[Note that these responses are broken into a concise answer, with the option of expanding text to read a more detailed description.]

Coercive Medical Practices at Rushville

Is civil commitment of “sexually violent persons” (SVPs) a psychiatric/medical issue?

Drawing on the authority of psychiatric science, the state can legally incarcerate individuals convicted of sex offenses for an indefinite period of time after they have served the entirety of their prison sentences. Critics, including the American Psychiatric Association, argue that civil commitment reduces the complex causes of sexual violence to “mental abnormality,” misusing psychiatric language to legally justify unconstitutional indefinite detention. It is impossible for civil commitment to “cure” committed individuals, because state diagnosed psychiatric illnesses often rely upon dubious or rejected psychiatric diagnoses and assessment methods.

Furthermore, treatment offered is often invasive, further traumatizing, medically dubious, and politically-motivated; it constitutes a thin alibi for indefinite incarceration.

[Expand]
To civilly commit an individual, the state must show that they have a mental disorder "affecting the emotional or volitional capacity that predisposes a person to engage in acts of sexual violence," making them a danger to others (725 ILCS 207). The state petitions for civil commitment based on staff evaluations of individuals convicted of sex offensess, who must ascribe a diagnosis upon them to make them eligible for commitment. Along similar lines, a civilly committed person must graduate through several stages of therapy and prove to both evaluators and a court that they are "no longer dangerous or mentally impaired" (Kansas v. Hendricks).

Who determines risk, diagnosis, and treatment progress? Is SVP civil commitment supported by major psychiatric and public health organizations?

Psychiatric and actuarial risk evaluations and determinations of treatment progress are made by state employees and staff of corporations with vested financial and political interests in indefinite detention. Civil commitment affords almost no room for second opinions, transparency, or standards set out by the American Psychiatric Association, which opposes SVP civil commitment, along with other major psychiatry and health experts.

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Typically, corporations like Liberty Healthcare profit on an expanding population of civilly committed people. In a ruling on a Fourteenth Amendment complaint brought by a Rushville resident against Liberty Healthcare Corporation, a federal District Court raised the concern that Liberty's staff "*alone* have the authority to determine the detainees' right to be released" (emphasis added).[1]

Unlike almost any other medical or therapeutic context, civilly committed people face obstacles to obtaining independent medical opinions or challenging the standards of "care" they receive in Rushville. Like a prison, Rushville confines residents and this confinement is based upon the medical determinations of an institution with a vested financial interest in keeping them locked up. This is especially troubling given that residents are subjected to invasive, traumatic, and scientifically dubious forms of testing, like the penile pethysmograph and polygraphy, and medical "therapy," like chemical castration. The very diagnoses forensic psychologists apply to "sex offenders" lack basis in psychiatry; instead, they were invented to provide a constitutional basis to indefinitely incarcerate individuals who have already served their time.

[1] Hughes v. Dimas et al. 2016, pg. 3.

To this end, the American Psychiatric Association strongly opposes civil commitment programs. In 1998, at the dawn of civil commitment, its Task Force Report on Sexually Dangerous Offenders concluded:

> Sexual 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… Psychiatry must vigorously oppose these statutes…

Mental Health America, the leading community-based nonprofit advocating for those with living with mental illness, likewise strongly opposes civil commitment for sex offenses:

> They focus on punishment rather than treatment, deal with people who often do not have a treatable mental illness, increase stigma, distort civil commitment, risk the safety of other persons in mental health facilities, divert resources from mental health care and inappropriately burden the mental health system with a criminal justice function for which it is not funded or equipped.

Both organizations reject the legal underpinnings of civil commitment, which asserts that sexual offenders have a treatable mental illness that predisposes them to sexual violence. Below, we break down controversial techniques used to keep individuals committed at Rushville.

Are frequently used diagnostic criteria like paraphilia not otherwise specified (PNOS) and sexual sadism reliable medical categories? How did civil commitment come to rely on them?

It is difficult, if not impossible, to distinguish between individuals who harm who have a diagnosable psychiatric sexual disorder and those who do not. Civil commitment/forensic evaluators are at odds with the mainstream of psychiatry, abusing psychiatric diagnoses like PNOS and sadism to advance carceral agendas under the alibi of medicine. Forensic psychologists invented diagnoses to legally justify indefinite incarceration.

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One reason major psychiatric, psychological, and public health organizations oppose civil commitment for sex offenses is that sex offenses happen for all sorts of reasons besides psychiatric disorder. Feminist activists and researchers especially have shown us the *ordinariness* of sexual violence within a patriarchal, white supremacist, and queerphobic society. Sexual violence is most often rooted in demands for power and domination, as well as abuse-related trauma, than in deviant sexual orientation.

Yet the state, legally, can only civilly commit people with a psychiatric order, and these orders are justified by assigning individuals “paraphilia disorder” diagnoses (DSM-V: “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling

with phenotypically normal, physiologically mature, consenting human partners" that causes harm to others**).** However, distinguishing between the relatively rare number of individuals who harm because of a clearly delineated psychiatric illness versus the many more who harm due to complex social, political, and psychic factors remains deeply problematic. As one of the lead authors of DSM-IV writes, "no convincing body of published scientific evidence indicates…that mental health professionals can reliably differentiate SVPs from more typical recidivists who may be sexually dangerous but lack a mental abnormality" (Frances & Wollert 2012, pg. 409). Furthermore, several of the major psychiatric diagnosis used in civil commitment lack consensus and medical validity. For example, a 2022 comprehensive review of research on sexual sadism disorder and coercive paraphilic disorder found that their definitions "are inconsistent and lack reliability," despite their "significant implications" in civil commitment proceedings

In the first decade of SVP civil commitments, the second largest proportion of committed individuals were men who raped women. However, rape in and of itself does not signal a psychiatric disorder. After the birth of civil commitment, however, forensic psychologists began incorrectly using the DSM-IV diagnosis Paraphilia-Not Otherwise Specified (PNOS) and, after its removal from DSM-V, sexual sadism disorder, to justify indefinite "treatment" for individuals who have committed rape.

The problem is that, even by empirical estimates, 90-95% of rape is not underlain by psychiatric causes like uncontrollable sadistic urges. However, state-sponsored forensic psychologists began using PNOS as a broad diagnostic category to commit individuals whose behavior fails to meet the stricter, well-defined criteria of a specific diagnosis. PNOS is called a "wastebasket diagnosis," originally used so psychiatrists could bill insurance companies even in the absence of a definite and medically substantiated psychiatric disorder. These forensic psychologists essentially invented medical categories to expand the reach of civil commitment (see Zander 2008 for an account of this invention process).

Thus, psychiatric researchers and historians argue that the diagnosing clinicians in civil commitment cases have "virtual *carte blanche*" to "invent new diagnoses based on [their] subjective determination" (Zander 2008, pg. 464). They charge these clinicians with a "misuse of the DSM," holding up "unofficial and makeshift diagnostic labels" as solid and well-defined psychiatric terms (Frances & Wollert 2012, pg. 410).

See our review of court cases in Illinois for a fuller account of the role psychiatric diagnoses play in Illinois civil commitment proceedings.

What methods are used to determine if a committed individual has been cured? Are these methods objective or can they be used subjectively and coercively to gatekeep indefinite detention?

The report "Inside Illinois Civil Commitment" reveals four key medically controversial, invasive, and coercive methods deployed in Illinois' civil commitment process. This includes use of the STATIC-99R risk assessment tool, penile plethysmography, chemical castration, and polygraphy. These tools are ostensibly used to assess (and, in the case of chemical castration, correct) residents' supposed pathological desires and likelihood of recidivism. Several, like chemical castration and penile plesmythography, have their historical roots in the now discredited and condemned practices of early sexology, such as John Money's conversion therapy and nonconsensual sex reassignment surgery.

Residents must pass through unreliable or subjective assessment methods in order to become eligible for release from Rushville. This makes civil commitment's goal of treatment and release an empty promise to all but a few; Rushville has a 6% treatment success (i.e. release) rate.

As the exhibition Obstacles to Rehabilitation and Release highlights, a major reason for this is the subjective, political, and often retributive nature of treatment progress at Rushville. Below, we show how the imprecise and subjective nature of assessment tools contribute to this state of de facto indefinite incarceration.

What is the STATIC-99R? Is it reliable?

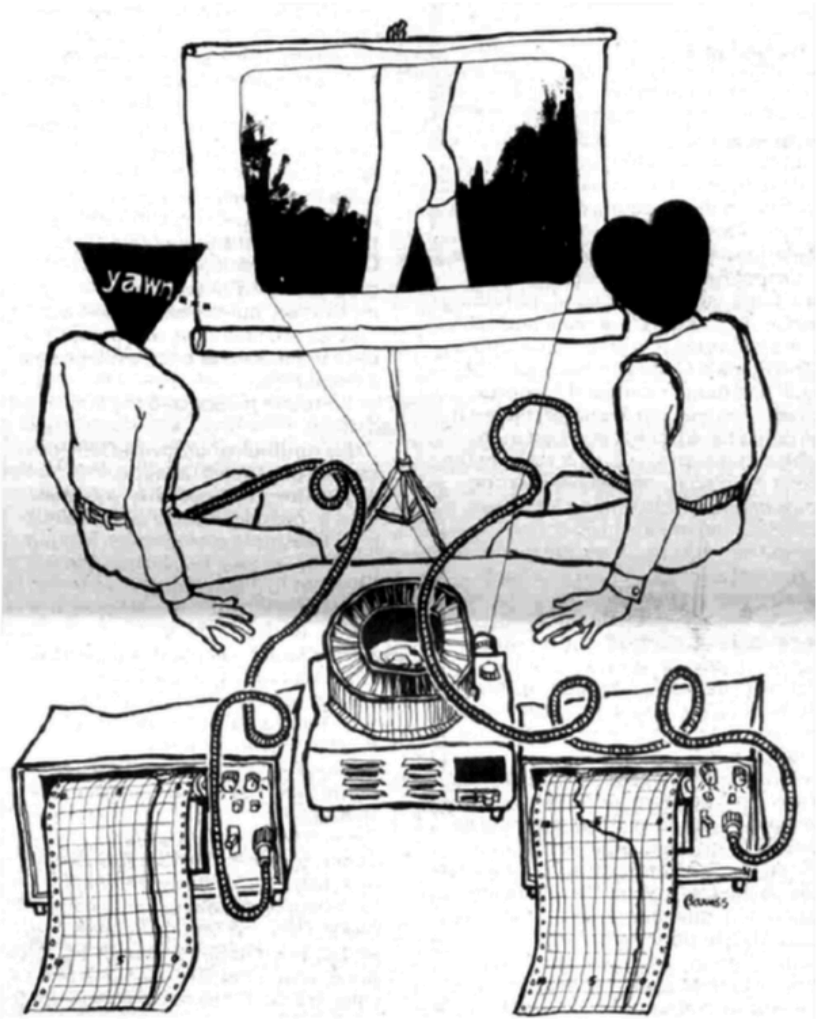
A mental illness diagnosis alone is insufficient to justify involuntary detention. The state must also show that the individual in question poses a serious risk to themself or others. The STATIC-99R, along with STATIC-2002R, are the most widely used of risk assessment tools used to estimate an individual's future risk of recidivism. These measures explicitly target men who have sex with men and nonromantic individuals. They were developed principally by practitioners affiliated with law enforcement agencies and are rooted in theories developed to uphold carceral contexts.

[Expand]
All residents committed at Rushville (except those who committed themselves) were done so because of the risk they pose, as predicted by a STATIC assessment tool. The STATIC-99R explicitly discriminates against men who have sex with men (MSM) and single individuals: individuals who have harmed men (versus women), as well as individuals who have never lived with a lover for more than two years, are guaged as a higher risk and subject to greater rates civil commitment. This contributes to the overrepresentation of MSMs in civil commitment facilities.

Studies suggest that the STATIC-99R's accuracy rate is highly variable. Researchers demonstrate that "it is essentially impossible to establish a risk estimate with a high level of confidence" using the 99R in SVP cases (Donaldson, Abbott & Michie 2012). Even optimistic estimates of the STATIC-99R put its accuracy at around 70% and only 26% of those deemed scorers reoffend, suggesting that ¾ of individuals held as a risk to society are held under false pretenses (Baudin et al. 2021). Researchers have also cautioned practitioners on the applicability of population estimates derived from 99R scores to predicting likelihood of recidivism for an individual undergoing civil commitment proceedings (Amenta, Guy, and Edens 2003).

What is Penile Plethysmography (PPG)? How is it used in civil commitment treatment?

PPG is a device that measures bloodflow to an individual's penis while they are shown sexually suggestive content, which is considered an indicator of arousal and measure of deviant sexual desire. It is the most commonly used measure of deviant sexual arousal in males (Grady, Brodersen & Abramson 2011, pg. 235). 11 Rushville residents report undergoing PPG. They describe this practice as humiliating and report that the media shown to them during the exam is disturbing. The practice is unstandardized and psychometrically unreliable, and produces 'deviant' responses even among "normal" populations. It was first widely used in midcentury conversion therapy/medical torture of homosexuals.



Charles Bonnell's 1977 illustration of PPG for Body Politic*, Canada's then leading homosexual magazine, reproduced in Ha (2015).*

[Expand]
PPG suffers from a lack of standardization and potential for false results, challenging its claims to scientific reliability and sensitivity. Measurement methods, pornographic stimuli, and whether the test is used for scientific versus forensic purposes vary, resulting in inconsistencies (see Blumberg 2018, pp. 600-604): "The potential for false results is undoubtedly heightened due to the lack of standardization in administration." Wilson & Miner (2016) note that the test has a low sensitivity for "sexual deviance" like pedophilia, giving true positive results 40-60% of the time among individuals who have sexually harmed children. Furthermore, they write that "the phallometric method has not enjoyed strong support in regard to reliability," noting only "acceptable" internal consistency only under certain circumstances, as well as low test-retest reliability. Additionally, erections can occur because of friction, general excitement, and anxiety.

PPG is humiliating, invasive, and rooted in homophobic sexology. Kurt Freund developed PPG to quantify male sexual desire and make taboo desires legible. The main target of early PPG research was homosexuality; PPG was initially used in medically abusive conversion therapy. In an attempt to "devaluate" homosexuality, Freund and colleagues injected men with homoerotic responses to nausea-inducing drugs while exposing them to homoerotic imagery. Other practitioners used PPG to administer electroshock when patients became erect to non-heterosexual imagery (Ha 2015, pg. 211, 221-2).

Ha (2015) lists several problematic assumptions of Freund and others in developing PPG:

> "First, they presumed that the possession of sexual desire was a key component of masculinity. Second, these studies were decidedly phallocentric and privileged the penis and its erections as indicative of male sexual desire. Third, they assumed that sexual preferences were akin to tastes that could be ranked hierarchically. Fourth, they took for granted the idea that normal masculinity necessitated the direction of sexual attention toward appropriate sex objects—namely, adult women. Fifth, and most signicantly, they assumed that normal, masculine sexual preferences could be learned" (pg. 208).

Ultimately, the failure of these theories to pan out convinced Freund and the APA that sexual orientation is not modifiable by psychotherapy or conversion therapy.

How is polygraphy involved in civil commitment? Does progress toward release require passing a polygraph test? Are they reliable?

Polygraphy is used to determine a resident's treatment progress and assess risk of reoffending. Residents must pass a polygraph test to move from one stage of treatment to the next. However, polygraph tests are inherently unreliable; they are not even admissible as evidence in court. Studies of polygraph accuracy rates are highly variable, to the point that psychologists deem them unscientific. 116 survey respondents at Rushville reported undergoing polygraph testing. They report that the use of a polygraph creates a culture of distrust that is a barrier to creating a healing treatment environment.

What is chemical castration? Is chemical castration administered as treatment at Rushville?

Chemical castration uses drugs to deprive individuals of the ability to experience sexual desire and engage in sexual activity. The severity of civil commitment laws has produced an upswing in chemical castration, with civilly committed individuals opting into it in an effort to prove their suitability for release. Nine states, including California and Alabama (but not Illinois), mandate chemical castration of some individuals who commit sexual harm, either as part of their sentence or as a condition of their parole. Critics strongly oppose chemical castration as medical violence that violates individuals' bodily autonomy, strips human dignity, and risks potentially fatal health complications (e.g. Stinneford 2006). 25 survey respondents at Rushville report undergoing chemical castration.

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In Illinois, chemical castration takes the form of an anti-androgen that prevents the testicles from producing androgens like testosterone. Besides depriving patients of sexual desire, chemical castration broadly alters the body's hormonal makeup, resulting in severe side effects, including osteoporosis, cardiovascular disease, impaired metabolism, insomnia, migraines, severe mood instability, depression, and stroke (Douglas et al. 2013). Sullivan & Mullen (2012) note that, "despite longstanding recognition of some apparent correlation between testosterone levels and aggression, possibly violent offending, and even more tenuously, sexual offending, the nature of the relationship remains elusive." Rice & Harris (2011) warn that "little is known about the long

term effects of [chemical castration] in general, and sexual recidivism in particular, or about long-term health effects."

Critics emphasize that chemical castration is an inethical form of medical violence. Tellingly, sexologist John Money pioneered chemical castration. Money's involuntary sex reassignment of David Reimer is a textbook case of medical abuse which tarnished his reputation one that established a pattern of medical violence against intersex individuals. Trans activist Andrea James has catalogued John Money's direct contributions to anti-trans psychiatry and trans-exclusionary radical feminist (TERF) ideology.