2026 IL App (1st) 240578

No. 1-24-0578

First Division
October 13, 2026

IN THE

APPELLATE COURT OF ILLINOIS

FIRST DISTRICT

In re COMMITMENT OF MICHAEL HUGHES	)	
	)	Appeal from the
(The People of the State of Illinois	)	Circuit Court of
Petitioner-Appellee,	)	Cook County.
v.	)	
	)	No. 10 CR 80013
Michael Hughes,	)	
Respondent-Appellant).	)	Honorable
	)	Michael Clancy and
	)	Nicholas Kantas,
	)	Judges, Presiding.

JUSTICE COBBS delivered the judgment of the court, with opinion.

Presiding Justice Ellis and Justice Howse concurred in the judgment and opinion.

OPINION

¶ 1 Following a bench trial, respondent Michael Hughes was found to be a sexually violent person (SVP) under the Sexually Violent Persons Commitment Act (SVP Act or Act) (725 ILCS 207/1 *et seq.* (West 2020)). After a dispositional hearing, respondent was committed to the Department of Human Services (DHS) for secure treatment. Respondent now appeals, raising several claims of error. For the reasons that follow, we affirm.

¶ 2 I. BACKGROUND

¶ 3 In 1997, respondent pled guilty in various cases to a total of one count of predatory criminal sexual assault, six counts of criminal sexual assault, and nine counts of aggravated criminal sexual abuse in connection with the sexual abuse of at least eight boys. Respondent was also charged with two additional counts of aggravated criminal sexual abuse and criminal sexual assault but was never prosecuted because the alleged victim died in an accident while the case was pending. The victims ranged from 10 to 14 years old and were players on youth baseball or football teams coached by respondent. The offenses occurred either at respondent's home or office, often after respondent supplied the victims with alcohol or marijuana and showed them pornography. Respondent was sentenced to 24 years in prison for these offenses.

¶ 4 A. The State's SVP Petitions

¶ 5 On July 29, 2010, the State filed a petition to civilly commit respondent as an SVP based on an evaluation by Dr. John Arroyo. Dr. Arroyo diagnosed respondent with "Paraphilia, Not Otherwise Specified, Non-consent" (PNOS-Nonconsent), a congenital or acquired mental disorder involving persistent sexual attraction to nonconsenting partners. The State's petition asserted that Dr. Arroyo's evaluation showed that respondent's condition affected his emotional or volitional capacity and made him substantially probable to commit future acts of sexual violence.

¶ 6 On September 3, 2019, the State filed an amended SVP petition adding an evaluation from Dr. David Suire, who diagnosed respondent with "Pedophilic Disorder, Sexually Attracted to Boys, Nonexclusive Type; Other Specified Paraphilic Disorder (OSPD), Sexually Attracted to Adolescent Males, Nonexclusive Type and Other Specified Personality Disorder with Antisocial and Narcissistic Features." Like the State's initial petition, the amended petition asserted that

respondent's mental disorders affected his emotional or volitional capacity and made it substantially probable that he would commit further sexually violent acts.

¶ 7 B. Respondent's First Motion Exclude a Hebephilia Diagnosis

¶ 8 On December 19, 2014, respondent filed a "Motion to Bar Testimony of Evidence Related to an Alleged Hebephilia Diagnosis Pursuant to *Frye*" (see *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923)). The motion cited *In re Detention of New*, 2014 IL 116306, ¶ 3, where the respondent had been convicted of sexually abusing a 12-year-old boy and a 14-year-old boy. Based in part on these convictions, the State's evaluator in *New* diagnosed the respondent with a paraphilia based on "sexual attraction to early adolescent males," a condition our supreme court described as "otherwise known as hebephilia." *Id.* ¶¶ 3, 33. The respondent filed a pretrial motion to bar testimony about this diagnosis on the grounds that it was not generally accepted within the psychiatric and psychological communities. *Id.* ¶ 4. The circuit court denied the motion and proceeded to trial without first holding a hearing pursuant to *Frye*. *Id.* ¶ 5. On appeal, our supreme court held that the diagnosis of hebephilia was subject to the admissibility standards set forth in *Frye* and thus remanded for the circuit court to hold a hearing to determine whether the diagnosis was generally accepted in the relevant scientific community. *Id.* ¶ 53.

¶ 9 In the present case, respondent's motion asserted that, despite using different terminology, Dr. Suire essentially diagnosed him with hebephilia. Similarly, respondent contended that Dr. Arroyo's diagnosis of a paraphilic attraction to nonconsenting partners was "actually [a] hebephilia diagnos[i]s in disguise" because Dr. Arroyo reported that respondent's victims were unable to give legal consent because they were underage. Accordingly, respondent argued that the circuit court should bar Dr. Suire and Dr. Arroyo's diagnoses "unless the State meets its burden of proving general acceptance following a *Frye* hearing."

¶ 10 The State initially responded that *New* had "no impact" on this case because respondent was "not diagnosed with hebephilia." The State argued that Dr. Arroyo diagnosed PNOS-Nonconsent because respondent was "not simply attracted to children who have started to enter puberty," but was instead "aroused by force and manipulation," which he happened to use against minor victims. Because Illinois courts had already deemed PNOS-Nonconsent to be generally accepted, the State contended that a *Frye* hearing was unnecessary.

¶ 11 The circuit court denied respondent's motion, reasoning that *New* did not affect established precedent that PNOS-Nonconsent was a generally accepted diagnosis. Thus, the court did not rule on whether a hebephilia diagnosis was generally accepted.

¶ 12 C. Respondent's Second Motion to Exclude a Hebephilia Diagnosis

¶ 13 Several years later, in September 2019, respondent filed a renewed motion "to preclude any testimony regarding any paraphilia or paraphilic disorder involving sexual attraction to adolescents also known as 'hebephilia.' " Citing aspects of Dr. Arroyo and Dr. Suire's depositions, respondent again contended that, despite using different labels, the State's experts effectively diagnosed him with hebephilia.

¶ 14 In response, the State acknowledged that since respondent's original request for a *Frye* hearing, "sexual attraction to adolescent males, which is the same thing as pedophilia had come to light during the deposition." The State also confirmed that at least one of its experts diagnosed respondent with hebephilia. In light of the State's change in position, the circuit court set the matter for a *Frye* hearing on hebephilia.

¶ 15 D. The *Frye* Hearing

¶ 16 At the *Frye* hearing, Dr. David Thornton testified for the State as an expert in the evaluation and risk assessment of sex offenders. Dr. Thornton completed a report on the acceptance of a

hebephilia diagnosis, which he defined as a "preferential sexual interest in children who are in the early stages of puberty." He distinguished hebephilia from pedophilia, which is a sexual preference for "prepubescent" children. Dr. Thornton explained that pedophiles are attracted to children in Tanner stage 1 of physical development, which researchers generally consider ages 10 and under. Hebephiles, on the other hand, are attracted to children in Tanner stages 2 and 3, "which children normally go through the period from when they are about 11 to 14" years old. Minors 15 years of age and older are likely to be more developed and in Tanner stages 4 and 5, which are not associated with a mental disorder. However, Dr. Thornton cautioned that different children develop at different ages and rates. Additionally, evaluators "[a]lmost never" know what Tanner stage a victim is in and thus usually make diagnoses based on general guidelines and the available facts of each case.

¶ 17 Regarding the general acceptance of hebephilia, Dr. Thornton examined numerous published studies, including research from the Kurt Freund Laboratory (Freund Laboratory) in Toronto, Canada. The Freund Laboratory was renowned for demonstrating hebephilia in some men using a penile plethysmograph (PPG), a diagnostic device that detects sexual arousal by measuring involuntary changes in penile volume and blood flow. Dr. Thornton also relied on his own clinical experience, particularly field studies measuring the reliability with which experts can diagnose hebephilia from the same set of facts. Dr. Thornton testified that these field studies yielded "very good" reliability scores for hebephilia, showing that it can be diagnosed "a bit better" than many other recognized conditions like schizophrenia or bipolar disorder.

¶ 18 Ultimately, Dr. Thornton opined that a hebephilia diagnosis was "definitely" generally accepted under *Frye*. He explained that researchers who study hebephilia are "strongly pro" in accepting the diagnosis and "pretty well invariably acknowledge the existence of hebephilia and

will accept it as a mental disorder." Experts who are often hired by prosecutors also "pretty much all" accept hebephilia whereas "most" defense experts do not. The remaining experts are "mixed" and "split 50/50" in accepting hebephilia. Thus, according to Dr. Thornton, "it's clear that overall there is a majority opinion in favor" of accepting hebephilia as a valid diagnosis.

¶ 19 On cross-examination, respondent's counsel questioned Dr. Thornton on hebephilia's exclusion from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Dr. Thornton acknowledged that the DSM did not adopt a proposal to enumerate hebephilia as a recognized paraphilia, but testified that he gave no weight to that decision because the DSM only enumerates a few of the many paraphilias known to exist. Dr. Thornton reiterated that hebephilia is properly diagnosed using the DSM's general framework for other, nonspecified paraphilias.

¶ 20 Dr. Thornton further recognized that, at least for purposes of a pedophilia diagnosis, the DSM states that prepubescent children are "generally age 13 and under." He explained that this language had been criticized by many experts in the field who believe that it was more accurate to say that prepubescent children are generally ages 10 and under. Thus, Dr. Thornton opined that the DSM's definition can be "a little bit misleading" and cause hebephilia to be "misdiagnose[d]" as pedophilia in some cases. Upon questioning by the circuit court, Dr. Thornton testified that most researchers have come to define hebephilia as "a sexual interest in Tanner stages 2 and 3, children generally aged between 11 and 14."

¶ 21 Dr. James Cantor also testified as an expert for the State. Like Dr. Thornton, Dr. Cantor explained that hebephilia is defined by a sexual preference for "pubescent children" in Tanner stages 2 and 3, which is generally from ages 11 to 14. In contrast, pedophilia is a preference for prepubescent children in Tanner stage 1, which is typically ages 10 and under. However, also like

Dr. Thornton, Dr. Cantor cautioned that "the age of puberty differs a little bit between kids" and can depend on various factors such as gender and nutrition.

¶ 22 Further in line with Dr. Thornton, Dr. Cantor opined that PPG research from the Freund Laboratory and others have shown a "very, very reliable finding" that hebephilia exists. Dr. Cantor also discussed his own research that showed physiological differences among pedophiles, hebephiles, and those with a sexual preference for adults.

¶ 23 Finally, Dr. Cantor testified that hebephilia was more researched than any of the paraphilias listed in the DSM other than pedophilia. He surveyed 50 different studies on hebephilia, all but two of which suggested that hebephilia was a distinct mental condition. Dr. Cantor explained that the two outlier studies used small sample sizes and defined hebephilia to include an interest in 15-and-16-year-olds, which is broader than the definition typically used by researchers. According to Dr. Cantor, scientists and researchers in the field were "virtually unanimous" in accepting hebephilia as an identifiable mental disorder.

¶ 24 Dr. Thomas Zander testified for respondent as an expert in forensic psychology and the assessment of sex offenders. He was a "semiretired" forensic psychologist who primarily evaluated sex offenders for civil commitment proceedings. Dr. Zander opined that a hebephilia diagnosis is not generally accepted among mental health professionals. In particular, Dr. Zander stated that sexual attraction to minors in Tanner stages 1 through 3 is associated with pedophilia. According to Dr. Zander, there is not a "separate legitimate diagnosis called hebephilia," and if anything, what some call hebephilia is mostly a "redundant subset" of pedophilia.

¶ 25 Dr. Zander rejected Dr. Thornton and Dr. Cantor's definition of hebephilia as referring generally to 11-to-14-year-olds, instead endorsing the DSM's definition that pedophilia includes attraction to children 13 and under. Dr. Zander criticized the State's experts for "fail[ing] to

recognize the practical reality of how these research based proposals will play out in [ ] everyday life and *** in the courtroom." Instead, Dr. Zander claimed that most experts would not consider an attraction to 14-year-olds to be a disorder because 14-year-olds are typically in Tanner stages 4 or 5. According to Dr. Zander, proposals to add hebephilia to the DSM were rejected because the inclusion of 14-year-olds would allow those with normal sexual interests to be diagnosed with a mental disorder.

¶ 26 After hearing arguments from the parties, the circuit court issued an oral ruling that the State had met its burden in showing that a hebephilia diagnosis was generally accepted in the psychological and psychiatric communities. Thus, the court allowed the State to introduce evidence of the diagnosis at trial.

¶ 27 E. Respondent's Motion to Exclude a Pedophilia Diagnosis

¶ 28 On November 2, 2021, respondent filed a new motion *in limine* to exclude testimony regarding "diagnoses that have not been proven to be generally accepted." More specifically, respondent argued that although the circuit court ruled that hebephilia was generally accepted, Dr. Suire did not diagnose with him hebephilia. Instead, Dr. Suire diagnosed *pedophilia* based on the DSM's guidance that children under 13 are generally prepubescent. Respondent argued that the court "necessarily" rejected this definition of pedophilia because it "directly contradict[ed]" the ages that the State's witnesses testified to at the *Frye* hearing. The court denied respondent's motion.

¶ 29 F. Bench Trial

¶ 30 The matter proceeded to a bench trial beginning on August 22, 2023. At trial, Dr. Suire testified as the State's expert in the evaluation and risk assessment of sex offenders. Dr. Suire completed a clinical evaluation to determine whether respondent met the criteria for an SVP. As

part of his evaluation, Dr. Suire reviewed records and conducted a videotaped interview with respondent. Dr. Suire completed his initial evaluation in January 2011 and updated the evaluation four times, most recently in September 2022.

¶ 31 Dr. Suire summarized respondent's criminal history as follows. In 1983, respondent was sentenced to four years of probation for "indecent liberties with a child and assault." The charges arose from an incident in which respondent, then 17, forced a 15-year-old boy to perform oral sex on him. Respondent threatened to kill the victim if he told anybody what had happened. In 1984, respondent was charged with battery after drinking Southern Comfort and attempting to unbutton a male victim's pants. The victim was able to fight respondent off, and respondent was not ultimately convicted of any charges.

¶ 32 Defendant received 24 years in prison after pleading guilty to numerous counts of predatory criminal sexual assault, criminal sexual assault, and aggravated criminal sexual abuse for offenses occurring between 1994 and 1997. The victims, eight boys ranging from 10 to 14 years old, were players on youth sports teams coached by respondent. Generally, the offense involved respondent luring the victims to his home or office, where he would provide them with liquor mixed with Mountain Dew and sometimes marijuana. Respondent would often put on a pornographic movie and proceed to fondle and perform oral sex on the victims. Respondent admitted in interviews to victimizing six of the boys but claimed that he falsely plead guilty to abusing the other two. He explained that he gave the victims alcohol and marijuana because he believed it made them less likely to tell their parents about the abuse.

¶ 33 After the convictions in the 1997 cases, another man also came forward with similar accusations against respondent. The man alleged that in the mid-1980s, when he was between 12 and 14 years old, he awoke one night on a baseball trip to find respondent, then an assistant coach

of the team, performing oral sex on him. The man alleged that respondent threatened to kill him and his family if he reported the incident. Sometime later, the man was at respondent's home when respondent offered the man alcohol, touched the man's penis over his pants, and attempted to kiss him on the mouth. Respondent admitted to Dr. Suire that he had had "sexual contact" with the man.

¶ 34 Dr. Suire also testified that respondent had an "above average" disciplinary record in the Illinois Department of Corrections (IDOC), with only 1 "major" violation and 11 "minor" violations. However, IDOC at one point classified respondent as a "predator" because he was "grooming" a "much younger" inmate. Respondent admitted that he was "deep in his cycle" during that time. Respondent participated in sex offender treatment for two years but left the program against his therapist's recommendation. While in IDOC custody, respondent had completed some "treatment-type activities," such as group discussions, but had consistently refused specific treatment for sex offenders. Respondent told Dr. Suire that he did not need to participate in sex offender treatment at DHS because he "felt he had done the work he needed to do."

¶ 35 Ultimately, Dr. Suire diagnosed respondent with three mental disorders using the DSM: (1) pedophilic disorder, sexually attracted to boys, nonexclusive type; (2) other specified paraphilic disorder (OSPD)-sexually attracted to adolescents, nonexclusive type; and (3) OSPD with antisocial and narcissistic features. Dr. Suire testified that the criteria for pedophilic disorder included sustained sexual interest in prepubescent children, which the DSM defined as children 13 years of age and under. Dr. Suire opined that respondent met these criteria due to repeated sexual contact with children 13 and under which caused harm to the victims and placed respondent's career, reputation, and freedom at great risk.

¶ 36 Dr. Suire diagnosed respondent with OSPD-sexually attracted to adolescents under the general paraphilia framework outlined in the DSM. Dr. Suire defined "adolescents" as those who are "pubescent," meaning that they have "gone through some aspect of puberty" but are not yet fully developed. Generally, "adolescents" were likely to be 14 or 15 years old. Dr. Suire acknowledged that he did not know the exact Tanner stages of respondent's victims but diagnosed him based on a pattern of repeated offenses involving victims in the general age range.

¶ 37 Finally, Dr. Suire explained that he diagnosed respondent with a personality disorder due to a "combination of antisocial and narcissistic traits" that Dr. Suire opined raised his risk of sexual recidivism. In particular, Dr. Suire identified factors such as respondent's repeated offending, recklessness, and lack of remorse. Dr. Suire also testified that respondent was "pretty entitled" and had a "very high view of himself" consistent with a narcissistic personality disorder. Indeed, respondent acknowledged that he had "kind of a narcissistic personality" during his interview. Dr. Suire stated that these diagnoses are acquired or congenital disorders that affected respondent's emotional or volitional capacity and predisposed him to commit future acts of sexual violence.

¶ 38 To evaluate respondent's risk of recidivism, Dr. Suire used two reputable actuarial instruments called the Static-99 Revised (Static-99R) and Static-2002 Revised (Static-2002R). Respondent scored a four on the Static-99R, placing him in the "above average" risk range. His "relative risk" score was 1.96, meaning he was nearly twice as likely to reoffend as the typical offender in the sample. Respondent scored a six on the Static-2002R, again placing him in the "above average risk" category. The relative risk for that score was 2.63, meaning respondent was more than two-and-a-half times more likely to reoffend than the typical sex offender. Dr. Suire opined that these instruments tend to underestimate the true risk of recidivism because they only

consider offenses that resulted in criminal charges. Thus, the instruments do not capture offenses that are not detected or do not result in formal charges for some other reason.

¶ 39 Aside from the static actuarial instruments, Dr. Suire also considered various factors known to increase or decrease an offender's risk of recidivism. Dr. Suire identified respondent's deviant sexual interests, "offense supported attitude," and "prudent hostility" as dynamic factors that increased his risk of reoffending beyond what was captured by the actuarial instruments. Dr. Suire explained that he identified these factors due to respondent's stated sexual interest in minors, his claims that the victims instigated several of the offenses, and his persistent complaints of unfair treatment while in custody. Dr. Suire also considered that "older research" suggested respondent's personality disorder, substance abuse, and history of being physically abused elevated his chance of reoffending.

¶ 40 Lastly, Dr. Suire opined that there were no additional "protective factors" that decreased respondent's risk of recidivism. Dr. Suire testified that respondent's participation in treatment was not a protective factor because respondent stopped treatment in 2002 against his therapist's advice. Dr. Suire also concluded that respondent had learned some treatment-related concepts but did not demonstrate an ability to change his behavior. For example, Dr. Suire noted that respondent was unable to refrain from "grooming" a much younger inmate despite recognizing that he was in his "cycle" at the time. Dr. Suire also explained that respondent's age, which was 57 at the time of trial, was not a protective factor because it was already considered by the actuarial instruments. Based on the totality of the circumstances, Dr. Suire determined that respondent was substantially probable to reoffend, meaning that he was "[m]uch more likely than not" to commit further acts of sexual violence.

¶ 41 On cross-examination, Dr. Suire clarified that he "[e]ssentially" diagnosed respondent with hebephilia, stating that "the combination of the pedophilic disorder and [OSPD-sexually attracted to adolescents] probably captures hebephilia in it." He explained respondent's "primary sexual interest is 12-to-14-year-old boys," which would indicate both pedophilia and hebephilia depending on how developed the particular victims were. Dr. Suire generally considered children 13 and under to be prepubescent under the DSM's definition but acknowledged that some 13-year-olds would be in the developmental stages associated with hebephilia. Dr. Suire also recognized that it was "not uncommon" for some experts to define hebephilia as a sexual interest 11-to-14-year-olds.

¶ 42 Regarding respondent's risk of reoffending, Dr. Suire testified that he used an "unstructured" approach of adjusting respondent's static actuarial instrument scores. This approach involved identifying the presence of dynamic and protective factors and then using research and his own clinical judgment to determine how each factor affected the probability that respondent would reoffend. Dr. Suire did not modify the static scores with a "structured" adjustment method such as the STABLE-2007 or VRS-SO because he believed that respondent's lack of treatment and unwillingness to be interviewed prevented reliable scoring on those instruments.

¶ 43 Following Dr. Suire's testimony, the State entered into evidence certified copies of respondent's convictions. The parties stipulated that these convictions qualified as sexually violent offenses under the Act.

¶ 44 After the State rested, respondent moved to strike Dr. Suire's testimony on the basis that the State had not proven that his diagnoses were generally accepted. Specifically, respondent again contended that Dr. Suire was contradicted by the State's *Frye* hearing witnesses because they

testified that pedophilia was associated with attraction to children aged 10 and under and hebephilia was associated with attraction to children aged 11 to 14. Respondent also moved for a directed finding, alleging that the State failed to prove that respondent had a mental disorder as defined by the SVP Act. The circuit court denied both of respondent's motions.

¶ 45 Respondent then called Dr. Arroyo as his expert witness in forensic psychology and sex offender risk assessment. Dr. Arroyo issued his initial report in July 2010, which was followed by a series of updated reports ending in August 2023. Respondent repeatedly declined to be interviewed, so Dr. Arroyo completed all of his reports based solely on the documentary evidence in respondent's file.

¶ 46 Like Dr. Suire, Dr. Arroyo began his risk evaluation with the Static-99R and the Static-2002R. Dr. Arroyo scored respondent as a four on the Static-99R, placing him in the "above average" risk category. This score correlated to an "absolute risk" of 17% for the routine sample of sex offenders and approximately 32% for the "high risk" group of offenders. Respondent scored a five on the Static-2002R, which translated to an absolute risk score of approximately 25%.

¶ 47 Dr. Arroyo further testified that he used different means of adjusting these static scores in his various reports. Prior to the 2023 updates, Dr. Arroyo modified respondent's scores using the STABLE-2007. Based on this methodology, Dr. Arroyo initially concluded that respondent met the criteria to be considered an SVP. However, Dr. Arroyo changed his opinion in 2023 because he began using the VRS-SO to modify static actuarial scores. According to Dr. Arroyo, the VRS-SO was the more accurate method in cases where the subject refused to be interviewed.

¶ 48 Ultimately, respondent scored a 34 on the VRS-SO, placing him in the "average" risk category. Factoring this score into the static instruments, Dr. Arroyo calculated that respondent's absolute risk of recidivism was 7.7% for 5 years and approximately 12.5% for 10 years. Dr. Arroyo

opined that he no longer believed that respondent was an SVP because these scores did not suggest he was substantially probable to reoffend.

¶ 49 On cross-examination, Dr. Arroyo clarified that he diagnosed respondent with OSPD-nonconsent and other specified personality disorder with antisocial and narcissistic traits. Dr. Arroyo stated that these diagnoses were mental disorders under the Act and were chronic in that "[t]hey don't go away by themselves" but could be managed through treatment. Dr. Arroyo also testified that respondent's conditions were congenital or acquired and affected his emotional or volitional capacity. When asked whether respondent's disorders predisposed him to engage in acts of sexual violence, Dr. Arroyo replied that, "They may, but it's my opinion that they don't in Mr. Hughes' case." Upon questioning by the circuit court, Dr. Arroyo reiterated that he changed his opinion on whether respondent was an SVP in June 2023 because he began using the VRS-SO to adjust actuarial risks scores.

¶ 50 Respondent also called Dr. Brian Abbott as an expert witness. Dr. Abbot testified that he was contacted by respondent's counsel to determine whether he agreed with the reports from the State's evaluators. Dr. Abbott reviewed the documents in the case and interviewed respondent in May 2016. Dr. Abbott then issued an initial report in July 2017 in which he found that respondent was not an SVP. Dr. Abbott interviewed respondent again in July 2023 and issued an updated report thereafter. Like the initial report, Dr. Abbott's updated reports also concluded that respondent did not meet the criteria to be considered an SVP.

¶ 51 More specifically, Dr. Abbot concluded that respondent suffered from post-traumatic stress disorder (PTSD) from being sexually abused as a child, but that the condition did not affect his emotional or volitional capacity or predispose him to commit acts of sexual violence. Dr. Abbott explained that respondent's offending was a "maladaptive way of coping" with his trauma by

seeking the "power and control" he lacked as a child. However, Dr. Abbot found "no evidence" that respondent's PTSD gave him difficulty controlling his sexually violent behavior. For example, Dr. Abbott found that respondent's minimal disciplinary history while in custody indicated that he could control whatever sexual urges he may have.

¶ 52 Dr. Abbott further testified that he did not diagnose respondent with pedophilic disorder because although some of his victims were "likely" prepubescent, others were too old to assume so without more evidence. Dr. Abbott explained that not all who sexually offend against children have pedophilic disorder. Instead, the DSM identifies five factors that tend to separate offenders with pedophilic disorder from those without: (1) an expressed sexual interest in prepubescent children, (2) use of child pornography, (3) boy victims, (4) multiple child victims, and (5) victims unrelated to them. Dr. Abbott opined that respondent met only three of the five criteria because he had not expressed an interest in prepubescent children or been known to use child pornography. To the contrary, Dr. Abbott recalled that respondent told one evaluator in 2012 that his ideal sexual partner was not a prepubescent child, but a six-foot-tall man with long hair and a "swimmer's build." Dr. Abbott also recalled respondent telling him about a "young, immature-looking" intellectually disabled man in DHS custody. Respondent stated that he might have been sexually attracted to such a person in the past, but that he was no longer interested.

¶ 53 Despite finding that respondent did not have a mental disorder under the Act, Dr. Abbott also evaluated respondent's risk of recidivism with the Static-99R. Respondent scored a five, placing him in the "above average" risk category. That score was associated with a 12.8% chance of reoffending within five years among the routine sample group. Dr. Abbott did not report respondent's likelihood to reoffend within 10 years because he felt it was irrelevant to whether respondent was currently a danger to reoffend.

¶ 54 Dr. Abbott also supplemented his Static-99R results with the VRS-SO. He opined that a "structured" adjustment method like the VRS-SO was more reliable than Dr. Suire's unstructured analysis because the unstructured method tends to introduce subjectivity and overestimate the risk of recidivism. Dr. Abbot explained that the VRS-SO was designed to evaluate how treatment affects an offender's risk of recidivism. In this case, Dr. Abbott compared respondent at the time he entered IDOC custody in 2000 to the time of trial in 2023 by assigning him a numerical score in various categories. According to Dr. Abbott, respondent showed an 11-point improvement since entering custody, which placed him in the "lower third" in terms of risk to reoffend. In particular, Dr. Abbott credited respondent with improvement in sexual deviance and sexual compulsivity because he was now comfortable with his homosexuality and did not engage in inappropriate sexual activity while in custody. Respondent also reported that he no longer fantasized about sex with minors or masturbated to his previous victims. After factoring in the VRS-SO results, respondent's 5-year risk of reoffending dropped to 5.8%, which Dr. Abbott testified would not qualify as a substantial probability of recidivism under the Act.

¶ 55 G. Respondent's Motion to Admit *Frye* Hearing Evidence

¶ 56 Following Dr. Abbott's testimony, respondent made an oral motion to admit into evidence the testimony and reports from the State's experts at the *Frye* hearing. The State responded that such evidence was "irrelevant" to the issues at hand because "the State's witnesses did not diagnose the respondent with hebephilia." The court denied respondent's motion.

¶ 57 H. Closing Arguments and the Court's Ruling

¶ 58 During closing arguments, respondent argued that the State failed to prove that he had a mental disorder under the Act, alleging that Dr. Suire "made up" the diagnosis of OSPD-sexually attracted to adolescents and incorrectly diagnosed him with pedophilia where there was no

evidence that any of his victims were prepubescent. Respondent also maintained that the State did not prove that he was substantially probable to commit future acts of sexual violence because Dr. Suire was biased, "inexplicably failed" to use a structured adjustment method like the VRS-SO, and engaged in "statistical gymnastics" by relying on subjective and unquantifiable dynamic factors.

¶ 59 The State countered that Dr. Suire credibly diagnosed respondent with mental disorders involving sexual attraction to underage boys, as evidenced by respondent's statements and numerous offenses involving boys between the ages of 12 and 14. The State also contended that respondent had a substantial probability of recidivism based on his "above average" scores on the actuarial instruments, the presence of several dynamic factors, and the absence of any significant protective factors.

¶ 60 After taking the matter under advisement, the circuit court issued the following ruling on December 13, 2023. First, as the parties stipulated, the court noted that respondent had been convicted of multiple sexually violent offenses. The court also found that respondent had a mental disorder within the meaning of the Act, observing that both Dr. Suire and Dr. Arroyo reached that conclusion based on respondent's records and the DSM. Finally, the court credited Dr. Suire's testimony that respondent was substantially likely to reoffend. The court stated that Dr. Suire's evaluation was the most "comprehensive" and considered both actuarial instruments and other empirical factors specific to respondent's case. The court further noted that Dr. Arroyo agreed that respondent was substantially probable to reoffend for many years until changing his opinion in 2023. Although the court acknowledged that both of respondent's experts now thought respondent was not substantially probable to reoffend, the court assigned greater weight to Dr. Suire's

testimony because it was "more credible" and "more convincing." Accordingly, the court found that respondent was an SVP.

¶ 61 Respondent filed a timely posttrial motion, which he then amended on February 2, 2024. The amended motion argued that the State failed to prove that respondent was an SVP beyond a reasonable doubt and that the circuit court erred by allowing the State to elicit testimony about diagnoses that were not generally accepted. The court denied the motion and, after a subsequent dispositional hearing, committed respondent to a secure DHS facility.

¶ 62 This appeal followed.

II. ANALYSIS

¶ 63 A. Hebephilia and the *Frye* Hearing

¶ 64 Respondent raises numerous claims of error on appeal. We begin by addressing several related arguments concerning the diagnosis of hebephilia and the circuit court's handling of the *Frye* hearing. Respondent generally contends that the court erred in ruling that hebephilia was a generally accepted diagnosis at the *Frye* hearing and in allowing Dr. Suire to testify at trial about a paraphilic disorder related to pubescent boys that the State did not first prove was generally accepted.

¶ 65 In Illinois, the admission of scientific evidence is governed by the *Frye* standard. *In re Commitment of Adams*, 2021 IL App (1st) 182049, ¶ 40. Under *Frye*, new or novel scientific evidence is admissible at trial only if the methodology or scientific principle upon which it is based is " 'sufficiently established to have gained general acceptance in the particular field in which it belongs.' " *In re Commitment of Simons*, 213 Ill. 2d 523, 529-30 (2004) (quoting *Frye*, 293 F. at 1014). " '[G]eneral acceptance' " does not require that the methodology in question is accepted by all or even a majority of experts in the relevant field. *Id.* at 530. Rather, a methodology is generally

accepted under *Frye* so long as the underlying method used to generate an expert's opinion is reasonably relied upon by experts in the relevant field. *Id.* The proponent of the evidence has the burden of showing that the opinion is generally accepted. *People v. Beck*, 2017 IL App (4th) 160654, ¶ 105. A circuit court's determination on whether there is general acceptance in the relevant scientific community is subject to *de novo* review. *Id.* ¶ 107.

¶ 66 We note that the parties in this case acknowledged that a *Frye* hearing was required under *New*, where our supreme court held that the general acceptance of hebephilia was not sufficiently established to admit the diagnosis without a *Frye* hearing. *New*, 2014 IL 116306, ¶¶ 39-53. Subsequent to *New*, however, at least one panel of the Second District has affirmed the circuit court's post-*Frye* hearing ruling that hebephilia was generally accepted. *In re Commitment of Bauer*, 2020 IL App (2d) 180905, ¶¶ 21-30, *appeal denied*, No. 126218 (Ill. Sept. 30, 2020). We are aware of no case—and respondent cites to none—in which hebephilia was ruled to be not generally accepted.

¶ 67 Nevertheless, the crux of respondent's arguments on appeal is that Dr. Suire *did not* diagnose him with hebephilia. Thus, respondent asserts that whether hebephilia is generally accepted was nonjusticiable as a "hypothetical issue that had no bearing on this case." Similarly, respondent contends that because Dr. Suire's diagnosis of OSPD-sexually attracted to adolescents was not the same as a hebephilia diagnosis, it was never established as a valid, generally accepted diagnosis.

¶ 68 To untangle these issues, we must consider whether Dr. Suire's diagnosis was consistent with the testimony of the State's witnesses at the *Frye* hearing. In evaluating whether a diagnosis is generally accepted, we look to the substance of the diagnosis rather than the specific label attached to it. *Adams*, 2021 IL App (1st) 182049, ¶¶ 53-56 (finding that precedent on the general

acceptance of PNOS-nonconsent applied to the diagnosis of OSPD-nonconsent where the different terminology was "no more than a relabeling or clarification of the elements of essentially the same disorder"). Our review of the record shows that Dr. Suire and the State's *Frye* witnesses all testified that a persistent sexual attraction to prepubescent children was associated with the generally accepted diagnosis of pedophilia (also called pedophilic disorder) and that a persistent attraction to children in the early stages of puberty was associated with hebephilia. All of these witnesses also testified that sexual attraction to older teenagers who were nearly as physically developed as adults was not a mental disorder.

¶ 69 Respondent's argument that Dr. Suire's diagnosis "contradicted" the concept of hebephilia that was found to be generally accepted at the *Frye* hearing relies entirely on differing testimony as to what age children are likely to be in a given stage of development. To be sure, the State's *Frye* witnesses both testified that children are generally in the stage associated with pedophilia from ages 10 and under and in the stages associated with hebephilia between 11 and 14. This is slightly different than Dr. Suire, who relied on the DSM's guidance that prepubescent children are generally 13 and under.

¶ 70 Although Dr. Suire and the *Frye* witnesses explained pedophilia and hebephilia with slightly different age ranges, we do not agree with respondent that this difference rendered Dr. Suire's diagnoses wholly inconsistent with those discussed at the *Frye* hearing. Indeed, Dr. Suire himself testified that his diagnosis of OSPD-sexually attracted to adolescents was "[e]ssentially" the same as hebephilia. Moreover, all the State's witness explained that the core of a hebephilia diagnosis is a sexual attraction to "pubescent" children in the early stages of puberty. Importantly, the witnesses also all testified at some length that the age ranges were general guidelines and that different individuals develop at different ages. For example, Dr. Suire explained that hebephilia

could involve sexual attraction to a pubescent 13-year-old. Because respondent had numerous victims between the ages of 12 and 14, Dr. Suire opined that "some of that would be pedophilic" whereas "[s]ome of that is going to fall into adolescence or pubescent" depending on the development of the particular victims.

¶ 71 We also observe that the record belies respondent's attempt to differentiate Dr. Suire's testimony from that of the *Frye* witnesses by claiming that he based his diagnosis on victims older than 14. Respondent's argument is based on Dr. Suire's report containing incidents in which respondent had sexual contact with a 15-year-old and a 16-year-old at a time when respondent was also in his late teens. However, Dr. Suire explained that he "probably should have left [those incidents] out" to avoid confusion but decided to include them in his report only to "alert the treatment advisers" that respondent began having sexual contact with underage males at a young age. Dr. Suire clarified that those incidents "do not meet [the] criteria" for a mental disorder and that his diagnoses were instead based on respondent offending against at least six different victims between the ages of 10 and 14. Thus, we conclude that Dr. Suire's diagnosis of OSPD-sexually attracted to adolescents was covered by the court's ruling at the *Frye* hearing.

¶ 72 Although respondent primarily attacks the circuit court's *Frye* ruling on justiciability grounds, we further find that the court had sufficient evidence to find that hebephilia was generally accepted. Indeed, the court in this case heard virtually identical evidence as in *Bauer*, where the Second District affirmed the circuit court's finding that hebephilia was generally accepted. *Bauer*, 2020 IL App (2d) 180905, ¶¶ 11-30. Here, as in *Bauer*, both Dr. Thornton and Dr. Cantor explained the history of hebephilia and the substantial research that established it as an identifiable condition. *Id.* ¶¶ 11, 14. Both experts also testified that a significant percentage of those in the relevant scientific communities accepted hebephilia as a legitimate diagnosis. *Id.* ¶¶ 12, 16. While we are

not necessarily bound by *Bauer* (*People v. Hilliard*, 2021 IL App (1st) 200112, ¶ 28), we find its reasoning persuasive, and respondent makes no argument that we should depart from it. Accordingly, we find that the circuit court did not err in finding that hebephilia was a generally accepted diagnosis or in allowing Dr. Suire to testify to the substantially similar diagnosis of OSPD-Sexually Attracted to Adolescents.

¶ 73 It also bears mentioning that, hebephilia aside, respondent's status as an SVP was also supported by Dr. Suire's diagnosis of pedophilia. The *Frye* hearing in this case was not aimed at pedophilia, and pedophilia was only mentioned at the hearing to differentiate it from hebephilia. This is unsurprising, as numerous cases have affirmed a finding that the respondent was an SVP based on a pedophilia diagnosis. See, *e.g.*, *In re Commitment of Fields*, 2014 IL 115542, ¶¶ 26-27; *In re Commitment of Montilla*, 2022 IL App (1st) 200913, ¶¶ 70, 78, 115; *In re Commitment of Evans*, 2021 IL App (1st) 192293, ¶¶ 16, 25, 72. Respondent does not contest that pedophilia is generally accepted *per se* but argues that Dr. Suire's particular diagnosis should have been excluded because it conflicted with the testimony of the State's *Frye* witnesses. This argument is again based on differing testimony as to the general age ranges associated with pedophilia. However, the argument fails for the same reasons detailed above: all witnesses testified that the core of a pedophilia diagnosis is a sexual interest in prepubescent children. Although there was some disagreement as to when children typically begin puberty, it was the circuit court's role to resolve this conflict in the evidence. *Adams*, 2021 IL App (1st) 182049, ¶ 58. It was reasonable for the circuit court to rely on the DSM as an authoritative source. *New*, 2014 IL 116306, ¶ 42. We also note that respondent's own expert, Dr. Abbott, conceded that at least some of respondent's victims were "likely" prepubescent. Thus, the evidence established that respondent had a mental condition regardless of his attacks on the hebephilia diagnosis. See *In re Detention of Stanbridge*,

2012 IL 112337, ¶ 74 (reviewing court may affirm the circuit court on any basis appearing in the record).

¶ 74 B. Sufficiency of the Evidence

¶ 75 Respondent next argues that the circuit court's judgment should be reversed because the State failed to prove that he was an SVP beyond a reasonable doubt. When a respondent challenges the sufficiency of the evidence, a reviewing court considers whether, viewing the evidence in the light most favorable to the State, any rational trier of fact could find the elements beyond a reasonable doubt. *Adams*, 2021 IL App (1st) 182049, ¶ 58. It remains the trier of fact's responsibility to evaluate witness credibility, resolve any conflicts in the evidence, and decide which inferences to draw from the evidence. *Id.* Thus, we will not retry the respondent or substitute our own judgment for the that of the trier of fact. *Evans*, 2021 IL App (1st) 192293, ¶ 40. Rather, we will reverse the trier of fact's determination only if the evidence is "so improbable or unsatisfactory it leaves a reasonable doubt." *Id.*

¶ 76 In an SVP case, the State must establish beyond a reasonable doubt that the respondent (1) was convicted of a sexually violent offense and (2) has a mental disorder that (3) makes it substantially probable that he will engage in future acts of sexual violence. *Fields*, 2014 IL 115542, ¶ 20. Here, respondent challenges only the final two elements: that he has a mental disorder under the Act and that he is substantially probable to commit additional sexually violent acts.

¶ 77 1. Mental Disorder

¶ 78 The Act defines " '[m]ental disorder' " as "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes a person to engage in acts of sexual violence." 725 ILCS 207/5(b) (West 2020). In evaluating whether the State proved that a respondent has a

mental disorder, we "routinely rely on expert testimony and defer to the factfinder's determinations regarding an expert's credibility." *Evans*, 2021 IL App (1st) 192293, ¶ 41.

¶ 79 Here, respondent contends that the State failed to establish the mental disorder element because, although Dr. Suire diagnosed him with two paraphilias related to underage boys, the State did not present evidence showing what developmental stages respondent's victims were in. Stated another way, respondent argues that the evidence did not support Dr. Suire's diagnosis of a pedophilic disorder because there was no direct evidence that any of respondent's victims were prepubescent.

¶ 80 We disagree. Dr. Suire diagnosed respondent with a pedophilic disorder involving recurrent sexual attraction to prepubescent children. Dr. Suire based this conclusion largely on the fact that respondent committed numerous sexual crimes against children aged 10 to 13 years old. Dr. Suire also testified that respondent's condition met the Act's definition of a mental disorder because it was either congenital or acquired, affected his emotional or volitional capacity, and predisposed him to commit acts of sexual violence.

¶ 81 As respondent points out, Dr. Suire readily acknowledged that he did not know what Tanner stage any of the victims were in at the time of the offense. Dr. Suire also conceded that some children are no longer prepubescent by age 13. However, Dr. Suire explained that he relied on the DSM's definition of prepubescent, as well as respondent's numerous offenses and statements about his attraction to underage children. We also note that Dr. Abbott, respondent's own expert, testified that he believed respondent "did have some prepubescent victims." Viewing this evidence in the light most favorable to the State, we find that a rational trier of fact could have found that respondent had a mental disorder under the Act.

¶ 82 2. Substantially Probable of Reoffending

¶ 83 Respondent also contends that the State failed to prove that he was substantially probable to commit future acts of sexual violence. For purposes of the Act, "substantially probable" means that the respondent is "much more likely than not" to reoffend. (Internal quotation marks omitted.) *In re Commitment of Haugen*, 2017 IL App (1st) 160649, ¶ 24. This determination cannot be reduced to a mere mathematical or statistical formula (*In re Detention of Hayes*, 321 Ill. App. 3d 178, 188 (2001)), and an expert witness need not offer any specific or exact testimony in order to sufficiently connect the respondent's mental disorder to his risk of reoffending (*In re Commitment of Montanez*, 2020 IL App (1st) 182239, ¶ 76). Instead, the trier of fact must make a " 'commonsense judgment' " based on the totality of the circumstances and factors that increase or decrease the respondent's risk of recidivism. *In re Commitment of Gavin*, 2024 IL App (1st) 230246, ¶ 44 (quoting *Hayes*, 321 Ill. App. 3d at 188).

¶ 84 In this case, respondent argues that the recidivism rates associated with his scores on the static actuarial instruments are "insufficient on their own" to satisfy the State's burden, especially because he would qualify for an age-based score reduction three years after trial. However, the record shows that respondent's static scores placed him in the "above average" category for recidivism risk and meant he was almost twice as likely to reoffend as compared to the sample of sex offenders. Several cases have affirmed a finding that the respondent was an SVP based on similar scores. See, *e.g.*, *Montilla*, 2022 IL App (1st) 200913, ¶¶ 23-30; *Montanez*, 2020 IL App (1st) 182239, ¶ 35; *In re Commitment of Tittelbach*, 2018 IL App (2d) 170304, ¶¶ 14-15.

¶ 85 Regardless, this court has repeatedly rejected attempts to reduce the concept of substantial probability to a mathematical formula or statistical analysis. See *Hayes*, 321 Ill. App. 3d at 188; *Gavin*, 2024 IL App (1st) 230246, ¶ 44. Additionally, the State's evidence was not limited to the actuarial instruments alone. It is entirely proper for an expert witness to adjust the results of static

actuarial instruments with dynamic and protective factors, as "[f]ocusing solely on the actuarial scores is an untenable position." *Montanez*, 2020 IL App (1st) 182239, ¶ 69. Respondent recognizes as much but contends that Dr. Suire failed to adequately explain why and how dynamic factors increased his chance of reoffending. However, Dr. Suire identified several "empirical factors" shown to increase recidivism risk, including respondent's deviant sexual interest, offense supported attitude, personality disorder, substance use, and history of being physically abused. Dr. Suire also considered protective factors such as respondent's participation in sex offender treatment but opined that this did not decrease his recidivism risk because he stopped treatment against the recommendation of his therapist and had not attended for 20 years. Dr. Suire's inability to quantify precisely how much each factor increased respondent's risk of future offenses did not prevent the circuit court from making a holistic determination that respondent was substantially probable to reoffend. See *Hayes*, 321 Ill. App. 3d at 188.

¶ 86 In a similar vein, respondent criticizes Dr. Suire's assessment because, unlike respondent's experts, he did not supplement the static actuarial instruments with a "structured" adjustment method like the STABLE-2007 or the VRS-SO. However, Dr. Suire explained that, because respondent refused to be interviewed or participate in sex offender treatment, he did not have sufficient information to complete either structured adjustment method. Respondent cites no authority holding that an expert is required to use a structured adjustment method rather than an unstructured one. To the contrary, this court has routinely affirmed SVP findings based on an expert's use of an unstructured adjustment method. See, *e.g.*, *Montilla*, 2022 IL App (1st) 200913, ¶ 120; *Evans*, 2021 IL App (1st) 192293, ¶¶ 63-67; *In re Commitment of Moody*, 2020 IL App (1st) 190565, ¶ 63. Essentially, Dr. Suire opined that the unstructured adjustment method was more reliable given the information available in this case, and respondent's experts stated the opposite.

It was for the circuit court, as trier of fact, to resolve this battle of the experts. The court was entitled to find Dr. Suire more credible, and we will not reweigh the evidence or substitute our own judgment for that of the circuit court.

¶ 87 Additionally, we find that the two cases upon which respondent relies are readily distinguishable. First, in the unpublished case of *In re Commitment of McCormack*, 2021 IL App (1st) 181930-U, ¶¶ 12, 28-29, the static actuarial instruments showed that the respondent had an "average" risk of reoffending, but the State's expert testified that dynamic factors increased that risk such that the respondent was substantially probable to reoffend. On appeal, this court concluded that the State "left too much to inference" because its expert never provided a solid explanation as to why the respondent's recidivism risk was substantial. *Id.* ¶ 42. Similarly, in *Gavin*, 2024 IL App (1st) 230246, ¶¶ 47-69, the State's expert "undercut his own assessments" and "buckled when asked how he reached his conclusions" that dynamic factors made the respondent substantially probable to reoffend. For instance, the State's expert conceded that he did not have sufficient information to assess how the respondent's health affected his risk of recidivism even though the respondent was over 60 years old, had hip replacement surgery, and walked with a cane. *Id.* ¶¶ 58-64.

¶ 88 Unlike *Gavin* and *McCormack*, in this case Dr. Suire adequately explained which dynamic factors he identified and how they affected respondent's likelihood of committing sexual violence. It was the province of the circuit court, as trier of fact, to evaluate the expert testimony to determine whether respondent was substantially probable to reoffend. *Haugen*, 2017 IL App (1st) 160649, ¶ 25. Because the testimony was sufficient to support the circuit court's judgment, we will not disturb that judgment on appeal.

¶ 89 3. Clear and Convincing Evidence

¶ 90 As a final point on this matter, respondent also argues, in the alternative, that the State also failed to prove that he was an SVP under the lesser burden of clear and convincing evidence. In *Addington v. Texas*, 441 U.S. 418, 433 (1979), cited by respondent, the United States Supreme Court held that due process requires a standard equal to or greater than clear and convincing evidence in cases involving involuntary civil commitment. In Illinois, as noted above, Act requires the State to prove its case beyond a reasonable doubt at the initial commitment proceeding. 725 ILCS 207/35 (West 2022). Because proof beyond a reasonable doubt is a higher standard than clear and convincing evidence, the Act thus exceeds the minimum demands of due process at this stage, as proof bey. *People v. Craig*, 403 Ill. App. 3d 762, 769 (2010).

¶ 91 Respondent concedes this point but merely seeks to preserve the issue of whether the State's evidence satisfied the clear and convincing standard for a future appeal. Because we have already found that the State's evidence was sufficient to prove that respondent was an SVP beyond a reasonable doubt, we also find that the State's evidence was clear and convincing.

¶ 92 C. Alleged Misstatements of Law

¶ 93 We next address respondent's argument that reversal is required because, regardless of what judgment the evidence *could* sustain, the circuit court in this case "did not find that the State met its burden of proof beyond a reasonable doubt." Respondent bases this claim solely on one instance where, in announcing its decision, the circuit court stated that "the State has *substantially* met it's [*sic*] burden beyond a reasonable doubt." (Emphasis added.) According to respondent, the inclusion of the word "substantially" in the court's oral remarks means that the court found that the State's evidence almost, but not completely, rose to the level of beyond a reasonable doubt. As such, respondent concludes that the court erred in determining that he was an SVP without requiring the State to meet its full burden of proof.

¶ 94 However, the circuit court is presumed to know and properly apply the law regarding the burden of proof. *People v. Cameron*, 2012 IL App (3d) 110020, ¶ 28. This presumption is rebutted only where the record contains "strong affirmative evidence to the contrary." *Id.* Here, the record clearly shows that the circuit court was familiar with the requirements of the Act and the State's burden of proof. Thus, we must presume that the court would not have found respondent to be an SVP had it not decided that the State met its burden of proof beyond a reasonable doubt.

¶ 95 Respondent does very little to rebut this presumption. The single remark challenged by respondent is ambiguous at best, and most likely a benign phrasing in the court's oral statements. This is especially so where the court invoked the reasonable doubt standard on numerous occasions, most notably immediately prior to the challenged remark when it explained that "[t]he State must prove beyond a reasonable doubt that the Respondent[']s mental disorder makes it substantially probable he will engage in sexual violence." The court then went on to explain what may constitute a substantial probability under the Act and ultimately found that the State had met its burden. Simply put, respondent falls far short of overcoming the presumption that the circuit court knew and correctly applied the law. Thus, we reject respondent's assertion that the circuit court did not find that the State met its burden beyond a reasonable doubt.

¶ 96 Similarly, respondent further contends that the circuit court misstated the law by (1) stating that "substantially probable" means "more likely than not" rather than "much more likely than not" and (2) using the phrase "substantially likely" or "substantial likelihood" on several occasions rather than the Act's language of "substantial probability."

¶ 97 As previously noted, we must presume that the circuit court knew and correctly applied the law absent a strong affirmative showing to the contrary. *Id.* Aside from a few isolated phrases in the court's oral remarks, respondent does not identify anything to demonstrate that the court

misapplied the law. Rather, our review of the record again suggests that the court merely misspoke or was slightly imprecise with its language.

¶ 98 In any event, respondent makes no attempt to explain how he was possibly prejudiced by the misstatements. He does not describe, for example, the difference between a "substantial likelihood" and a "substantial probability," if any, or how this affected the court's analysis. Nor does respondent offer any reason to believe that the court was mistaken about the definition of a substantial probability to reoffend. The court's comments as a whole show that it understood and correctly applied the legal standards under the Act. See *In re Commitment of Gavin*, 2019 IL App (1st) 180881, ¶¶ 53-56 (no error or prejudice despite the circuit court stating that substantial probability meant that the respondent was " 'more likely than not' " to reoffend). Thus, no error occurred.

¶ 99 D. Failure to Recall Evidence

¶ 100 Somewhat related to the above, respondent also maintains that the circuit court deprived him of due process when it failed to accurately recollect "crucial evidence" that Dr. Arroyo testified that his mental disorders did not predispose him to engage in acts of sexual violence. According to respondent, this evidence was important "because it demonstrated that [he] did not suffer from a mental disorder as defined by the SVP Act," and so the court was wrong to discredit his experts on the grounds that they disagreed with each other on whether respondent had a mental disorder under the Act.

¶ 101 Respondent is correct on the basic point that a mental disorder under the Act must be a condition that "predisposes a person to engage in acts of sexual violence." 725 ILCS 207/5(b) (West 2020). However, a review of the record shows that the court accurately recalled Dr. Arroyo's testimony. On cross-examination, Dr. Arroyo answered, "I did," when specifically asked whether

he "diagnose[d] Mr. Hughes with a mental disorder *under the Act*." (Emphasis added.). Dr. Arroyo also confirmed that, until he used the VRS-SO in 2023, he found that respondent satisfied all the requirements to be considered an SVP. Dr. Arroyo confirmed that he changed his opinion only because the VRS-SO showed that respondent was not substantially probable to reoffend. In other words, nothing changed Dr. Arroyo's original opinion that respondent had a mental disorder under the Act. Although Dr. Arroyo stated that respondent was not predisposed to commit sexual violence, it is clear that he was merely explaining his opinion that respondent was not substantially probable to reoffend. Based on this record, the circuit court correctly recalled that Dr. Arroyo diagnosed respondent with two mental disorders but did not believe that they made him substantially probable to reoffend. We therefore reject respondent's argument.

¶ 102 E. Admission of *Frye* Hearing Evidence

¶ 103 Finally, respondent argues that the circuit court erred in denying his motion to admit the testimony and underlying reports from the State's *Frye* hearing experts into evidence.

¶ 104 Evidentiary rulings are generally left to the circuit court's sound discretion. *People v. Perkins*, 2018 IL App (1st) 133981, ¶ 53. A reviewing court will reverse a circuit court's decision to exclude certain evidence only where the court abused its discretion, which occurs only where the court's ruling is arbitrary, fanciful, or so unreasonable that no reasonable person would take the view adopted by the court. *Id.*

¶ 105 Here, respondent contends that he was prejudiced by the circuit court's ruling because he could have used the *Frye* hearing evidence to show that Dr. Suire's diagnoses were contradicted by the State's *Frye* experts. The State counters that the *Frye* hearing evidence was irrelevant to the trial issues and was thus properly excluded.

¶ 106 We agree with the State. Evidence is admissible at trial only if it is relevant. Ill. R. Evid. 402 (eff. Jan. 1, 2011); *In re Detention of Melcher,* 2013 IL App (1st) 123085, ¶ 42. Evidence is relevant where it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." Ill. R. Evid. 401 (eff. Jan. 1, 2011).

¶ 107 Although respondent asserts that the *Frye* hearing evidence was probative of whether Dr. Suire's diagnoses were generally accepted, this was the precise issue answered at the *Frye* hearing. *Melcher,* 2013 IL App (1st) 123085, ¶ 56 (purpose of a *Frye* hearing is to filter out conclusions based on unsound science). Thus, whether Dr. Suire's diagnoses were generally accepted was not an issue at trial, which renders the *Frye* hearing evidence irrelevant.

¶ 108 In any event, the court's exclusion of this evidence was harmless. As explained above, respondent simply overstates any conflict between Dr. Suire's diagnoses and the concept of hebephilia that the circuit court found generally accepted at the *Frye* hearing. We fail to see how respondent was prejudiced by the exclusion of the *Frye* hearing evidence where the court clearly considered it and the argument that it contradicted Dr. Suire's testimony when ruling on respondent's motion to admit the evidence. Under these circumstances, we find that the circuit court did not abuse its discretion in denying respondent's request to admit the *Frye* hearing evidence.

¶ 109 III. CONCLUSION

¶ 110 For the reasons stated, we affirm the judgment of the circuit court.

¶ 111 Affirmed.

***In re Commitment of Hughes*, 2026 IL App (1st) 240578**

Decision Under Review:	Appeal from the Circuit Court of Cook County, No. 10-CR-80013; the Hon. Michael Clancy and the Hon. Nicholas Kantas, Judges, presiding.
Attorneys for Appellant:	Michael R. Johnson, of Law Office of Michael R. Johnson LLC, of Oak Park, for appellant.
Attorneys for Appellee:	Kwame Raoul, Attorney General, of Chicago (Jane Elinor Notz, Solicitor General, and Katherine M. Doersch and Madeline Callaghan, Assistant Attorneys General, of counsel), for the People.