Nonexclusive type Specify if: Sexually attracted to males Sexually attracted to females Sexually attracted to both Specify if: Limited to incest

Italics highlight the differences.

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shown in the top section of Table 1; one for paraphilic disorders that do not involve nonconsenting victims (i.e., sexual masochism disorder, fetishistic disorder, and transvestic disorder), shown in the center section; and one for pedophilic disorder, shown in the bottom section.

As was the case with DSM-IV-TR, Criterion B for those paraphilic disorders in which the paraphilic interest potentially involves a nonconsenting victim requires that the individual act on the sexual urges or that the sexual urges or fantasies cause distress or impairment, whereas Criterion B for the other para-

philias requires only that the fantasies, urges, or behaviors cause distress or impairment. The behavioral expression of pedophilic disorder often involves non-consenting victims, since prepubescent children cannot legally give consent to sexual activity. However, the diagnostic criteria for pedophilic disorder have retained their DSM-IV-TR wording and thus differ from the DSM-5 diagnostic criteria for the other paraphilic disorders involving nonconsenting victims.

Although many of DSM-5's wording changes occurred for editorial purposes and are likely to be forensically inconsequential (e.g., in frotteuristic disorder Criterion A, changing "involving touching or rubbing against a nonconsenting person" (Ref. 10, p 570) to "from touching or rubbing against a nonconsenting person" (Ref. 1, p 691)), some of the changes have important forensic implications. Most notably, the overall structure of Criterion A has been changed in a way to address a forensically significant editing error introduced into DSM-IV¹⁶ (and perpetuated in DSM-IV-TR). This error, a misplaced "or," allowed the diagnosis of a paraphilia to be based entirely on the presence of criminal sexual behavior, sidestepping the requirement that the behavior be a manifestation of a deviant sexual arousal pattern.^{5,19}

The DSM-IV work group never intended to change the operational definition of paraphilia diagnoses. As part of an effort to make the wording of the clinical significance criteria (CSC) consistent across the DSM-IV disorders, Criterion B for all of the paraphilias was replaced in DSM-IV by the standard CSC wording: "the fantasies, sexual urges, or behaviors cause clinically significant impairment in social, occupational, or other important areas of functioning" (Ref. 16, p 523). Criterion A was amended by adding "behavior" along with "fantasies" and "urges" to emphasize that it is behavior that most typically brings individuals to clinical attention.

Nevertheless, some forensic evaluators interpreted the phrase "or behaviors" to indicate that a paraphilia diagnosis could be based solely on the presence of the criminal sexual behavior, without trying to connect that behavior causally to the paraphilic arousal pattern. In fact, not every offender's sexually deviant behavior is driven by a paraphilic sexual arousal pattern, and sexually violent behavior, such as child molestation or rape, is not indicative that a paraphilic arousal pattern is the cause of the behavior. For ex-

ample, in an analysis of the psychiatric diagnoses of a sample of 113 male sex offenders, Dunsieith and colleagues²⁰ found that only 58 percent had a paraphilic disorder.

The change in the Criterion A wording places the presence of a persistent and intense atypical sexual arousal pattern at the center of the definition of a paraphilia, moving behaviors (along with sexual urges and fantasies) into subsidiary roles as possible manifestations of the deviant sexual arousal pattern. In theory, behavioral data such as repeated sexual offenses should be considered indicative of a paraphilia only if it can be established that the behavior is being driven by a persistent and intense deviant sexual arousal pattern. In practice, however, given that individuals evaluated in forensic settings are likely to be less than forthcoming about their sexual proclivities, establishing the presence of a paraphilic sexual arousal preference can be challenging. Forensic evaluators will by necessity sometimes have to infer its presence from the nature and pattern of the person's behaviors (e.g., repeated frotteuristic behavior in an individual who has ample opportunities to engage in nonfrotteuristic sexual behavior with consenting partners). Nevertheless, given the explicit requirement that the behaviors be a manifestation of an atypical sexual arousal pattern, forensic evaluators should endeavor to provide additional support for their inference. Acquiring such support requires attempts to establish that other explanations for the behaviors, such as substance intoxication or opportunistic behavior in a person with antisocial personality disorder, have been ruled out.⁵

Notably, these corrections to Criterion A have not been incorporated into the DSM-5 criteria for pedophilic disorder, thus perpetuating the risk that the diagnosis of pedophilic disorder will be made solely on the basis of criminal behavior. As a result of a quirk in the DSM-5 revision process, the ultimate rejection²¹ of proposed changes in the pedophilia criteria set resulted in the default reversion to the DSM-IV-TR criteria.¹² Thus, the criteria for pedophilic disorder in DSM-5 are virtually identical to those in DSM-IV-TR and still include the misplaced and problematic "or" in Criterion A. This discrepancy in wording should not be construed as indicative of some fundamental difference between pedophilic disorder and the other paraphilic disorders in terms of the importance of establishing that the behavior is a manifestation of an atypical sexual arousal

APPENDIX 7

pattern. In fact, compared with other paraphilic disorders, child molestation is even more likely to occur for nonparaphilic reasons. For example, a study by Seto and Lalumière²² of more than 1,000 child molesters, conducted with phallometric testing as a validator, demonstrated that less than one-third had an underlying pedophilic arousal pattern.

Several other changes in the diagnostic criterion wording may also have forensic implications. Revisions of the definitions of the atypical focus for sexual sadism disorder, transvestic disorder, and fetishistic disorder may result in a more inclusive application of the diagnostic criteria. Criterion A in sexual sadistic disorder in DSM-5 does not include the DSM-IV-TR requirement that the sadistic acts be "real, not simulated" (Ref. 12, p 574), potentially broadening the definition by adding those who are only interested in simulated acts involving suffering. The DSM-IV-TR restriction for transvestic disorder that limited the diagnosis to heterosexual males has been removed, thus allowing the diagnosis to be made in females and homosexual males as well. The definition of fetishistic disorder has been expanded beyond a focus on nonliving objects to include a highly specific focus on nongenital body parts. This paraphilic focus previously was identified as partialism and was diagnosed in previous DSM editions under paraphilia NOS. The extent to which these changes will in fact cause more individuals to be included in these categories is unclear.

The wording of Criterion B, the harm component, for those paraphilic disorders that may involve nonconsenting participants has been changed in several ways. The criterion now clarifies that acting on paraphilic urges qualifies for the diagnosis only if the behavior involves a nonconsenting individual: for example, a diagnosis of frotteuristic disorder in which the individual's behavior involves rubbing against a person on a crowded subway car. Behavior that occurs with a consenting partner, such as sexually sadistic acts with a partner who has sexual masochism, is now explicitly excluded from the diagnosis.

The second half of the harm criterion has also been changed, replacing the DSM-IV-TR phrase "marked distress or interpersonal difficulties" (Ref. 12, p 568) with "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Ref. 1, p 689). This change effectively broadens the diagnoses in two ways. First, it expands on the types of functioning that can be impaired as a

result of the paraphilic urges or fantasies. The DSM-IV harm requirement was limited to the interpersonal realm, whereas DSM-5's includes both occupational functioning and "other important areas of functioning." Second, the DSM-IV requirement for "marked distress" has been replaced with the phrase "clinically significant distress." Depending on how one interprets the meaning of the terms "marked" and "clinically significant," this change could be construed as lowering the required level of distress needed to meet Criterion B.

A new Criterion C, which requires a minimum age of 18, has been added to the criteria set for voyeuristic disorder, restricting the diagnosis to adult individuals. According to DSM-5, because "adolescence and puberty generally increase sexual curiosity and activity," this criterion was added "to alleviate the risk of pathologizing normative sexual interest and behavior during pubertal adolescence" (Ref. 1, p 687). Therefore, intense and persistent voyeuristic urges, fantasies, or behaviors can be considered indicative of a paraphilic disorder only if they persist into adulthood. As noted by Federoff and colleagues,¹⁵ however, it is not clear why adolescent curiosity involving voyeuristic acts should be treated differently from similar adolescent curiosity and activity about other sexual behaviors that would still be diagnosable as paraphilic disorders in DSM-5, even if they occurred before age 18.

Changes in the Paraphilia Course Specifiers

DSM-5 includes two new course specifiers, "in full remission" and "in a controlled environment," that apply to every paraphilic disorder (again with the exception of pedophilia, for the reasons mentioned above). According to the rationale that was provided on the DSM-5 web site (the Rationale section for paraphilic disorders on the DSM-5 Development Web Site, accessed October 16, 2012, no longer accessible), whereas "there is no expert consensus about whether a longstanding paraphilia can disappear spontaneously or be removed by therapy . . . there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be ameliorated by therapy or reduced to acceptable levels." Thus, the in-full-remission specifier acts as an indicator of the persistent absence of distress, impairment, or harm to others (Criterion B) without regard to the possible contin-

ued presence of the paraphilic sexual arousal pattern (Criterion A). Moreover, "because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges" (the Rationale section for paraphilic disorders on the DSM-5 Development Web Site, accessed October 16, 2012, no longer accessible), the in-full-remission specifier applies only to individuals not living in a controlled environment. For those individuals living in settings where there are no opportunities to act on their paraphilic urges, the specifier, in a controlled environment, would apply.

Of particular interest from a forensic perspective was the decision to provide a specific duration threshold indicating the minimum amount of time (i.e., at least five years) during which the individual must not have acted on his paraphilic urges nor have experienced any clinically significant distress or impairment. Although research suggests that the longer an individual in the community has not acted on his urges, the lower his risk of acting on them in the future,²³ there is in fact no empirical evidence that the five-year point represents an inflection point in decreased risk of relapse. Nonetheless, because of the tendency in the legal system and elsewhere to reify the DSM criteria,²⁴ there is a strong likelihood that the five-year duration enshrined in the DSM-5 remission specifier will be used inappropriately to justify setting minimums for duration of commitment.

Diagnosing Paraphilic Disorders in Nonforthcoming Individuals

Perhaps the clearest indication that some of the changes in the paraphilic disorders section of DSM-5 were guided by forensic concerns is the various additions to the text addressing the challenge of applying the diagnostic criteria to individuals who are not forthcoming about the presence or impact of sexual pathology. Individuals, particularly in forensic settings, are motivated to deny or minimize deviant sexual urges or behaviors to avoid the negative forensic and social consequences of paraphilic disorder diagnoses. The DSM-IV-TR text was largely silent about the use of the paraphilic disorder diagnoses in forensic settings, noting only that "individuals who act out with a non-consenting partner in a way that may be injurious to the partner may be subject to arrest and incarceration" (Ref. 12, p 566).

In contrast, DSM-5 contains numerous additions to the descriptive text for paraphilic disorders intended to provide guidance to evaluators in forensic contexts. Specifically, the texts for the voyeuristic, exhibitionistic, frotteuristic, sexual sadism, and pedophilic disorders were written using the same template and include similar statements regarding their application to nondisclosing individuals. For example, the first sentence in the Diagnostic Features section for all of these disorders states: "The diagnostic criteria for [X] disorder are intended to apply both to individuals who more or less freely disclose this paraphilic interest and to those who categorically deny any sexual arousal from [X] despite substantial objective evidence to the contrary" (e.g., Ref. 1, p 687). Each Diagnostic Features section also includes a paragraph describing the various ways that nondisclosing individuals may present, followed by the comment that "despite their non-disclosing position, such individuals may be diagnosed with [a paraphilic disorder]" (e.g., Ref. 1, p 692). Each paragraph ends with the explicit statement that a history of recurrent paraphilic behavior is sufficient to meet criterion A: for example, "Recurrent frotteuristic behavior constitutes satisfactory support for frotteurism (by fulfilling Criterion A)" (Ref. 1, p 692). As discussed above, statements such as these that suggest that recurrent sexually offending behavior alone is sufficient to ascertain the presence of a paraphilia are in conflict with the evidence^(20,22) that a substantial proportion of sex offenses are not a manifestation of a paraphilic arousal pattern.

Moreover, such statements appear to run counter to the change in the Criterion A wording intended to clarify that the behaviors must be a manifestation of a paraphilic sexual arousal pattern. However, much depends on whether one interprets phrases such as frotteuristic behavior to mean implicitly that the modifier frotteuristic requires the behavior to be a manifestation of a frotteuristic arousal pattern or whether it is simply descriptive of the type of behavior (i.e., rubbing against an unsuspecting individual). It is too soon to tell to what extent this subtle difference in interpretation will be used in forensic evaluations to argue for or against the necessity of establishing that the behavior is a manifestation of a paraphilic arousal pattern.

Voyeuristic, exhibitionistic, frotteuristic, and sexual sadism disorders each include additional text indicating that the construct of "recurrent" behaviors

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can be interpreted as "having acted on the sexual urges with three or more victims on separate occasions" (Ref. 1, p 687) or with fewer victims if there are multiple occasions of acting on the paraphilic urges with the same unwilling individual. Victim count requirements were originally part of the proposed diagnostic criteria sets for these paraphilic disorders (as well as for pedophilic disorder), but were ultimately rejected from inclusion in the criteria sets²⁵ because of the lack of broad clinical consensus. Moreover, the proposal to include victim count requirements in the diagnostic criteria was derived entirely from a single study²⁶ that examined the diagnostic sensitivity of phallometric testing for pedophilia. Given that this study did not include any subjects with the four DSM-5 paraphilic disorders that actually include this victim count threshold in their descriptive texts, the validity of these thresholds should be considered questionable and raise concerns regarding both false-positive and false-negative diagnoses. Curiously, although the text for pedophilic disorder also notes that the "presence of multiple victims . . . is sufficient but not necessary for diagnosis" (Ref. 1, p 698), it avoids offering a specific victim count.

Use of Other Specified Paraphilic Disorder and Unspecified Paraphilic Disorder

DSM-5, as did its predecessor DSM-IV-TR, includes eight specific paraphilic disorders: voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic, and transvestic. These eight disorders were selected for inclusion in DSM-5 because they are relatively common, and some of them involve behaviors that "because of their noxiousness or potential for harm to others, are classed as criminal offenses" (Ref. 1, p 685). However, the range of stimuli that can form the basis of a persistent and intense sexual arousal pattern is potentially limitless, and some of these patterns can undoubtedly lead to negative consequences in some individuals. The question thus arises regarding the appropriate use of the residual other specified paraphilic disorder and unspecified paraphilic disorder categories for presentations that do not meet criteria for one of the eight specified paraphilic disorders.

The DSM-IV diagnosis paraphilia NOS has been replaced with two disorders in DSM-5, other specified paraphilic disorder and unspecified paraphilic

disorder, as the result of a system-wide standardized DSM-5 change to each residual DSM-IV not otherwise specified (NOS) category. Both other specified disorder and unspecified disorder categories are considered to be residual. They are intended to be used for presentations that do not meet the criteria for any specific DSM-5 disorder; for presentations of uncertain etiology with respect to whether the condition is substance induced, due to another medical condition, or primary; and for presentations where there is insufficient information to make a more specific diagnosis. In the case of the paraphilic disorders, these residual categories are intended to be used when there is an atypical sexual focus that is not covered by one of the eight specific types of paraphilic disorders and the atypical sexual focus causes clinically significant distress in social, occupational, or other important areas of functioning.

Whether a sexual arousal pattern should be considered atypical depends on the definition of the term paraphilia. In defining paraphilia, DSM-5 has reversed the trend (present since DSM-III), to sidestep attempts to define typical versus atypical sexual arousal patterns explicitly. The last edition of the DSM that defined abnormal sexuality, DSM-II, indicated that the sexual deviation category applied to "individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances, as in necrophilia, pedophilia, sexual sadism, and fetishism." (Ref. 11, p 44). DSM-III defined paraphilias rather vaguely as "unusual or bizarre imagery or acts necessary for sexual excitement" (Ref. 10, p 266). DSM-III-R²⁷ and DSM-IV offered no definition whatsoever, simply defining a paraphilia by concatenating the types of sexual arousal patterns that comprise the eight specific paraphilias.

In contrast, DSM-5 defines a paraphilia by exclusion by first defining normal foci of sexual arousal (i.e., "sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners") (Ref. 1, p 685) and then defining a paraphilia as being intense and persistent sexual interest in anything else. Although intended to be more precise than the DSM-IV-TR definition, the definition in DSM-5 has been criticized as providing even less clarity.²⁸ It has also been criticized as being overly broad^{28,29} (e.g., in-

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cluding viewing individuals who are aroused by non-penile and nonvaginal sex¹⁵ and those aroused by looking at pornography³⁰ as paraphilic).

The decision to use other specified paraphilic disorder versus unspecified paraphilic disorder depends on whether the clinician wants to specify explicitly the type of atypical paraphilic focus. If the other specified paraphilic disorder is used, the clinician is expected to add the name of the atypical paraphilic focus that is causing the clinically significant distress or impairment (e.g., other specific paraphilic disorder, coprophilia). The unspecified paraphilic disorder diagnosis is used in situations in which the clinician knows but chooses not to specify the atypical paraphilic focus or in situations in which there is insufficient information available to indicate the precise nature of the atypical paraphilic focus.

The other specified and unspecified paraphilic disorders diagnoses are provided (as are all of the residual other specified and unspecified categories in DSM-5), to ensure that a diagnostic code is available for any conceivable psychiatric presentation that a clinician might encounter. When used in forensic settings, however, these residual categories do not carry with them the same degree of utility as the specific named categories and thus have the potential to be misused. Indeed, the paraphilia disorder NOS category, with the nonofficial addenda of the terms nonconsent or hebephilia, has been used in SVP evaluations as the basis for claiming that individuals convicted of rape or of having sexual relations with underage individuals have a paraphilia and thus qualify for civil commitment under SVP statutes.^{31,32} DSM diagnoses are generally admissible in court because they are considered by the field of psychiatry to be widely recognized and clinically valid categories that can be reliably assessed. By virtue of their residual and often idiosyncratic nature, cases diagnosed as other specified paraphilic disorder or unspecified paraphilic disorder are, by definition, outside of what is generally accepted by the field and thus should be used in forensic contexts only with great caution. Moreover, unlike the specific DSM paraphilic disorders categories that have an accompanying psychiatric body of literature indicating a range of likely courses and treatment responses, the paucity of such information for these residual categories greatly limits their forensic utility.

The provision for allowing the clinician to include the name of the atypical sexual focus within the other

specified paraphilic disorder rubric may be misleading, especially to judges and juries who are not familiar with DSM-5 naming conventions. These residual specifiers may give the appearance that these categories are equivalent to the eight specific paraphilic disorders in terms of their acceptance by the field and their empirical backing and thus may appear to be equivalent in appropriateness for use in sexually violent predator commitment proceedings. However, the ability to incorporate the name of the atypical sexual focus within the other specified paraphilic disorder rubric was intended only to facilitate clinical communication of the reason for the use of the residual category and not to provide quasi-legitimacy for the use of these as yet not officially accepted categories for forensic purposes.

Unsuccessful Proposals to Include Additional Specific Paraphilic Disorders in DSM-5

During the DSM-5 revision process, some of the most controversial proposals were those that would have expanded the pool of individuals who would qualify for a diagnosis of a specific paraphilic disorder. These included proposals to add a new paraphilic disorder for individuals who are sexually aroused by sexual coercion (paraphilic coercive disorder) and the expansion of pedophilic disorder to include attraction to pubescent children (pedohebephilia). Concerns about these proposals revolved around their impact on the evaluation of sex offenders charged with rape (in the case of paraphilic coercive disorder) and sexual offenses against adolescents (in the case of pedohebephilia).

Proponents argued that there are individuals with these foci of sexual arousal and that there is research and forensic utility in including the diagnoses as specific paraphilias in DSM-5.³³⁻³⁷ Opponents raised concerns about validity and reliability (for example, the lack of data establishing reliability in differentiating nonparaphilic rapists from those driven by a rape paraphilia), and potential for misuse, especially with regard to use in sexually violent predator commitment evaluations.^{31,32,38-41}

Ultimately, proposals to include these as official categories in DSM-5, as categories in the research appendix of "Conditions For Further Study," or as examples of other specified paraphilic disorders, were rejected because of concerns about the strength of their empirical bases and their potential for false positives.

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The rejection of these proposed categories should cast doubt on the appropriateness of their use in forensic settings, especially for the purposes of qualifying individuals for sexually violent predator commitment. However, the new paraphilia definition, which includes sexual interest in nonphysically mature and nonconsenting individuals, seems to suggest that such sexual interests could be included under the rubric of other specified paraphilic disorder. Whether it will now be easier or more difficult to make a convincing argument that a sexual offender charged with rape should have a diagnosis of other paraphilic disorder, nonconsent, as the qualifying mental disorder and thus be considered for civil commitment remains to be seen.

Conclusion

Paraphilic disorders, by virtue of their forensic import, exemplify the difficulty of integrating psychiatric concepts and concerns with those of the legal system and society in general. Although all DSM-5 changes require consideration of potential false positives and false negatives, the impact of the paraphilia diagnoses on such determinations as eligibility for SVP commitment, parental custodial and visitation rights, length of incarceration, and the risk category for community notification laws highlights the importance of achieving the right balance.

Even though virtually every change in the paraphilic disorder categories and criteria potentially has significant forensic ramifications, it is too soon to tell what their actual forensic impact will be. Will these changes make it easier to assign psychiatric diagnoses to sexually violent predators and therefore to commit them involuntarily after prison terms? Will it make a difference in treating them and reintegrating them into the community? Will the newly formalized distinction between paraphilias and paraphilic disorders reduce the stigma for those with atypical sexual interests who do not cause harm? Their ultimate impact will depend on how the legal system incorporates these new definitions into statutes and case law.

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Commentary: Inventing Diagnosis for Civil Commitment of Rapists

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Abstract

In the past two decades, public fear and antipathy toward sexual offenders have led to public registries of their names and addresses, longer prison sentences, consideration of the death penalty, and civil commitment laws that allow potentially lifetime preventive detention after these offenders complete prison sentences. Twenty states and the federal government have enacted such civil commitment laws. Some forensic evaluators of rapists base findings supporting such commitment on the diagnosis of paraphilia not otherwise specified, using this miscellaneous category as a substitute for a proposed diagnosis that was rejected for inclusion in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1986. Despite the deliberate rejection of such a hypothesized rape paraphilia for DSM, and despite a continued lack of research supporting the validity or interrater reliability of such a diagnosis, it is widely used as a basis for confining rapists. This article discusses the history and ethics-related implications of this forensic practice.

In 1984, a Wisconsin court convicted [Brown] of first-degree sexual assault...and sentenced him to 20 years in prison. In 1998, as [Brown] was approaching his release date, the State petitioned to civilly commit him. A jury trial was held, and the State called Dr. Dennis Doren as an expert witness. Doren testified that [Brown] was a sexually violent person because he had Paraphilia-NOS-Nonconsent.... Doren acknowledged that the psychiatric community did not recognize...[this] disorder and that he had created it himself because he perceived a gap in the American Psychiatric Association's Diagnostic and Statistical Manual [Ref. 1, pp 1-2].

In the past two decades, the public has exhibited a fear of sexual offenders that is greater than the fear of other violent criminals or even terrorists,² despite the facts that sex crimes constitute a relatively small proportion of reported violent crimes in the United States,³ and rates of sex crimes have decreased dramatically during this period.^{3,4} This public fear and antipathy have resulted in unprecedented measures for social control of sexual offenders, including laws requiring public notification of their prison release⁵; public registries of their names and addresses⁵; residence restrictions⁵; increased punishments, including death penalty legislation⁶; and, starting in 1990, new civil commitment laws to detain them preventively.

These so-called Sexually Violent Person/Predator (SVP) commitment laws were intended for sexual offenders who had completed their terms of imprisonment. The state could then petition to have them civilly committed and confined in prison-like treatment facilities for an indeterminate time. To date, 20 states and the federal government have enacted SVP commitment laws. Opponents of such laws consider them to be unconstitutional preventive detention.⁷ Defenders of the laws argue that they are a reasonable exercise of the state's authority for civil commitment of persons with mental disorders that make them dangerous to others.⁸ Although the U.S. Supreme Court has upheld the constitutionality of these laws,⁹ controversies remain among all parties involved in these cases.

SVP Civil Commitment Cases and Forensic Diagnosis

<http://www.jaapl.org/content/36/4/459.pdf>

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2

Just as SVP commitment laws have generated considerable legal controversy, so have certain practices of forensic psychiatrists and psychologists who testify as experts in the trials of SVP commitment cases. The forensic assessments of sexual offenders facing commitment under SVP commitment laws are almost exclusively performed by psychologists. There are at least three possible reasons for the near absence of forensic psychiatrists from this arena. First, most of these cases have a fee-retainer potential that is less than most forensic psychiatrists can expect in other types of cases. Second, one of the primary tasks in these cases—sexual offender risk assessment—is an area of specialized expertise that has been pioneered both in research and practice primarily by psychologists. Finally, the American Psychiatric Association (APA) has taken a strong position in opposition to SVP commitment laws. In 1998, its Task Force Report on Sexually Dangerous Offenders declared:

[S]exual predator commitment laws represent a serious assault on the integrity of psychiatry, particularly with regard to defining mental illness and the clinical conditions for compulsory treatment. Moreover, by bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment... [P]sychiatry must vigorously oppose these statutes; to preserve the moral authority of the profession and to ensure continuing societal confidence in the medical model of civil commitment [Ref. 10, p 173].

In addition, the APA filed *amicus curiae* briefs arguing against the constitutionality of SVP commitment in the two cases in which the U.S. Supreme Court upheld such laws. One psychiatrist even resigned his position as chief psychiatrist of a state hospital rather than acquiesce to the civil commitment of a sexual offender.¹¹ Thus, it is not surprising that very few psychiatrists are involved in forensic evaluations of persons facing SVP commitment.

Given the imprimatur that the U.S. Supreme Court placed on SVP commitment laws,⁹ the debates about SVP commitment among forensic psychiatrists and forensic psychologists are about appropriate practice in performing forensic evaluations. Generally, these laws require the state to prove that the person facing commitment, referred to as the respondent, has a mental disorder that predisposes him to engage in sexual violence and that he is likely to do so. The U.S. Supreme Court's decision in *Kansas v. Crane*⁹ added the requirement that the respondent have a volitional impairment, which the Court defined as "serious difficulty in controlling behavior" (Ref. 9, p 413). Most of the forensic assessment controversy has revolved around the methodology of the risk assessment necessary to determine if the respondent is likely to commit future acts of sexual violence. The dispute in SVP commitment trials and in the published literature has concentrated most heavily on the appropriateness of the use of actuarial risk assessment instruments.⁷ By comparison, the subjects of mental disorder and volitional impairment have received short shrift. This article focuses on forensic assessment related to mental disorders and, specifically, on a particular diagnosis often relied on to make the determination that the respondent has a mental disorder that qualifies him for SVP commitment. This article will refer to psychiatrists and psychologists who perform forensic evaluations in SVP commitment cases as "forensic evaluators."

How Rapists Are Diagnosed in SVP Commitment Cases

Because civil commitment of sexual offenders is an exercise of the state's police power to prevent crime, it can only avoid being unconstitutional preventive detention if it is based on a judicial finding that the committed individual has a diagnosed mental disorder.⁹ In *Kansas v. Crane*, the U.S. Supreme Court referred to the need for such a diagnosis in its summary of the constitutional prerequisites for civil commitment of a sexual offender:

[T]here must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the *psychiatric diagnosis*, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case (emphasis added) [Ref. 9, p 413].

The most prevalent diagnosis among men subject to SVP commitment laws is pedophilia.¹²⁻¹⁴ These are men who have been convicted of crimes prohibiting sexual contact with children under the age of 14. The second most prevalent diagnosis among men subject to SVP commitment is paraphilia not otherwise specified (PNOS).¹²⁻¹⁴ This diagnosis is often applied to men convicted of sexual assaults of women (i.e., rapists).¹³ For example, a typical study showed that, in Washington state, this diagnosis applied to 42.6 percent of the men held pursuant to that state's SVP commitment law.¹⁴

The application of PNOS as a diagnosis of rapists was popularized by Dennis Doren, a state hospital psychologist from Wisconsin, whose 2002 book, *Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond*,¹⁵ has become the bible for many forensic evaluators in SVP commitment cases, especially those who testify primarily for the prosecution. Doren contends that the diagnosis of PNOS, along with his self-coined specifier, nonconsent, is appropriate "[i]f the offender has repetitively and knowingly enacted sexual contact with nonconsenting persons over a period of at least six months (specifically for sexual arousal to the nonconsensual interaction), and the behavior has caused him significant impairment in social, occupational, or other areas of functioning" (Ref. 15, p. 67). Doren sets forth a list of 13 polythetic diagnostic criteria (9 inclusionary and 4 exclusionary) for forensic evaluators to use in assessing whether the rapist's pattern of behavior has been specifically for sexual arousal to the nonconsensual interaction.¹⁵ Doren's unprecedented recommendation of the application of PNOS to diagnose rapists, and the apparent adoption of that recommendation by many forensic evaluators in SVP commitment cases,¹⁴ raise important questions of professional conduct. Before a discussion of these topics, a review of DSM history preceding this diagnostic practice is in order.

Are Nonsadistic Rapists Legitimately Diagnosable? History of the DSM Answer

Why is it necessary for Doren and forensic evaluators following his lead to rely on the miscellaneous category of PNOS to diagnose rapists? The only adult diagnosis in DSM-IV-TR that specifically refers to rape in its text description is sexual sadism, a paraphilia that requires that "the suffering (including humiliation) of the victim [be] sexually exciting to the person" (Ref. 16, p. 574). The prevalence of this diagnosis among rapists is quite rare, estimated at 5 to 10 percent.¹⁷ Even among men civilly committed as sexually violent predators, the prevalence of the diagnosis of sexual sadism is generally low, with one study finding it at six percent in 14 states, and not all of these offenders were rapists.¹³

No edition of the DSM has ever included a specific diagnosis for which the criteria included nonsadistic rape. Nor does the current *International Classification of Diseases* (ICD-10) include such a diagnosis.¹⁸ However, two researchers have posited the existence of a psychopathology involving rape behavior. Money,¹⁹ who asserted the existence of 136 paraphilias (including fellatio and transgenderism), applied the terms "biastophilic rapism or raptophilia" to rapists whose sexual arousal requires that victims, "typically a stranger, should be unsuspecting of what is about to happen, and should be maximally terror-stricken and resistant."²⁰ However, this definition describes rapists who are already diagnosable with sexual sadism, according to the DSM-IV-TR classification.¹⁶ Abel and colleagues acknowledged that DSM does not include a paraphilia for nonsadistic rapists, but argued that it should do so "because many individuals report having recurrent, repetitive, and compulsive urges and fantasies to commit rapes" (Ref. 21, p. 18). However, they conceded, "The scientific evidence must be balanced with society's acceptance of such a categorization" (Ref. 21, p. 19).

From 1983 to 1986, attempts were made to insert a proposed diagnosis called paraphilic coercive disorder (PCD) into DSM-III-R,²² with the following diagnostic criteria:

- Over a period of at least six months, preoccupation with recurrent and intense sexual urges and sexually arousing fantasies involving the act of forcing sexual contact (for example, oral, vaginal, or anal penetration; grabbing a woman's breast) on a nonconsenting person.
- It is the coercive nature of the sexual act that is sexually exciting, and not signs of psychological or physical suffering of the victim (as in sexual sadism).

The individual repeatedly acts on these urges or is markedly distressed by them. (Ref. 23, p 2).

The proposed diagnosis of PCD was made along with proposals for two other diagnoses: masochistic personality disorder and premenstrual dysphoric disorder.²⁴ The three proposed diagnoses generated what the *New York Times* reported as "vigorous opposition" (Ref. 25, p C1). The American Psychological Association, the American Orthopsychiatric Association, the National Association of Social Workers, and the National Organization for Women mounted strong opposition to the proposed diagnoses.²⁴ Even the U.S. Department of Justice, which rarely takes public policy positions on matters related to mental health, argued that the proposed diagnosis of PCD would be used by criminal defendants to avoid legal responsibility in criminal prosecutions for rape.²⁴ After opposition to the three proposed diagnoses was expressed at a meeting of the Work Group to Revise DSM-III, the group's chairman, Robert Spitzer, admitted, "We didn't anticipate the strong objections of many, both in psychiatry and psychology, to this proposal. The discussion was very heated" (Ref. 25, p C1).

The opposition to the proposal for PCD should have been expected given that, by the mid 1980s, it was widely accepted that rape is a violent assault motivated by the rapist's desire for power and dominance rather than by sexual arousal, a concept advanced in popular culture by Susan Brownmiller's 1975 best-selling book, *Against Our Will: Men, Women, and Rape*,²⁶ and in the research literature by a body of empirical studies of the time. For example, a 1977 study that ranked the rapist's motivation in accounts from 132 rapists and 92 victims found, "[T]he offenses could be categorized as power rape... or anger rape... There were no rapes in which sex was the dominant issue; sexuality was always in the service of other, nonsexual needs" (Ref. 27, p 1239). Similarly, in 1984 a study that examined social and demographic variables in a sample of 985 incarcerated males to compare rapists to child molesters, nonsexual violent offenders, and property offenders found that, "in general, rapists were most often similar to both serious property and violent offenders. Rapists differed most often from other sex offenders" (Ref. 28, p 157). The proposal for PCD also contradicted the then-recent reform of the criminal law, which reconceptualized rape from being the result of the rapist's uncontrolled sexual desire to being a crime of intentional assault.²⁹ This reform included new evidentiary rules that prevented the victim's dress and demeanor from being portrayed as provocative or insufficiently resistive.²⁹

Within professional psychiatry, there was considerable opposition to the proposed diagnoses. Psychiatrist Judith Herman said of the proposed diagnosis of PCD, "The diagnosis is not sufficiently based on behavioral criteria. ...[T]he diagnosis of paraphilic coercive disorder does not belong in DSM-III" (Ref. 30, p 25). The then President of the American Academy of Psychiatry and the Law wrote, "Indeed it is the consensus that such categories may well be embarrassing to psychiatry as a whole" (Ref. 31, p 1). At a meeting of the two APA committees primarily responsible for revising DSM-III, forensic psychiatrist Loren Rorh expressed reservations about PCD, which "included concerns about its reliability, the lack of information about its prevalence and epidemiology among rapists, problems with differential diagnosis...and possible forensic implications" (Ref. 32, p 1). The APA received hundreds of letters and petitions containing thousands of signatures from mental health professionals and others who objected to the validity of the proposed diagnoses. The controversy over the proposed diagnoses was covered by news media internationally.³³

Even one of the initial proponents of the proposed diagnosis of PCD eventually expressed doubts about its validity and acceptability. Days before the APA Board vote on the proposed diagnosis, forensic psychiatrist Park Dietz noted that, since research showed that both rapists and nonoffenders are aroused by images of sexual coercion, the evidence was "insufficient to draw strong conclusions from these two types of data alone as to the strength of the presumed relationship between the arousal pattern...[of rapists] and the commission of sexual assaults" (Ref. 34, p 1). He added, "The proposed diagnosis is not generally accepted in the psychiatric community. ... I should add that most forensic psychiatrists oppose the diagnosis..." (Ref. 34, pp 1-2).

Based on the strong opposition and the concerns raised as to the validity of the proposed diagnosis of PCD, the APA Board of Trustees rejected it by a vote of 10 to 4 on June 28, 1986.^{24,35} The minutes of this board meeting refer to PCD and the other simultaneously considered diagnoses as having been "extensively

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discussed" with a focus on "the scientific foundation for the three categories proposed for inclusion in DSM-III-R" (Ref. 35, p 34). The minutes also state, "it was suggested by a number of members that further research was needed to validate the status of these categories as diagnostic classifications" (Ref. 35, p 34). Describing the board's decision, a member of both committees that had originally recommended the diagnosis, explained that it "was found wanting credibility and lacking acceptance among psychiatrists..." (Ref. 36, p 1). The newspaper of the American Medical Association explained that the APA Board rejected the proposed diagnosis "because of the preliminary nature of the data and the difficulty physicians have in differentiating PCD from other disorders" (Ref. 37, p 41).

The history and text of DSM following the APA's rejection of PCD does not suggest any intent that the diagnostic concept that it embodied be used even within the PNOS miscellaneous category, as the following evidence demonstrates. First, after rejecting PCD, the APA Board approved DSM-III-R, which defines PNOS as describing paraphilias "that are less commonly encountered" (Ref. 22, p 280)—a definition that essentially remains in DSM-IV-TR as "less frequently encountered" (Ref. 16, p 567). It is unlikely that the rape behavior postulated by the proponents of PCD would be "less commonly encountered" than the more extreme behavior diagnosed as sexual sadism.^{13,17}

Second, whereas the APA Board rejected PCD outright, it placed the two other, simultaneously proposed (and equally controversial) diagnoses in the DSM-III-R²² appendix,³⁵ thereby allowing their application under an NOS category.¹⁶ Had the APA Board intended that PCD also be diagnosed via PNOS, it would have placed PCD wording in the PNOS category or, at least, in the DSM appendix. In fact, documentary evidence that is contemporaneous with the APA's rejection of PCD confirms the intent of the APA Board not to include the failed diagnosis in the PNOS category. After the board's rejection of PCD, Fred Berlin, one of the original proponents of PCD, criticized the board-approved draft of DSM-III-R as "a conscious effort to leave out the fact that some men rape as a consequence of being turned on by the coercive rather than the sadistic elements of rape" (Ref. 38, p 4). Referring again to the board's conscious effort not to include the PCD concept in the PNOS category, he added, "Again...it troubles me a great deal that no mention of those individuals who are preoccupied with thoughts and urges that center around issues of coercion are not at least mentioned" (Ref. 38, p 5).

Third, following the controversy over PCD, the APA never reconsidered it,³⁹ but, starting in DSM-IV⁴⁰ and continuing in DSM-IV-TR,¹⁶ new V-codes were inserted to cover perpetrators of sexual coercion and rape. V-codes, as defined in DSM-IV and DSM-IV-TR, are assigned when the person has a problem that is not by itself considered to be a mental disorder, but that may nevertheless be what DSM-IV-TR refers to as "a focus of clinical attention" (Ref. 16, p 731). One such classification is sexual abuse of an adult, which is coded either as V61.12, if the focus of clinical attention is on a perpetrator who has abused a partner, or V62.83, if the perpetrator has abused a nonpartner.¹⁶ The perpetrators of sexual abuse to which this V-code applies are those who engage in "sexual coercion, rape" (Ref. 16, p 738), the very persons to whom Doren would apply PNOS. The fact that DSM-IV-TR includes this rape-related designation in the V-codes is further evidence that the drafters of DSM-IV-TR meant to exclude nonsadistic rapists, not only from the paraphilias category, but, also, from the entire classification of mental disorders.

In the 16 years following the major controversy and ultimate rejection of the proposed diagnosis of PCD, there remained a broad consensus in clinical and forensic subspecialties of psychiatry and psychology that nonsadistic rapists are not appropriately diagnosable. However, Doren challenged that consensus with his 2002 book, recommending the diagnosis of PNOS-nonconsent for rapists who act "specifically for sexual arousal to the nonconsensual interaction" (Ref. 15, p 67), a definition essentially identical to the rejected diagnosis of PCD. A 2005 article that reviewed the extent to which Doren's recommendation had been accepted by published experts in the assessment and treatment of paraphilias concluded:

In summary, the weight of opinion among experts in the treatment of paraphilias is that the omission of non-sadistic rape from the paraphilias category in the DSM was, and continues to be, a deliberate decision of the American Psychiatric Association. None of these experts has published a statement supporting the use of the diagnosis of paraphilia-

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NOS for rapists. Thus, Doren (2002) appears to stand alone among published experts in defending this use of the diagnosis [Ref. 12, p 45].

However, more recently, three published discussions of the diagnosis of PNOS have also applied it to rapists to various degrees. The proposed diagnostic criteria of DeClue⁴¹ encompass anyone who has had "over a period of at least six months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a nonconsenting person, and...the person has acted on these urges, or the sexual urges or fantasies cause distress or interpersonal difficulty" (Ref. 41, p 512). Because DeClue allows that the behavioral requirement of this proposed diagnosis be satisfied simply by repeated nonconsensual sexual behavior, any rapist who reoffended over at least six months would qualify. Thus, DeClue's use of PNOS is broader than Doren's, since Doren requires that the rapist act "specifically for sexual arousal to the nonconsensual interaction" (Ref. 15, p 67).

Frances *et al.*,⁴² assert that "PNOS, nonconsenting partners, is an inherently weak construct, given the lack of a set of defined criteria" (Ref. 42, p 381). These authors do not acknowledge Doren's 13 polythetic diagnostic criteria for assessing whether the rapist's pattern of behavior has been "specifically for sexual arousal to the nonconsensual interaction" (Ref. 15, pp 67-77), but they do suggest, "[S]uch diagnosis would require considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to arousal" (Ref. 42, p 380). They add, "One acceptable standard for using it may be to demonstrate clear substantiation of urges and fantasies, either inferred by the acts perpetrated on the victim, or by the interview information..." (Ref. 42, p 380).

Similarly, First and Halon state, "There are certainly some dangerous sexual offenders in our society whose sexual offenses are clearly driven by a paraphilic sexual arousal pattern involving fantasies and urges to commit rape, and it may be appropriate to apply a diagnosis of paraphilia NOS to such individuals" (Ref. 43, p 452). They urge that this diagnosis be applied to rapists "with extreme caution" and only based on evidence "to establish the presence of a deviant sexual arousal pattern in which the offender is aroused specifically by the nonconsensual nature of the sexual act" (Ref. 43, p 452). Like Doren and Frances *et al.*, First and Halon offer suggested diagnostic criteria from which diagnosticians may infer whether the rapist was aroused by the nonconsensuality of the rape and allow an inference of paraphilic arousal to be made from "the pattern of rape behavior" (Ref. 43, p 452). And, like Doren and Frances *et al.*, First and Halon offer no empirical evidence to support their assertions that men rape because they are "aroused specifically by the nonconsensual nature of the sexual act" (Ref. 43, p 452).

In light of the clear DSM history of deliberate rejection of a proposed paraphilia for rapists whose rape behavior is motivated by sexual arousal to the nonconsensuality of the rape (PCD), the prevalent use of PNOS as a proxy for that rejected diagnosis and the advocacy of such use by Doren, DeClue, Frances *et al.*, and First and Halon raise important concerns regarding professional conduct in forensic psychology and forensic psychiatry. The balance of this article will analyze these concerns.

Are DSM's NOS Categories Intended for Forensic Assessment?

According to DSM-IV-TR, a diagnosis may be based on an NOS category when the clinical presentation "conforms to the general guidelines for a mental disorder in the diagnostic class, but the symptomatic picture does not meet the criteria for any of the specific disorders" (Ref. 16, p 4). The NOS category is also available when the clinical presentation "conforms to a symptom pattern that has not been included in the DSM-IV classification but that causes clinically significant distress or impairment" (Ref. 16, p 4). Obviously, these provisions give the diagnostician virtual *carte blanche* to omit DSM-required criteria for specific diagnoses when the general criteria for the diagnostic class are met or simply to invent new diagnoses based on the subjective determination that "the symptom pattern...causes clinically significant distress or impairment" (Ref. 16, p 4). No wonder the NOS category is often referred to as a "wastebasket diagnosis" (Ref. 44, p 310).

While such license may have its place in clinical settings where the major consequence of its use is the ability of the clinician to bill third-party payers, in

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the forensic context, the unbridled use of NOS categories may have critical consequences for case outcome. In the SVP commitment context, the ability of a forensic evaluator to assign a paraphilia diagnosis to a rapist-respondent may literally determine whether the respondent is civilly committed. For example, in one study of a sample of 450 men evaluated for SVP commitment in Florida, a diagnosis of PNOS raised the odds of commitment by an astounding 10,580 percent,⁴⁵ an outcome that may be explained by the fact that a forensic evaluator need only resort to a miscellaneous diagnosis when some diagnosis is needed to justify a recommendation of civil commitment. However, the DSM allowance of an NOS diagnosis in clinical settings does not mean that standards of professional conduct allow such use for forensic assessments in which the stakes are typically much higher.

The text of DSM-IV-TR itself suggests that appropriate use of the manual for forensic assessments relies on specified diagnoses, not the *ad hoc* invention and application of a diagnosis by a forensic evaluator employing an NOS category. In this regard, DSM-IV-TR states:

The use of DSM-IV in forensic settings should be informed by an awareness of the risks and limitations... When used appropriately, diagnoses...can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), *the use of an established system of diagnosis enhances the value and reliability of the determination.* By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time (emphasis added) [Ref. 16, p xxxiii].

Thus, DSM-IV-TR emphasizes that appropriate use of the manual in forensic settings relies on "an established system of diagnosis," which it then describes as being "based on a review of the pertinent clinical and research literature" and a description of the disorder's "longitudinal course" (Ref. 16, p xxxiii). Clearly, this delineation of the appropriate use of DSM in forensic contexts limits such use to DSM's specified diagnoses, which provide text detailing "clinical and research literature" and "longitudinal course," not to NOS diagnoses, which neither include such text nor are part of the "established system of diagnosis," but are, instead, *ad hoc* inventions of individual diagnosticians. Whereas the DSM basis in research, field testing, and professional consensus makes for the "established system" of specified diagnoses, the reliance on NOS categories by forensic evaluators amounts to the "ungrounded speculation about mental disorders" (Ref. 16, p xxxiii) in the forensic context that DSM warns against.

Ethical and Legal Constraints on the Use of NOS Diagnoses in Forensic Assessment

In most jurisdictions, an expert opinion from a forensic psychiatrist or forensic psychologist is admissible in court only if she or he testifies that the opinion is made "with reasonable medical certainty" or "with reasonable psychological/scientific certainty," respectively.⁴⁶ *Black's Law Dictionary* defines this standard as one "based on the general consensus of recognized medical thought" (Ref. 47, p 1273). Similarly, most states require that expert testimony be grounded in "scientific validity...and reliability" (Ref. 48, pp 594-595) or "general acceptance in the particular field to which it belongs" (Ref. 49, p 1014). NOS diagnoses are the antithesis of "reasonable certainty," because they are *ad hoc* applications based on the idiosyncratic opinion of an individual diagnostician, not the consensus of recognized thought that would be reflected in a specified diagnosis. In fact, DSM-IV-TR defines NOS diagnoses as one of the "ways in which a clinician may indicate diagnostic uncertainty" (Ref. 16, pp 4-5). Thus, it is difficult to imagine how a forensic evaluator could testify "with reasonable certainty" that a diagnosis of PNOS, used as an equivalent for PCO, is scientifically valid, reliable, and accepted in the field, when, in fact, it is based on a construct that was deliberately rejected as unsupported by research and the behavioral sciences when it was considered for inclusion in the manual of diagnosis that is based on professional consensus.

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Forensic psychologists using the diagnosis of PNOS as a proxy for the rejected diagnosis of PCD may be violating at least two standards of the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct."⁵⁰ Sec. 9.01(a) of that Code, entitled "Bases for Assessments" states, "Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings" (Ref. 50, p. 13). That standard then cross-references Section 2.04, entitled "Bases for Scientific and Professional Judgments," which requires that "[p]sychologists' work [be] based upon established scientific and professional knowledge of the discipline" (Ref. 50, p. 5). These cross-referenced standards are contrary to the practice of using the diagnosis of PNOS as a substitute for PCD, because the practice would be a "diagnostic or evaluative statement" unsupported by "established scientific and professional knowledge of the discipline" (Ref. 50, p. 13). This lack of support from the discipline is evidenced not only by the APA's deliberate, informed rejection of the proposed diagnosis of PCD, but also by the fact that the rejection was based on a determination of a lack of both scientific validity and professional consensus to support the proposed diagnosis.

Similarly, the American Psychology-Law Society's "Specialty Guidelines for Forensic Psychologists" require forensic psychologists to use knowledge consistent with accepted clinical and scientific standards in selecting data collection methods and procedures for an evaluation" (Ref. 51, p. 661). Their statements and testimony must be "communicated in ways that will promote understanding and avoid deception," and, when testifying, they must present findings "in a fair manner" that precludes "distortion or misrepresentation" (Ref. 51, pp. 663-664). A proposed update of these guidelines would also admonish forensic psychologists to be "sensitive to the problems posed by using a clinical diagnosis in forensic contexts and consider and qualify their opinions and testimony appropriately" (Ref. 52, p. 14). These ethics mandates are inconsistent with the forensic practice of using the miscellaneous PNOS category as a proxy for an equivalent diagnosis that was deliberately rejected for inclusion in DSM. A psychologist engaging in this practice despite these mandates would exacerbate the ethics breach by failing to disclose to all parties that the NOS diagnosis is being used despite DSM history and text to the contrary and an absence of professional consensus or research supporting the validity or interrater reliability of the diagnosis.

Psychologists who violate the foregoing ethics may be simultaneously violating comparable legal provisions that regulate their licensure. For example, two states that have SVP commitment laws, Wisconsin and Florida, prohibit licensed psychologists from "[r]eporting distorted, erroneous, or misleading psychological information" (Ref. 53, p. 11) or "[m]aking misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter."⁵⁴ respectively. Licensing laws in most states also reference the American Psychological Association's Code of Ethics in their statutes and/or administrative code, making violation of standards of ethics a potential basis for discipline by the licensing board. Finally, misdiagnosis of prisoners by psychologists may constitute negligence under state law⁵⁵ or, in certain circumstances, a civil rights violation under federal law.⁵⁶

Forensic psychiatrists are guided by the *Ethics Guidelines for the Practice of Forensic Psychiatry*,⁵⁷ which admonish them to "adhere to the principle of honesty and...strive for objectivity" (Ref. 57, p. 3). Appelbaum has referred to this ethics principle as "truth-telling" (Ref. 58, p. 2). In application, this principle means "Testimony...should accurately reflect the scientific data on the subject at hand and the consensus of the field. When the testifying expert goes beyond the data or controverts generally accepted professional understandings, that deviation should be made clear" (Ref. 58, p. 2). Given that the proposed diagnosis of PCD was considered, debated, and rejected by the APA, a proxy PNOS diagnosis does not "reflect the consensus of the field." Forensic evaluators who choose to do so anyway should at least disclose that their use of the miscellaneous diagnosis is contrary to the history and text of DSM, and that it is unsupported by research to establish its validity. This lack of research grounding for a purported rape paraphilia was recognized by the APA Board of Trustees when, in 1998, it approved publication of a report that stated:

Whether or not any rapist has a paraphilia represents a controversial issue in the research literature. DSM-IV has not classified paraphilic rapism as a mental disorder. Some researchers believe that a small group

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of rapists have diagnostic features similar to those with other paraphilias. The ability to make the diagnosis with a sufficient degree of validity and reliability remains problematic. In addition, other research has shown that many rapes are not the product of primary sexual interests, but rather represent an exercise in power and control [Ref. 10, pp 169-170].

Research Support for Validity or Reliability of a Rape Paraphilia Diagnosis Is Still Lacking

Twenty-two years after the APA's rejection of PCD and a decade after its reconfirmation of the lack of empirical support for a rape-related paraphilia, there still is little research to support such a diagnosis and much to call it into question. Given the infinite range of human sexual response, there may indeed be some men who rape, to use Doren's phrase, "specifically for sexual arousal to the nonconsensual interaction" (Ref. 15, p 67). However, "numerous questions remain to be answered before such behavior may be considered a valid diagnostic taxon. Doren attempts to justify his claim as to the legitimacy of PNOS to diagnose rapists by simply asserting, "Finding some cases throughout the physiological assessment literature strongly supports the existence of this paraphilic condition" (Ref. 15, p 65). The fact that "some cases" may be found of incarcerated rapists who show sexual arousal to video or audio depictions of rape scenes does not mean that such arousal is pathologic or distinguishable from the arousal that nonrapists may exhibit under the same circumstances. Nor does it mean that men showing such arousal to artificial stimuli will experience or act on such arousal in the community. In fact, as Park Dietz suggested to the APA Board in 1986,¹⁴ the assumed positive correlation between such arousal and rape behavior may be illusory.

Doren also attempts to justify his use of PNOS to describe a hypothesized rape paraphilia by citing the description of this hypothesis in the research literature.⁵⁹ The mere description or assertion of the existence of a rape paraphilia by researchers no more makes it a valid diagnostic taxon than did the invention of a mental disorder called drapetomania, the pre-Civil War diagnosis applied to African-American slaves seeking freedom.⁶⁰ The question of whether acting on sexual arousal to nonconsensual sexual interactions is pathological (and not just antisocial and morally reprehensible) is, ultimately, more of a value judgment than a scientific one. Is it logical to label rape behavior that is hypothetically driven by the rapist's sexual arousal as pathological when that label is not applied to armed robbery driven by a heroin addict's craving? If a mental disorder diagnosis can be applied to any criminal act that satisfies the criminal's cravings, then much of the criminal code could be engrafted into the DSM. Thus, it should not be surprising that leading rape researchers have not concluded that rape behavior is either pathological or caused by mental disorder.⁶¹ In fact, current research continues to support the research of the 1980s, when PCD was rejected by the APA Board, that, psychologically, rape is sexualized violence in which the perpetrator desires to dominate or control the injured party rather than to experience ultimate erotic fulfillment.⁶²

The legitimacy of a diagnostic classification must also depend on its discriminative validity (i.e., its ability to discriminate disorder from nondisorder).⁶³ A PCD-equivalent PNOS diagnosis raises the question of whether it is even possible to measure accurately a rapist's arousal to nonconsensuality. Putting aside the debate about the validity of penile plethysmography (PPG) for this purpose,⁶⁴ even Doren admits, "In general, PPG physiological findings for rapists are not consistent for all groups of such offenders and under all conditions" (Ref. 15, p 64). A 2005 review of the entire body of PPG research comparing rapists to nonrapists concluded:

Rapists are characterized by high mating effort and antisociality. Are individual differences in propensity to rape also related to a paraphilic (or other) sexual disorder? There is strong phallometric evidence that many rapists are sexually different from men who do not commit rape. *The meaning of the difference is yet unclear* (emphasis added) [Ref. 61, p 127].

This review, by leading researchers on rape, showed that, in PPG studies, while rapists generally showed more arousal in response to rape stories than nonrapists, this difference was often explained as a function of the stories depicting particularly brutal and violent scenes more suggestive of the

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diagnosis of sexual sadism than a PCD type of arousal. When rapists were compared with nonrapists using stimuli that were coercive but not sadistic, and therefore more consistent with a PCD-supportive hypothesis, the differences were often nonexistent.^{65,66} In any event, since PPG testing is rarely part of forensic evaluations for SVP commitment cases,⁶⁷ the discriminability of purported PCD-type rapists from other rapists or even nonrapists using PPG is largely academic.

While the PPG evidence supporting a PCD rape theory is as inconclusive today as it was in 1986 when Park Dietz brought that inconclusiveness to the attention of the APA Board, the evidence of diagnostic reliability of the diagnosis of PNOS is even worse. Levenson⁶⁸ analyzed the cases of 295 sex offenders who were assessed by two independent forensic evaluators to determine whether the men should be referred for SVP commitment. She found that the diagnosis of PNOS had an interrater reliability κ coefficient of only .36, which is regarded as poor reliability.⁶⁹ When reanalyzing the data two years later, Packard and Levenson⁷⁰ used statistical methods more likely to find higher rates of reliability, but the proportions of agreement for PNOS were still only .68. In an analysis of the Levenson and Packard study, Wollert⁷¹ found that their reliability data were inflated. Wollert's own empirical study of interrater reliability with the Doren version of PNOS-nonconsent yielded evidence of very poor reliability.⁷¹

Conclusion

Thus, the APA's decision to reject the proposed diagnosis of PCD is as justified today by the paucity of evidence as to the validity and reliability of such a diagnosis as it was in 1986. Yet that decision is minimized by Doren,¹² Frances *et al.*,⁴² and First and Halon.⁴³ For example, Frances *et al.*, erroneously claim, "The discussion about paraphilic coercive disorder was not widely promulgated to the general clinical community" (Ref. 42, p 380), an assertion contradicted by extensive APA records and news media accounts,^{25,30-33,35-37} by the hundreds of letters to the APA in opposition to PCD,³³ and the year-long furor within the APA that was rivaled only by the 1973 debate and rejection of another DSM paraphilia: homosexuality.⁷² If the APA's explicit 1986 rejection of PCD may be overridden by a forensic evaluator's *ad hoc* application of an equivalent diagnosis couched as PNOS, could homosexuality again be diagnosed, now by using PNOS, despite the APA's 1973 rejection of homosexuality as a valid diagnosis? Since the scope of PNOS is limited only by the imagination of the diagnostician and his or her willingness to assert that the diagnosed condition causes "clinically significant distress or impairment" (Ref. 16, p 4), such an abuse is not inconceivable, especially given the prevalence of so-called reparative/conversion therapies⁷³ to attempt alteration of homosexual orientation. This illustrates why heeding the history and intent behind DSM is so important to ensure the legitimacy of diagnosis and the professional integrity of those who apply it.

Diagnosis should never be a pretext for social control,⁷⁴ be it to enforce sexual morality or preventive detention. Imagine the bewilderment of a man who has been civilly committed to a prison-like facility, potentially for the rest of his life, based on a diagnosis that the court described as one not recognized by psychiatry but advanced by a psychologist who "perceived a gap in the American Psychiatric Association's Diagnostic and Statistical Manual" (Ref. 1, p 2). Standards of professional conduct demand that forensic evaluators resist rogue, politically-driven diagnosis. Forensic evaluators must report and testify about diagnosis with reasonable certainty, not invented pretextuality.

American Academy of Psychiatry and the Law

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Paraphilia NOS, Nonconsent: Not Ready for the Courtroom

Allen Frances, MD, and Michael B. First, MD

Sexually violent predators (SVP) constitute a serious potential risk to public safety, especially when they are released after too short a prison sentence. Twenty states and the federal government have developed a seemingly convenient way to reduce this risk. They have passed statutes that allow for the involuntary (often lifetime) psychiatric commitment of mentally disordered sexual offenders after prison time is up. In three separate cases, the Supreme Court has accepted the constitutionality of this procedure, but only if the offender's dangerousness is caused by a mental disorder and is not a manifestation of simple criminality. The idea that paraphilic rape should be an official category in the psychiatric diagnostic manual has been explicitly rejected by Diagnostic and Statistical Manual of Mental Disorders (DSM)-III, DSM-III-R, DSM-IV, and, recently, DSM-5. Despite this, paraphilia NOS, nonconsent, is still frequently used by mental health evaluators in SVP cases to provide a mental disorder diagnosis that legitimizes psychiatric commitment and makes it appear constitutional. This commentary will show how the diagnosis paraphilia NOS, nonconsent, is based on a fundamental misreading of the original intent of the DSM-IV Paraphilia Workgroup and represents a misuse of psychiatry, all in the admittedly good cause of protecting public safety. (Pore)

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The legal system unwittingly created a dilemma for itself 30 years ago when it adopted fixed sentencing as a civil rights reform. Replacing indeterminate sentencing was a well-intended effort to provide consistency and to reduce possibly biased judicial discretion. As often happens, the solution to correct one serious problem caused another. Fixed sentencing had the unfortunate, unintended consequence of greatly reducing prison time for the most dangerous sexual offenders. The fixed sentence for rape was set at about seven years (determined by averaging the previously widely varying indeterminate sentences, ~~so as not to affect the number of needed prison beds~~).

The worst offenders (who would have been incarcerated much longer if judges had had their usual discretion) got a big break and were on the loose in the prime of life. There was understandable public out-

rage when recently released offenders reoffended, sometimes in the most horrible ways imaginable.

Twenty states and the federal government attempted to fill the public safety breach by passing statutes allowing for the continued incarceration of a particularly dangerous offender, but only if he could be demonstrated to have a mental disorder that was responsible for predisposing him to be at continuing risk for recidivism. Any incarceration beyond the allotted prison sentence could not be justified constitutionally under criminal auspices, because it would be a double-jeopardy infringement of civil liberties and preventive detention. Instead, the commitment had to be civil and psychiatric and was justified by the long (but not really very pertinent) precedent of involuntary psychiatric commitment for the acutely dangerous mentally ill.

The constitutionality of the SVP statutes has been frequently challenged at the state level and at the Supreme Court.^{1,2} The most pertinent Supreme Court case (*Kansas v. Hendricks*¹) led to a five-to-four narrow and hedged acceptance of the statutes. Justice Kennedy, in his separate concurring opinion, made clear that his swing vote was predicated on the presence of mental disorder as a condition of commitment. Being dangerous is not enough, since released criminals are also potentially dangerous. There is no

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constitutional justification for civil psychiatric commitment unless a mental disorder is present. The statutes cannot be used to detain common criminals who remain dangerous.

The trick is how to define mental disorder so that it separates those eligible for psychiatric commitment from the common run of criminals who must be released for constitutional reasons when their time is up, regardless of the risk they continue to pose. The rub is that there is no good, conceptually clear, and operational definition of mental disorder, either in psychiatry or in the law. The Supreme Court made clear that the legal system need not be limited to medical or psychiatric definitions, but then completely dodged the crucial question of how mental disorder should be defined and diagnosed in legal proceedings. Presumably, the definition would be left to the states to decide, but that it does not help very much. The state statutes all use almost exactly the same words to define mental disorder and do it in language that is impossibly vague and provides no real guidance. Nor can we look to the medical community for much help in providing a bright line. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision, Text Revision (DSM-IV-TR),³ introduction states that "it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'." It "lacks a consistent operational definition that covers all situations" [Ref. 3, p xxx].

In summary, the legal system is using questionably constitutional civil commitment statutes as a bailout to solve the problem created by fixed sentencing (and the resulting short prison terms for the most dangerous sex offenders). The legitimacy of the statutes depends completely on the offender's having a mental abnormality, but the states' definition of what is meant by "mental abnormality" is, as just stated, impossibly vague. The Supreme Court has refused to take advantage of its several opportunities to produce a clear legal definition. Lacking an operational legal definition of mental abnormality, the default position for mental health SVP evaluators and for the courts is to rely on the DSM-IV-TR. In practice, the statutes are triggered only if it can be determined that the offender qualifies for a DSM-IV-TR diagnosis.

Which brings us to the purpose of this commentary: to explain why the widespread use of paraphilia NOS, nonconsent, as a qualifying diagnosis in mental health proceedings is inappropriate and based on

a misunderstanding of the wording and intent of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).⁴

The Origins of Paraphilia NOS, Nonconsent, as Grounds for Civil Commitment

As Chair and Editor of the Text and Criteria in DSM-IV, we are ultimately responsible for much of the confusion. The wording of the DSM-IV Paraphilia section was written long before the issue of SVP commitment arose and was written with clinicians, not forensic proceedings, in mind. We were not aware of the consequential problems that would later arise from the fact that the section lacked the clarity and precision necessary for legal purposes. The inartful wordings allowed many evaluators in SVP determinations to misread seriously what DSM-IV was actually trying to convey.⁵ The DSM-IV Paraphilia Workgroup had definitively rejected the claim that rape should be considered a mental disorder, but a misreading of the poorly worded paraphilia section allowed evaluators to form just the opposite impression: that rape could often be considered a form of paraphilia. There was then an unfortunate snowballing, fad effect. The fact that paraphilia NOS, nonconsent, has been widely used (really misused) by the community of SVP evaluators has given it an undeserved aura of authority and acceptability.

Much has been made in legal settings of the wording of the opening sentence of the DSM-IV-TR paraphilia section. "The essential features of a paraphilia are recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other non-consenting persons" (Ref. 3, p 566). This sentence has been erroneously taken to be some kind of authoritative DSM-IV-TR definition of paraphilia and is then used to justify the diagnosis of a qualifying mental disorder called paraphilia NOS, nonconsent, under the mistaken assumption that the text implies that the DSM-IV-TR recognizes the existence of an arousal pattern focused on the nonconsenting nature of the sexual behaviors.

In fact, it was never anticipated that the opening sentence of the section would be considered a forensic definition of paraphilia or be used in determining the suitability of long-term psychiatric incarceration.

tion.⁶ It was meant instead as no more than a simple table of contents to summarize the specific types of paraphilias included in the DSM-IV, sorting them by deviant arousal pattern into convenient categories.

"Nonhuman objects" referred to fetishism and transvestic fetishism; "suffering and humiliation" covered sadism and masochism; and "children and other nonconsenting persons" covered pedophilia, exhibitionism, voyeurism, and frotteurism, all of which happen to involve nonconsenting individuals.

* Doren provides the clearest and most influential illustration of mistaken interpretation of these sentences. Noting that "for whatever reasons, the DSM-IV failed to enumerate separately a paraphilia related to raping," he poses the question, "does this mean that DSM-IV totally omits such a condition?" (Ref. 5, p 65). Doren answers his own question with an authoritative-sounding "no," asserting that "the DSM-IV does include a paraphilia related to rape within its definitional paragraphs" (Ref. 5, p 65). After quoting the introductory sentence noted above, he concludes that "this set of phrases clearly relates to defining characteristics of voyeurism and exhibitionism" and "also define a type of 'nonconsent,' however, that pertains to raping as well" (Ref. 5, p 65).

As noted above, this was most certainly not our intention. The phrase was not at all meant to include rape and instead describes only the victims of exhibitionism, voyeurism, frotteurism, and pedophilia. In fact, it was the deliberate intent of DSM-IV to exclude any reference in DSM-IV to rape as a paraphilia. That is why rape is not listed under the various examples of paraphilia NOS and is not listed in the DSM-IV Index.

Complicating matters, a small editing mistake in the DSM-IV A criterion for paraphilias (i.e., the erroneous use of "or" instead of "and" to join the list of fantasies, sexual urges, behaviors)⁷⁻⁹ has encouraged some forensic evaluators to claim that a diagnosis of paraphilia NOS, nonconsent, can be made based solely on the fact that the person committed rape, without any attempt to establish that the person is in fact sexually aroused by nonconsensual sex. Indeed, noting that "evaluators do not typically enjoy the benefit of a truly honest disclosure of the subject's sexual fantasies and urges," Doren recommends that "examiners most commonly need to rely on documentation of the subject's behaviors alone instead"

(Ref. 5, p 66). Again, this was not the intent of DSM-IV.

The Forensic Misuse of NOS Categories

DSM-IV includes 46 not otherwise specified categories to allow clinicians to diagnose and code patients who do not fit well into any of the official categories. This is based on clinical judgment alone, with no criteria provided. NOS diagnoses apply for presentations that are subthreshold, atypical, of uncertain etiology, or based on insufficient information. The NOS categories are provided because psychiatric presentations are so various and idiosyncratic. It would be impossible to have specific labels for every conceivable presentation. Not otherwise specified diagnoses are meant to be no more than residual wastebaskets provided by DSM-IV to encourage research and for the convenience of clinicians when coding patients who do not fit within one of the specific DSM-IV categories.

Here is all that DSM-IV-TR says about paraphilia NOS: "A residual category, Paraphilia Not Otherwise Specified, includes other Paraphilias that are less frequently encountered" (Ref. 3, p 567) and "examples include, but are not limited to telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, klismaphilia, and urophilia" (Ref. 3, p 576). DSM-IV specifically did not include either rape or nonconsent as an NOS example, because paraphilic rapism had been considered and ruled out as a paraphilia in Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III),¹⁰ Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R),¹¹ and DSM-IV.^{4,12} We did not want to provide any backdoor opening for its use via NOS.

The problem is that paraphilia NOS has been widely misapplied in SVP hearings to criminals who have no mental disorder by evaluators who have misinterpreted DSM-IV. Psychiatric diagnoses from the DSM-IV-TR are generally considered admissible in court because they are accepted by the field at large as widely recognized, clinically valid categories that can be reliably assessed. By virtue of their residual and idiosyncratic nature, cases given the label of NOS are by definition outside of what is generally accepted by the field as a reliable and valid psychiatric disorder. Furthermore, the NOS categories do not have criteria sets and therefore can never be diagnosed reliably. Because it is unlikely that different evaluators would

agree on a paraphilia NOS diagnosis, there is no reason to accept the NOS diagnosis of any given evaluator. The use by evaluators of the paraphilia NOS diagnosis fails to satisfy the standards that should be required for expert testimony. Clearly this misuse must be corrected if we are to protect the integrity of psychiatric diagnosis and the inviolability of constitutionally guaranteed civil rights.

The question arises of whether paraphilia NOS, nonconsent, should ever play a role in SVP proceedings (i.e., whether it should ever be allowed by judges and ever be taken seriously by juries). The argument for not entirely excluding paraphilia NOS is that, very occasionally, there may be a rapist whose behavior actually is motivated by paraphilia (i.e., he is able to achieve sexual arousal only or primarily when fantasizing about or performing the act of rape). The argument for rejecting all forensic use of the diagnosis paraphilia NOS, nonconsent, is that allowing these exceptions provides a backdoor invitation to its continued shameful and widespread misapplication to all the many rapists who receive the diagnosis despite being no more than simple criminals. The sad history of SVP evaluations makes compellingly clear that any opportunity for misuse of paraphilia NOS is likely to be seized on to justify unwarranted psychiatric commitment.

If paraphilia NOS, nonconsent, is ever allowed in court, it should only be when supported by incontrovertible evidence that fantasizing or performing a rape is a specific and necessary sexual stimulus for the rapist. Such evidence should include that rape scenarios are the primary focus of an offender's sexual arousal, that rape has been his major form of sexual activity, and that he has demonstrated a strong and sustained preference for and reliance on rape pornography. Such evidence must be direct, not inferential. The inference that a rapist is motivated by paraphilia if it is based entirely on the fact that he has committed rape should never be allowed. The evidence supporting an NOS diagnosis should necessarily be much stronger and more unequivocal than that required to support an official DSM diagnosis, both because the paraphilia NOS diagnosis is so inherently unreliable and because it has been so universally abused by evaluators. Any significant doubt or lack of clarity in the documentation suggests that paraphilia NOS is overused and misapplied. It is imperative that SVP evaluators be retrained on the proper use of the DSM-IV diagnosis of paraphilia and that their

work be subjected to quality control and reliability testing.

Paraphilic Coercive Disorder: A Four-Time DSM Reject

Paraphilic coercive rapism was first suggested at a conference in 1976 during the preparation of DSM-III. It was rejected. It was suggested again in 1986 during the preparation of DSM-III-R and was again rejected. The evidence presented was extremely thin—a few small plethysmograph studies suggesting that rapists were differentially aroused by images of coercive sex.¹³⁻¹⁵ Moreover, women's committees within and without the American Psychiatric Association were concerned that rape would be reconceptualized from a crime to a mental disorder. They were fearful that this would provide rapists with a psychiatric excuse to offload responsibility and were concerned that the diagnosis might be misunderstood and misused in forensic settings. A 1986 Washington, D.C., conference brought together proponents and critics of the proposal. DSM-III-R had a permissive attitude generally biased in favor of new diagnoses, but the overwhelming consensus was against coercive paraphilic rapism. The evidence for it was too weak, there was no particular need for it, and the risks of misuse were too great.

There was no support for including coercive rapism in DSM-IV, no suggestions for its inclusion, no perceived need, and no upwelling of convincing research. The absence of support, combined with continued concerns about potential misuse and a much higher threshold for adding new diagnoses guaranteed that rape would have no place in DSM-IV. We also consciously decided not to include any reference to rape among the diagnoses covered by paraphilias NOS, for fear it would allow a backdoor entry of this questionable diagnosis.

That the proposal to include coercive paraphilia as an official diagnosis in the main body of DSM-5 has recently been rejected confirms the previous decisions to reject paraphilic rape that were made for DSM-III, DSM-III-R, and DSM-IV. It is unanimous: a rapist is not someone who has a mental disorder and psychiatric commitment of rapists is not justified. This is an important message to everyone who is involved in approving psychiatric commitment under sexually violent predator (SVP) statutes. The evaluators, prosecutors, public defenders, judges, and juries must all recognize that the act of being a

rapist is almost always an aspect of simple criminality and that rapists should receive longer prison sentences, not psychiatric hospitalizations.

The DSM-5 rejection of paraphilic coercive disorder as an official category was necessary because the rationale and the supporting evidence were so thin.^{16,17} The proposal was supported by only a few very preliminary studies reporting differential sexual arousal, with rapists tending to have heightened arousal to coercive sexual stimuli.¹⁸⁻²¹ It is not at all clear why this differential arousal pattern (assuming it holds in larger and better controlled studies) should by itself constitute grounds for establishing a mental disorder. The observation that those who have raped tend to be more excited and less inhibited by coercive cues does not prove that they have a stable paraphilic pattern of intense, recurrent urges geared to coercion as a specific trigger. Furthermore, studies^{22,23} have suggested that the factor best differentiating rapists from nonrapists is the absence of the usual inhibitory effect of coercion on sexual arousal, rather than coercion being the focus of sexual arousal (which is the fundamental feature of a paraphilia). Lack of inhibition speaks to criminality, rather than paraphilia.

✖✖ Even more to the point, there is no research to guide how a criteria set for paraphilic coercive disorder should be written and whether it could ever be reliably diagnosed. Reliability of paraphilia diagnoses in SVP commitment settings has already been shown to be problematic for even the established DSM-IV paraphilias.²⁴ Recall that the Supreme Court ruling in *Hendricks* supporting the constitutionality of SVP statutes rests exclusively on the distinction between mental disorder (which can be used to justify civil psychiatric commitment) and everyday criminality (which is not a constitutionally acceptable cause for further incarceration, however dangerous the individual). We have no research evidence whatsoever that forensic raters can reliably agree when attempting to sort rapists into one of these two groups. This ✖ lack of proven reliability is especially troubling when we consider the huge consequences that can follow in the legal system from what would necessarily be an untrustworthy diagnosis. The differential diagnosis of rape behavior would have to include rape for gain (e.g., by pimps or sex traffickers), opportunistic rape, date rape, gang rape, rape for dominance, rape under the disinhibiting influence of substances, rape related to an antisocial personality pattern of criminality,

and rape influenced by other mental disorders (e.g., mania or mental retardation). It seems very uncertain that SVP evaluators can reliably pick out the rare paraphilic rapist from this array, assuming that such individuals exist at all.

We also have no information on the predictive validity of the proposed paraphilic coercive disorder. Are individuals so classified more or less likely to repeat offend? Are they more or less likely to participate in and gain from treatment? What kind of treatment, if any, works? This body of research literature in its very most formative stages of development and nowhere near ready to support a diagnosis with such inherent risks of forensic misuse.

Which brings us to one continuing problem raised by what has been posted on the DSM-5 web site regarding paraphilic coercive disorder. The DSM-5 Paraphilia Subworkgroup proposes placing coercive paraphilia in an appendix for disorders requiring further research. The research appendix was meant as a placement option for proposed new mental disorders that were clearly not suitable for inclusion in the official body of the manual, but might nonetheless be of some interest to clinicians and researchers. In preparing DSM-IV, we had very strict rules and high hurdles for adding any new diagnosis: only a few suggestions made the cut, while close to 100 were rejected.²⁵ Because it was no more than an unofficial tag along, we had no similar qualms about including some of the rejected diagnoses in the appendix. This seemed like a benignly obscure way to encourage further research.

If paraphilic coercive disorder were like the average rejected DSM suggestion, it would similarly make sense to park it in the appendix, as has been suggested by the work group. This might facilitate the work of researchers and also provide some guidance to clinicians in assessing the rare rapist who does have a paraphilic pattern of sexual arousal. Paraphilic coercive disorder, however, is not the average rejected DSM diagnosis. It has been, and continues to be, badly misused to facilitate what amounts to an unconstitutional abuse of psychiatry. Whether naively or purposefully, many SVP evaluators continue to widely misapply the concept that rape signifies mental disorder and to inappropriately use NOS categories where they do not belong in forensic hearings. Including paraphilic coercive disorder in the DSM-5 appendix and suggesting it as a possible example of the proposed other specified paraphilic disorder category would confer an undeserved backdoor legal

legitimacy on a disavowed psychiatric construct. Little would be gained by such inclusion, and the risks of promoting continued sloppy psychiatric diagnosis and questionable legal proceedings are simply not worth taking. The rejection of rape as grounds for civil commitment must be unequivocal, to eliminate any possible ambiguity and harmful confusion. We did not include any reference to paraphilic coercive disorder in DSM-IV, and it should not find its way in any form, however humble and unofficial, into DSM-5. The inclusion of paraphilic coercive disorder in the DSM-5 appendix is a bad idea because the appearance of this white elephant anywhere in DSM-5 could be used to justify the use of paraphilia NOS in SVP commitments.

Conclusions

Rape is always a crime and is never, by itself, sufficient evidence of a mental disorder. There was little interest (and very limited research) in the psychiatric status of rape until it became a convenient way to subject rapists to involuntary psychiatric commitment after their prison sentences had been served. Inappropriately redefining rape as a mental disorder helped to close the legal loophole created when fixed sentencing drastically reduced the prison terms of the worst sexual offenders. The recent widespread misuse of the diagnosis paraphilia NOS in SVP hearings has resulted from a misinterpretation of the intent of DSM-IV-TR. Its overuse represents an inappropriate medicalization of criminal behavior to serve a practical public safety purpose.

The intentions of SVP evaluators are well meaning and honorable: to protect society in a way that has also been sanctioned as constitutional by the Supreme Court.²⁶ Paraphilia NOS, nonconsent, is not a legitimate mental disorder diagnosis and seems more an excuse for keeping dangerous sex offenders locked up. Certainly, no one wants rapists set loose on the streets prematurely, but better solutions than paraphilia NOS, nonconsent, must be found. The misuse of psychology and psychiatry to bail out a legal system loophole has its own set of dire professional and civil liberty risks. The violation of constitutionally guaranteed rights via a mental disorder gambit is a slippery slope tempting state misuse of the mental health professions in other ways. Mental health professionals in other countries have been turned into state-sponsored tools in the oppression of political dissidents. Mental health professionals in this country are currently filling ethically questionable roles in the interrogations of suspected terrorists.

The collaboration between the legal system and mental health professions is necessary and usually extremely beneficial, but it works only if the mental health professions jealously guard the independence and integrity of their judgments. Even the best intended misuse of psychiatric diagnosis to curb risks to society is not worth the cost. The good and necessary cause of protecting public safety can be much better and more honestly served in other ways that avoid paraphilia NOS, nonconsent. Going forward, the obvious fix is to reinstate the use of indeterminate sentencing, allowing long prison terms when it seems appropriate. Fortunately, this is the current trend, and the SVP statutes will be less necessary in the future as sentences become longer. This still leaves the interim problem of how best to apply the statutes to those prisoners or parolees who were sentenced under the previous system. There is no easy answer, but paraphilia NOS, nonconsent, is the wrong answer.

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Exhibit # 6

Matter of State of New York v Jason C.

Annotate this Case

[*1] Matter of State of New York v Jason C. 2016 NY Slip Op 26018 Decided on January 22, 2016 Supreme Court, Kings County Riviezzo, J. Published by New York State Law Reporting Bureau pursuant to Judiciary Law § 431. This opinion is uncorrected and subject to revision before publication in the printed Official Reports.

Decided on January 22, 2016

Supreme Court, Kings County

In the Matter of the Application of the State of New York, Petitioner,
against

Jason C., Respondent, For Civil Management Pursuant to Article 10 of the Mental Hygiene Law.

19136/2013

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Dineen A. Riviezzo, J.

Issue Presented

In this proceeding under Article 10 of the Mental Hygiene Law, the respondent, Jason C., moved by motion, dated November 21, 2013, for an order precluding all testimony at trial concerning the diagnosis that forms the basis of the Petition for Civil Commitment filed by the State of New York ("Petitioner" or "the State") on June 7, 2013. Specifically, respondent alleges that the diagnosis, paraphilia, not otherwise specified (non-consent) ("paraphilia, NOS (nonconsent)"), is not a diagnosis generally accepted by the relevant scientific community and thus, the use of expert testimony for that purpose should be precluded under Frye v United States (293 F 1013, 54 App DC 46 [DC Cir 1923]). Petitioner opposed the motion. Another Judge of this court granted a Frye hearing on the respondent's specific diagnosis described in that court's [*2]February 19, 2015 opinion as "Other Specified Paraphilic Disorder (non-consent)" or "OSPD (nonconsent)" in recognition of the change in nomenclature from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ("DSM-IV") to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-V") from "paraphilia, NOS" to "Other Specified Paraphilic Disorder."

This court held extensive hearings, at which six experts were called. The State called three experts: (1) Dr. Robin Wilson, a forensic psychologist with extensive clinical experience in the treatment of sex offenders, including work as the Clinical Director

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of the Florida Civil Commitment Center, as the first Sex Offender Treatment Specialist with the Federal Correctional Service of Toronto, Canada, and as the Research Director at the Clarke Institute of Psychiatry (a prominent psychiatric teaching hospital in Toronto, Canada); (2) Dr. Christopher Kunkle, Director and Chief Psychiatric Examiner of the Bureau of Institutional Sex Offender Treatment for the New York State Office of Mental Health ("OMH") who oversees the psychiatric examiners who conduct evaluations for the State of New York pursuant to MHL Article 10; and (3) Dr. David Thornton, Director of the Sand Ridge Secure Treatment Center, the sex offender treatment facility of the State of Wisconsin, and one of the developers of the STATIC-99, a prominent risk assessment instrument.

~~Respondent also called three experts:~~ (1) Dr. Leonard Bard, a clinical and forensic psychologist based in Massachusetts, now in private practice who has conducted over 1200 forensic examinations of sexually dangerous persons under the Massachusetts General Law 123A and 128 (the equivalent NYS MHL Article 10); (2) Dr. Raymond Knight, the Mortimer Gryzmish Professor of Psychology at Brandeis University and the developer of leading typological models for rapists and child molesters; and (3) Dr. Cynthia Calkins, Associate Professor of Psychology at John Jay College of Criminal Justice whose professional research and peer reviewed publications focus on sexual violence policies such as the efficacy of civil confinement laws, community notifications and GPS monitoring and the clinical functioning of sex offenders subjected to those laws.

Argument of the Parties

Respondent argues that the State has failed to prove that the diagnosis of OSPD (non-consent) is a reliable diagnosis that has been accepted by the relevant scientific community. Specifically, respondent argues that there is no established criteria for the diagnosis, or consensus as to its definition, nor has the diagnosis been subject to vigorous scientific research published in peer reviewed publications which could be duplicated and tested — a necessary pre-requisite to any diagnosis gaining general scientific acceptance. Respondent also emphasizes that the diagnosis was rejected for inclusion in the latest version of the DSM-V after rigorous review which, respondent argues, is strong evidence of its rejection by the relevant scientific community. Finally, respondent notes that the diagnosis is used almost exclusively by state evaluators in sexually violent predator proceedings — a population which does not reflect the general psychiatric community.

The State argues that it has met its burden to prove that the general category of "Other Specified Paraphilic Disorder" is generally accepted in the relevant scientific community, as well as the additional qualifying diagnosis of "non-consent" also known as "paraphilic coercive disorder." The State provided to the court three New York State Supreme Court opinions issued in the context of Article 10 proceedings which denied an application for a Frye hearing for OSPD (non consent) [*3] on the grounds that the respondents in those cases failed to make a prima facie showing. Further, the State listed seventeen states in which this diagnosis is used in the context of those state's sexually violent predator ("SVP") laws.

Frye Hearing: Elements and Burden of Proof

In general, the inquiry under Frye is "whether the accepted techniques, when properly performed, generate results accepted as reliable within the scientific community generally" (People v Wesley, 83 NY2d 417, 422, 611 NYS 2d 97, 633 NE 2d 451 [1994]). The burden of proving general acceptance in the relevant scientific community rests upon the proponent of the disputed testimony (See Zito v Zabarsky, 28 AD3d 42, 812 NYS 2d 535 [2d Dept 2006]; People v Kanani, 272 AD2d 186, 709 NYS 2d 505 [1st Dept 2000], lv denied 95 NY2d 935, 744 NE 2d 148, 721 NYS 2d 612 [2000]). Admissibility under Frye requires a showing that:

- 1) the expert is competent in the field of expertise which he or she purports to address at trial. This element is not disputed in this case;
- 2) the testimony is based on scientific principles or procedures which have been sufficiently established to have gained general acceptance in the particular field involved. In this regard, the hearing court does not determine whether or not a novel scientific theory is reliable, but only whether it is generally accepted in the relevant scientific community. The emphasis is on "counting scientists' votes" (Wesley, 83 NY2d at 439 [Kaye, Ch. J., concurring]).
- 3) the proffered expert testimony is "beyond the ken" of the jury (See Matott v Ward, 48 NY2d 455, 459, 399 NE 2d 532, 423 NYS 2d 645 [1979]; People v Cronin, 60 NY2d 430, 433, 458 NE 2d 351, 470 NYS 2d 110 [1983]). It is not disputed by the parties, and it is evident, that the subject of a DSM diagnosis is beyond the ken of the ordinary person; and,
- 4) the testimony is relevant to the issues and facts of the individual case, and more probative than prejudicial. Evidence is relevant if it has any tendency in reason to prove the existence of any material fact, i.e., if it makes determination of the action more probable or less probable than it would be without the evidence. However, even if relevant, the probative value must outweigh the prejudice to the other side. A trial court may exercise its discretion and preclude "technically relevant" evidence

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"if its probative value is substantially outweighed by the danger that it will unfairly prejudice the other side or mislead the jury" (People v Scarola, 71 NY2d 769, 777, 525 NE 2d 728, 530 NYS 2d 83 [1988]).

In engaging in a Frye analysis, the court may consider scholarly articles on the subject matter for the purpose of understanding "general acceptance." Both sides, indeed, submitted numerous writings and journal articles on the subject of paraphilic disorders. Because Frye is concerned with "head counting" of experts, the state of knowledge in the profession is at issue and scholarly articles and journals are, therefore, admissible as reflecting those matters which are generally accepted in the relevant scientific community (See, e.g., People v Wernick, 215 AD2d 50, 52, 632 NYS 2d 839 [2d Dept. 1995], aff'd 89 NY2d 111, 651 NYS 2d 392, 674 NE 2d 322 [1996]; Fraser v 301-52 Townhouse Corp., 57 AD3d 416, 870 NYS 2d 266 (1st Dept 2008) [plaintiffs placed in evidence nearly 40 articles, treatises and other published studies concerning the relationship between building dampness and mold and sickness in humans; defendants placed approximately 15 such publications in evidence]).

While the court found that all of the experts were credible witnesses and acknowledges their extensive knowledge, experience and passion for their work, it did not, as is explained in more detail below, concur with all of their opinions. The court has made factual findings based upon only those portions of the testimony relevant to its legal conclusions. In addition, the court considered the post-hearing written submissions of the parties, and consulted numerous scholarly articles that were both received into evidence and mentioned or relied upon by the experts. For the reasons which follow, the court holds that the general diagnosis of "Other Specified Paraphilic Disorder" is a generally accepted diagnosis in the relevant scientific community. As to the specifier at issue here, "non-consent," the court holds that the State has not met its burden to prove under Frye that the respondent's specific diagnosis of OSPD (non-consent) is generally accepted in the relevant scientific community.

Respondent's Criminal History

Respondent's criminal history includes four convictions for sexual assault. On December 19, 1994, respondent forcibly raped his former girlfriend when the victim was 13-years-old and he was 19-years-old. Respondent punched her repeatedly on her face and stomach, choked her, and threatened her with metal cane and a gun that he had placed on the table. While that case was pending, on January 13, 1996, respondent approached a 16-year-old stranger on a subway platform, grabbed her and forced her to his apartment two blocks away. He locked her in a room, repeatedly slapped her, forced her to perform oral sex on him, and attempted to rape her. On March 15, 1996, he pleaded guilty to two counts of sexual abuse in the first degree to satisfy both indictments and received a sentence of one to three years incarceration concurrent on both. Respondent was paroled on September 11, 1998 and discharged from parole on March 11, 1999.

Only eight months later, on October 26, 1999, respondent forced a 19-year-old girl to perform oral sex on him while he punched and slapped her, placed his finger in her anus and threatened to snap her neck while claiming he was in possession of a gun. While the State's Petition for Civil Confinement asserts that the victim was unknown to the respondent, respondent describes her as a "paramour" (Respondent's Notice of Motion to Preclude Expert Testimony at 2). On August 9, 2000, he pleaded guilty to attempted sexual assault in the first degree and was sentenced to one to three years incarceration which he completed on October 30, 2002.

In the Spring of 2004, respondent raped at knife point a 12-year-old girl he knew from the neighborhood who had come over to his house. He blindfolded her, slapped her, raped her, placed his penis in her mouth, orally penetrated her and placed his fingers in her anus. He was not arrested until 2008. He was convicted on January 21, 2009 of attempted rape in the first degree and sentenced to six years incarceration and five years post release supervision. The State subsequently filed the Petition for Civil Commitment on October 24, 2013 based on this qualifying offense.

Respondent's Diagnoses

According to the Petition for Civil Commitment, the psychiatric examiner who initially evaluated the respondent and diagnosed him with a mental abnormality was Dr. Trevor Floyd, a licensed psychologist for the New York State Office of Mental Health (OMH). After reviewing respondent's criminal history, documents in the possession of OMH and the NYS Department of Corrections and Community Supervision (DOCCS) and conducting a three-hour and twenty minute interview with the respondent, Dr. Floyd concluded that respondent suffers from the following disorders listed in the DSM-V: antisocial personality disorder (ASPD) and alcohol use disorder, [*4]severe, in a controlled environment. Dr. Floyd considered, but did not assign, sexual sadism disorder.

Subsequently, pursuant to MHL § 10.06(e), the State had court-appointed examiner John A. Thomassen, Ph.D. evaluate respondent. Dr. Thomassen also reviewed the relevant documents and conducted a two and one-half hour interview with the respondent. Dr. Thomassen agreed that respondent suffered from a mental abnormality but concluded that respondent's DSM-V diagnoses were ASPD and OSPD (non-consent). He also ruled out a diagnosis of sexual sadism.

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POINT I

The DSM-V Diagnosis of "Other Specified Paraphilic Disorder"

Is Generally Accepted in the Psychological Community

This court previously ruled in a Frye hearing conducted just a few months prior to this one that the DSM-V diagnosis of "Other Specified Paraphilic Disorder," formerly called paraphilia, not otherwise specified in the DSM-IV, is generally accepted in the psychological community (State v. Mercado, 2015 NY Misc LEXIS 4018; 2015 NY Slip Op 25367; 19 NYS 3d 658 [Sup Ct, Kings County, August 11, 2015]). Respondent offered no testimony in this Frye hearing that would cause this court to change its ruling and, indeed, the respondent has not argued as such in his post-hearing briefs.

As this court noted in Mercado, with regard to these "catch-all" diagnoses, the DSM-V makes clear that they are legitimate, indeed, necessary diagnoses. The DSM-V, in fact, instructs in its prefatory chapter that:

X When full criteria are not met, clinicians should consider whether the symptoms presentation meets criteria for an other specified' or unspecified' designation.

(American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 21 [5th Edition 2013]). Within the chapter on paraphilic disorders, which is at issue here, the DSM-V authors confirm that while only eight specific paraphilic disorders are listed with criteria in the DSM-V:

Many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual or for others, rise to the level of a paraphilic disorder. The diagnoses of other specified and unspecified paraphilic disorders are therefore indispensable and will be required in many cases.

(Id. at 685). Indeed, even respondent's expert, Dr. Bard, testified that "not otherwise specified" and "other specified disorders" are categories that are useful in clinical practice and especially in the context of paraphilias where it is used with the "lesser or rarely seen paraphilias" along with a specifier (Bard tr at 381-382).

POINT II

The State's Evidence In Support of OSPD (non-consent)

A. The Definition of OSPD (non-consent)

The State's three experts began their analysis with the general definition of a paraphilic disorder. The DSM-V defines a paraphilia as "any intense and persistent sexual interest other than [*5]sexual interest in genital stimulation or preparatory fondling with phenotypical normal physically mature consenting human partners" (Wilson tr at 103 citing American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 685 [5th Edition 2013]). According to Dr. Wilson, stated another way, a paraphilia is a "recurrent, intense sexual arousing fantasy or urge or behavior that involves either children, inanimate objects or non-consenting persons" (Wilson tr at 96). Similarly, Dr. Kunkle described a paraphilia as "an abnormal, persistent and intense sexual interest, arousal or behaviors involving either the pain and suffering of another, children or other non-consenting persons, or inanimate non-human objects" (Kunkle tr at 19). For the paraphilia to be a disorder, however, the paraphilic interest must cause distress or impairment to the individual such that it interferes with their work or family life or results in trouble with the law or harm to others (Wilson tr at 97).

Dr. Wilson opined that the very definition of what constitutes a paraphilic disorder encompasses a "paraphilic rape disorder" in that an interest in non-consenting human partners is a disorder (Wilson tr at 104-105). Dr. Wilson further explained:

There is a construct within the science that shows, consistently, that, there is a group of offenders who engage in their behavior specifically because it's the non-consenting element of the victim that causes them the sexual arousal that they are seeking to obtain.

(Wilson tr at 105). Dr. Wilson opined that there is not a paraphilia specifically named "non-consent," but rather the disorder goes by the name of "biastophilia" which he defined as a paraphilia in which "the specific reason for engaging in that behavior is that the individual is sexually aroused by the fact that the person he's being sexually involved with is not consenting to the behavior. So, it's the non-consenting element that makes him most sexually aroused" (Wilson tr at 105-106). According to Dr. Wilson, other names that describe the same condition are "paraphilic rapism" and "paraphilic coercive disorder or PCD" (Id. at

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106). Dr. Wilson testified that the proposal to include PCD in the DSM-V contained the exact same definition as OSPD (nonconsent), namely,

people who are being aroused by the coercive element of the sexual interaction. That meaning, that, the person is not consenting, is putting up some degree of fight to the behavior and it's the fact that the person is not interested in being sexually involved with the client and that they are fighting back, such that they have to be coerced that's the part that the individual finds most sexually arousing.

(Wilson tr at 106).

The State's experts opined that OSPD (non-consent) is on a spectrum or dimension with other paraphilic disorders already mentioned in the DSM-V. In Dr. Wilson's opinion, there is a "lot of kind of dimensionality with respect to a number of different classes of disorders" in the DSM, an example is depression (Wilson tr at 107). There are many degrees of being depressed (Id.). Similarly, he opined that there is a spectrum or dimension to sexual interactions between people with consensual sex at one end of the spectrum and sexual sadism at the other (Id.). Sexual sadism is a disorder with a set of criteria within the chapter on paraphilic disorders in the DSM-V (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 695 [5th Edition 2013]). Sexual sadism involves an extreme level of brutality and physical harm that is arousing to the actor, while the victim is "absolutely terrified" (Wilson tr at 109). Dr. Wilson explained,

[I]f you sort of toned down the violence, there is a point at which the focal aspect of the paraphilic interest is the fact that the person is not consenting and that they are putting up some degree of a struggle, but the violence that's being used is only the amount of violence necessary to ensure compliance.

(Wilson tr at 109-110).

Dr. Wilson set PCD within the construct of "courtship disorders," which he described as disorders that are based upon the stages of courtship common to animals and humans alike (Wilson tr at 111). He testified that this "courtship disorder hypothesis" figures prominently in the DSM-V "in terms of trying to explain how certain paraphilic disorders tend to cluster together" (Wilson tr at 113). According to Dr. Wilson, the first stage of courtship is identifying the partner with whom you wish to be sexual (Wilson tr at 111). The second stage is attracting that partner's attention (Id. at 111-112). Dr. Wilson explained that this is why male birds have brighter feathers (Id. at 112). The third stage is pre-coital tactile interaction, such as holding hands, petting, and kissing (Id.). The fourth stage is sexual intercourse (Id.).

The paraphilias, Dr. Wilson argued, "map on quite nicely," so that a dysfunction in the first stage of courtship produces voyeurism — "peeping into window, you know, sort of trying to surreptitiously view others" (Wilson tr at 112-113). A dysfunction in the second phase, trying to attract the attention of others, would relate to exhibitionism and the third phase would be frotteurism, which is sexual urges or behaviors involving touching and rubbing against non-consenting persons (Wilson tr at 113). Dr. Wilson concluded that "the absence of any courtship behavior would be rape; which means that you don't, actually, go through these first three stages. You just go straight to the end" (Wilson tr at 113).

Dr. Wilson explained that there is a co-occurrence of these courtship disorder paraphilias, meaning that these paraphilias co-occur more often with each other than with other paraphilias (Wilson tr at 172). He testified that while the DSM-V does not contain a paraphilic rape disorder, there is support for the courtship disorder hypothesis in the preamble of the paraphilic disorder chapter in the DSM-V that calls voyeurism, exhibitionism and frotteurism "courtship disorders" as a means to distinguish them from the other five paraphilic disorders listed in the chapter (Wilson tr at 174-175 citing American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 685 [5th Edition 2013]).

Finally, Dr. Kunkle defined OSPD (nonconsent) as follows:

the intense or persistent sexual interest would be in sexual encounters where there is a lack of consent from the person, the other person. In essence they would be resistant to or coerced, forced into sexual contact. That is the underline (sic) interest of the perpetrator.

(Kunkle tr at 20).

B. Support for the Diagnosis in the Literature

Dr. Thornton's testimony focused primarily on the three types of studies that have been conducted on the diagnosis of OSPD (non-consent): studies using a penile plethysmograph, rating scale studies and self-report studies (Thornton tr at 250-251).

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i. Penile Plethysmograph or PPG studies

Studies using a penile plethysmograph or PPG involve placing a sensor on a man's penis to measure his erectile response while he is exposed to different sexual stimuli (Thornton tr at 250-251). Dr. Thornton described a meta analysis conducted by Martin L. Lalumiere and others in which groups of men were exposed to two different sets of stimuli — one that depicts two adults engaged in mutually consenting sexual activity and the other of a man raping a woman against her will (see Lalumiere, M.L., Quinsey, V.L., Harris, G.T., Rice, M.E., & Trautrima, C., Are Rapists Differently Aroused by Coercive Sex in Phallometric Assessments? Ann. NY Acad. Sci 989 at 211-224 [2003]). According to Dr. Thornton, the study demonstrated that the "normal" population of men show much stronger erectile responses to depictions of consenting sex than to depictions of rape (Thornton tr at 253). Convicted rapists, on average, show indifference to those two stimuli. However, a look amongst the convicted rapists demonstrates that between one-third and one-half will show stronger responses to depictions of rape than they will to depictions of consenting sex (Id.). This, Dr. Thornton argues, is evidence that these individuals are aroused by stimuli associated with non-consent such that their responses to the rape stimuli are greater than their responses to the consenting stimuli (Thornton tr at 255). This is measured by a positive rape index which is the ratio of the PPG responses to stimuli associated with coercive sexual encounters relative to the PPG responses to stimuli showing consensual sexual encounters (Id.).

In addition to this meta analysis, Dr. Thornton also examined the files of thirty-three convicted rapists confined in the Sand Ridge Secure Treatment Center, all of whom had been subjected to PPG testing using three sets of stimuli: consensual sex, a rape scenario and a third, more brutal rape scenario involving physical battery or even murder which corresponds with the DSM-V diagnosis for sexual sadism (Thornton tr at 258-259). According to Dr. Thornton, fifty percent of the participants showed a preference for consensual sex, twenty percent for coercion and twenty percent for brutality (Thornton tr at 259; Thornton, D., Evidence Regarding the Need for a Diagnostic Category for a Coercive Paraphilia, American Psychiatric Association [2009]).

ii. Rating Scale Study

In addition to his PPG study, Dr. Thornton detailed a study he presented at the Association for the Treatment of Sexual Abusers ("ATSA") conference in 2011 involving sixty-five patients convicted of rape who were also confined at the Sand Ridge Secure Treatment Center (Thornton tr at 260). The purpose of the study was to attempt to establish the inter-rater reliability of clinicians distinguishing the diagnosis of OSPD (non-consent) from sexual sadism (Thornton tr at 263, 268). Dr. Thornton created a checklist or a rating scale for "what (he) then called paraphilic rape, which means much the same as non-consent" and the study was also meant to establish the internal consistency of the checklist (Thornton tr at 260, 267-268). According to Dr. Thornton, the paraphilic rape checklist was based on "research literature and on my experiences on what the clinicians used to make inferences" that a rape-related paraphilia existed that was not sexual sadism (Thornton tr at 260-261). His list of items suggesting the presence of a rape-related paraphilia less than severe sexual sadism were: (1) evidence of planning; (2) evidence of a script being repeated; (3) history of three or more rapes/sexual assaults that use threats of violence to gain control of an unwilling victim; (4) history of carrying out one or more rapes when consensual sex was available; (5) evidence of salient coercion or behavior deliberately designed to induce fear, suffering or injury, beyond that required to control the victim during sexual assaults; (6) history of sadistic/rape elements in consensual sexual behavior (e.g. pretend rape, strangling sexual partners during sex act); (7) PPG [*6] data indicating preferential arousal to coercion or arousal to sadistic themes; and (8) self-report of rape or sadistic fantasy/urges (Thornton tr at 261-263).

Dr. Thornton testified that this paraphilia rape checklist was compared to a sexual sadism checklist that he "largely borrowed" from a published study by J. Nitschke and colleagues (Thornton tr at 263; Nitschke, J, Osterheider, M. & Mokros, A., A Cumulative Scale of Severe Sexual Sadism, 21 Sexual Abuse: A Journal of Research and Treatment 262- 278 [2009]). Dr. Thornton's severe sexual sadism checklist is a seven-item cumulative scale: (1) offender tortures the rape victim, inflicts intense pain substantially beyond that intrinsic to being raped (inserting needles, hanging victim); (2) humiliates rape victim beyond that intrinsic to being raped (use of bodily secretions or excretions); (3) mutilates sexual body parts of victim; (4) mutilates non-sexual body parts of victim; (5) uses physical object to inflict pain to the sexual areas of the rape victim's body; (6) makes threats designed to terrify rather than coerce the victim; and (7) strangles, cuts or stabs victim prior to or during the sex act (Thornton tr at 263).

In Dr. Thornton's study, two clinicians, one of whom was the treating physician and the other an independent clinician, were asked to go through patient files "with the idea that if you had several of these items [from the paraphilic rape checklist] present this would be the kind of picture which would lead a clinician normally to infer that paraphilic rape was present" (Thornton tr at 261). Dr. Thornton testified that the two scales had "a fairly high level of internal consistency" and there was about two-thirds agreement between independent raters — a reasonable reliability (Thornton tr at 267, 269). According to Dr. Thornton, the study was meant to answer the question, does the paraphilic rape checklist measure something which is independent of sexual sadism? (Thornton tr at 270): Of the sixty-five participants, twenty had at least four signs present on the paraphilic rape checklist (Thornton tr at 272). Of those twenty, eight had no signs of sexual sadism and six had clear evidence of

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sexual sadism (Id.). The remaining six were in the middle — showing some signs of severe sexual sadism but not enough for a complete diagnosis (Id.). This demonstrated to Dr. Thornton that eight individuals among sixty-five convicted of rape confined within this facility met his own definition of OSPD (nonconsent) as a separate diagnosis from sexual sadism (Thornton tr at 274).

iii. Self-Report Study

Dr. Thornton testified that the most reliable form of a self-report study is under research conditions that guarantee anonymity or confidentiality (Thornton tr at 275). He cited one such study co-authored by the respondent's expert, Dr. Raymond A. Knight, which Dr. Thornton testified offered support that arousal to coercion is on a continuum with severe sexual sadism (Thornton tr at 276 citing Knight, R.A., Sims-Knight, J. & Guay, J.P., Is a Separate Diagnostic Category Defensible for Paraphilic Coercion?, 41 Journal of Criminal Justice at 90-99 [2013]). At the hearing, Dr. Thornton proffered Table 3 from that study which contained seventeen items on a continuum ranging from least sadistic type behaviors, such as having thoughts about forcing sex' and making a female do what I want turns me on' to the most sadistic behaviors such as beating a woman while having sex' (Thornton tr at 276). Dr. Thornton concluded that "other specified paraphilic disorder (nonconsent) could also be understood as just a lesser form of the things that are being characterized under severe sexual sadism" (Thornton tr at 282). Dr. Thornton later testified on cross examination that he and Dr. Knight, the respondent's expert, had proposed replacing the diagnosis of sexual sadism in the DSM-V with a diagnosis called the "agonistic continuum" which would recognize that these disorders, OSPD (non-consent) and sexual sadism, are on a continuum [*7] and not distinct categories (Thornton tr at 354-355). Nonetheless, Dr. Thornton acknowledged the importance of separating out the two groups for purposes of treatment needs and to minimize the greater prejudicial effect of the "sadist" label in the courts (Thornton tr at 285-286).

Lastly, Dr. Thornton explained that his unit records every diagnosis made by state evaluators in Sexual Violent Predator ("SVP") proceedings in Wisconsin (Thornton tr at 282). One in five patients were given the diagnosis of paraphilia (non-consent) in 2014 (Thornton tr at 283). Of the 345 persons confined at the Sand Ridge Secure Treatment Center, twenty percent meet the criteria for OSPD (non-consent) (Thornton tr at 317).

POINT III

The Specifier "non-consent" or "paraphilic coercive disorder"

Is Not Generally Accepted Within The Psychological Community

While the general category of Other Specified Paraphilic Disorder is generally accepted in the scientific community, this Frye hearing made clear that the specifier that is attached to the general diagnosis must be carefully scrutinized for its general acceptance.

A. There Is No Clear Definition Or Criteria for the Proposed Disorder

Other than giving the general definition of what this proposed disorder is, namely arousal to non-consent, the State has not provided this court with a clear understanding of what the agreed upon criteria is for the diagnosis. Each of the State's experts proffered his own understanding of how it would be diagnosed. Further, it was also very clear from the literature that there is no agreed upon criteria for this condition even among SVP practitioners. As a starting point then, the court cannot find a diagnosis "generally accepted" when there is not, at the very least, a generally accepted criteria that defines the condition. In this context, a judicial finding that this diagnosis is generally accepted would provide no clarity as to what "this diagnosis" actually is — other than in name and general definition.

First, there have been various terms for this proposed disorder throughout the years and the State's experts did not agree as to whether or not all of the terms are synonymous. While Dr. Wilson and Dr. Kunkle said the terms are synonymous or essentially the same, (Wilson tr at 105-106; Kunkle tr at 43), Dr. Thornton explained that while this condition has been called biastophilia, paraphilia (non-consent) and paraphilia coercive disorder, these definitions are not synonymous, but, in fact, overlap and are all attempts to describe the same thing at different times corresponding to the creation of the DSM IV-TR and DSM-V (Thornton tr at 304). Dr. Thornton testified, without further explanation, that in his estimation the criteria for biastophilia was more accurate and more in line with the criteria he testified to, discussed above, than the criteria that was proposed for paraphilic coercive disorder (Dr. Thornton tr at 305-306). Dr. Knight also explained that each of these proposed disorders, including the additional terms "preferential rape" and "sexual assault disorder," had "very different operational definitions" and are "largely non-overlapping criteria" in that they would not cover the exact same group although they were "targeting the same area, which is an area of having fantasies of coercing a particular individual" (Knight tr at 471).

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Moreover, each of the State's experts proffered his own diagnostic criteria. For example, Dr. Kunkle defines OSPD (non-consent) as "a pattern of sexual interests, arousal or behaviors involving non-consenting sexual encounters" (Kunkle tr at 21). He formed this definition from "the literature and research that I have reviewed and my experience in evaluating, treating sex offenders" (Kunkle [*8]tr at 48). Dr. Kunkle explained his diagnostic criteria as follows:

(1)a "pattern of convictions or charges related to forced sexual encounters either by physical force, coercion, trickery, threats where the victim of those acts shows evidence of lack of consent" (Kunkle tr at 22-23). However, he acknowledged that not every serial rapist meets this criteria and the practitioner would have to rule out other causes (Id.);

(2)a "pattern of rapes or forced sexual encounters that first of all had a pretty clear, reasonably clear, sign of the implication that there wasn't going to be consent" such as "evidence of planning" or a "stranger abduction" (Kunkle tr at 23-24).

On cross-examination, Dr. Kunkle opined that he would start with the general rule of three rapes but depending on other factors two rapes or even one rape would be enough "if the person is admitting to those types of acts or arousal patterns" (Kunkle tr at 47);

(3)the frequency of the behavior, e.g. "I will be considering whether an individual has been charged with previous acts of that sort and how quickly they returned to that behavior" (Kunkle tr at 24);

(4)a "recognizable pattern of behavior that speaks to the person's paraphilic interest" such as scripted fantasies (Kunkle tr at 25); and

(5)a report by the individual that he is interested in non-consent or is having fantasies about raping women (Kunkle tr at 25).

Dr. Thornton's eight criteria from his paraphilic rape checklist, summarized above, had elements that differed from Dr. Kunkle's such as having coercive sex when consensual sex was available. Dr. Knight demonstrated that Dr. Thornton's criteria in his paraphilic rape checklist came from a variety of sources such as previously published papers of other researchers, and opined that three of the items on the checklist were "unique" to Dr. Thornton (Knight tr at 557).

In arguing for its inclusion in the DSM-V as a stand-alone diagnosis, Dr. Thornton published yet another set of proposed criteria in a 2009 article that had three criteria: (1) over a period of at least six months, recurrent, intense sexually arousing fantasies or sexual urges focused on sexual coercion, as indicated by self-report, laboratory testing or behavior; (2) the person is distressed or impaired by these attractions, or has sought sexual stimulation from forcing sex on three or more non-consenting persons on three occasions; (3) the diagnosis would not be made if patient meets the diagnosis for sexual sadism disorder (Thornton, D., Evidence Regarding the Need for a Diagnostic Category for a Coercive Paraphilia, American Psychiatric Association: Arch Sex Behav [2009]).

Dr. Wilson's diagnosis criteria was focused more on distinguishing OSPD (non-consent) from sexual sadism (Wilson tr at 133). Dr. Wilson testified that he "would want to know that, first and foremost, the victim was not consenting; that, there was some degree of force, that she was either restrained or that she was maybe tied up, maybe she was given some sort of intoxicant that would reduce her overall ability to fight back" (Wilson tr at 133). Dr. Wilson described an evaluation he conducted where the victim reported that there were times when the perpetrator "seemed to experience somewhat less arousal... (during) times when she wasn't crying as hard or where she wasn't struggling as much" (Wilson tr at 134). He also would include in the definition, the rapist who incapacitates the victim using drugs because the drugs would be a way to overcome the victim's resistance (Wilson tr at 193). Dr. Wilson opined that the rapist who preys upon mentally incapacitated individuals who are not capable of consenting could be similarly diagnosed with OSPD (non-consent) although he would need more information (Wilson tr at 195-196). Dr. Wilson would [*9]even include pedophiles in the definition if the child was struggling and fighting back and the perpetrator was aroused by that struggle (Wilson tr at 197). Thus, Dr. Wilson would include in the definition any perpetrator aroused by the non-consensual nature of the encounter regardless of how it came to be that the person has manifested the non-consent (Wilson tr at 202).

While both Dr. Thornton and Dr. Kunkle testified that a criteria of three rapes would help define the disorder, Dr. Wilson testified that the number of rapes would not be the "biggest indicator for me" in distinguishing sexual sadism from OSPD (nonconsent), but rather he would "want to know more about what happened, what the experience was for the victim, what the nature of the behavior was on the part of the offender" (Wilson tr at 182).

Within the research literature, it was clear that there were differing criteria even among those working within the SVP community, which is where this diagnosis is being used if not exclusively, than clearly predominantly. For example, Dr. Denis Doren, who is a recognized leader in the field of civil confinement, published a book with nine criteria for the diagnosis (see

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Calkins tr at 612; Knight tr at 470, 551). Dr. Doren, in fact, testified at an SVP hearing in Wisconsin that he developed this diagnosis himself to "fill a purported gap" (Brown v Watters, 599 F.3d 602; 2010 U.S. App. LEXIS 5701 [2010])[FN1]. Dr. Knight testified about another proposed scale presented at an ATSA conference in 2010 by Drs. Gary Zinik and Jesus Padilla that has eighteen criteria (Knight tr at 470, 551, 556, 563).

Some of the proposed criteria are in-and-of-themselves controversial. For example, Dr. Calkins testified that there is nothing pathological about rape fantasies and that even "normal" adult men and women have such fantasies (Calkins tr at 615). Dr. Knight testified that males in general have a very high prevalence of these kinds of coercive fantasies (Knight tr at 583). Dr. Bard testified that rape fantasies are about control and domination and are not deviant (Bard tr at 402). Dr. Wilson also, perhaps inadvertently, identified another problem with this criteria. He testified that about fifty times or so back in the 1980s men would come into his office and acknowledge or admit that they are aroused by non-consent type scenarios or videos (Wilson tr at 186). However, he said, that "pretty rarely" happens now due to changes in the law that have made it harder for individuals to self-present and get help (id.). In fact, Dr. Wilson testified that such self-reports have not happened in the last ten years (Wilson tr at 186). And yet, the State's evidence demonstrated that these self-reports of rape fantasies or urges are the primary way to distinguish the paraphilic rapist from the rapist motivated by non-paraphilic reasons such as violence, control, antisociality or cognitive distortions.

Finally, Dr. Knight testified, in greater detail than is necessary to summarize here, that many [*10] of the criteria proposed — such as "the frequency of the occurrence of rape" and "the planning of the offenses" — have no correlation to each other (Knight tr at 552-553). Other proposed criteria such as "at the time of the crime, consensual sex was available" appear to have no data to support it (Knight tr at 555-556). And yet, for other criteria, such as "rape fantasies" discussed above, clinicians lack sufficient details such as the nature of the fantasies and their duration (Knight tr at 583).

The fact that this proposed diagnosis is still evolving and has yet to have a recognizable and generally accepted set of criteria was apparent in Dr. Kunkle's testimony about the use of this diagnosis at the Office of Mental Health (OMH) in the context of Article 10 proceedings. From March 2007 to February 2015, there were 13,000 cases referred to OMH for possible civil confinement (Kunkle tr at 28). Of those, 1,100 were referred for a psychiatric evaluation (thus, 12,000 cases were reviewed and deemed not to meet the criteria for civil confinement) (Kunkle tr at 29). Of the 1,100 cases, 124 had paraphilia, NOS (non-consent) or OSPD (nonconsent) as the specifier (Kunkle tr at 29). However, half of those diagnoses were given in the first two years of the enactment of MHL Article 10 (Kunkle tr at 30). The remaining approximately sixty diagnoses were in the subsequent seven years from 2009 to the present at approximately eleven per year (Kunkle tr at 30-31). Of the 124 diagnoses, only 112 were actually petitioned for civil commitment (Kunkle tr at 31-32).

When asked by the Court why half of the total paraphilia non-consent diagnoses occurred in only the first two years of the program, as compared to the second half occurring over the subsequent nine years, Dr. Kunkle speculated that within the first two years of the program, OMH was using contractors or evaluators that were not within the sex offender program (Kunkle tr at 68). He stated that "whereas over the years we have better defined and better trained people on assigning the diagnosis" (Kunkle tr at 68).

Finally, the State's experts did not agree with each other about where this purported diagnosis fits among other diagnoses more commonly accepted. For example, Dr. Thornton called Dr. Wilson's proposed courtship disorder a "hypothesis" (Thornton tr at 363) and that

I have always been rather skeptical about whether or not that this courtship disorder hypothesis is correct. It's a way of making sense of these things, but I've never been entirely convinced that this was the correct way of understanding these behaviors.

(Thornton tr at 364).

B. This Proposed Diagnosis Cannot Be Reliably Distinguished From Other Motivations for Rape such as Antisociality or Sexual Sadism

All six experts agreed on the importance of determining the motivation for rape whether it is anger, vindictiveness, an antisocial or psychopathic personality type (a disregard for the law and rules and rights of others), or cognitive distortions which are "faulty thinking patterns that might cause somebody to think things like, you know, she was asking for it" (Calkins tr at 625). The difference is important in order to properly treat the offender. As Dr. Wilson explained, "for someone who is fundamentally antisocial" the focus would be "more on their values and attitudes about the world, because they are engaging in rape behavior as a consequence of not having much [*11] regard for others, being a sort of, generally callous and — you know, not considering of others" (Wilson tr at 136). Different motivations for rape might also effect determinations about risk management and interventions (Wilson tr at 136-137).

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* Absent an admission by a patient to having non-consent fantasies or urges, the State's experts did not explain how they would distinguish the paraphilic rapists from those who rape out of anger or cognitive distortion or for psychopathic or antisocial reasons since all of the suggested criteria discussed above are equally applicable to non-paraphilic rapists (see eg Wilson tr at 114). For example, Dr. Wilson believes that there is a "small but distinct group of people who the reason why they engage in that behavior is, specifically, because they want to be having sex with someone who is not consenting" (Wilson tr at 122). However, he further acknowledged that a man who rapes for paraphilic reasons needs to be distinguished from a man who is "more antisocially inclined" as in one who rapes because he is "sexually aroused, he wants to have sex and he doesn't really care whether or not the other person consents. If the other person did consent, he'd be perfectly happy to have sex with them" (Wilson tr at 123). Dr. Wilson further described the thoughts of a person who rapes for reasons of antisociality as: "I'm always angry at women. I just take sex from anyone I can get it from. I don't really care whether she says yes or no. It's all about me. It's my needs first" (Wilson tr at 184). While Dr. Wilson opined that raping because one is angry at women, in general, can still suggest paraphilic behavior so that if that anger leads to sexual arousal the paraphilia might still be "on the table to look at," he did not describe how that distinction could be made (Id.).

Before the Court of Appeals' decision in *Matter of State of New York v Donald DD. & Kenneth T.*, 24 NY3d 174, 996 N.Y.S.2d 610, 21 N.E.3d 239 (2014) this distinction might not have mattered because either motivation for rape, whether a cognitive distortion related to antisocial personality disorder ("ASPD") or a paraphilia, could have conceivably formed the basis of a mental abnormality. However, because ASPD alone is now not enough to form the basis of a mental abnormality, this distinction is now vitally important to separate out those subject to civil commitment from those who now are not. What the court found most convincing was the testimony and research that demonstrated that the proposed disorder of OSPD (non-consent) cannot be reliably distinguished from the recognized disorder in the DSM-V of sexual sadism. Sexual sadism was defined by Dr. Wilson as "people who derive sexual pleasure from inflicting pain and suffering on others" (Wilson tr at 179). He continued that "the level of pain and suffering is, in most cases, quite severe" (Id.). Dr. Wilson testified that on this spectrum of OSPD (non-consent) to sexual sadism, "on the low end" would be "some degree of restraint, some degree of pain or perhaps humiliation" (Wilson tr at 135). While on the high end of the spectrum, one might find things like "cutting, strangling, terrorizing, brutalizing" (Id.). He acknowledged that "the main problem is that somewhere between those two, there is, kind of DMZ or "demilitarizing zone" (Wilson tr at 135, 181).

* As noted above, Dr. Thornton initially believed as recently as 2009 that OSPD (non-consent) was a freestanding construct from sexual sadism. In fact, in his 2009 article, Dr. Thornton proposed two different criteria sets for what he called paraphilic coercive disorder, one as a distinct diagnosis cited above and the other as a form of sexual sadism (Thornton, D., Evidence Regarding the Need for a Diagnostic Category for a Coercive Paraphilia, American Psychiatric Association: Arch Sex Behav [2009]). However, since then he has changed his mind and in the article he co-authored with Dr. Knight in 2011 he now believes that these two are related on a continuum that they call the "[*12]" agonistic continuum" (Knight tr at 525, 528, 530-532; Thornton tr at 354-355; Knight, R.A., Thornton, D., Paraphilic Coercive Disorder: Framing the Debate, Dialogue on Paraphilic Coercive Disorder: Moving Toward an Empirically Based Consensus, 12 Sex Offender Law Report at 33-48 [2011]).

As Dr. Knight wrote in a separate article, "[t]he preponderance of the evidence supports a dimensional latent structure for the components of rape and argues against the proposition that there exists a paraphilic, sexualized or preferential taxon that could serve as a foundation for a distinct diagnostic category" (Knight, R., Is a Diagnostic Category for Paraphilic Coercive Disorder Defensible?, 39 American Psychiatric Association: Arch Sex Behav at 423 [2010]). A taxon is naturally occurring category that has cutoffs provided by nature (Knight tr at 533-534). As Dr. Knight testified since paraphilic coercive disorder appears to be on a spectrum or dimension with sexual sadism, then "any criteria that were proposed to identify the cutoff for a diagnostic category for PCD would likely be arbitrary" (Knight, R., Is a Diagnostic Category for Paraphilic Coercive Disorder Defensible?, 39 American Psychiatric Association: Arch Sex Behav at 423 [2010]). The result being that any criteria set would be necessarily over or under inclusive, have no established validity, and would result in great error in its application (Knight tr at 533-538, 542). As Dr. Knight testified, this idea that paraphilic coercive disorder is on a scale with sexual sadism is a hypothesis or theory that "we're just starting to do the research" such that this theory is "not ready for prime time" (Knight tr at 525-526).

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The State relied heavily on the PPG studies to support their claim that OSPD (non-consent) exists, can be reliably measured, and is, therefore, generally accepted. However the testimony and literature demonstrated that even PPG testing cannot reliably distinguish the purported OSPD (non-consent) diagnosis from antisociality, psychopathy and sexual sadism.

For example, Dr. Wilson acknowledged that the PPG cannot consistently distinguish between OSPD (non-consent) and sexual sadism because there are times when sexual sadists will respond to the coercive stimuli the same way the "non-consent people do" (Wilson tr at 126). When asked about the state of the research and literature in terms of precisely differentiating between OSPD (non-consent) and sexual sadism, Dr. Wilson again acknowledged that "there's a lot of gray space between these two" (Wilson tr at 181). And clinically, Dr. Wilson continued that it matters because "we might treat these two populations somehow differently" when it comes to decisions concerning the allocation of resources, release decisions and issues of sentencing (Wilson tr at 130).

Even the 2003 PPG meta-analysis that the State relied upon which was conducted by some of the undisputed leading researchers of the causes of rape (Lalumiere, Quinsey, Harris et al) concluded that an interesting question for future research is to distinguish among "three theoretically distinct sexual arousal patterns as they apply to rapists' phallometric responses" (see Lalumiere, M.L., Quinsey, V.L., Harris, G.T., Rice, M.E., & Trautrima, C., Are Rapists Differently Aroused by Coercive Sex in Phallometric Assessments?, 989 Ann. NY Acad. Sci at 221 [2003]).

The first hypothetically possible profile reflects biastophilia, sexual arousal to sexual activities involving a nonconsenting, struggling, resisting, but not necessarily injured or physically suffering, victim. The second possibility is sadism. The third possibility is simply general antisociality.

(Id.). Thus, the authors recognized that the PPG is measuring all three of these potential causes [*13] of arousal.

In an article that he co-authored with Dr. Knight in 2011, Dr. Thornton acknowledged the problem with using the PPG to distinguish between this proposed paraphilia and antisociality or psychopathy (Knight, R.A., Thornton, D., Paraphilic Coercive Disorder: Framing the Debate, Dialogue on Paraphilic Coercive Disorder: Moving Toward an Empirically Based Consensus, 12 Sex Offender Law Report at 33-48 [2011]). "The major empirical data for admitting PCD (paraphilic coercive disorder) as a paraphilia derive from PPG studies, which . . . do not adequately differentiate the excitation aspect of sexual responsivity from the inhibitory mechanisms" (Id. at 45) Meaning that for any given individual "it may be unclear how far their rape index (or indeed sexual arousal during a rape) reflects coercion cues, abnormally exciting sexual arousal, versus coercion cues, abnormally failing to inhibit sexual arousal" (Id). The rape index is the ratio of sexual arousal to coercive stimuli to the sexual arousal to consensual stimuli (Knight tr at 504). So where "normal" men would find the distress of the victim as inhibiting, some men responding to the rape scenarios with a positive rape index might not find the coercion exciting or arousing, but rather, lack the ability to be inhibited by the stress cues of the victim (Knight tr at 504, 508). This lack of inhibition, Dr. Knight testified, indicates the presence of psychopathy, in that the rapist lacks the ability to respond to distress cues of his victims (Knight tr at 514).

In a 2012 follow-up study to the 2003 PPG study, Lumiere acknowledged that this "antisociality explanation does not posit a preference for violence or nonconsent, only a relative absence of inhibition in sexual response to these cues" since the antisocial rapists are "more likely to be indifferent to the feelings of others" (Seto, M.C., Lalumiere, M.L., Harris, G.T., Chivers, M., The Sexual Responses of Sexual Sadists, 12 Journal of Abnormal Psychology at 740 [2012]).

Ultimately, this Court was convinced that the data does not yet exist to demonstrate that those who do rape are doing so for a paraphilic reason related to sexual sadism — or a so-called lesser form of sexual sadism, OSPD (nonconsent) — rather than out of opportunity or for antisocial reasons (Knight tr at 524-525). As Dr. Thornton stated "the research evidence indicates that there's a real phenomenon there and that, at least, some time, under some condition, people could describe it with reasonable accuracy" (Thornton tr at 358). The State simply has not proven to this court under what condition at what time the phenomenon could be accurately diagnosed such that it can be considered generally accepted in the relevant scientific community. c. The Studies Offered by the State to Support the Diagnosis Do Not Reflect a Wide, Significant, Well-Rounded Body of Research that Supports the Validity of This Diagnosis

Dr. Knight testified that other than himself and Dr. Thornton there have been very few researchers who have published on this proposed diagnosis in peer reviewed journals (Knight tr at 480-481). The import of this is that there has been little peer-review

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on the two major considerations that apply to both psychological research and general science — the reliability and validity of a diagnosis (Knight tr at 482).

With respect to a diagnosis' validity, Dr. Calkins testified that the "validity of (a) construct or idea . . . it's, in a sense, it's truth. And validity gives us an understanding or tries to help us establish whether this thing that we believe is a disorder really and truly exists" (Calkins tr at 602). Dr. [*14]Calkins explained that "predictive validity" can be important when establishing the validity of a diagnosis. Predictive validity "refers to what we might expect or be able to predict down the road or down the line if somebody is diagnosed with a disorder" (Calkins tr at 603). Dr. Calkins continued,

we would want, with the disorders, to be able to predict certain things and be able to distinguish groups down the line. So, if we weren't able to do that, that might give us some indication that this diagnosis or the construct that we have is not clear, because we're not able to make predictions about what — whether, for example, that person might recidivate or not in the future, whether they would respond favorably to treatment or not, perhaps, what kind of treatment they might respond most favorably to. So all of this would help us really to establish that this diagnostic construct exists.

(Calkins tr at 604). Here, there have been no "long term follow-up studies" where, for example, individuals diagnosed with this condition were compared with a group who were not and the clinicians would "follow them up five or ten or twenty years down the road, again, to see how well they performed in treatment or whether or not they recidivated" (Id.). Dr. Knight mentioned only one such study by Hanson & Morton-Bourgon that indicated that a sexual interest in rape and violence has a very low predictive validity for recidivism (Hanson, R.K., Morton-Bourgon, K., Predictors of Sexual Recidivism: An Updated Meta-Analysis 2004-02, Public Safety and Emergency Preparedness Canada at 491-492 [2004]).

Reliability is essentially "[c]an we make error free judgments? It, in its essence, is consistency. Is there something that exists that either we can agree upon or that we can demonstrate exists over time or if we make measure for it that all of those measures correlate [sic] with each other?" (Knight tr at 482-483). Inter-rater reliability is a measure of how much different raters agree with the greatest agreement being the most reliable (Knight tr at 483). The Kappa coefficient is a measure that takes into account the chance agreement between raters and gives you a measure for how much those raters agree (Knight tr at 483). Dr. Thornton testified that the inter-rater reliability for his Sand Ridge Secure Treatment Center study, summarized above, was .50, which as Dr. Knight testified is, at best, moderate to fair (Knight tr at 484). As Dr. Knight opined, such studies, conducted in a very controlled situation, reflect higher reliability than what would occur "in the field" (Knight tr at 485). Even Dr. Thornton acknowledged that the study within Sand Ridge Secure Treatment Center is of select samples of a population which, as Dr. Thornton acknowledged are "higher risk and have more mental disorders . . . I suppose it is a little bit like saying, if you went into a hospital, you would find people were sick" (Thornton tr at 302).

Dr. Bard concurred: "[W]e don't have for this diagnosis . . . valid, empirically, validated criteria that have been subject to cross validations in a number of different settings in order to gain general acceptance" (Bard tr at 396). Dr. Bard further pointed out that there have been no assessments of real life offenders in an attempt to understand what motivates them. He distinguished these types of "real-life" studies from the PPG studies which are phallometric assessments done in a controlled laboratory setting (Bard tr at 421-423). Dr. Bard testified that the current understanding of what motivates rapists was developed from doing assessments on real life offenders. This subtyping of the motivation of offenders has been developed starting in the 1990s and none of this historical research into the motivations for rape have never suggested or included a paraphilic [*15]disorder (Bard tr at 421-423)(Calkins tr at 621-626).

POINT IV

Other States' Use of OSPD (non-consent) Is Not Compelling

As evidence that the diagnosis of OSPD (non-consent) is a generally accepted diagnosis in the psychological community, the State argues that seventeen other states have used the diagnosis in SVP proceedings (Petitioner's br. at 6 and Wilson tr 137). [FN2] The court has, therefore, surveyed decisions from these other states in an attempt to determine whether the diagnosis was deemed admissible after a Frye hearing, or similar evidentiary hearing, as was conducted by this court. After an extensive search of the case law, this court has not found, nor has the State provided, one case that reports that a Frye or Daubert hearing has been conducted to determine the admissibility of paraphilia, NOS (non-consent) or OSPD (non-consent). Rather, this Court notes that there has been very little direct challenge to the validity of the diagnosis in the states cited the petitioner (See King, C. M., Wylie, L. E., Brank E. M., & Heilbrun, K., Disputed Paraphilia Diagnoses and Legal Decision Making: A Case Law Survey of Paraphilia, NOS, Nonconsent Psychology. Public Policy, and Law. <http://dx.doi.org/10.1037/law0000018>).

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Most notably, the courts of at least six states have held that "expert testimony from psychologists and psychiatrists about a sex offender's mental illness or abnormality is not subject to Frye" (See *In re Detention of Berry*, 160 Wn. App. 374 fn. 15; 248 P.3d 592; 2011 Wash. App.

LEXIS 546 [Court of Appeals, Div. 1, 2011].)FN3] Therefore, any diagnosis offered is exempt from preliminary judicial review in these states.

Other courts, like those in Illinois and New Jersey, have repeatedly denied requests for Frye hearings on the diagnosis of paraphilia, NOS (nonconsent) by taking judicial notice of "unequivocal and undisputed prior judicial decisions or technical writings on the subject" (see e.g. *In re Detention Hayes*, 2014 IL App (1st) 120364; 8 N.E.3d 650; 2014 Ill. App. LEXIS 236 [2014]). However, after [*16]an exhaustive search of the case law, this court was unable to determine any case in those states, such as New Jersey, that originated the basis for admissibility. For example, courts in Illinois and Wisconsin have relied on two Seventh Circuit decisions, *McGee v. Bartow*, 593 F.3d 556, 580 [7th Cir. 2007]) and *Brown v. Watters*, 599 F.3d 602; 2010 US App. LEXIS 5701 [7th Cir. 2010]) which were both habeas corpus proceedings. In *McGee*, the Seventh Circuit held that "the diagnosis of a paraphilic disorder related to rape is not so unsupported by science that it should be excluded absolutely from consideration by the trier of fact" (*McGee*, 593 F.3d at 580 (emphasis added)). Three years later in *Brown*, the Seventh Circuit reaffirmed its holding in *McGee* reasoning that the diagnosis of paraphilia, NOS (nonconsent) is not so unfounded or insufficient as to violate due process and that, therefore, the validity of the diagnosis is proper consideration for the fact finder in weighing the evidence (*Brown*, 599 F.3d at 616). In either articulation, this standard differs greatly from the "general acceptance" standard set forth in Frye. Thus, the State's reliance on these decisions from other states that have not conducted Frye hearings to determine the admissibility of the "non-consent" diagnosis overlooks New York State's specific jurisprudence that encourages the admission of expert testimony only once it has met the requirements of Frye (See *People v. LeGrand*, 8 NY3d 449; 867 N.E.2d 374; 835 N.Y.S.2d 523; 2007 NY LEXIS 325; [2007]; *People v. Wesley*, 83 NY2d 417, 423, 633 NE2d 451, 611 NYS2d 97 [1994]; *People v. Wernick*, 89 NY2d 111, 116, 674 NE2d 322, 651 NYS2d 392 [1996]; *People v. Rogers*, 247 AD2d 765; 669 N.Y.S.2d 678; 1998 NY App. Div. LEXIS 1866 [1998]).

This court also cannot ignore the concern expressed by the Court of Appeals in *Matter of State of New York v Donald DD*. (24 NY3d 174, 996 N.Y.S.2d 610, 21 N.E.3d 239), that in general, the paraphilia, NOS diagnoses may not meet the requirements of Frye. Since *Donald DD*., the Second Department has specifically held that a Frye hearing must be conducted to resolve the question of whether the diagnosis of paraphilia, NOS (non-consent) has achieved general acceptance in the psychiatric and psychological communities so as to make expert testimony on that diagnosis admissible (*Matter of State of New York v Richard S.*, 133 AD3d 672; 2015 NY App. Div. LEXIS 8320; 19 N.Y.S.3d 320 [2d Dept Nov. 2015]; see also *State v. Mercado*, 2015 NY Misc LEXIS 4018; 2015 NY Slip Op 25367; 19 NYS 3d 658 [Sup Ct, Kings County, August 11, 2015]).

This court has found only one other case outside of New York State that has now ordered a Frye hearing on this purported diagnosis (*People v LaBlanc*, 238 Cal App 4th 1059; 189 Cal. Rptr 3d 886; 2015 Cal App LEXIS 646 [July 22, 2015]). In *LaBlanc*, the Court of Appeals of California, Fourth Appellate District concluded that a defendant made a colorable, nonfrivolous showing that his diagnosis of paraphilic coercive disorder is not scientifically valid and thus, a Frye hearing was warranted (*Id.*).

Finally, the State, here, urges this court to rely on three New York State Supreme opinions which admitted testimony on paraphilia, NOS (non-consent) by a finding that the diagnosis was generally accepted based upon written submission, thus denying a Frye hearing (see *Matter of State v Todd L.*, Supreme Court Queens County, September 21, 2015, Aloise, J. Index No. 13814/00; *Matter of State v. Alfred B.*, Supreme Court Nassau County, September 28, 2015, Corrigan, J. SP No. 000012X-2014; *Matter of State v. Daryl W.*, Supreme Court Dutchess County, October 13, 2015, Foreman, J. Index No. 1524/14). However, in the context of Frye, "relying exclusively upon prior judicial decisions to establish general scientific acceptance can be a hollow ritual" if the underlying issue of scientific acceptance has not been adequately litigated" (*Donaldson v. Central Illinois Public* [*17]Service Co., 199 Ill 2d 63; 767 NE 2d 314; 2002 Ill LEXIS 283 [2002]).

POINT V

Limited Use in only SVP Proceedings is Not

General Acceptance by the Relevant Scientific Community

The State has not convinced this court that the relevant scientific community is just those engaged in SVP proceedings or that a greater extended community of psychological or psychiatric practitioners find this diagnosis to be generally accepted. Dr. Bard testified that he has only seen the diagnoses used by government experts in SVP proceedings (Bard tr at 416-417). Dr. Knight similarly testified that this condition is "mostly diagnosed in either the institutions that have been created for civil confinement or in the areas in which you are doing civil commitment considerations" (Knight tr at 478). Nothing in the State's case

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contradicts Dr. Knight's conclusion and the State's three experts, who are tremendously respected in their field and by this court, have also worked extensively in the context of SVP proceedings.

The Court found the article co-written by Thornton and Knight very instructive on this point. (Knight, R.A., Thornton, D., Paraphilic Coercive Disorder: Framing the Debate, Dialogue on Paraphilic Coercive Disorder: Moving Toward an Empirically Based Consensus, 12 Sex Offender Law Report at 33-48 [2011]). The authors acknowledge that the diagnosis is being used extensively in SVP proceedings and that clinicians there are "seeking ways of describing what they believe to be real clinical phenomena" but there are still no generally accepted criteria for diagnosing OSPD (nonconsent) even among those in the field using it (Id. at 44).

This Court cannot help but ask, if this disorder exists, why isn't there convincing evidence that it exists outside the realm of civil confinement? If this disorder is a matter of the human condition, then shouldn't this paraphilia be seen in a context outside of SVP proceedings? The State's primary evidence that this diagnosis can be seen outside of SVP proceedings was Dr. Wilson's testimony that he has "probably interacted with ten to twelve thousand sex offenders in the last thirty-one years" (Wilson tr at 160) and of those, he estimated that approximately two to three thousand had OSPD (nonconsent) (Wilson tr at 163-164). However, he acknowledged that this is a "higher than average preponderance of these sorts of diagnoses" because he worked in a research department tasked with finding out the diagnostic parameters around "odd paraphilias" (Wilson tr at 162).

On the other hand, Dr. Bard testified for the respondent that in his thirty years of clinical work and having evaluated more than 1500 individuals, he has never had a patient tell him that he is motivated to rape because of the non-consensual nature of the rape. (Bard tr at 394-395, 417). Dr. Bard rejects both continuum suggested by both Dr. Thornton and Dr. Wilson as not supported by the research (Bard tr at 400). Dr. Bard opined that men rape because of: cognitive distortions, "because they have perceived needs for domination over women, control over women, feeling more masterful, feeling more adequate," or when "things go wrong in their lives, when they can't sustain relationships, when they feel rejected or demeaned or inferior. There's nothing paraphilic about that" (Bard tr at 395, 400). As evidence of this, he says every treatment program he has ever reviewed - New York, Virginia, Washington - focuses on cognitive distortions, intimacy problems, and general self-control problems (Bard tr at 401).

POINT VI

[*18] The Rejection of this Proposed Diagnosis from Inclusion in the DSM-V

 Respondent argues that the repeated rejection of some form of this paraphilia non-consent diagnosis for inclusion as a disorder in the DSM is evidence that the diagnosis is not generally accepted. As Dr. Knight explained in his history of the creation of the DSM, some form of paraphilia (non-consent) was proffered starting with the DSM-III in the 1980s to the present version of the DSM-V, however each rendition was rejected for apparently different reasons ranging from fear that perpetrators could use the diagnosis at criminal trials to mount an insanity defense to concerns about its scientific validity (Knight tr at 464-466). Dr. Knight himself, having been involved with the DSM-III-R and the DSM-V, initially voted to include some version of the proposed disorder in the DSM-III-R but vehemently opposed its inclusion in the DSM-V (Knight tr at 466). Dr. Knight believes that in the history of the DSM, "this might hold the record of the most rejected disorder in the history of the DSM" (Id.). The respondent argues that these repeated proposals at the time of each DSM revision constitute a "peer review" of the proposed diagnosis, and is evidence of the diagnosis not being generally accepted by the scientific community.

However, ultimately, this Court does not find this argument very compelling because as this hearing demonstrated, the DSM is a political document that rarely changes and the reasons for inclusion or exclusion of any particular diagnosis are complex.

Dr. Calkins acknowledged that "the general approach to the DSM and to each edition of the DSM is a specially conservative approach" (Calkins tr at 645). In fact, it was her understanding that for the DSM-V there were "maybe 100 or so disorders proposed and most of these, the large majority, were rejected" (Id.). Dr. Thornton confirmed that the revision of the DSM is a "conservative process" and that the "same diagnoses from the very beginning maybe 50 years ago - carried on with it" (Thornton tr at 362).

It was also clear from the testimony and the research literature that, similar to the passing of local, state and national legislation, the process of editing and drafting updated versions of the DSM is, as both Dr. Knight and Dr. Thornton acknowledged, a political process. (Knight tr at 447, 454; Thornton tr at 368). For example, a 2008 paper in the Journal of American Academy of Psychiatry and Law reported that the American Psychiatric Association - the authors of the DSM - "has taken a strong position in opposition to SVP commitment laws and in fact filed amicus curiae briefs in opposition to the constitutionality of SVP laws in the two cases in which the United States Supreme Court upheld such laws (Zander, T.K., Commentary: Inventing Diagnosis for Civil Commitment of Rapists, 36 J Am Acad Psychiatry Law at 460 [2008]). Thus, it comes

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as no surprise to this court that while the paraphilic sub-work group recommended that OSPD (non consent) be added to the DSM-V, the APA chose not to include it (Calkins tr at 648-649; Knight tr at 465-466).

CONCLUSION

It comports with the testimony, the research literature and in some regard common sense that there are persons on a sexual sadism scale who are sexually excited by the use of force and violence but to a degree that is less than what would be currently diagnosed as sexual sadism. The court commends efforts by Drs. Thornton, Knight and Wilson to set a uniform criteria by which this purported diagnosis can be used in the SVP setting to avoid its overuse. While this court deeply appreciates the potential import of this decision, the State has proven at this point [*19] in time that this diagnosis is only a working hypothesis - a theory - one not yet generally accepted or in the words of Dr. Knight "not ready for prime time."

Respondent's motion is granted.

This constitutes the Decision and Order of the Court.

Date: January 22, 2016

Dineen A. Riviezzo, J.S.C.

Footnotes

Footnote 1: As the Brown court wrote in its opinion:

On cross-examination, Dr. Doren admitted that the indicators used to reach a diagnosis of paraphilia NOS nonconsent were not identified in the DSM; instead, they were indicators Dr. Doren himself had identified to bridge the gap or deficiency [that] ... exist[s] in the DSM[] that he had offered to the field in his own book on the subject of civil commitment. (Wis. R.95, Tr.AA at 32, 34.) When asked for a professional organization that accepted his clinical indicators for the diagnosis of paraphilia NOS nonconsent, Dr. Doren further admitted that there isn't a single one.

(Brown v Watters, 599 F.3d 602; 2010 U.S. App. LEXIS 5701 [2010] (internal citations omitted)).

Footnote 2: Petitioner's brief lists the following states, without citation, as jurisdictions that have permitted the diagnosis of paraphilia, NOS (nonconsent) and OSPD (nonconsent): Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin.

Footnote 3: Footnote 15 cites the following cases: See, e.g., Commonwealth v. Dengler, 2004 PA Super 38, 843 A.2d 1241, 1245 (agreeing with out-of-state cases and holding "that psychological or psychiatric testimony of an expert at an SVP proceeding is not novel scientific evidence subject to Frye"), *aff'd*, 890 A.2d 372 (2005); Westerheide v. State, 767 So. 2d 637, 657-58 (Fla. Dist. Ct. App. 2000) ("The admission of expert testimony from psychologists and psychiatrists for the purpose of predicting future dangerousness caused by mental illness or abnormalities is nothing new or novel to the law"); People v. Ward, 71 Cal. App. 4th 368, 373, 83 Cal. Rptr. 2d 828 (1999) ("Kelly-Frye applies to cases involving novel devices or processes, not to expert medical testimony, such as a psychiatrist's prediction of future dangerousness or a diagnosis of mental illness" (citing People v. Kelly, 17 Cal. 3d 24, 549 P.2d 1240, 130 Cal Rptr. 144 (1976))); see also In re Det. of Bolton, 343 Ill. App. 3d 1223, 1228, 800 N.E.2d 128, 279 Ill. Dec. 286 (2003) (noting that "a psychologist's or psychiatrist's opinion as to an individual's future dangerousness is generally admissible when that opinion is based upon clinical observation or the evaluator's personal experience"); People v. Therrian, 113 Cal. App. 4th 609, 615-16, 6 Cal. Rptr. 3d 415 (2003) (Frye hearing not required where actuarial test was merely starting point and not sole basis for psychologist's opinion regarding offender's risk of recidivism); Logerquist v. McVey, 196 Ariz. 470, 1 P.3d 113, 123 (2000) ("Frye is inapplicable when a qualified witness offers relevant testimony or conclusions based on experience and observation about human behavior for the purpose of explaining that behavior").

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Exhibit # 7

Matter of State of New York v Kareem M.

Annotate this Case

[*1] Matter of State of New York v Kareem M., 2016 NY Slip Op. 50427(U), Decided on March 29, 2016
Supreme Court, New York County Conviser, J. Published by New York State Law Reporting Bureau
pursuant to Judiciary Law § 431. This opinion is uncorrected and will not be published in the printed
Official Reports.

Decided on March 29, 2016

Supreme Court, New York County

In the Matter of the Application of The State of New York, Petitioner,
against

Kareem M., Respondent, For Commitment Under Article 10 of the Mental Hygiene Law.

30006\2014

New York State Attorney General Eric Schneiderman (Elaine Yacyshyn, of counsel) for the Petitioner.

Mental Hygiene Legal Services (Jessica Botticelli, Kimberly Tate-Brown and Maura Klugman, of counsel)
for the Respondent.

Daniel P. Conviser, J.

The Respondent is the subject of a petition for sex offender civil management pursuant to Article 10 of the Mental Hygiene Law ("Article 10", the "Sex Offender Management and Treatment Act" or "SOMTA"). The instant decision concerns this Court's conclusion following a Frye hearing (See Frye v. United States, 293 F. 1013 [D.C. Cir.1923]) about whether the diagnosis proffered by the State here, "Other Specified ~~Paraphilic Disorder ("OSPD"), arousal to non-consenting persons"~~ has gained general acceptance in the relevant psychiatric community. This diagnosis was also referred to by a number of equivalent terms during the hearing including the shorthand "OSPD Non-Consent", its predecessor term (as explained infra) "Paraphilia Not Otherwise Specified (Paraphilia NOS) Non-Consent", "Blastophilia" (derived from the Latin word for rape), Paraphilic Coercive Disorder ("PCD"), Paraphilic Rapism or simply "Non-Consent". For the reasons outlined infra, the Court holds that these diagnoses are not generally accepted in the relevant scientific community under the Frye standard.

STATEMENT OF FACTS

I. RESPONDENT'S CRIMINAL HISTORY AND DIAGNOSES [FN1]

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The instant offense arose from charges concerning nine victims on nine occasions in 2000 and resulted in the Respondent's conviction for multiple counts of Sodomy in the First Degree [*2] and related crimes. Mr. M. is currently 40 years old. His instant crimes all followed a similar pattern. Mr. M. would follow his female victims, who ranged in age from 11 to 18, into an elevator or stairwell of a building, usually threaten the use of a knife and then demand and in multiple cases receive oral sex. After ejaculating into his victims' mouths, he would flee. Mr. M. reported during an interview that "the look of fear in the victims was a thrill" and a turn on for him". [FN2] He also reported that he was unable to stop offending, wanted to get caught and let some of his victims who cried too much leave. He admitted to having up to ten victims but was not sure if there were more.

The State's expert, Dr. Field, initially diagnosed Mr. M. with Other Specified Paraphilic Disorder ("OSPD") "arousal to nonconsensual oral sexual activity" and Antisocial Personality Disorder ("ASPD"). His current diagnosis, as noted supra, is OSPD "arousal to nonconsenting persons" and ASPD. Dr. Field noted that Mr. M. was aroused to his victims' fear. He did not outline in detail, however, any of the diagnostic criteria he used to assign his OSPD diagnosis. He opined that Mr. M. suffered from a Mental Abnormality under Article 10.

The Respondent's expert, Dr. Leonard Bard, found in a report dated October 20, 2014 that Mr. M. could not be diagnosed with a paraphilia (a sexual disorder, defined infra) or ASPD and did not suffer from a Mental Abnormality. With respect to the "Non-Consent" diagnosis, Dr. Bard opined that this diagnosis had "recently been rejected for inclusion in the diagnostic manual [of mental disorders] . . . It is a condition created for legal proceedings like this one and given its lack of any specific criteria or underlying research, should be considered both unreliable and invalid". [FN3]

II. EVIDENCE PRESENTED AT THE HEARING

Six psychologists or psychiatrists testified at the hearing, three for each party. The Court also received multiple articles into evidence. The testimony and articles are described below. The factual portion of this Decision begins with an explication of the Diagnostic and Statistical Manual of Mental Disorders.

The DSM-5 and its Prior Editions

All of the experts analyzed the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (the "DSM-5"). That manual's provisions and history are also one basis for this Court's decision. The provisions of the DSM-5 and immediately preceding edition are therefore first outlined here. The manual's historical development is outlined in the summary of the witness testimony.

The DSM was first published in 1952 and has gone through multiple numerical iterations with the most recent 5th edition published in 2013. The immediately preceding edition, the DSM-4-TR (Text Revision) was published in 2000. Dr. David Thornton described the DSM as an attempt by American psychiatry to harmonize diagnostic practices. It has been called the "Bible of mental disorders" and is "like the institutional embodiment for the consensus of main [*3] treatment and psychiatric opinion in the United States" (Thornton, 28-29). [FN4] Dr. Raymond Knight described the manual as including "a consensus of experts in psychiatry about those particular disorders that should be treated" (506). It is the result

"partly of tradition", partly of a consensus of leading psychiatrists, partly of "politics" and to "some extent influenced by research". (Thornton, pp. 28-29). The manual emerges "through a complex, hierarchical process informed by expert working groups, consultation on possibilities, and multi-layered review" (Thornton, Power Point, p. 2).[FN5]

* The DSM-5 classifies eight named paraphilic disorders (not including the disorder at issue here). It defines the word "paraphilia" as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (685).[FN6] One may have a paraphilia, however, without having a paraphilic disorder. A paraphilia describes a sexual interest and is a "necessary but not . . . sufficient" predicate for a paraphilic disorder (686). 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" (685-686). The eight listed paraphilic disorders are: Voyeuristic Disorder, Exhibitionistic Disorder, Frotteuristic Disorder, Sexual Masochism Disorder, Sexual Sadism Disorder, Pedophilic Disorder, Fetishistic Disorder and Transvestic Disorder.

The DSM-5 also includes the diagnosis "Other Specified Paraphilic Disorder" ("OSPD"), which, with the specifier "Non-Consent" is at issue here. The OSPD provision reads in relevant part:

This category [Other Specified Paraphilic Disorder] applies to 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. The other specified paraphilic disorder category 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. This is done by recording "other specified paraphilic disorder" followed by the specific reason (e.g., "zoophilia").[FN7] (705).

This passage goes on to provide 6 non-exclusive examples of OSPD diagnoses: the sexual attraction to obscene phone calls, corpses, animals, feces, enemas and urine. The DSM [*4] also includes the diagnosis "Unspecified Paraphilic Disorder" ("UPD"), which is not at issue here. These are paraphilias where a clinician chooses not to specify the reason the criteria for one of the eight listed paraphilias have not been met, including presentations for which there is insufficient information.

According to the manual, the eight listed disorders were chosen because "they are relatively common, in relation to other paraphilic disorders" and because some are classified as crimes. The manual notes that this list is not exhaustive and that "[m]any dozens" of paraphilias have been identified and named". The diagnoses of OSPD and UPD, according to the manual, "are therefore indispensable and will be required in many cases" (685). The DSM-5 also includes a section entitled "Conditions for Further Study" described as "conditions on which future research is encouraged" (783). OSPD Non-Consent is not listed as one of these conditions. The distinction between conditions for which detailed criteria are provided and the general OSPD and UPD categories is not limited to paraphilic disorders but applies similarly to all disorders in the DSM-5. Thus, disorders for which specific criteria are not provided by the DSM are covered by the formulations "other specified disorder" and "unspecified disorder". The DSM gives as an

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example of the former "other specified depressive disorder, depressive episode with insufficient symptoms" (15).

The DSM edition immediately prior to the DSM-5 was the DSM-4-Text Revision (the "DSM-4-TR"). The DSM-4-TR had a different nomenclature for categorizing paraphilias. Conditions were not broken into "paraphilias" and "paraphilic disorders". Nor did the DSM-4-TR have two categories: OSPD and USPD. Rather, a single category of disorder called "paraphilia" existed. The OSPD and USPD category equivalent in the DSM-4-TR was "Paraphilia Not Otherwise Specified" ("Paraphilia NOS"). Drs. Thornton and Kunkle opined that the general Paraphilia NOS category was generally accepted in the psychological community under the DSM-4-TR. The 8 listed paraphilias in the DSM-5 are comparable to the paraphilias listed in the DSM-4-TR and its immediately preceding edition the DSM-4 (without the "TR" designation).

Testimony of State Witness: Dr. David Thornton

Dr. Thornton is the research director of the "Sand Ridge Center" which treats sex offenders under the Wisconsin "Sexually Violent Persons" or "SVP" program.[FN8] He received a psychiatry degree in the United Kingdom but is not licensed to practice psychiatry in the United States. He previously worked extensively in the British prison system doing policy based research and developing programs, including treatment programs for sex offenders. He began working at the Wisconsin SVP program in 2001 as its treatment director. In 2013, he became the director of the system's research unit.

Dr. Thornton worked as an "expert advisor" to the group developing the DSM-5's paraphilia section. The concept of a "paraphilia" was introduced in the DSM's third edition (the [*5]DSM-3). Any experience a human being may have can be "sexualized" by someone. "[Y]ou may not be attracted by the idea of progressively cutting flesh off somebody and eating it but there are people who are . . ." (32). Four or five hundred sexual interests have been categorized and given pseudo-Greek or Latin names. Dr. Thornton said the eight named paraphilias in the DSM-5 were those which "commonly presented themselves for treatment". Id. It is difficult to say why the eight named paraphilias were chosen because it is partly based on tradition.

Under the Wisconsin SVP program, about 20% of offenders receive an OSPD Non-Consent diagnosis. The diagnosis is used in other states and is used "more commonly" in SVP programs than in the community generally (61-62). The diagnosis is also more of a focus in SVP programs than in other criminal justice contexts. He said that in one DSM-5 field trial, it was determined that no one outside the SVP Program context met the criteria for PCD. Dr. Thornton opined that OSPD Non-Consent was a generally accepted diagnosis in the psychiatric community.

In "OSPD Non-Consent" "the sexual interest is in the imposition of sexual activity on another person, whose behavior clearly signals that they don't want sex to happen". This involves "struggle and resisting" by the victim who is seen to "loathe strongly" and experience "psychological suffering" (65). OSPD Non-Consent meets the definition of a paraphilia under the DSM-5 because a paraphilia can include a sexual interest with an other than consenting adult partner. He said that he and a number of other researchers believed there is a "sadism continuum". On the most severe end is brutality and the possibility of future killings. Further down the scale are arousal to bondage, humiliation and fantasies of

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hurting people, fantasies of scaring someone into sexual consent or forcing someone to do something. OSPD Non-Consent is a "lesser form of sadism". Id. Not all forcible rapes are a manifestation of the disorder.

Research into this issue has come in three forms. First are Penile Plethysmograph, or "PPG" tests. These are tests which measure a subject's physical sexual arousal through the use of a sensor on the shaft of a penis to measure changes in penis size in response to visual or aural stimuli, for example, depictions of consensual vs. coercive sex. Such tests are generally used and accepted in the clinical psychology community. A stronger response to rape stimuli than to stimuli depicting consensual sex would support a Non-Consent diagnosis. A collection of PPG studies have indicated that most men are more attracted to consensual than coercive sex.

Normally, cues indicating mutual sexual interest increase PPG arousal while cues indicating female coercion inhibit sexual arousal at least partially. For convicted rapists and men indicating a willingness to rape, however, there is an association between coercion cues and heightened arousal. "Among rapists typically between a third and a half will show stronger responses to stimuli depicting coercion than to stimuli depicting consent".[FN9] Dr. Thornton outlined the results of a study of 33 rape offenders who were assessed using a PPG rape stimulus set and received stimuli in three categories: consensual, coercive and brutal (the latter corresponding to a sexual sadism diagnosis). He found that 48% of rapists had a consensual preference, 30% a coercive preference and 21% a brutality preference.

A second research method involves "rating scales" and Dr. Thornton's development of a "Paraphilic Rape Checklist" meant to detect a Non-Consent diagnosis not rising to the level of [*6]sexual sadism. The items on the checklist are: evidence of pre-planning, evidence of a rape script being repeated, a history of three or more sexual assaults, a history of carrying out one or more rapes when consensual sex was available, evidence of coercion beyond what is required to obtain victim compliance, a history of sadistic acts like strangling, PPG data and self-reports of a rape or sadistic fantasy or urge. These measures are meant to distinguish an offender who has a rape preference from one who rapes opportunistically or because he is antisocial but is not attracted to the nonconsensual aspect of a rape. Dr. Thornton also developed a "Severe Sadism" checklist which includes items evidencing torture, infliction of intense pain, humiliation, mutilation, the use of objects, cutting, strangling or threats designed to terrify rather than only coerce. This checklist is derived from similar checklists compiled by other researchers. He testified that other "paraphilia colleagues" had developed their own rape scales but was not aware whether those other scales incorporated elements of his checklist (137-138).

Dr. Thornton conducted a study on the reliability of the Paraphilic Rape Checklist ("PRC") and Sadism Checklist ("SC"). He found that different evaluators agreed on scoring for each checklist 64% of the time which he described as moderate.[FN10] He said that the scales had a higher rating with respect to their internal consistency among scored items, with this percentage being 77 or 78%. He next found that there was a correlation between the number of behavioral signs in the PRC with the percentage chance a subject would be aroused to a coercive sexual scenario in a PPG test or report a rape fantasy. Subjects with one behavioral sign, for example, had a preferential PPG result or self-report 50% of the time while subjects with 4, 5 or 6 behavioral signs had those results 100% of the time. Comparing these results to

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those on the SC checklist, he concluded that "[p]araphilic rape partly overlaps with severe sadism but has substantial variance that is independent of severe sadism" but also cautioned that these results might be attributable to measurement error.[FN11] Non-Consent and Sexual Sadism are part of a continuum with 25% of cases overlapping and 75% not overlapping. Half of those subjects whom Dr. Thornton found had evidence of paraphilic rape were diagnosed with Sexual Sadism and half were not.

Research by Dr. Knight (another witness at the instant hearing) used subject self-reports and determined arousal to coercion in what he described as an "Agonistic, or Sadism Continuum", which is a series of 17 increasingly coercive fantasies or behaviors beginning with "Make female do I want turns me on [SIC]" to "Beaten woman while having sex".[FN12] The scale was described as a "probabilistic Guttman". [Dr. Thornton, in the Court's view, did not explain in detail what a "probabilistic Guttman" scale is but according to Wikipedia, "on a Guttman scale, items are arranged in an order so that an individual who agrees with a particular item also agrees [*7]with items of lower rank-order".[FN13] Dr. Thornton presented a chart in his Power Point of Dr. Knight's work but did not explain the statistical percentages in the chart. The significance of the percentages was not self-evident.]

Dr. Thornton testified that it is "possible" to assess rape related paraphilias reliably but that does not mean clinicians in routine practice do so (107-108). Clinicians may be influenced by the "allegiance effect" (influenced to make findings in accordance with the position their employer is taking) and routine clinical practice may lack the rigor of controlled studies. Dr. Thornton said that state evaluators "invariably" used Non-Consent diagnoses and that evaluators for defendants "generally" did not use them (109). He said the diagnosis was "consistent" with the DSM. Id. It is rare that a person will be treated for a Non-Consent disorder outside a forensic setting. He also said that in Wisconsin there are evaluators who are not prosecutors but are employed by the courts or the State and generally use the diagnosis. The "diagnosis has been applied too widely" (113). He divided rapists into three categories: sexual sadists, opportunistic rapists who use rape as a method to have sex and rapists with a non-sadistic rape paraphilia. He estimated that generally about 30-50% of rapists (by forcible compulsion) could be diagnosed with PCD.

[Recommendations regarding paraphilias under the DSM-5 were first considered by the "sub-work group" then forwarded to a more general "work group" on "Sexual and Gender Identity Disorders"[FN14] and finally subject to approval or disapproval by the board of the American Psychiatric Association (APA).] The paraphilia sub-work group did not have any role in the decision to not include PCD in the DSM-5 Appendix as a condition warranting further study. Non-Consent has been repeatedly rejected as a named paraphilia by the DSM both because it would open the door to excessive civil commitments and because it might allow rapists to argue they were not guilty by reason of a mental disability. Dr. Thornton and others conducted three "field trials" for the Non-Consent diagnosis during the time it was being considered for inclusion in the DSM-5, in Wisconsin, Florida and California. The rejection of Non-Consent in the DSM was "political" in the sense that the APA "is strongly opposed to ... civil commitment" and ultimately makes decisions about what is included in the manual (129).

He described the inter-rater reliability (the degree to which two evaluators looking at the same subject would reach the same diagnosis) of Non-Consent in the field trials as "moderate" and about as reliable

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as the established diagnosis of Sexual Sadism (130). One reason for the rejection of the Non-Consent diagnosis in the DSM-5 was that it was "hard to fully distinguish PCD from sexual sadism" (131). It is not true that the non-specifically identified paraphilias are only those which are rarely seen. For example, bestiality is quite common among Wisconsin SVP patients but is not one of the eight listed paraphilias.

The PPG is a good indicator of arousal but is imperfect like other measures. The proposed DSM-5 criteria for PCD and the criteria used in the field trials were different from the Paraphilic Rape Checklist designed by Dr. Thornton.

Testimony of State's Witness: Dr. Christopher Kunkle

Dr. Kunkle has been the director and chief psychiatric examiner of New York State's sex [*8]offender civil management program operated by the Office of Mental Health ("OMH") since 2012. He received his Ph.D. in 2007, began working at an OMH psychiatric center which managed SOMTA patients that year and has continued doing such work since then. Dr. Kunkle defined OSPD Non-Consent as "intense and persistent sexual arousal to nonconsensual sexual activity that includes either force or verbal threat to coerce the individual into sexual behavior" (181). He said he determined Non-Consent diagnoses by looking at prior behaviors, psychological or sexual testing and an offender's statements. He would consider whether the offender had evidenced a pattern of rapes, as opposed to one incident, whether the victims were strangers, whether there was evidence of sexual fantasies involving rape and whether the rapes were planned.

Dr. Kunkle described the results of a database review of cases screened by OMH from the enactment of SOMTA (in 2007) until February 12, 2015 during which 13,000 offenders were subject to initial OMH screening. 1,120 were subject to a psychiatric evaluation. Of that number, 124 were given a Non-Consent diagnosis. Article 10 petitions were filed in 112 of these 124 cases.[FN15] Approximately half of these 124 diagnoses (58) occurred during the first two years of the statute's implementation (192-193). Dr. Kunkle said he believed the disorder was diagnosed more frequently during the first two years of Article 10 because OMH had contracted extensively with outside evaluators at that time to conduct evaluations, because evaluators did not receive the training later provided by OMH or because evaluators were not "well-educated" about paraphilias (194). OMH became "more specific about assigning the [Non-Consent] diagnosis" as time went on. Id.

In response to the question of whether offenders diagnosed with NOS Non-Consent in 2007 or 2008 were "misdiagnosed" Dr. Kunkle replied: "I don't know". He opined that were such offenders diagnosed incorrectly, "I would fathom those cases were meted by the court process" (217) and said that if an OMH clinician came to a conclusion that a Non-Consent diagnosis was no longer appropriate the clinician would provide that opinion during an annual review for a confined offender, for example. He said he was not aware of a case which had been "flat out misdiagnosed" but made it to the SOMTA commitment stage (217-218). When asked what criteria State evaluators used in 2007 and 2008 to diagnose Non-Consent, Dr. Kunkle replied: "I don't know". When asked whether these criteria were the same ones OMH used today, he replied: "I don't know" (218).

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Dr. Kunkle opined that the diagnosis of OSPD Non-Consent was generally accepted in the psychiatric community and said that "there is a strong basis of research and practice indicating that the consensus of individuals believe this condition exists" (196). He opined that even among evaluators who generally work on behalf of respondents in SOMTA proceedings, there are some who believe the diagnosis is legitimate. The disorder was not included in the DSM-5 as a specifically named paraphilia because there were individuals who did not believe it could be precisely diagnosed and some who had political views on the subject. By "political" he meant the view that the diagnosis was being used to "drive an agenda that's not clinical in nature, [*9]such as a civil commitment; the incarceration of individuals" (203). In the past, there were also concerns among victims that the diagnosis could furnish an excuse for rape.

Dr. Kunkle testified that he was not aware of Dr. Thorton's paraphilic rape checklist. He said he had reviewed the research of multiple people in arriving at the criteria he used to diagnose Non-Consent. He acknowledged that he did not have PPG results for offenders he assessed for the disorder in all cases. He did not provide a clear answer to the question of whether a person who was not inhibited by a victim's resistance (as opposed to an individual who was affirmatively aroused by such resistance) would have OSPD Non-Consent. He said it would depend in part on whether a behavior would recur.

OMH currently provides general guidance about the markers for Non-Consent but each evaluator determines the criteria he or she will use to diagnose the disorder (218). OMH currently has 18 or 19 evaluators, none of whom have opined that the diagnosis of Non-Consent does not exist. OMH has not conducted any studies to determine the inter-rater reliability of evaluators diagnosing the disorder.

Testimony of State's Witness: Dr. Robin Wilson

Dr. Wilson is a psychologist who treats, evaluates, trains and consults regarding sex offenders and sex offender risk assessments. As a graduate student, he worked for Dr. Kurt Freund, who invented the PPG test and has conducted PPG testing. He received a Ph.D. in cognitive science in 1996. From 1998 until 2005 he was the chief psychologist for the Canadian Correctional Service. He worked at the Florida civil commitment program which is run by a private company from 2007 until 2011 and became its clinical director. Now in private practice he is retained both by the State and respondents.

Dr. Wilson estimated that there are 150 to 250 paraphilias which have been named but "not all of these are common enough to warrant their own diagnostic framework" (257). Some, also, have not "sort of been well-established enough" to warrant specific DSM criteria. Id. Scientific literature describing an attraction to non-consensual sex dates back over 100 years. He described the phenomenon as a "strong degree of sexual arousal" to having sex against the will of the victim (272). Under the DSM paraphilia definition, normal sexual arousal requires arousal to sex with a "consenting" adult. Dr. Wilson described a "taxon" as something which could be discretely defined while a dimensional construct indicates something that exists by degrees. He said Non-Consent was dimensional because arousal could exist on a continuum from consensual to sadistic. As the continuum increases, an offender may be sexually aroused by the violence itself (rather than only the victim's non-consent) with the high end of the scale being sexual sadism. Information about arousal to non-consent can be gleaned from the reports of victims, perpetrators or PPG tests.

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Dr. Wilson distinguished an attraction to non-consent from coercive sexual behavior which arises from other causes like intoxication, group behavior, not understanding that "no means no" or people who were "jerks" or "somehow anti-social" (283). He opined that OSPD Non-Consent was generally accepted in the scientific community. Dr. Wilson recounted "meta analyses" of PPG studies. A meta analysis is a compilation of the results of multiple studies providing a greater sample size than one study. "[W]hat the PPG studies have shown is that consistently, people who engage in rape, show more of a sexual arousal to scenes or scenarios of sexual coercion of rape than people who never have engaged in the behavior" [or ever been [*10]known to have engaged in the behavior] and also more sexual arousal than people who have engaged in non-sexual violence (287). "The PPG literature has shown that we can consistently differentiate people who engage in rape from people who do not" (289). Dr. Wilson said his research attempted to determine the subset of rapists whose arousal is due in part to the non-consent of the victim where non-consent "is part of what makes them more sexually aroused" (290). He said the disorder exists for a person where the "primary driving force" behind sex is the attraction to non-consent.

In the continuum between normal sexual behavior and sexual sadism there is a significant grey area particularly in the middle. "[T]here's no precise diagnostic framework that would split those cases [in the continuum] with one hundred percent certainty" (296). People on the low end can be distinguished from people on the high end. One manifestation of the higher end of the continuum is violence above what is required to ensure victim compliance. Studies by Raymond Knight have been successful to some extent in distinguishing people with sexual sadism from those with a lesser paraphilic disorder. There is a higher degree of inter-rater reliability in diagnosing sexual sadism. There is not a clear distinction between violence used to ensure victim compliance and sexual sadism where an offender is aroused by the violence itself. It is also difficult to draw a line between a person attracted to non-consent and a sexual sadist. One way to attempt to do this is by the use of the "Severe Sexual Sadism Scale" which attempts to rank offenders with respect to acts of extreme violence, terror or humiliation. The research on this is "still emerging" (303).

Referencing his work in Canada, Dr. Wilson said he had seen OSPD Non-Consent applied in non-SVP contexts "[o]n hundreds if not thousands of occasions" (306). He opined that the OSPD Non-Consent diagnosis was generally accepted among persons in prosecution roles in SVP proceedings and that there was an "implied bias" in holding such positions (308). He said that persons working for the state in other contexts diagnosing and treating sex offenders also used the diagnosis. With respect to private practitioners, there are a "large number of people who are using it" and some people who don't. Id. With respect to psychiatric professionals working for respondents, some people use it and some don't. He opined the diagnosis is not one of the named paraphilias because it does not have a well enough established diagnostic framework both with respect to distinguishing Non-Consent from sexual sadism and distinguishing rapists with a paraphilia from those without one. Since the latter distinction relies on self-reports which subjects may not want to provide "we don't necessarily always know" why a rapist offends (311). A person diagnosed with Non-Consent, compared to a rapist without a paraphilia, has a condition which is more "intractable" and therefore would be at a higher risk to re-offend, other things being equal (311-313).

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With respect to inter-rater reliability a percentage of 60 or 70 would be moderately reliable while in a forensic setting it would be better if the percentage were 80 or higher. He said that a PCD study he conducted had an inter-rater reliability percentage of 83. Dr. Wilson said he did not use any specific criteria for diagnosing OSPD Non-Consent and did not use Dr. Thornton's paraphilic rape checklist or a Non-Consent checklist created by Dr. Dennis Doran in his book "Evaluating Sex Offenders". He said he used criteria from the DSM-5 paraphilia sub-work group to diagnose Non-Consent. A person who commits multiple rapes is more likely to have PCD than an offender who commits one rape. He agreed that the diagnosis has been [*11]overused in the past.

Dr. Wilson opined that Non-Consent was rejected as a specific DSM-5 diagnosis both because it was difficult to define and because "the DSM can be as much a political document as . . . a diagnostic tool" (326). He said that some perspectives about violence against women suggest rape is a crime of power, control and violence but that there are a "small subset" of offenders who commit rapes "for fundamentally — paraphilic reasons" (327). Part of the "political reasoning" for not including a defined rape paraphilia was that assigning a clinical diagnosis to rapists could be seen as excusing their behavior and be offensive to women. This concern began with the DSM-3 and continues.

Rapists are more aroused to non-consent in PPG tests than non-rapists. In surveys, about a quarter to a half of all men report that if they could have sex with anyone, anytime, without permission, they would do so. However, the percentages become lower when the question includes information about the sexual partner being unhappy, even where these questions also include the stipulation that the man would not be punished. A fair number of men have engaged in some sexually coercive behavior by the age of 35. "The issue of rape is a really complicated one which is part and parcel of the reason why we don't have a precise diagnostic framework for it in a thing like DSM-5 . . ." (336).

Dr. Wilson agreed that, "broadly speaking" "one cannot reliably distinguish between nonconsent and sexual sadism" (338-339). He also agreed that "you cannot reliably distinguish between someone who is aroused by the nonconsent of the victim versus somebody who is raping despite the nonconsent" (339). However, research has demonstrated increased PPG responses to coercive scenarios among rapists. Different evaluators may use different criteria to diagnose Non-Consent but these differences are "fine details" (344-345).

Testimony of Respondent's Witness: Dr. Erik N. Schlosser

Dr. Schlosser is a forensic psychologist who primarily works providing sex offender evaluations with most of his work done in Article 10 cases. He received his Ph.D. in 1997 and is board certified in forensic psychology. He previously worked as a psychologist for the Navy, the Utah Prison system, and from 2006-2008 at the Central New York Psychiatric Center (CNYPC) operated by OMH. Article 10 was enacted in 2007 and while at OMH he worked on developing protocols, policies and procedures under the new statute. He described this as "building a plane while flying it" (360).

X According to Dr. Michael First, who communicated with the DSM-5 paraphilia sub-work group, Non-Consent was rejected for inclusion as a named paraphilia in the DSM-5 because of a "lack of empirical research and supported foundation as well as a concern about false positives [persons being diagnosed

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with the condition who did not have it]" (368). Dr. Schlosser testified concerning field trials to assess inter-rater reliability for the proposed DSM-5 PCD diagnosis at civil commitment centers in Florida and Wisconsin (discussed supra). "Validity" refers to whether a diagnosis exists and can be distinguished from other conditions. No field tests were done to assess the validity of the PCD diagnosis for inclusion in the DSM-5.

One of these studies yielded a Kappa coefficient in the .5 range and another found a Kappa in the .6 range, which would both be "fair to good" depending on how a researcher [*12]viewed Kappa coefficients (338). [FN16] The concern about PCD's inclusion in the DSM-5, however, was about false positives. Inter-rater reliability declines when evaluations move from a field test into the real world. There are three reliability issues which arise with respect to PPG tests. First, are problems with the way the test is administered, which result in invalid PPG results in half of cases. Second, in a forensic context, subjects may seek to defeat the PPG, for example, by masturbating prior to the test to decrease arousal. Medication can also confound the test.

* It is difficult to distinguish a male who is aroused by non-consent from a male who is not inhibited by it. The etiology of an attraction to non-consent has been difficult to establish and it is also difficult to distinguish a person who is sexually aroused to non-consent from a person responding to non-consensual stimuli in a PPG study, for example, because of "a trauma based reaction to past victimization" (398). With respect to research distinguishing rapists who have or do not have PCD, "we're just not there as a field yet". Id. Most evaluators who believe PCD is a legitimate diagnosis rely on a book written by Dennis Doran in 2002 about evaluating sex offenders which particularly concerns SVP proceedings. The DSM-4-TR has introductory language indicating that a paraphilia can concern attractions to non-consenting persons but Dr. Schlosser believes that language was intended as an introductory provision for some of the eight named paraphilias and was not intended to allow the use of PCD as a legitimate diagnosis. He based that conclusion on the writings of Dr. Allen Francis, the editor of the DSM-4-TR. The DSM-5 does not have this prefatory language.

PCD may be an appropriate diagnosis in some cases in a clinical setting but should not be used forensically because of its lack of research and clarity. It is used most often by state evaluators in SVP proceedings. Most evaluators who diagnose Non-Consent do so based on behaviors only, which is illegitimate. Dr. Schlosser believes the diagnosis is not generally accepted in the psychiatric community and that there is only "a very very small subgroup" of mental health professionals who accept it. Most professionals who work with sex offenders focus on interventions rather than diagnoses. The Non-Consent diagnosis is generally accepted among state evaluators. It is not generally accepted among most private practitioners who may be retained by either the State or respondents in SVP proceedings, although some clinicians use it. It is generally not accepted by People who work for SVP respondents.

Dr. Schlosser acknowledged that he had assigned the PCD diagnosis twice since the publication of the DSM-5 in cases where a subject also had sadistic traits but would not do so now because "at this time the data required to make that diagnosis has not been defined enough for me to do so" (414). Virtually no offenders evaluated under Article 10 have had PPG studies and a very small minority have made self-reports regarding Non-Consent. Without those tools, Non-Consent cannot be diagnosed. Dr. Schlosser

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testified that Non-Consent is on a continuum with sexual sadism but cannot be reliably distinguished from that latter disorder. Most people in the psychological community believe rape is more of a non-sexual phenomenon involving anger and other things rather than a sexual phenomenon. He said Non-Consent was not generally [*13] accepted in the board-certified forensic psychiatric community and among all evaluators who work in SVP proceedings it is "more evenly split" (423). State evaluators may find the diagnosis acceptable because of an "allegiance effect". When Article 10 was enacted, the Non-Consent diagnosis was used "regularly and easily" but is used less now (432). OMH did not have criteria for diagnosing Non-Consent when Dr. Schlosser worked there.

Testimony of Respondent's Witness: Dr. Raymond Knight

Dr. Knight testified that he is a psychologist who has been employed for his entire professional career in that field at Brandeis University where he is currently the chair of the Psychology Department. His extensive research on sexual aggression began in 1977 and became a focus of his research work in 2000. He has authored numerous peer-reviewed studies including work on paraphilias and sexual aggression. He is a former president of the Association for the Treatment of Sexual Abusers (ATSA) and continues to be very involved in the organization. Dr. Knight was an advisor to the paraphilia sub-work group for the DSM-5 and involved in prior DSM formulations.

A condition called "sexual assault disorder" was first proposed in 1976 as part of the DSM-3 but was rejected because evaluators believed it might be used as an excuse to exculpate rape offenders as being mentally ill. A similar disorder was then considered for the DSM-3-TR in 1985. That proposal, by Dr. Knight, was for what he called a "preferential rapist" and was rejected because of problems with its scientific validity. A similar disorder was rejected in the DSM-4 and DSM-4-TR. It was also rejected for inclusion in the research Appendix for both manuals.

A similar proposal was made for the DSM-5 and resulted in a very public debate. The DSM-5 paraphilia sub-work group ultimately did not recommend a Non-Consent diagnosis for inclusion as a named paraphilia because of its weak empirical data (532). He said the fact that the DSM-5 described normal sexual arousal as applying to "consenting human partners" did not mean that PCD is a valid disorder. He described PCD as "the most rejected disorder in DSM history" (532) having been rejected for inclusion as a specified disorder in the DSM five times. It was a condition for people who "wanted a diagnosis that they could use for rapists". Id. Dr. Knight opined that given the current state of research, Non-Consent cannot be distinguished from Sexual Sadism.

Unfortunately, the Court found most of Dr. Knight's testimony incomprehensible. Much of that testimony concerned his attempt to explain graphs and charts which the Court could not follow. The Court repeatedly indicated it did not understand Dr. Knight's testimony, at one point saying simply: "You can keep going, it is all lost on me" (585). The transcript of Dr. Knight's testimony also contains apparent typographical errors. Consider these representative quotations:

We are talking about not the measures that we have but what the latent underlying structure is behind those measurements and we weren't able to measure those things until Paul Meehl [spelled this way in the transcript] called — measurements called taxometrics fashion analysis. It is very difficult it will blow

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you away; much more complicated a very simple notion we can give you outcome of consistent [spelled this way in the transcript] studies about that notion very — a taxon is a naturally occurring difference in kind [the court understood that last [*14]clause] (593).

I am going to go straight, if you have a taxon you can get specific etiology; we could have one paraphilia that indicates that it might be some — whether you don't have a taxon there are multiplicity of variables added to make that. The last one is for me as a researcher, it tells me how I analyze data if I have dimension I use the extreme group of analyses and I am going to be all screwed up and get very confusing results. You have to use appropriate analysis, kind of variables that you have only whereas here we only look at a cutoff issue (594).

[Explaining a chart] We are down here at the bottom, that's how we see the world, we do not see the world from a God's eye view or Miss Jones if you are not an atheist. We don't see reality as it is in and of itself, we see it from down here with measurements if we have a — if we have a taxon there is a group that is provided by nature and the best differentiation of the group is at the intersection right here between the taxon and the complement (595).

Similar issues arose on cross-examination and in questioning by the Court. When the Court attempted to solicit Dr. Knight's views on whether the Non-Consent diagnosis was generally accepted in the psychiatric community, for example, Dr. Knight, in the Court's view, simply refused to answer the Court's questions, insisting on answering his own questions and at one point repeatedly insisting that a question the Court was posing was really two questions, not one (632-638).[FN17]

Testimony of Respondent's Witness: Dr. Cynthia Calkins

Dr. Calkins has been a licensed psychologist since 2003, has a Masters of Legal Studies and is a professor of psychology at John Jay College of Criminal Justice who specializes in the study of sexual offenders. She conducts and supervises research on sexual offending, teaches and supervises students doing clinical work. She has never seen a Non-Consent diagnosis used outside an SVP program and has never evaluated an SVP respondent.

Dr. Calkins opined that OSPD Non-Consent is not a generally accepted diagnosis in the psychiatric community, if the community is defined as psychologists or psychiatrists generally. She asserted this was the relevant community to consider, arguing, for example, that if general acceptance was being assessed for a disorder like depression, that "is not something that is only diagnosed by a very, very small pocket of all psychiatrists or psychologists. We accept this as a generally accepted diagnosis because we see it in community health centers, we see it in [*15]hospitals, we see it in the community, we see it in prisons ... " (99). Similarly, pedophilia is diagnosed everywhere and patients sometimes arrive at a community health center outside any forensic context and are diagnosed with the disorder.

Another community which could be considered would be the several thousand practitioners who work with sex offenders as reflected in the membership of ATSA or ("the ATSA community"). Dr. Calkins opined that Non-Consent is not generally accepted in that community and that she had not seen it used outside SVP programs. A third possible category would be evaluators who work for SVP programs. She

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estimated there are 100,000 psychologists or psychiatrists in the United States, 20 states with SVP programs with 25 evaluators per state yielding 500 SVP evaluators with roughly half (250) employed by the State. This final group uses the diagnosis. "[T]hat comes out to around one quarter of one percent of the entire psychological, psychiatrist community, who would use this diagnosis in any kind of regular way" (104).

Dr. Calkins opined that the DSM is "a good measure of what's considered to be generally accepted in the field" (105). The Non-Consent diagnosis "really doesn't exist" outside SVP cases (106). A diagnosis should have "validity" meaning it is true or real. It should also be able to be diagnosed reliably, meaning that clinicians would agree a given person had it. Dr. Calkins referenced two studies, one of which she co-authored, described in the Appendix infra, which concluded that there was poor inter-rater reliability for the Paraphilia NOS diagnosis generally. These studies did not measure inter-rater reliability for the paraphilia NOS Non-Consent diagnosis, however.

A number of factors indicate the Non-Consent diagnosis is not valid. First, it has been rejected for inclusion as a named paraphilia in the DSM five times. Other OSPD diagnoses have not been so rejected. Second, there have been no studies on the "predictive validity" of the diagnosis, that is, studies which would indicate it was predictive of some future behavior. Third, there have been few causal studies of why rape offenders offend. Fourth, rape has historically been considered a crime not a mental disorder. Fifth, there have been no published "field trials" which have examined how the disorder is diagnosed in practice although Drs. Thornton and Wilson conducted field trials which did not result in a published study and were not peer reviewed. These studies indicated fair to moderate reliability in diagnosing PCD by trained clinicians using criteria developed by the researchers. These criteria, however, are not used by other clinicians who diagnose the disorder. Non-Consent is different than other OSPD paraphilias because while other OSPD paraphilias are rare, rape is not.

Dr. Calkins opined that Non-Consent is part of a dimension along a sadism scale and cannot be reliably distinguished from sexual sadism. None of the potential measures of validity (outlined immediately supra) indicate Non-Consent is a valid diagnosis. She opined that PPG tests are useful for treatment but not sufficiently reliable to make diagnoses in a legal setting because of their high rates of false positive and negative results. PPG devices are not uniform, subjects can deliberately suppress arousal and arousal may be increased or decreased because of artificial laboratory settings. Dr. Calkins does not believe a criminal rapist can be distinguished from a paraphilic rapist through PPG tests or otherwise. Rape fantasies are common among both men and women. Dr. Calkins acknowledged that the DSM-5 does not prohibit the use of OSPD diagnoses in legal proceedings.

Articles Received in Evidence

The Court received multiple articles in evidence written by psychologists or psychiatrists who have evaluated sex offenders or conducted research in the field. Some of these articles were opinion pieces reflecting the authors' views on the validity of the Non-Consent diagnosis and others recounted the results of research studies. The articles the Court believed were most relevant are summarized here except with respect to one article which was cited by the New York Court of Appeals in *State v. Donald*

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DD. and Kenneth T. 24 NY3d 174 (2014) ("Donald DD" or "Kenneth T.") which is outlined in the discussion of that case, *infra*. Additional articles received in evidence are outlined in an Appendix to this Decision. The articles other than those in the Appendix are given shorthand designations next to their titles.

"The DSM-5 and Paraphilic Disorders" (Michael First Article)[FN18]

This article outlines issues which arose in adopting the DSM-5's paraphilia section. The author notes that unlike other DSM sections, paraphilias are primarily diagnosed in forensic settings. There were three particularly contested DSM-5 paraphilia proposals: to add PCD and a new named paraphilia called "Hypersexual Disorder" and to broaden the pedophilic diagnosis to include pubescent as well as prepubescent children. None of these proposals were adopted. The DSM-4 and 4-TR, according to the author, had a "forensically significant editing error . . . This error, a misplaced or' allowed the diagnosis of a paraphilia to be based entirely on the presence of criminal sexual behavior, sidestepping the requirement that the behavior be a manifestation of a deviant sexual arousal pattern" (195). The DSM-5 now generally has the deviant sexual arousal pattern as its centerpiece and places behaviors and fantasies in subsidiary roles.

Dr. First asserts the OSPD category is "intended to be used for presentations that do not meet the criteria for any specific DSM-5 disorder; for presentations of uncertain etiology with respect to whether the condition is substance induced, due to another medical condition, or primary; and for presentations where there is insufficient information to make a more specific diagnosis" (198). "By virtue of their residual and often idiosyncratic nature, cases diagnosed as [OSPD] . . . [including PCD] are, by definition, outside of what is generally accepted by the field and thus should be used in forensic contexts only with great caution" (199).

"Commentary: Inventing Diagnosis for Civil Commitment of Rapists" (Zander Article)[FN19]

[This article was written prior to the adoption of the DSM-5 and thus in part analyzed the "NOS" category under the DSM-4 and 4-TR]. Non-Consent is not a diagnosis under the "International Statistical Classification of Diseases and Related Health Problems" or "ICD-10". [FN20] Attempts to provide a PCD diagnosis in the DSM-3-TR from 1983 to 1986 resulted in "vigorous [*16]opposition" from multiple organizations (461). It was understood by the 1980's that rape "is a violent assault motivated by the rapist's desire for power and domination rather than by sexual arousal". *Id.* The APA Board rejected the proposal in 1986 by a vote of 10-4. Two new proposals were included at that time in the DSM Appendix as conditions warranting further study but the Non-Consent diagnosis was not.

The DSM-4-TR assigned "V-codes" applicable to sexual abuse involving "sexual coercion rape". V-codes do not describe a mental disorder but rather problems which are "a focus of clinical attention" (463) (citations omitted). This is further evidence the DSM did not intend PCD to be diagnosed in the "NOS" category. While the vague standards of the NOS category may be appropriate in clinical settings that category should not be used in forensic settings because NOS diagnoses are "ad hoc inventions of individual diagnosticians" (465). The Non-Consent diagnosis is not generally accepted in the field because "it is based on a construct that was deliberately rejected as unsupported by research and the

behavioral sciences when it was considered for inclusion in the manual of diagnosis that is based on professional consensus" Id. The author asserts that psychologists who use the Non-Consent diagnosis may be in violation of APA ethical standards because the diagnosis is not supported by established scientific and professional knowledge. Some men may rape because of a paraphilia but more research needs to be done to allow the Non-Consent diagnosis to be used in forensic settings.

"Commentary: Muddy Diagnostic Waters in the SVP Courtroom" (Prentky Article)[FN21]

Diagnoses in SVP proceedings "frequently are reflexive and indefensible" (456). The DSM was never intended to differentiate between categories of sex offenders with the result that offenders are placed in categories (like pedophilia) primarily based on behaviors and the needs of the legal system. It is plausible that some rapists have a paraphilia but "in practice this newly contrived diagnosis [Non-Consent] reflects bad faith, bad science, and often, bad clinical judgment". Id. The diagnosis has questionable reliability and there is considerable scientific evidence that rape is associated with "misogynistic anger, negative or hostile masculinity, rape-related cognitive distortions . . . and impersonal sex" Id. (citation omitted).

"Are Rapists Differentially Aroused by Coercive Sex

in Phallometric Assessments?" (LaLumiere Article)[FN22]

A review of previous studies indicates that rape offenders as well as men who report they have engaged in coercive sexual behavior, on average, responded with greater sexual arousal as measured by PPG tests to sexually coercive scenarios than other men. A new study compared 24 men charged with a sexual assault against a woman with offenders who had committed non-sexual violence against a woman and non-offending men (the latter two groups being the "comparison" samples). The participants were shown audio consenting and coercive sexual scenarios. "[C]omparison participants showed a preference for consenting scenarios, whereas rapists showed little discrimination between rape and consenting scenarios and perhaps a slight preference for rape" (218). An interesting question for future research is whether a distinction [*17] can be made among three sexual arousal patterns. The first is an attraction to non-consensual sex, but not necessarily sex involving physical injury or suffering. The second is to sadism, the sexual arousal to suffering. The third is to antisociality, the indifference to the feelings of others. "Sexual Arousal to Erotic and Aggressive Stimuli

in Sexually Coercive and Noncoercive Men" (Lohr Article)[FN23]

This paper concerned two studies. Both involved 24 male college students. In the first, students were equally divided into a "sexually coercive group" and a control group based on their answers to questions. PPG results were obtained after showing the participants a range of videotaped sexual scenes ranging from consensual to sadistic. "Participants in the sexually coercive group showed significantly greater physiological arousal than did those in the control group in response to the rape scenarios involving verbal pressure, verbal threats, physical force and sadistic rape." (239). The arousal differences began when force was introduced into the videos. At that point, the noncoercive group's arousal declined while the coercive group's arousal remained stable or increased. This is consistent with the

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"sexual inhibition" hypothesis of rape which suggests that sexual aggression is more likely when cues of non-consent fail to inhibit sexual response. The data indicated, however, that "the sexually coercive group preferred consensual sexual scenarios over force scenarios". (239). The study also found that non-sexual aggression towards women was not arousing to either group. "[T]he groups did not differ in their responsiveness to videotape presentations depicting consensual activity . . ." Id.

In the second study, a similar group of 24 men was measured using only auditory stimuli. The results of this study were consistent with the first study with respect to the sexually coercive group. However, while the control group exhibited some sexual arousal to force scenarios in the first study, possibly due to naked slides, they exhibited no significant arousal to force audio tapes. The authors opine that this is because the control group required "significantly provocative" cues to result in arousal. "[C]oercive males appear to be aroused by minimal sexual cues" (240).

Is a Separate Diagnostic Category Defensible for Paraphilic Coercion? (Knight Article)[FN24]

This paper, co-authored by hearing witness Dr. Raymond A. Knight, explored whether PCD could be reliably distinguished from Sexual Sadism by reviewing PPG studies in order to assess the DSM-5 proposal to include a PCD disorder separate from Sexual Sadism. The authors concluded that PCD was not a categorically separate disorder from Sexual Sadism but rather a lower degree of "agonistic fantasizing and behavior on a continuum" (91) and that the creation of a separate disorder for PCD under the DSM-5 was therefore not justified. The authors also recommended against including PCD as a subject for further study under the DSM because this would tend to facilitate its acceptance as a bona-fide disorder.

Anecdotal Evidence Derived From This Court's Practice

The Court has also taken judicial notice of its experience in SOMTA cases. This Court has presided over 14 SOMTA trials since 2008, written numerous SOMTA decisions and [*18]presided over every other type of SOMTA proceeding on multiple occasions (other than annual review hearings for confined offenders). The Non-Consent diagnosis has been assigned in many of these cases. This Court has therefore noted its own admittedly anecdotal experiences at certain points in its legal analysis.

CONCLUSIONS OF LAW

III. THE FRYE STANDARD & ITS GENERAL APPLICATION TO OSPD & USPD

The Frye test considers the "question of whether the accepted techniques, when properly performed, generate results accepted as reliable within the scientific community generally." *People v. Wesley*, 83 NY2d 417, 422 (1994); see also, *Parker v. Mobil Oil Corporation*, 7 NY3d 434 (2006). The scientific principle "must be recognized" and "sufficiently established to have gained general acceptance in the particular field in which it belongs". Id., at 422-424, quoting *Frye*, supra. "The Frye test emphasizes counting scientists' votes, rather than verifying the soundness of a scientific conclusion". Id. at 439 (Kaye, Ch.J., concurring) see also, *People v. LeGrand*, 8 NY3d 449 (2007). Under the Frye test, the burden of proving general acceptance rests on the party presenting the disputed evidence. *Zito v. Zabarsky*, 28

AD3d 42, 44 (2d Dept 2006). General acceptance can be established through "texts and scholarly articles", expert testimony and judicial opinions. *People v. Wernick*, 215 AD2d 50, 52 (2d Dept 1995), affirmed, 89 NY2d 111 (1996).

The vast majority of the evidence presented at the hearing addressed the question of whether the diagnosis of OSPD Non-Consent was based on consistent criteria and was valid and reliable. While this testimony was relevant to the inquiry here, it did not directly address the question the Court must decide. As Judge Abdus-Salaam, then writing for the First Department explained, the Frye test:

often involves considering whether a sufficient quantum of other experts in the same field accept the reliability of the theory or process. . . Since the implication of this approach is that it entails a process of weighing the views of each sides' experts, it is not surprising that a trial court would be tempted to weigh the relative merits of the experts introduced by each side to decide whether the proposed expert testimony is reliable. However, even where the court's task is weighing, or counting, the scientists' votes, nevertheless, it is not the court's job to decide . . . which expert's conclusions are correct." *Marsh v. Smyth* 12 AD3d 307, 311 (1st Dept 2004) (emphasis in original).

In *Zito v. Zabarsky*, supra, the Court held that "general acceptance does not necessarily mean that a majority of the scientists involved subscribe to the conclusion. Rather it means that those espousing the theory or opinion have followed generally accepted scientific principles and methodology in evaluating clinical data to reach their conclusions". 28 AD3d at 44, quoting *Beck v. Warner-Lambert Co*, 2002 NY SlipOp 4043 (U), 6-7. The First Department recently cited that proposition with approval in *Sadek v. Wesley*, 117 AD3d 193 (1st Dept 2014).

OSPD or USPD Generally vs. OSPD Non-Consent

Initially, it is also important to recognize the distinction between whether the diagnosis of OSPD with a valid specifier is generally accepted and whether OSPD with the specifier "Non-Consent" meets the Frye test. It is clear to this Court that the OSPD designation itself is generally accepted in the psychiatric community assuming a valid specifier is attached to it. [*19]Justice Riviezzo, following a Frye hearing, provided an extended analysis of why the general OSPD diagnosis is valid in *State v. Mercado*, 50 Misc 3d 512 (Kings County Supreme Court 2015) and this Court generally concurs in that analysis.

The DSM-5 unquestionably provides that the OSPD diagnosis with an appropriate specifier is valid. There are paraphilias and paraphilic disorders concerning the sexual arousal to corpses, animals and feces, for example, notwithstanding the fact that such disorders are not among the eight listed paraphilias in the DSM-5. Some commentators have opined that OSPD diagnoses are simply never appropriate in forensic settings because of their lack of defined criteria. In this Court's view, however, the evidence at the hearing did not support that proposition and in any event, that general question is not at issue here. It is also clear to this Court that the general diagnosis of Unspecified Paraphilic Disorder (USPD) is generally accepted in the psychiatric community. Justice Gross reached that conclusion after a Frye hearing in *State v. Harris*, 48 Misc 3d 950 (Bronx County Supreme Court 2015).

IV. BASIS FOR THIS COURT'S HOLDING

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This Court has concluded the Non-Consent diagnosis is not generally accepted in the relevant psychiatric community for the following reasons, each of which will be discussed in turn:

(1) The New York Court of Appeals has indicated a strong inclination towards the conclusion that PCD is not a legitimate diagnosis.

(2) In a decision after a Frye hearing on the same question as here, the trial Court in State v. Jason C., 2016 NY SlipOp 26018 (Kings County Supreme Court [Riviezzo, J.]) recently held the Non-Consent diagnosis is not generally accepted. While this Court does not agree with every aspect of the Jason C. decision, it finds much of the Court's reasoning and its ultimate conclusion persuasive.

(3) The DSM-5 clearly supports the view that PCD is not a generally accepted diagnosis.

(4) The state did not prove that when the "scientists votes are counted" in the relevant psychiatric community, PCD is generally accepted.

(5) PCD cannot be reliably diagnosed given the current state of psychiatric knowledge. Even assuming PCD is a legitimate diagnosis, it has been overused and abused in SVP cases.

(6) The Court does not find the fact that Non-Consent has been used as an SVP diagnosis in other states to warrant the conclusion that it is legitimate here.

1. The View From the Court of Appeals:

"Junk Science Devised For the Purpose of Locking Up Dangerous Criminals"

In Kenneth T., the Court's four judge majority decision dismissed the petition on grounds of legal insufficiency. The majority also addressed the Non-Consent diagnosis at issue here, [*20]however. The Court's assertions regarding that diagnosis relied on an earlier three judge dissenting opinion in State v. Shannon S., 20 NY3d 99 (2012) which opined that a different Article 10 diagnosis would likely not meet the Frye test. The Kenneth T. Court's assertions about the Non-Consent diagnosis, and other appellate rulings on Article 10 Frye issues, have prompted a wave of motions in New York courts about whether various diagnoses and assessments applied in Article 10 cases are generally accepted.[FN25]

In Kenneth T. the State's expert testified that the Respondent, who had been convicted of one completed and one attempted forcible rape, had Paraphilia NOS involving fantasies, urges and behaviors towards non-consenting persons. The Court first asserted that "Paraphilia NOS is a controversial diagnosis" and a "catch-all" category for diagnoses not specifically listed in the DSM. 24 NY2d at 186. The Court went on to note that the three dissenting judges in Shannon S. who were now part of the Kenneth T. majority, had said the paraphilia NOS diagnosis presented by two of the state's expert witnesses in that case "amount[ed] to junk science devised for the purpose of locking up dangerous criminals" and expressed "grave doubt" such a diagnosis would survive a Frye hearing. Id., quoting Shannon S., supra, 20 NY3d at 110 (Smith, J., dissenting). In Shannon S., however, the Paraphilia NOS Non-Consent diagnosis was not at issue. The expert in that case diagnosed the Respondent with Paraphilia NOS Hebephelia, which he defined as a paraphilic attraction to pubescent girls.

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There are certainly arguments that Paraphilia NOS Hebephilia is a problematic diagnosis. But the fact that Paraphilia NOS Hebephilia has the same "NOS" prefatory designation as Paraphilia NOS Non-Consent does not make the validity of these diagnoses necessarily equivalent, anymore than the fact that because Paraphilia NOS Necrophilia, (a sexual attraction to corpses), may be a valid diagnosis, Paraphilia NOS Non-Consent must be valid as well. The Shannon S. majority upheld the validity of the Paraphilia NOS Hebephilia diagnosis in that case and the dissenting judges in Shannon S. disagreed with that ruling.[FN26] The decision did not [*21]address Paraphilia NOS Non-Consent in any way.

The Kenneth T. Court referenced in a footnote at least one aspect of what it perceived were the problems with the Non-Consent diagnosis saying: "[p]rominent members of the psychiatric community have criticized the practice of diagnosing so-called paraphilia NOS nonconsent' on the basis of a history of committing sex crimes". n. 6. That footnote referenced two articles, one of which was received as evidence in the instant motion: "Paraphilia NOS Nonconsent: Not Ready for the Courtroom" (the "Frances Article").[FN27]

In this opinion piece, the authors make it clear that they are skeptical of SVP statutes generally. The two authors were the Chair and Editor of the Text and Criteria for the DSM-4 paraphilia section and assert they are responsible for what they see as the confusion surrounding the Non-Consent diagnosis which they say is illegitimate. They attribute the confusion to the fact that the DSM-4 was written prior to the advent of SVP statutes and that language in the DSM-4-TR definition of paraphilia references the fact that a paraphilia can involve "suffering and humiliation" as well as "children or other non-consenting persons". (Article, p. 556). "In fact", the authors say, "it was never anticipated that the opening sentence of the section would be considered a forensic definition of paraphilia or be used in determining the suitability of long-term psychiatric incarceration". Id.

The operative language in the paraphilia definition of the DSM-4-TR, according to the authors, was rather designed as a table of contents to catalog the eight named paraphilias. PCD was rejected for inclusion as a named paraphilia in the DSM-5 because "the rationale and supporting evidence [for the disorder] were so thin". Id., p. 559. "The differential diagnosis of rape behavior would have to include rape for gain . . . opportunistic rape, date rape, gang rape, rape for dominance, rape under the disinhibiting influence of substances, rape related to an antisocial personality pattern of criminality and rape influenced by other mental disorders. . . " Id. Research on the disorder is in the "most formative stages of development". Id. The second article cited by the Kenneth T. Court, (which was not received as evidence during the instant hearing), had one author (Dr. Allen Frances) in common and is entitled: "Defining Mental Disorder when It Really Counts: DSM-IV-TR and SDP/SVP Statutes"[FN28] This opinion piece was published three years prior to the preceding article and makes similar arguments.

[*22]The Kenneth T. majority held that the principle of stare decisis indicated the Shannon S. majority holding that Paraphilia NOS Hebephilia was a valid diagnosis in that case should not be overruled. Kenneth T. and Shannon S., however, again considered two completely different disorders, linked only by the fact that they were both one of hundreds of possible diagnoses in the NOS category.

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In this Court's view, the Kenneth T. court's description of the Non-Consent diagnosis as "junk science devised for the purpose of locking up dangerous criminals" also conflated two related issues. As the Kenneth T. Court argued, the Non-Consent diagnosis, as discussed infra, has been misused in SVP cases. On the other hand, the important work done by researchers like those who testified at the instant hearing to identify a rape paraphilia is clearly not "junk science". The effort to understand why men rape, to determine whether some rapes result from a paraphilia, to identify which men might rape and ultimately to prevent rape are obviously goals of paramount importance. The effort to define a rape paraphilia is an emerging discipline. It is not an invalid one. The Court of Appeals has not ruled on whether PCD is a legitimate disorder. It would obviously consider the record of a Frye hearing were it presented.[FN29] But the Court has also obviously already stated a strong point of view on the issue. Wholly apart from whether that view is correct, the Court's assertions must be given weight here.

2. State v. Jason C. Held That PCD is Not a Generally Accepted Diagnosis

In a wholly different category is the trial court's decision in State v. Jason C. Unlike Kenneth T., Jason C. is obviously not binding on this Court. But this Court finds both the ultimate conclusion and much of the Court's reasoning in Jason C. uniquely persuasive. In Jason C., Justice Riviezzo conducted a Frye hearing on instant question in which six expert witnesses testified; five of whom also testified in the instant matter.[FN30] She then conducted an exacting analysis, extensive legal research and considered essentially the same arguments made by the parties here. While Justice Riviezzo's focus differed from the Court's here and while this Court does not agree with all of her conclusions, the Court did find much of her analysis persuasive.

Justice Riviezzo focused most of her analysis not on the task of "counting scientists votes" (as the Court did here) but on the threshold question of whether PCD can be reliably diagnosed. She reached the following conclusions:

* [T]here is no agreed upon criteria for this condition [PCD] even among SVP practitioners. . . [T]he court cannot find a diagnosis generally accepted' when there is not, at the very least, a generally accepted criteria that defines the condition. 2016 NY SlipOp at 10.

This proposed diagnosis cannot be reliably distinguished from other motivations for Rape [*23] such as Antisociality or Sexual Sadism. Id., p 13.

* [T]here has been little peer review on the two major considerations that apply to both psychological research and general science — the reliability and validity of a diagnosis. Id., p. 17 (citation omitted).

The Court found the fact that other states with SVP programs allowed the diagnosis (discussed infra) not persuasive and held that "[t]he State has not convinced this court that the relevant scientific community is just those engaged in SVP proceedings or that a greater extended community of psychological or psychiatric practitioners find this diagnosis to be generally accepted" Id., p. 20.

3. The DSM-5 Clearly Supports the View That PCD is Not Generally Accepted

As Dr. Knight testified, a condition called "sexual assault disorder" was first proposed in 1976 as part of the DSM-3 but was rejected. A similar disorder was considered for the DSM-3-TR in 1985 but was rejected again because of concerns about its scientific validity. A similar disorder was again rejected by the DSM-4, 4-TR and DSM-5. It has also been twice rejected for inclusion in the DSM as a condition warranting further study. As noted supra, the process for adopting a new paraphilia diagnosis in the DSM-5 included three stages: a recommendation from the paraphilia sub-work group, the approval or disapproval of the "work-group" on sexual disorders and finally a vote by the APA board. After significant discussion and research, the PCD proposal was never recommended by the first of these entities. (Knight 532).

Dr. Thornton testified that the DSM has been called the "Bible of mental disorders" and is "like the institutional embodiment for the consensus of main treatment and psychiatric opinion in the United States" (28-29). Dr. Knight described the manual as including "a consensus of experts in psychiatry about those particular disorders that should be treated" (506). Other witnesses testified similarly. Witnesses also consistently opined the DSM was a "political" document. This assertion had a partially pejorative connotation meant to convey that the rejection of Non-Consent as a named paraphilia in multiple DSM versions was less about diagnostic legitimacy than other agendas. Two broad "agendas" were identified. The first, going back decades, was to not legitimize rape as a psychiatric condition when it was in reality a brutal violent crime which subjugated women. While there was some evidence that agenda remains vibrant today, a different concern has arisen with the advent of SVP statutes: a "political" determination to not use the creation of a Non-Consent paraphilia as a vehicle to subject rapists to civil confinement.

The hearing evidence indicated the APA, which ultimately must approve new diagnoses under the DSM, opposes SVP laws. The New York State Psychiatric Association indeed expressed vehement opposition to the adoption of Article 10 in New York when the bill was presented to Governor Spitzer for his signature in 2007:

... "[M]ental abnormality" as defined [under Article 10] is essentially a vague and circular determination that has no scientific or clinical basis. "Mental abnormality" as defined in the bill remains a non-medical definition of what purports to be a clinical condition which usurps psychiatric terminology to achieve a social and political result. Because "mental abnormality" has no medical foundation, mental health professionals, [*24]including psychiatrists, have no special expertise in assessing individuals for the presence of "mental abnormality" as defined in the bill.[FN31]

The hearing evidence made clear that the great skepticism among many psychologists and psychiatrists about SVP laws has likely influenced decisions about whether PCD should be designated as a named paraphilia.[FN32]

The DSM-5 provides no rule that a condition which has been explicitly rejected as a named disorder can then not be validly assigned an "Other Specified" designation. The fact that the DSM has repeatedly rejected the inclusion of a defined Non-Consent paraphilia for "political" reasons, however, is another way of making the obvious point that a consensus has never developed in the psychiatric community to include it as a named paraphilia. It has never been generally accepted. The psychiatric community has

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repeatedly "counted votes" in its "sub-work" groups, committees or membership to see if PCD warrants a specified paraphilia designation. The proposition has been rejected — five times over a period of 40 years. Dr. Knight characterized it as "the most rejected disorder in DSM history" (532). With respect to the Frye standard, whether that occurred for legitimate diagnostic reasons or less worthy "political" goals doesn't matter. As Dr. Knight argued: "Repeated rejection of paraphilic coercive disorder proposals constitutes substantial evidence that this disorder and its variants are not generally accepted by the relevant scientific and professional community".[FN33]

Of course, it is not that simple because the OSPD category is generally accepted if accompanied by a legitimate specifier. But the evidence at the hearing indicated that disorders are given OSPD designations rather than listed as named paraphilias for three reasons. The first is that the disorder is rarely seen. But there was no evidence at the hearing that paraphilic rape was not included as a specified disorder because it was rare and extensive evidence that rape is unfortunately not a rare occurrence. The second reason, as Dr. Thornton testified, is tradition, or to perhaps put it differently, inertia. But that is a normal feature of any political process. It is usually more difficult to change something through a deliberative system than to keep it the same. The DSM approval process is obviously bureaucratic and difficult. But the fact that PCD has never overcome the bar of tradition is not an argument that it is legitimate. It is an argument that it has never gained general acceptance.

The third reason a disorder does not become a specified condition under the DSM is that it has not been sufficiently defined or researched. Multiple witnesses for both sides said that has been an important reason for PCD's rejection. Dr. Wilson testified that "[t]he issue of rape is a really complicated one which is part and parcel of the reason why we don't have a precise diagnostic framework for it in a thing like DSM-5..." (336). Dr. Schlosser said the disorder's rejection was based on the "lack of empirical research and supported foundation as well as a concern about false positives" (368). Dr. Thornton testified that one reason for the rejection of the Non-Consent diagnosis in the DSM-5 was that it was "hard to fully distinguish PCD from sexual sadism" (131). Rationales like this explain why the Frye standard exists. It exists to prevent the use of scientific methods of questionable reliability and validity.

The history of the deliberative processes which have repeatedly rejected Non-Consent also provide no indication its rejecters believed it would continue to be validly applied as an NOS (or later OSPD) diagnosis. The evidence indicated the opposite. It revealed that some psychologists were so concerned the diagnosis might remain viable even after its rejection that they urged its exclusion in the DSM-5 even as a condition warranting further study. The increased assignment of the diagnosis over the past twenty years has not been based on a clinical imperative. It has been primarily driven by SVP statutes which require a diagnosis to subject rapists to civil confinement.

Frye hearings typically concern whether a scientific method or technique is so new or novel as to not yet have gained general acceptance in the relevant scientific community. See, e.g., Marsh v. Smyth, 12 AD3d 307, 310 (1st Dept 2004) (Saxe, J. concurring). The Frye case itself described the inquiry as considering "when a scientific principle or discovery crosses the line between the experimental and demonstrable stages." 293 F at 1014. There is nothing new or novel about the Non-Consent diagnosis. It has been the subject of debate for decades. What has not yet been demonstrated is that the disorder is valid or

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reliable. That (along with "political" agendas and tradition) explains why it has never been adopted as a named paraphilia.

This Court also does not credit the view that language in the DSM-4, 4-TR and DSM-5 introductory provisions concerning paraphilias support the view that PCD was intended to be diagnosed in forensic settings. The DSM-5, as noted in the definition *supra*, does define normal sexual arousal, *inter alia*, as being towards "consenting human partners" and defines paraphilias generally by what they are not (i.e., not normal patterns of sexual arousal) rather than what they are. Thus, one can certainly argue that by defining normal sexual arousal as being to consenting human partners, an attraction to non-consenting human partners is a paraphilia by definition. The Frances Article cited by the Court of Appeals in Kenneth T., in responding to similar arguments regarding different language in the introductory paraphilia section of the DSM-4-TR, however, noted that this earlier general language was intended to provide a table of contents for the named paraphilias and was never intended to legitimize the use of Non-Consent diagnoses in forensic settings. The paraphilia definition in the DSM-5, in requiring that among other attributes normal sexual arousal must be to consenting adults and that arousals outside this category are paraphilias, likewise implicitly references criterion sets for multiple named paraphilias which include non-consent including Sexual Sadism Disorder, Frotteuristic Disorder, [*25] Exhibitionistic Disorder and Voyeuristic Disorder. [FN34]

The State Did Not Prove That When the "Scientists Votes Were Counted"

PCD Has Obtained General Acceptance in the Relevant Scientific Community

Some legal determinations are based on which party bears the burden of proof. That is, a result is compelled because the party with the burden does not meet it, while the opposite result might be reached were the burden placed on the opposing party. That, in this Court's view, is what occurred here with respect to what the Court will refer to as the "head count" that is, the enterprise of attempting to determine how the votes of the relevant scientific community on the instant question would be tallied were a hypothetical election held. The conflicting evidence at the hearing did not demonstrate that OSPD Non-Consent was generally accepted. Nor did it demonstrate the converse.

The first question which must be asked with respect to the head count is what community should be considered. There are three reasonable possibilities. The first are psychologists and psychiatrists generally. The second are psychologists or psychiatrists who have as a meaningful part of their practice the diagnosis, evaluation or treatment of sex offenders or perform research in the field. Dr. Calkins noted that a useful measure of those practitioners would be members of the field's primary professional association, ATSA, or what she called the "ATSA Community". The third possibility would be psychologists and psychiatrists who work in SVP proceedings. Case law provides no clear answer for which psychiatric community should be considered here.

The Court of Appeals found the diagnosis of "Rape Trauma Syndrome" was generally accepted in *People v. Taylor*, 75 NY2d 277 (1990). While the Court did not explicitly articulate which scientific community it was relying upon in that case, it prominently cited to the DSM-3-R for the proposition that rape could lead to posttraumatic stress disorder to support its conclusion that Rape Trauma syndrome was a

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generally accepted diagnosis. In citing to the DSM the Court appeared look to the psychiatric community generally, rather than a smaller group. In *People v. Wernick*, supra, the Court similarly held that the question of whether "neonaticide syndrome" was generally accepted in the scientific community in a case where the defendant was convicted of killing her newborn child was whether the condition was "generally accepted in the field of psychiatry or psychology". 215 AD2d at 52.

The trial court in *People v. Thomas*, 46 Misc 3d 945 (Westchester County Supreme Court, 2014 [Zambelli, J.]) addressed an analogous question in denying a Frye hearing about whether the diagnosis of "Shaken Baby Syndrome" had general acceptance. It held that it was the field of medicine generally rather than the field of biomechanics which was the relevant community. The Defendant apparently argued that the causation question at the heart of the case, whether, inter alia, the acceleration and deceleration force necessary to cause subdural hematomas could be generated by shaking a baby, was best answered through the science of biomechanics. The Court found, however, that physicians had been routinely found competent to [*26]opine on medical causation in such cases.

On the other hand, in holding that expert testimony concerning factors influencing the reliability of eyewitness identifications had been generally accepted, the Court of Appeals in *People v. LeGrand*, 8 NY3d 449 (2007) noted a survey demonstrating acceptance by "an overwhelming majority of the experts in this particular field" (apparently referring to experts in the field of eyewitness identification, rather than psychology or social science generally). 8 NY3d at 458. The Court held that three of the four factors proffered by the Defendant as being relevant to the reliability of eyewitness identification were "generally accepted by social scientists and psychologists working in the field". *Id.*

Former Chief Judge Kaye provided what may be the best analysis of these competing considerations in her concurring opinion in *People v. Wesley*, supra, which considered the general acceptance at the time of DNA evidence. She explained: "If the field [through which general acceptance is measured] is too narrowly defined, the judgment of the scientific community will devolve into the opinion of a few experts. The field must still include scientists who would be expected to be familiar with the particular use of the evidence at issue, however . . ." 83 NY2d at 438 (citation omitted). In accordance with that proscription, this Court believes the community which should be assessed here is the middle one outlined supra, the ATSA Community.

There are valid arguments that what should be considered here are the views of psychologists or psychiatrists generally. A person with PCD, however, would be unlikely to be seen outside a forensic context. A rapist does not typically contact a psychotherapist outside a forensic setting to seek treatment for his attraction to non-consenting partners. Such offenders are usually treated in prison, on parole, through probation departments, from court referrals or through SVP programs. (Thornton, 110). The therapists they are referred are usually those with experience in treating sexual disorders. A psychotherapist with a general practice would be unlikely to have an informed view about whether PCD was generally accepted because it would be a disorder she would rarely if ever encounter.

There was no evidence at the hearing that PCD is an accepted diagnosis among psychologists or psychiatrists generally. But that, in this Court's view, is not a fair question. The narrow class of

psychiatrists or psychologists who work in SVP programs is also not an appropriate community to review here for a different reason. The concern which motivated the strong views of the Court of Appeals on the instant Frye question was that PCD appeared to be an illegitimate classification designed only for civil commitment. Considering the narrow class of SVP practitioners would fail to undertake the broader inquiry inherent in the view that PCD might not be legitimate if it were only used in SVP cases. "A Frye court should be particularly cautious when . . . the supporting research is conducted by someone with a professional . . . interest in the technique" *People v. Wesley*, supra, [Kaye, J. concurring] (quotation omitted). There is also no rationale for narrowing the community in that way.

The State did not demonstrate that PCD was a generally accepted diagnosis in the ATSA community. The evidence at the hearing indicated that evaluators who are employed by the State in SVP programs overwhelmingly or perhaps even uniformly apply Non-Consent diagnoses. Evaluators employed by respondents in SVP programs often or usually do not consider the diagnosis legitimate, although the evidence indicated this view was not as uniform as the [*27] converse view of state evaluators. The hearing evidence indicated that psychologists or psychiatrists who might work in SVP programs for both the State or Respondents had mixed views on the subject. That was also what the evidence indicated with respect to the views of the ATSA Community generally. There is also a strong correlation between the type of work an evaluator does and whether the diagnosis is considered valid. In the instant case for example, the State's evaluator, Dr. Field, assigned a Non-Consent diagnosis while the Respondent's evaluator opined the diagnosis was illegitimate. These generally varying views are likely based in part on allegiance effects.

The evidence concerning the "head count" provided no clear answer on whether PCD is a generally accepted diagnosis in the ATSA Community. Since the burden on this motion is on the State, that lack of evidence supports the view that the instant motion must be denied. As former Chief Judge Kaye again cogently framed the issue: "Where controversy rages, a court may conclude that no consensus [on general acceptance under Frye] has been reached". *People v. Wesley*, supra, 83 NY2d at 439 [Kaye, J. concurring].

* There Are No Uniform Diagnostic Criteria for PCD

* In Jason C., Justice Riviezzo's primary reason for finding the Non-Consent diagnosis was not generally accepted was that there was no "generally accepted criteria that defines the condition". 2016 NY SlipOp at 10. The evidence at the instant hearing indicated the same thing. This Court does not agree, however, that the absence of such generally accepted criteria answers the question of whether the Non-Consent diagnosis has gained general acceptance. That, in this Court's view, is a different question.

It is certainly true that a court cannot find a diagnosis has gained general acceptance if a court cannot fathom what that diagnosis is. But that is not true here. All of the experts at the instant hearing shared a common understanding of what PCD is. It is a sexual arousal to a victim's manifestation of non-consent. Justice Riviezzo recognized the same point. Id. Moreover, even experts who have rejected PCD as a ~~legitimate paraphilia acknowledge there are likely some men who are sexually aroused to non-~~consenting partners.

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~~The differing criteria which the experts in this case used to define PCD and the problems with the validity and reliability of the diagnosis largely explain why PCD has not gained general acceptance. But, as Judge Abdus-Salaam, then writing for the First Department cautioned in the passage cited supra, a court should resist the temptation to find a diagnosis has not gained general acceptance because the court determines the diagnosis is not reliable. Marsh v. Smyth, supra. The ultimate question here is not whether PCD has uniform diagnostic criteria-is-reliable-or-is-even-valid. The question-is-whether-it-is-has gained general acceptance.~~

Differing PCD Criteria

As Justice Rivezzo outlined in much greater detail in Jason C., there are no uniformly applied diagnostic criteria for PCD. Dr. Thornton during the instant hearing testified in detail about the "Paraphilic Rape Checklist" he designed to assess the disorder. But other witnesses said they used different criteria to make PCD diagnoses. Dr. Kunkle, the State's leading SOMTA clinician, said he was not even aware of Dr. Thornton's checklist. Dr. Thornton testified about the field trials he used to evaluate PCD for inclusion in the DSM-5. But those field trials also didn't use the checklist he designed.

Dr. Wilson used still different criteria for diagnosing the disorder, noting that it existed [*28] when a person's "primary driving force" was an attraction to non-consent. Dr. Kunkle testified that even among the 18 or 19 OMH evaluators who assign Non-Consent diagnoses in New York SVP cases, there are no uniform criteria. Dr. Wilson testified that a book written by Dr. Dennis Doran, "Evaluating Sex Offenders", which had been widely consulted by SVP evaluators, used a still different Non-Consent checklist to assign PCD diagnoses. Dr. Thornton said other "paraphilia colleagues" also used different checklists to diagnose the disorder but he was not aware of the extent to which those other lists incorporated his own (Thornton, 138-139). There was also no consensus on the incidence of PCD among rapists. Dr. Thornton testified, for example, that in a PPG study he conducted, 30% of rapists had a coercive preference and 21% had a brutality preference. Dr. Wilson, however, described offenders who rape "for fundamentally paraphilic reasons" as a "small subset" of rapists generally.

The Difficulty of Distinguishing Arousal From Lack of Inhibition

~~The second major difficulty in assigning Non-Consent diagnoses is the extensive evidence presented at the hearing that it is difficult to distinguish a man who rapes because he is attracted to non-consent from a man who rapes because he is not inhibited by coercive cues. The former offender could be diagnosed with a rape paraphilia while the latter could not be. The LaLumiere and Lohr studies demonstrated this, in the Court's view, most plainly by presenting PPG evidence which supported the~~
view that subjects in the studies who were inclined to rape were not generally aroused to non-consent but were rather not inhibited by it. This has also been described as the distinction between rapists who have a paraphilia and those who are antisocial. The Frances Article cited by the Kenneth T. Court noted that any differential rape diagnosis would have to be able to distinguish PCD from rapes prompted by numerous other causes, including antisociality. Dr. Wilson acknowledged that "you cannot reliably distinguish between someone who is aroused by the nonconsent of the victim versus somebody who is raping despite the nonconsent" (339).

As Justice Riviezzo explained the issue in Jason C., citing Dr. Knight's testimony, "where normal' men would find the distress of the victim as inhibiting, some men responding to the rape scenarios [positively] might not find the coercion exciting or arousing, but rather, lack the ability to be inhibited by the stress cues of the victim" 2016 NY SlipOp at 16. Dr. Thornton presented PPG research which he said indicated that between a third and a half of rapists will show stronger responses to stimuli depicting coercion than to consent. He also presented research which showed a correlation between the behavioral signs on his Paraphilic Rape Checklist and the chance an offender would be aroused by coercive PPG cues or report a rape fantasy. But other evidence indicated distinguishing paraphilic from antisocial rapists was very difficult and that rape fantasies were common.

Even presuming it is possible to accurately distinguish paraphilic rapists from antisocial offenders, the evidence indicated such distinctions are generally not likely accurately assigned in practice. In Jason C., Dr. Thornton testified that "the research evidence indicates that there's a real phenomenon there and that, at least, some time, under some condition, people could describe it [PCD] with reasonable accuracy". Id., at 17. This Court fully credits that modestly stated conclusion. But that does not make the disorder appropriate for forensic use.

The Difficulty of Distinguishing PCD From Sexual Sadism

Multiple witnesses also testified to the difficulty of distinguishing PCD from Sexual [*29]Sadism. Dr. Wilson described research designed to distinguish non-consent from sadistic offenders as "still emerging" (303). He acknowledged that "broadly speaking" "one cannot reliably distinguish between nonconsent and sexual sadism" (338-339). Witnesses agreed that Non-Consent and sexual sadism exist on a continuum and that Non-Consent is a lesser version of sexual sadism. Experts agreed, however, that it was difficult to distinguish the two conditions, especially in a large middle grey area. Dr. Thornton, in fact, as noted supra, attributed the rejection of PCD in the DSM-5 in part to this issue.

Dr. Knight testified in Jason C. that since Non-Consent and sexual sadism exist on a continuum, "any criteria that were proposed to identify the cutoff for a diagnostic category for PCD would likely be arbitrary" and that any "criteria set would be necessarily over or under inclusive, have no established validity, and would result in great error in its application" 2016 NY SlipOp at 15. Dr. Wilson testified in Jason C. that PPG tests may not reliably distinguish between PCD and sexual sadism because the two categories of offenders sometimes respond to coercive stimuli in the same way. Id. Justice Riviezzo finally made the valid point in Jason C. that "there have been very few researchers who have published on [PCD] in peer reviewed journals. The import of this is that there has been little peer-review on the two major considerations that apply to both psychological research and general science — the reliability and validity of a diagnosis." Id. at 17 (citing the testimony of Dr. Knight).

The hearing indicated that there are important efforts being made to define PCD. The research done by the witnesses who testified at the hearing is impressive and commendable and it is unfortunate this fine work has been conflated with the separate problem of the misuse of that science in SVP proceedings. But, as multiple witnesses testified, that science is still developing. As Dr. Schlosser asserted, "we're just not there as a field yet" (398).

The Problems with Non-Consent Diagnoses Under Article 10 Since 2007

Whatever research problems exist in defining PCD, they pale in comparison to the reliability and validity problems the diagnosis has experienced in the real world of SVP proceedings, at least in New York. Dr. Schlosser testified that when Article 10 was enacted [in 2007], the Non-Consent diagnosis was used "regularly and easily" but is used less now (432). He described his work evaluating sex offenders at OMH in 2007-2008 as "building a plane while flying it" (360).

Dr. Kunkle, the State's leading SOMTA clinician, made the extraordinary statement that he simply didn't know whether offenders diagnosed with Non-Consent in 2007 and 2008 had been misdiagnosed and didn't know how the criteria used at that time compared with those used today. Dr. Schlosser noted that virtually no offenders initially evaluated for Article 10 have had PPG studies and very few had self-reports. Without such information, he said he did not know how a Non-Consent diagnosis could be made.[FN35]

In presiding over multiple SVP cases with Non-Consent diagnoses for the past 8 years, this Court cannot recall ever encountering a State evaluator who attempted to demonstrate an offender was affirmatively aroused to a victim's non-consent rather than not inhibited by it because of antisociality. The Court does not recall ever seeing the results of a PPG test indicating an attraction to non-consent presented by the State during a trial. It does not recall ever having an expert attempt to distinguish an alleged rape paraphilia from a sexual sadism disorder. Rather, experts in the cases this Court has presided over have generally looked primarily at an offender's coercive sexual behavior and then alleged this behavior was the result of an NOS paraphilia. But as Dr. Schlosser testified, diagnosing PCD only from sexually offending behavior is illegitimate. That is necessarily true since the uncontroverted evidence at the hearing demonstrated that a large proportion of rapists do not have a rape paraphilia. The instant case, in fact, is the only one this Court can recall in which a Defendant made statements indicating an arousal to victim's non-consent. That may be a welcome reflection of the use of more discriminating criteria by OMH evaluators in assigning the diagnosis. The instant hearing has also caused this Court to reflect on whether it has been lax in countenancing the use of Non-Consent diagnoses in the courtroom when they were primarily based on coercive sexual behaviors. The responsibility for the absence of scientific rigor in this field is not limited to OMH evaluators.[FN36]

The Argument That PCD is Legitimate Because It Has Been Found Valid in Other States

The State argues there are 17 states with SVP statutes which have allowed the use of Non-Consent diagnoses and that this provides compelling evidence the disorder is generally accepted. Justice Riviezzo conducted extensive research on this issue and found this argument unpersuasive. She determined there was not a single case in any of these jurisdictions which had ever reported the results of a Frye or Daubert [FN37] hearing on the admissibility of the Non-Consent diagnosis and at least six states which had held (contrary to the law in New York) that testimony about a sex offender's diagnosis was not subject to a Frye hearing. She explained that New York [*30]State had a jurisprudential history which provided for the admission of expert testimony in cases like this only when the Frye standard was met. She also found unpersuasive three New York trial court cases which had admitted Non-Consent

testimony and denied a Frye hearing based on written submissions, noting that none of these cases had adequately litigated the Frye issue. 2016 NY SlipOp at 18-20. This Court concurs with Justice Riviezzo's reasoning and conclusions on that issue.

V. THE IMPLICATIONS OF THIS DECISION

In Donald DD., the Court's four judge majority held "evidence that a respondent suffers from antisocial personality disorder ["ASPD"] cannot be used to support a finding that he has a mental abnormality . . . when it is not accompanied by any other diagnosis of mental abnormality". 24 NY3d at 177.[FN38] Two trial courts (this one and Justice Riviezzo) have now held that OSPD Non-Consent is not a valid diagnosis. Multiple trial courts, including this one and Justice Riviezzo, have also concluded that, based on Donald DD., the diagnosis of ASPD with psychopathy is not materially different from the diagnosis of ASPD alone and therefore cannot serve as a valid Mental Abnormality predicate, although a minority of trial courts have reached contrary conclusions.[FN39] What the confluence of these decisions might mean if they were eventually affirmed is that offenders who rape post-pubescent victims (or, as in this case, force such victims to engage in oral sex) would rarely be subject to Article 10.

The statute would continue to apply to pedophiles (or, depending upon the results of Frye hearings being held by this and four other courts, hebephilia, an attraction to pubescent minors). It might continue to apply to a minority of other offenders, for example an offender with a psychotic disorder.[FN40] ASPD (often with an accompanying diagnosis of psychopathy) and Non-Consent, however, are the two diagnoses which have generally allowed rapists to be subject to civil management. Without those diagnostic predicates, many of those offenders might no longer [*31]be subject to the statute. On the other hand, in a 3-2 decision, the Third Department in *State v. Richard TT.*, 132 AD3d 72 (3d Dept 2015), appeal dismissed, 26 NY3d 994, the Court found the combined diagnoses and conditions of ASPD, psychopathy, Borderline Personality Disorder, cannabis and alcohol abuse, "impulsive sexual behavior" and "hypersexuality" were sufficient diagnostic predicates.

The legal landscape shifted again on March 15, 2016 when the First Department reversed this Court's decision in *Jerome A.* in *State v. Jerome A. (Anonymous)*, supra. As noted supra, in *Jerome A.*, this Court found that the diagnosis proffered by the State of ASPD with psychopathy was not materially different from the diagnosis of ASPD alone and therefore required the petition's dismissal under Donald DD. This Court's decision was based on the fact that: (i) most trial courts had reached the same conclusion; (ii) the Donald DD. Court found that psychopathy was an "extreme form of ASPD" (n. 6); (iii) the Donald DD. Court dismissed the petition in that case, even though the Respondent was also diagnosed with psychopathy; (iv) Donald DD. held that ASPD "proves no sexual abnormality. It therefore cannot be the sole diagnosis that grounds . . . a [Mental Abnormality] finding" (24 NY3d at 190) [and psychopathy is also not a "sexual abnormality"]; (v) the DSM-5 describes ASPD and psychopathy as synonymous ("[ASPD] has also been referred to as psychopathy") (DSM-5, p. 659); (vi) the State's expert in *Jerome A.* agreed that under the DSM-5 "psychopathy and ASPD are essentially the same thing". Id.; (vii) the State's expert in *Jerome A.* described her conclusions regarding psychopathy as tentative;[FN41] (viii) the State's expert in *Jerome A.* testified that the Respondent's psychopathy provided him with greater volitional control than if he had ASPD alone [FN42], and (ix) the Court did not find the State expert

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psychologist's assertions about psychopathy derived from a literature review of "brain scan" evidence credible in other respects.[FN43]

The First Department, in *State v. Jerome A. (Anonymous)* appeared to reach the contrary conclusion.

They pointed out that the State's expert "offered extensive testimony regarding the [*32]distinctions between ASPD and psychopathy" and asserted that the Donald DD. Court "did not state that a diagnosis of ASPD with psychopathy is insufficient to support a finding of mental abnormality" (citing Donald DD).

The First Department also faulted this court's dismissal of the petition at the "early juncture" of a probable cause hearing saying: "In article 10 proceedings, issues concerning the viability and reliability of the respondent's diagnosis are properly reserved for resolution by the jury unless the respondent's evidence is deficient" (citations omitted).

In this Court's experience, Article 10 rape offenders diagnosed with ASPD can also often be diagnosed with psychopathy. Most rape offenders who might be diagnosed with Non-Consent can also be diagnosed with ASPD. If that is true, however, *State v. Jerome A. (Anonymous)* may resurrect Article 10 cases which might otherwise fail because offenders were diagnosed with ASPD, psychopathy and Non-Consent. The Non-Consent diagnosis, pursuant to the instant decision and *Jason C.*, may now be invalid. ASPD alone, under Donald DD., is clearly invalid. But ASPD with psychopathy would now appear to be a legally sufficient Mental Abnormality predicate under *State v. Jerome A. (Anonymous)*. In the instant case, however, Dr. Field in his 23 page report did not diagnose the Respondent with psychopathy. He noted in his listing of dynamic risk factors: "Psychopathy/Psychopathy Combined with Sexual Deviance — does not apply." Report, p. 6.

These shifting legal currents reflect the extraordinary lack of clarity in the rules governing these proceedings. This Court wrote extensively about those issues in its decision *State v. Floyd Y.*, 46 Misc 3d 1225 (A), 2015 NY SlipOp 50302 (U) at 14-17 (New York County Supreme Court 2015), reversed on other grounds, *State v. Floyd Y. (Anonymous)* 135 AD3d 70 (1st Dept 2015). There, this Court pointed out that in the 18 months prior to this Court's decision on March 10, 2015, the Court of Appeals decided nine Article 10 appeals. The Court of Appeals found the trial court erred, at least in part, in eight of those nine cases with the only exception being a venue change issue. The Court of Appeals reversed appellate division decisions which had affirmed trial court judgments or jury verdicts in six of those eight cases, with an additional case called into question by the Court's later decision in Donald DD. In every case in which a trial error was found, it concerned a ruling adverse to a respondent. The Court of Appeals has ruled in only one Article 10 case since then, holding the trial court erred in allowing a State expert to testify by video-conference but that the error was harmless. *State v. Robert F.*, 25 NY3d 448 (2015). The Court's last substantive decision addressing the legal standards applicable to Mental Abnormality determinations under Article 10 was *Kenneth T. and Donald DD.* which were decided on October 28, 2014.

Appellate division cases during the same period have raised a host of new questions. One need look no further than the 16 individual and often duplicative Frye hearings which are now in various stages to understand the extraordinary efforts being made to understand how these cases should proceed. It has

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now been almost nine years since Article 10 was enacted. The rules governing the statute, in this Court's view, are more confused than they have ever been. Today's decision will do little to change that.

March 29, 2016 _____

Daniel Conviser, A.J.S.C.

APPENDIX: ADDITIONAL ARTICLES RECEIVED IN EVIDENCE

1. "What Exactly is an Unusual Sexual Fantasy?" by Christian C Joyal et. al. J. Sex Med 2015; 12:328-340. This study surveyed sexual fantasies among men and women and found that "[t]hirty sexual fantasies were common for one or both genders, and only five were typical. . . . Submission and domination themes were not only common for both men and women, but they were also significantly related to each other." (Abstract).

2. "Examining the scope of questionable diagnostic reliability in Sexually Violent Predator (SVP) evaluations" Anthony D Perillo, et. al.: International Journal of Law and Psychiatry, November 22, 2013. Respondent's witness Dr. Cynthia Calkins was a co-author of this study.

This study evaluated the diagnoses assigned to 375 sexual offenders assessed for the SVP program in New Jersey. A diagnosis was made independently by two mental health professionals. 31% of offenders were diagnosed with Paraphilia NOS [the forerunner to the current DSM-5 diagnosis of OSPD] by at least one evaluator. The study used a "kappa coefficient" to assess the degree of agreement between evaluators. A kappa coefficient below .60 was considered "poor"; from .60 - .74 was considered "fair". and .75 and above was considered "good". The Paraphilia NOS kappa coefficient in the study was .35, indicating poor reliability between evaluators. In contrast, the coefficient for Pedophilia was .55, which approached a "fair" result. [The Court did not consider this study highly probative with respect to the instant motion, in part, because it considered the general "NOS" category, rather than the "NOS Non-Consent diagnosis at issue here].

3. "Reliability of Sexually Violent Predator Civil Commitment Criteria in Florida" Jill S. Levenson, Law and Human Behavior, Volume 28, N. 4 (August 2004) pp. 357-368.

This study examined 450 convicted sexual offenders in Florida which received a face-to-face evaluation for admission to the Florida SVP program. The asked the question: "when two evaluators assess the same offender, will they come to the same conclusions?" (p. 364). The kappa coefficient for Paraphilia NOS in this study was .36 [poor]. In contrast, the kappa coefficient for Pedophilia was .65 [fair]. [The Court did not consider this article highly probative for the same reasons outlined for the previous article].

4. "The Severe Sexual Sadism Scale: Cross-Validation and Scale Properties". A Mokros, et. al., American Psychological Association 1040-3590 2011. This study conducted an analysis of the "Severe Sexual Sadism Scale" which is a list of 11 yes or no questions meant to assess sexual sadism. The study concluded that both the reliability and criterion validity of the scale for diagnosing sexual sadism were good.

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5. "Is a Diagnostic Category for Paraphilic Coercive Disorder Defensible?" Raymond A. Knight, Archives of Sexual Behavior, American Psychiatric Association, November, 2009. This [*33]research review argued that there is little support in PPG data for a PCD category independent of Sexual Sadism. It also argued that PPG results support the view that rapists differ from non-rapists because rapists are not inhibited by coercive cues rather than affirmatively aroused by them. Both categories of PPG evidence support the argument that PCD should not be defined as a separate disorder.

Footnotes

Footnote 1:Facts regarding the Respondent's criminal history and diagnoses, unless otherwise indicated, are taken from the report of the State's psychiatric examiner, Dr. Ronald Field, issued on November 1, 2013, (hereinafter the "Report").

Footnote 2:Report, p. 5.

Footnote 3:Dr. Bard's report, p. 9.

Footnote 4:Parenthetical numerical references are to the transcript of the hearing testimony.

Footnote 5:A Power Point prepared by Dr. Thornton was received in evidence and is cited here as "Thornton Power Point".

Footnote 6:Parenthetical references to numbers without a preceding witness name in this section are to pages of the DSM-5.

Footnote 7:Zoophilia is a paraphilia involving a sexual attraction to animals.

Footnote 8:The term "SVP" or "SVP Programs" is used here as a shorthand to denote sex offender civil management programs like SOMTA. Twenty states and the federal government have sex offender civil management laws. All except New York and Texas require confinement for SVP offenders. New York provides for either confinement or community supervision; Texas requires only community supervision.

Footnote 9:Thornton Power Point, unnumbered page 9.

Footnote 10:This was apparently not a "Kappa" coefficient, which accounts for random chance agreement, as described in other research infra.

Footnote 11:Thornton Power Point, unnumbered p. 17.

Footnote 12:Id., p. 19.

Footnote 13:"Guttman scale", Wikipedia.

Footnote 14:See DSM-5, "DSM-5 Work Groups", 6th unnumbered page of the manual.

Footnote 15: The Article 10 statute contains detailed procedures for the screening of offenders by OMH and other agencies to determine which offenders should be subject to civil management. Those procedures are not recounted here.

Footnote 16: A "kappa coefficient" or "Cohen's kappa" is described by Wikipedia as "a statistic which measures inter-rater agreement for qualitative (categorical) items. It is generally thought to be a more robust measure than simple percent agreement calculation, since [it] takes into account the agreement occurring by chance". The Kappa scale goes from zero to 1.0 (388).

Footnote 17: Dr. Knight described himself during his testimony with a phrase the Court could not decipher. When the Court asked Respondent's counsel after the hearing to spell the term, the Court was informed that Dr. Knight had testified that he was a "Neo-Popperian Quinian" and then given this further unsolicited explanation by Dr. Knight: "Epistemologically I subscribe to Karl Popper's epistemology as revised by some of his students (particularly Imre Lakatos), and I am convinced by Willard Van Orman Quine's additional critiques of logical positivism". (email from Respondent's counsel, November 19, 2015).

Footnote 18: Michael B. First MD, J Am Acad Psychiatry Law 42:191-201, 2014.

Footnote 19: Thomas K. Zander, J Am Acad Psychiatry Law 36:459-69, 2008.

Footnote 20: The Court takes judicial notice that the ICD-10 is published by the World Health Organization and is commonly used throughout the world although in the United States, psychologists and psychiatrists generally use the DSM-5 to assign diagnoses. The ICD-10 is used in the United States, however, to assign billing codes and numerical designations for disorders in the DSM-5 are followed in that manual by roughly equivalent ICD-10 codes.

Footnote 21: Robert A. Prentky, et. al. J Am Acad Psychiatry Law 36:455-8, 2008.

Footnote 22: Martin LaLumiere, et al. Ann NY Academy of Sciences 989: 211-224 (2003).

Footnote 23: Bethany A. Lohr et. al. Journal of Abnormal Psychology, 1997, Vol. 106, No. 2 pp. 230-242.

Footnote 24: Raymond A. Knight, et. al., Journal of Criminal Justice 41 (2013) 90-99.

Footnote 25: New York trial courts, according to information compiled by the State Attorney General's office and Mental Hygiene Legal Services, have conducted, are conducting or have scheduled 16 individual Frye hearings on Article 10 diagnoses and procedures. In addition to Kenneth T., some of those hearings have also likely been prompted by the Second Department's decision in State v. Richard S., 133 AD3d 672 (2d Dept 2015) where the Court remitted a SOMTA case to the trial court ordering it to conduct a Frye hearing on the Non-Consent diagnosis after the trial and dispositional hearing concluded. The hearing in the instant case included six days of testimony; this Court is also in the midst of a second seven day Frye hearing on the Hebephilia diagnosis. These Frye hearings have or will consider the diagnoses of Unspecified Paraphilic Disorder, Other Specified Paraphilic Disorder, the use of the "PCLR" test, the "Screening Scale for Pedophilic Interests", "Gerontophilia" (a paraphilic attraction to elderly

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persons), OSPD Non-Consent (hearings in four courts), OSPD Hebephilia (hearings in five courts), "Hypersexual Disorder" and OSPD "arousal to teenage girls".

Footnote 26: The Shannon S. majority also asserted 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 in civil confinement proceedings. Paraphilia NOS, however [with the Hebephelia specifier in the case], has been found to be a viable predicate mental disorder or defect that comports with minimal due-process." 20 NY3d at 106-107 (citations and quotations omitted). In using that standard, the Shannon S. majority placed a burden on Paraphilia NOS proponents not remotely close to the Frye standard. A diagnosis which has not been rejected by a "near-universal" portion of the psychiatric community can nevertheless still obviously not be generally accepted. This Court, however, does not construe this isolated statement as indicating the Court of Appeals determined in Shannon S. to reject the Frye test and substitute a less rigorous standard for psychiatric diagnoses.

Footnote 27: Allen Frances MD & Michael B. First, MD, J Am Acad Psychiatry Law 39:555-61 (2011).

Footnote 28: Allen Frances, MD, et. al., J. Am Acad Psychiatry Law 36:375-84 2008.

Footnote 29: See Kenneth T., 24 NY3d at 187 (Noting that the Court had not ruled on whether the diagnosis of "paraphilia NOS" was valid "because here, as in Shannon S., no Frye hearing was requested or held").

Footnote 30: Dr. Leonard Bard testified for the Respondent in Jason C., but did not testify at the instant hearing and Dr. Erik N. Schlosser testified for the Respondent at the instant hearing but did not testify in Jason C. The witnesses at the two hearings were otherwise identical.

Footnote 31: Letter from Deborah Cross, M.D. President of the New York State Psychiatric Association, Inc., to David Nocenti, Counsel to the Governor regarding the Sex Offender Management and Treatment Act, March 12, 2007 (available in the bill jacket for Chapter 7 of the Laws of 2007).

Footnote 32: In determining that the Frye test must be used to assess whether PCD is a legitimate Article 10 diagnosis, our courts have consigned that question to a profession which is in large part openly hostile to SVP statutes. That is one important manifestation of the conflict between Article 10's public safety goals and its constitutional psychiatric prerequisites, a conflict which goes a long way towards explaining the continuing confusion over the legal rules governing these cases, discussed infra.

Footnote 33: October 20, 2015 Power Point presentation by Dr. Knight: unnumbered page 23.

Footnote 34: Justice Rivezzo in Jason C. did not find the DSM evidence persuasive on the general acceptance question. She reasoned that "the DSM is a political document that rarely changes and the reasons for inclusion or exclusion of any particular diagnosis are complex" 2016 NY SlipOp at 22.

Footnote 35: The acknowledgment by the State's leading SOMTA clinician that he doesn't know whether the 58 individuals diagnosed with Paraphilia NOS Non-Consent in 2007 or 2008 were properly

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diagnosed, doesn't know what criteria were used to evaluate them and doesn't know whether those criteria are the same ones used by OMH today obviously raises questions about the legitimacy of verdicts premised on those diagnoses. Dr. Kunkle's further assertion that he was not aware that any Non-Consent offender had ever been "flat-out misdiagnosed" by the State was also revealing. It appeared to connote that there were degrees of misdiagnosis with the State having never assigned the most egregious kind. On the other hand, as Dr. Kunkle testified, court appeals and mandated annual or biennial reviews for Article 10 respondents found to have a Mental Abnormality, if properly conducted, would have served to correct diagnostic errors made during the statute's early years.

Footnote 36: An example of such scientific rigor, in this Court's view, came in Judge Graffeo's three judge concurring opinion in *Kenneth T.* That concurrence found the petition should be dismissed not on legal insufficiency grounds, as the majority held, but because the State's expert did not adequately allege the Respondent's rapes resulted from a Non-Consent paraphilia, rather than a "need for power and control". 24 NY3d at 202.

Footnote 37: *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786 (1993) outlined the criteria for admissibility of expert testimony under federal law, which differ from the Frye standard which continues to be used in New York.

Footnote 38: This Court expressed its disagreement with the reasoning process the Court of Appeals used to find that ASPD alone cannot serve as a predicate for a Mental Abnormality and its agreement with the three judge Donald DD. dissenting opinion in its decision in *State v. Jerome A.*, 48 Misc 3d 1229 (A), 2015 NY SlipOp 51303 (U) at 6-7 (New York County Supreme Court 2015), citing the earlier decision of this Court in *State v. Michael R.*, 42 Misc 3d 1222 (A) (New York County Supreme Court 2014), reversed, *State v. Jerome A. (Anonymous)* 2016 NY SlipOp 01788 (1st Dept 2016). Multiple New York appellate courts prior to Donald DD. had concluded that ASPD could serve as a valid Mental Abnormality predicate (see *State v. Jerome A. supra* [citing cases]) and Justice Rivezzo recently expressed her disagreement with the Donald DD. holding in *State v. Kevin F.*, 2016 NY SlipOp 26071 (Kings County Supreme Court 2016). The arguments made in these decisions are not repeated here.

Footnote 39: See, e.g., *State v. Jerome A. supra*, (collecting cases); *State v. Kevin F. supra*.

Footnote 40: See *State v. E.B.*, (Unpublished Decision by this Court) Index # 30189/13, September 8, 2015, (rejecting motion for Article 10 Frye hearing on the diagnosis of Schizophrenia and holding that although the issue is far from clear, Schizophrenia may be a sufficient basis for a Mental Abnormality under Donald DD.)

Footnote 41: See e.g., *Jerome A. supra*, 2016 NY SlipOp at 13, quoting State's expert witness: "research is beginning to show" that psychopathy can exist without ASPD; "over time we will learn more, and we need more research"; "more research needs to be done to confirm it, but a lot of research shows that the brains are different"; psychopathy is "a condition which exists possibly outside of anti-social personality disorder" (emphasis added) (transcript citations omitted).

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Footnote 42: See, e.g., *Id.*, at 14: when compared to ASPD, psychopathy "involves a more calculating callous choice"; when compared to an ASPD offender, a psychopath's "behavior is more controlled"; generally describing Respondent's behavior as "planful", "calculating" and non-impulsive (transcript citations omitted).

Footnote 43: See, e.g., *Id.*, at 12 asserting without citing any study that brain scans of "unsuccessful" psychopaths differed from those of "successful" psychopaths: "their brains looked a little bit different than the ones who were successful or the ones who got caught, if that makes sense. The unsuccessful psychopaths have less frontal lobe matter and so on."; commenting at a different point on the same issue: "Now, those are just theories. There are lots of theories." (transcript citations omitted).

STATE OF SOUTH CAROLINA

COUNTY OF Aiken
STATE VS.

Richard Ridley

AKA:

Race: B Sex: M Age: 31

DOB: 1/3/71 SS#: 116-60-2861

Address:

DL# NY 430783463 SID# NY 5961554

FB1387335AK

In disposition of the said indictment comes now the Defendant who was ☐ CONVICTED OF or ☒ PLEADS

TO: Criminal Sexual Conduct 3rd Degree

in violation of § 16-3-654 of the S.C. Code of Laws, bearing CDR Code # 0/1/12/2

☒ NON-VIOLENT ☐ VIOLENT ☐ SERIOUS ☐ MOST SERIOUS ☐ 17-25-45

The charge is: ☒ As Indicted, ☐ Lesser Included Offense, ☐ Defendant Waives Presentment to Grand Jury.

The plea is: ☒ Without Negotiations or Recommendation, ☐ Negotiated Sentence, ☐ Recommendation by the State.

ATTEST:

Bruce Brink
Solicitor

Richard Ridley
Defendant

Kellon Perkins Bism
Attorney for Defendant

WHEREFORE, the Defendant is committed to the ☒ State Department of Corrections, ☐ County Detention Center, for a determinate term of 10 days/months/years or ☐ under the Youthful Offender Act not to exceed years and/or to pay a fine of \$; provided that upon the service of days/months/years and/or payment of \$; plus costs and assessments as applicable*; the balance is suspended with probation for months/years and subject to South Carolina Department of Probation, Parole and Pardon Services standard conditions of probation, which are incorporated by reference.

☒ The Defendant is to be given credit for 225 days/months jail time.

☐ CONCURRENT or ☐ CONSECUTIVE to sentence on:

SPECIAL CONDITIONS:

☐ RESTITUTION: ☐ Heard, ☐ Waived, ☐ Ordered

Total: \$ plus 20% fee: \$

Payment Terms:

☐ set by SCDPPPS

Recipient:

*Fine:

§14-1-206 (Assessments 100%)

§14-1-211(A)(1) (Surcharge)

§14-1-211(A)(2) (Surcharge)

§56-5-2995 (DUI Assessment)

3% to County (if paid in installments)

TOTAL 10.3.00

Pauline Funnery
Clerk of Court, Deputy Clerk

Court Reporter: Brenda Douglas
White - Clerk Green - Corrections

IN THE COURT OF GENERAL SESSIONS
INDICTMENT/CASE#:

2001 -GS- 02 - 15251

A/W#: G 871372

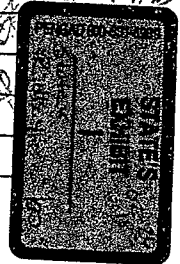
Date of Offense: 9/8/01

S.C. Code §: 16-3-654

CDR Code #: 0/1/12/2

☐ CASE RESTORED

SENTENCE
☒ PLEA ☐ TRIAL



PTUP
 days/hours Public Service Employment
Obtain GED
Attend Voc Rehab. or Job Corps
May serve W/E beginning
Substance Abuse Counseling
Random Drug/Alcohol Testing
Fine may be pd. in equal, consecutive weekly/monthly
pmts. of \$ beginning
\$ paid to Public Defender Fund.
Other:

PRESIDING JUDGE James R. Baul

Judge Code: 0/1/1/13

Sentence Date: 6/13/02

WITNESSES

Maryann Burgess, A.D.P.S.

Deputy Clerk

FILED
June 13, 2002
J. J. Hodard
Deputy Clerk

ARREST WARRANT NUMBER

G871372

ACTION OF GRAND JURY

True Bill

Constance S. Spurg
Foreperson of Grand Jury
Date: November 29, 2001

VERDICT

Foreperson of Petit Jury
Date:

DOCKET NO. 2001-GS-02-1565

The State of South Carolina

County of Aiken

COURT OF GENERAL SESSIONS

DECEMBER 3, TERM 2001

THE STATE

vs.

RICHARD D. RIDLEY

Indictment for

CRIMINAL SEXUAL CONDUCT
THIRD DEGREE

SC Code: 16-3-654

CDR Code: 162

Class FEL-E

STATE OF SOUTH CAROLINA
COUNTY OF AIKEN
DECEMBER 3, 2001
The undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the files and records of the Court.
23 Feb. 2002
LSFH
Deputy Clerk

STATE OF SOUTH CAROLINA)
COUNTY OF AIKEN)

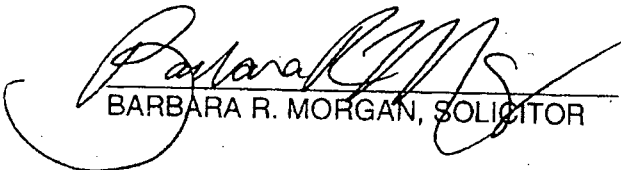
INDICTMENT

At a Court of General Sessions, convened on December 3, 2001, the Grand Jurors of Aiken County present upon their oath:

CRIMINAL SEXUAL CONDUCT IN THE THIRD DEGREE

That RICHARD D. RIDLEY did in Aiken County on or about September 8, 2001 commit the crime of Criminal Sexual Conduct In The Third Degree, in that the Defendant did commit a sexual battery, to wit: anal intercourse upon Myron K. Talbert which was accomplished through the use of coercion. All in violation of §16-3-654 of the Code of Laws of South Carolina (1976), as amended.

Against the peace and dignity of the State, and contrary to the statute in such case made and provided.


BARBARA R. MORGAN, SOLICITOR

RICHARD RIDLEY

SCDMH #: 10272762

Release Placement:

Mr. Ridley plans to reside at Band of Brother's Transitional Housing in Greenville County. This organization's goal is to supply men with true rehabilitation before sending them out into an environment that would be difficult to adapt and conform to without proper assistance, information, and guidance. They believe that with proper guidance and training these men will be productive citizens and leaders in their respective communities.

Pastor Sylvester Savage II and Band of Brother's Ministries provide resident transport to work, community programs, and various appointments (probation/parole, doctor's, social service agencies, interviews, counseling programs at various agencies, etc.) They also partnership with chaplains in one-on-one counseling sessions, case management and religious services.

The program housing fees are \$125 per week, with a \$150 deposit. The housing fees must be paid each Friday in advance for the upcoming week. Mr. Ridley completed a phone interview with Darrol Rice, General Manager and was tentatively approved for placement.

Address:

24 Pine Valley Rd.
Piedmont, SC 29673

Contact Person:

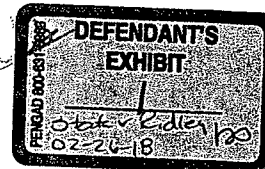
Pastor Sylvester Savage II-CEO
864-567-9919
bandofbrothers@rocketmail.com

Darrol Rice
864-420-8812
darrolrice@yahoo.com

Others in the household:

There will be several other men living in the housing environment.

Site Assessment: A previous site assessment was completed by the therapist and it was concluded that this placement was appropriate for residents.



Employment

Mr. Ridley does not currently have employment lined up. He reports that he will go to Vocational Rehabilitation and they will help him identify and secure competitive employment in the community.

- **Vocational Rehabilitation, Greenville Area Office and Work Training Center**
105 Parkins Mill Rd,

	Greenville, SC 29607 (864) 297-3066 • Vocational Rehabilitation, Anderson Area Office & Training Center 3001 Martin Luther King Jr Blvd, Anderson, SC 29625 (864) 224-6391 Band of Brother Prison Ministries reports that they assist the tenants with employment at a local chicken plant, House of Raeford - Columbia Farms Greenville Plant. • House of Raeford - Columbia Farms Greenville Plant 1354 Rutherford Rd Greenville, SC 29609 (864) -268-6917 Columbia Farms is a division of House of Raeford with headquarters in NC. Their Columbia Farms operation in Greenville, SC is a chicken processing plant. Providing the world's most complete line of poultry products is made possible by House of Raeford's unique combination of operations, which now encompasses eight facilities in North Carolina, South Carolina, Georgia, and Louisiana. Mr. Ridley also reports that he will attend SAGE CDL Training Technical Services. He has been in contact with: • Ms. Tara Elam Staff Assistant SAGE Technical Assistant 277 Dooley Road Lexington, South Carolina 29073 Local: (803) 520-8453 Toll Free: (866) 452-5157 Email: columbia@sageschools.com SAGE provides professional truck driver training that provides comprehensive CDL training courses, as well as basic, advanced, and specialized tractor-trailer training. SAGE is an established truck driver training leader across the country with a curriculum modeled after the highest training standards in the trucking industry. Per the Correct Care Payroll Coordinator, as of June 1, 2017, Mr.

Financial	Ridley currently has 1,185.14 in his Correct Care Account.
Supports	Mr. Ridley has identified several people as members of his support team. 1. Gerila Ridley (Mother) James Evans (Uncle) Elizabeth Evans (Cousin) Jamart Evans (Cousin) 385 Bayview Ave. Inwood, N.Y. 11096 (516) 284-7210 2. Hattie & Minnie Evans (Aunts) 103-4th Street Brentwood, N.Y. 11717 (516) 239-0719 3. Crystal Norman (Sons Mother) 9712 Hosmer St. Tacoma, WA. 98402 (253) 753-5495 4. Miguel, Atère, & Katere Norman (Sons) 9712 Hosmer St. Tacoma, WA. 98402 (253) 753-5495 5. Crystal Posey (Friend) 282 Neal Rd. Buena Vista, GA 31803 (229) 314-0730
Aftercare/ Sex Offender Therapy	Sex Offender Specific Treatment: Should Mr. Ridley desire to receive aftercare services for sex offender treatment, he can contact the following provider: • Dr. Paul Gunter, LMFT, LPC Center for Positive Family Living 311 Bennett Center Dr, Greer, SC 29650 (864) 968-9687 Dr. Paul Stewart Gunter is a Marriage and Family Therapist based out of Greer, South Carolina and his medical specialization is Marriage & Family Therapist. He practices in Greer, South

	Carolina and has the professional credentials of LMFT, LPC. Per Dr. Gunter, he provides group Sex Offender Therapy weekly for \$30 per session. He reported that all group members will be required to have a Psychosexual Evaluation and The Abel Assessment for Sexual Interest completed before they began group sessions. This information was confirmed by Dr. Gunter via phone on February 7, 2018.		
Probation Status	There was no current information that indicates probation status for Mr. Ridley. This information was verified by: The Aiken County Probation and Parole Office Brian Wilson (Team Leader) 1636 Hampton Ave NW Aiken, SC 29801 (803) 642-2123		
Sex Offender Registration	Mr. Ridley will register as a Sexually Violent Predator. He will report to: - Greenville County Law Enforcement Center 4 McGee Street Greenville, SC 29601 864-467-3200 Per Ms. Phyliss Lewis, Mr. Ridley will need to: - Complete a change of address with Richland County Sheriff's Office. - Report the Greenville County Sheriff's Office within three days of release. - Register every 3 months (January, April, July and October) - Every visit to the sheriff's office, he will be given an appointment for the next visit. - Mr. Ridley must register as a Sexually Violent Predator. - Pay \$150.00 per year to register. If he is unable to pay the fee, he will be required to establish that he falls below the poverty line. If it is determined that he does fall below the poverty line, the fee can be waved. - Register his birthday month of each year		
<table border="1" style="width: 100%;"> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>			

Discharge Plan

Social Security Card/Birth Certificate	Correct Care has a copy of Mr. Ridley's Social Security Card and Birth Certificate that will be returned to him upon is release. • South Carolina Department of Health and Environmental Control 200 University Ridge, Greenville, SC 29601 (864) 282-4100

South Carolina Department of Motor Vehicles	Mr. Ridley will report to the local DMV to retain a State ID and/or driver's license. • South Carolina Department of Motor Vehicles 300 University Ridge #105 Greenville, SC 29601 (864) 241-1145

RIDLEY

Exhibit K-5

Month Before I
Came To S.V.P.P.



South Carolina
Department of
Mental Health

Sexually Violent Predator Program
Master Treatment Plan

Ridley

Copy

Came 9-4-14 To S.V.P.P.

Resident's Name: Richard D. Ridley	Date of Plan: 8/10/2014
SCDMH # 1027-2762	SCDC#: 285091

Current Diagnosis	
Axis I	Other Specified Paraphilic Disorder, Biastophilia
Axis II	Antisocial Personality Disorder with narcissistic traits
Axis III	None Reported
Axis IV (list stressors)	Civil Commitment
Axis V- (current) GAF	N/A

Purpose and Goal of Treatment Plan: The purpose of this treatment plan is to inform and empower you regarding areas that will support your recovery. The plan will allow you to build upon strengths, develop skills, understand your offense history and risk factors, demonstrate responsibility, and prepare for your return to the community. This plan will focus on several areas, though this list may change as you progress in treatment. Satisfactorily completing a goal does not equal completion of treatment, but instead highlights progress and readiness to move to a different aspect in treatment.

Resident Strengths:	1) Mother's support. 2) Eager to start treatment.
Resident Liabilities:	1) Poor impulse control. 2) Lacking concern for others.
Cultural Factors:	1) High crime area. 2) Drug Dealer lifestyle (associated around gang members).

Treatment Need List: The list below will outline areas to be addressed in treatment. Not all areas will be covered at one time; as you progress in treatment, you will address different tasks. Additionally, this is not a complete list; at any time as your treatment needs emerge, a task maybe added when therapeutically appropriate. Please consult your treatment team to address this further.

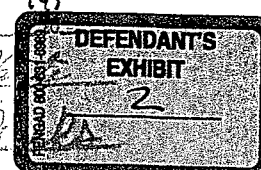
Treatment Need Category and Number	Specific Treatment Need	Evaluated By	Status
C = Clinical M = Medical/Nursing A = Activity Therapy W = Work Pay Program			A = Addressing R = Resolved D = Deferred C = Referred to Outside Consultant
C 1	Exploring Offending Patterns	Treatment Team and Annual Review	A
C 2	Develop Impulse Control	Treatment Team and Annual Review	A

9:33
SP

FILED

2:20

Shadell P.
Deputy Clerk



Exh. b.1 R-5

Clinical Goals

Clinical 1:	Exploring Offending Patterns
History & Assessment <i>False.</i>	Mr. Ridley was admitted on 9/4/14 to the Sexually Violent Predators Treatment Program (SVPTP). Since that time, Mr. Ridley received his orientation packet and has signed his consent forms for treatment. He started writing his sexual history cycle and is preparing to start Prep Group. According to the Pre-Commitment Evaluation (PCE), <u>Mr. Ridley has been charged with 17 sexual offenses against (16) females and (1) male and convicted of 12.</u> The specific ages of several victims remains unknown. It would be beneficial for Mr. Ridley to gain a better understanding of his offense patterns and his choice to offend sexually.
Staff Interventions, Activities or Resources	Process Group and Interdisciplinary Treatment Team will provide additional activities as needed, brief therapeutic individual interventions when appropriate.
Measurable Treatment Objective(s)	1) Understand Risk Factors. 2) Disclose Sexual and Non-Sexual offenses. 3) Present and discuss his sexual offenses in group.
Target Date	12/4/14

Clinical 2:	Develop Impulse Control
History & Assessment <i>False</i> <i>None</i> <i>None</i>	Mr. Ridley's Pre-Commitment Evaluation indicated that he has a long history of violent impulsive behavior starting in 1989. His non-sexual charges include, but are not limited to, Possession of Narcotic Drugs with Intent to Sell, Robbery in the First Degree and several Assault with Intent to Kill charges. Mr. Ridley reported to his case manager that he really needs to work on "impulse control."
Staff Interventions, Activities or Resources	Process Group and Interdisciplinary Treatment Team will provide additional activities as needed, brief therapeutic individual interventions when appropriate.
Measurable Treatment Objective(s)	1) Explore and discuss through written assignments ideas for self-regulating negative behavioral. 2) Present and discuss how poor impulse control led to his sexual offenses.
Target Date	12/4/14

Medical/Nursing Goals

Medical 1:	No Goals Reported at This Time
History & Assessment	
Staff Interventions, Activities or Resources	
Measurable Treatment Objective(s)	
Target Date	N/A

Richard Ridley
SCDC# 285091 2

Ex R-5

Activity Therapy Goals

Activity Therapy 1:	Be active in Activity Therapy
History & Assessment	Mr. Ridley is still very new to SVPTP, but he appears to be adjusting well. Activity staff have observed Mr. Ridley watching television out on the unit and interacting with some of his peers. Activity Therapy department will continue to encourage him to participate in scheduled AT activities that are of interest to him.
Staff Interventions, Activities or Resources	Activity Therapy Department and Interdisciplinary Treatment Team will provide additional activities as needed, brief therapeutic individual interventions when appropriate.
Measurable Treatment Objective(s)	Mr. Ridley will: 1) Participate in scheduled activities of his choice at least 2x a week.
Target Date	On-going

Work Pay Program Goals

Work Pay 1:	Job Skill
History & Assessment	Mr. Ridley is very new to the program. He has not been in the SVPTP program long enough to join the work program. He stated that he is looking forward to joining the work pay program soon.
Staff Interventions, Activities or Resources	The Work Pay program and Interdisciplinary Treatment Team will provide additional activities as needed, brief therapeutic individual interventions when appropriate.
Measurable Treatment Objective(s)	Mr. Ridley will: (after joining the work pay program) 1) Maintain green level in order to be eligible for work pay position. 2) Report to work as scheduled. 3) Manage his money appropriately.
Target Date	On-going

Resident Input:

Richard Ridley
SCDC# 285091 3

Ex: R-5

Resident Input:

Treatment Team Response/ Overall Summary:

Richard Ridley
SCDMH# 285091
4

Ex: R-5

Treatment Team Signatures:

Name (Print)	Signature / Date
1. <i>David Jones</i>	1. <i>David Jones</i> 9/25/14
2. <i>Richard Ridley</i>	2. <i>Richard Ridley</i> 9-25-14
3. <i>R. INESS</i>	3. <i>R. INESS</i> 9/19/14
4. <i>Paul J. Price</i>	4. <i>Paul J. Price</i> , WPC 9/24/14
5. <i>Harold Alexander</i>	5. <i>Harold Alexander</i> RN 9-24-14
6. <i>Bryant Norton</i>	6. <i>Bryant Norton</i> RN 9-24-14
7.	7.
8.	8.

Check Resident response to plan:

- ☐ Participated in plan formulation
- ☐ Understands but did not participate in formulation
- ☐ Does not appear to understand
- ☐ Resident given a copy
- ☐ If not given a copy, provide reason in the comment section located below.

Comments: _____

Richard Ridley
 SCDC# 285091 5

STATE OF SOUTH CAROLINA)
COUNTY OF AIKEN)
IN THE MATTER OF THE CARE)
AND TREATMENT OF)
RICHARD RIDLEY,)
PETITIONER.)

IN THE COURT OF COMMON PLEAS
SECOND JUDICIAL CIRCUIT

CASE NO. 2013-CP-02-01005

ORDER OF CONTINUED COMMITMENT

The trial of this case was held in the County of Aiken in the Court of Common Pleas the week of February 26, 2018. A jury of citizens from Aiken County heard this case pursuant to a request for a jury trial filed by the State. Assistant Attorney Christopher A. Morrow represented the State. A. Bea Hightower, Esquire, represented the Petitioner. The jury having heard the presentation of the evidence made the following findings of fact pursuant to South Carolina Code Sections 44-48-10 through 44-48-110:

The State has proven beyond a reasonable doubt that Petitioner's mental abnormality or personality disorder remains such that he is not safe to be at large and, if released, is likely to engage in acts of sexual violence.

NOW, THEREFORE, IT IS ORDERED THAT:

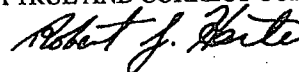
Petitioner Richard Ridley is to remain committed to the Department of Mental Health for his long-term control, care and treatment.

AND IT IS SO ORDERED.


DOYET A. EARLY III
Circuit Court Judge
Second Judicial Circuit
Court of Common Pleas

2-27, 2018
Aiken, South Carolina

A TRUE AND CORRECT COPY



By Charles Gifford Date 5/24/19
Deputy Clerk Plaufer

STATE OF SOUTH CAROLINA)
COUNTY OF AIKEN)
IN THE MATTER OF THE CARE)
AND TREATMENT OF)
RICHARD RIDLEY,)
PETITIONER.)

IN THE COURT OF COMMON PLEAS
SECOND JUDICIAL CIRCUIT
CASE NO. 2013-CP-02-01005

VERDICT FORM

Has the Respondent, the State of South Carolina, proven beyond a reasonable doubt that Richard Ridley's mental abnormality or personality disorder remains such that he is not safe to be at large and, if released, is likely to commit acts of sexual violence?

We, the jury, unanimously answer the question as follows:

☒

YES, the State of South Carolina has proven beyond a reasonable doubt that Richard Ridley's mental abnormality or personality disorder remains such that he is not safe to be at large and, if released, is likely to commit acts of sexual violence.

☐

NO, the State of South Carolina has not proven beyond a reasonable doubt that Richard Ridley's mental abnormality or personality disorder remains such that he is not safe to be at large and, if released, is likely to commit acts of sexual violence.

Kathy Prince
FOREPERSON

Feb. 27, 2018
Aiken, South Carolina

RECEIVED

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

JUN 21 2019

SC Court of Appeals

APPEAL FROM AIKEN COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

Case No. 2013-CP-02-01005
Appellate Case No. 2018-000527

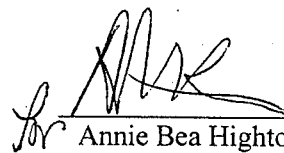
In the Matter of the Care and Treatment of:

Richard D. Ridley..... Appellant

CERTIFICATE RULE 210(G) SCACR

The Undersigned counsel for the Appellant certifies that the within Record on Appeal contains all material proposed to be included in the record for this appeal and no other material

Respectfully Submitted,



Annie Bea Hightower
2231 Devine Street, Suite 201
Columbia, SC 29205
Telephone: 803-799-5205
Fax: 803-799-5206
Email: bea@aikenandhightower.com
ATTORNEYS FOR APPELLANT

Columbia, SC
June 21, 2019