No. 24-539

IN THE

Supreme Court of the United States

KALEY CHILES,

Petitioner,

v.

PATTY SALAZAR, IN HER OFFICIAL CAPACITY AS EXECUTIVE DIRECTOR OF THE COLORADO DEPARTMENT OF REGULATORY AGENCIES, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF OF *AMICI CURIAE* CATHOLIC LICENSED COUNSELORS, HEALTH CARE PROVIDERS, EDUCATORS, MEDICAL ETHICISTS, AND PROFESSIONAL ORGANIZATIONS IN SUPPORT OF PETITIONER

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INTERESTS OF *AMICI CURIAE*[1]

Your *Amici*, identified in Appendix A, are a diverse group of professionals and organizations involved in the science and practice of mental healthcare. Many are practitioners in direct contact with patients and who assess, diagnose, and treat mental illnesses, independently or within multidisciplinary teams. Some are educators in academic institutions who train and equip future practitioners. Others conduct research that promotes the developing knowledge benefitting clinical practitioners and the patients they serve. Most are part of academic and religious organizations committed to Catholic education, including psychology/mental health education and student counseling, without compromise to the Catholic faith and the magisterium of the Catholic Church. Your *Amici* have a common interest in "talk therapy," a focused conversation to advance the best interest of the patient. The use of speech to assess, diagnose, and treat mental illness, including cases of sexual orientation and gender dysphoria, is paramount (1) to uphold the profession's standards of care in the same way as is done for all other official diagnostic categories and (2) to do so in conformity with the dignity of the human person as a body-soul unity.

SUMMARY OF ARGUMENT

As set out in Petitioner's Brief, those countries formerly in the forefront of treating minors suffering

1. No counsel for any party authored this brief in whole or in part. No person or entity other than *amici* and their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

with gender confusion and gender dysphoria by surgical and pharmaceutical means have called a halt to those procedures, as longitudinal studies do not confirm their presumed benefits. The medical authorities in those countries are now encouraging talk therapy instead. It is more than ironic, then, that jurisdictions like Colorado are limiting the scope of professional talk therapies for troubled children. It is also medically and psychologically harmful to them. Fortunately, the Free Speech Clause should put a stop to this.

Your *Amici* write to provide this Court with a greater understanding of what their counseling entails, both on a practical and philosophical level. The bottom line is that the "talk therapy" they provide is speech through and through. When a licensed attorney stands behind a podium to speak or files a brief to express his thoughts, it does not convert his speech to conduct. The same is true for licensed counselors. When they speak to their clients from their couch or desk, they are speaking, and it is wrong for the government to declare their practice "conduct" and assume the authority to determine what viewpoints they may and may not communicate.

Laws like Colorado's infringe on constitutionally protected speech by imposing viewpoint-based restrictions on therapists' dialogues with their clients and by enshrining a contested point of view into law. This is an impermissible state establishment of medical "truth" that chills diverse, conscientious models of healing. These restrictions violate not just a therapist's right to speak, but a client's right to hear and to choose a therapist whose worldview matches their own.

Your *Amici* will first describe the therapeutic process in which they engage their clients. They will then explain the importance of being able to counsel without viewpoint restrictions, but, instead, to have autonomy to think and speak based on clinical facts, to gather the most complete information possible, and to arrive at a reasoned clinical conceptualization and treatment plan informed by the worldview of both client and therapist. For your *Amici*, who all practice out of the Roman Catholic tradition, this is especially important, as the philosophy motivating the "conversion therapy" bans are inconsistent with that tradition.

ARGUMENT

I. Those Involved in the Therapeutic Process

1. Client Terminology

We use the terms *client* and *patient* interchangeably to refer to the person who seeks the professional expertise and assistance of a duly credentialed and licensed mental health professional.

Some terminology in usage today—including "queer," "nonbinary," "genderqueer," "gender-fluid," "transgender," "trans," "two-spirit"—does not constitute a clinical taxonomy. These are not bona fide medical or psychiatric terms, and the individuals who use these labels do not constitute a specific clinical-diagnosis group.[2]

2. *Cf.* Dept. of Health and Human Servs., *Treatment for pediatric gender dysphoria: Review of Evidence and Best Practices*, May 1, 2025.

The patients that seek therapy are assessed, diagnosed, and offered treatment according to recognized clinical taxonomies, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM)[3] and the International Classification of Diseases (ICD).[4]

2. Practitioner Terminology

The terms that identify the professional are organized by educational credentialing requirements.

1. *Counselors* are professionals whose education consists of a master's of arts or science degree or higher in counseling. Some practitioners earn master's degrees in pastoral counseling.

2. *Social workers*, whose education is a master's of arts or science degree or higher in social work, also engage in providing therapy.

3. *Psychologists* are professionals whose education consists of a doctoral degree (PhD or PsyD), and are referred to as "doctors." In addition to providing therapy, psychologists conduct research based on the profession's established scientific methodology, perform psychological assessments and forensic evaluations, hold academic appointments, and supervise other clinicians. In a few and specific

3. Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed., text rev. (DSM-5-TR) (Arlington, Va.: Am. Psychiatric Publishing, 2022).

4. World Health Org., *International Statistical Classification of Diseases and Related Health Problems: 10th Revision (ICD-10)*, 2019.

cases, psychologists prescribe medications (otherwise, this is only within the purview of psychiatrists, psychiatric advanced registered nurse practitioners, or primary care providers).

4. *Psychiatrists* are professionals who have obtained a medical degree (MD) or a doctor of podiatric medicine degree (DO) and are referred to as "doctors." In addition to providing therapy, psychiatrists conduct research based on the profession's established scientific methodology, perform psychiatric assessments and forensic evaluations, hold academic appointments, and supervise other clinicians. They prescribe medications as well as supervise or collaborate with advanced registered nurse practitioners and other primary care providers in this activity.

5. *Psychiatric Clinical Nurse Specialists* are advanced practice registered nurses whose education consists of a master's degree and who practice as clinical specialists in psychiatric and mental health. They are certified by their professional associations and licensed by their legal jurisdictions to provide comprehensive assessments, diagnoses, and treatment for individuals with mental health conditions, including medication management, psychotherapy, and crisis intervention. They also play a role in education, research, and leadership within the healthcare team.

6. *Practitioner, therapist*, and *psychotherapist* are common umbrella terms.

All professionals must successfully meet all academic, clinical, and jurisprudential criteria set by the respective regulating bodies—usually, the respective state's licensing authorities—to obtain a license to practice. All professionals that engage in mental health practice with clients are required by the laws of their jurisdictions to undergo a certain amount of hours of clinical training (often defined by regional and/or national standards).

These professionals are referred to in this brief as "therapists" or "psychotherapists." While they may have differing credentialing, they have the common ground of using psychotherapy when providing professional services to their clients.

II. Overview of the Modalities and History of Therapeutic Process: Counseling, Therapy, Psychotherapy

The therapeutic process, in its various designations of counseling, therapy, or psychotherapy, is defined by the meeting between the licensed professional and the client(s) seeking help.

1. *Individual* therapy addresses a single person, i.e., child, adolescent, or adult.

2. *Marital* therapy addresses a couple in various stages of life as a couple.

3. *Family* therapy addresses at least two family members who seek help with family dynamics.

4. *Group* therapy addresses an unrelated group of people that assemble around a core theme or purpose common to all members.

Traditionally, psychotherapy is performed in person, but can be done remotely. The length of therapy varies significantly from few sessions to several years.

By its very nature, psychotherapy is a voluntary enterprise for the patient, who is free to leave, even if this goes against the advice of the therapist. In specific situations treatment can be mandated by outside authorities, though this is strictly regulated by the statutes of the pertinent jurisdiction. The common end is decrease of symptoms, return to premorbid functioning, and/or achievement of a new level of healthy functioning.

Intended this way, therapy is not a one-way directive from the professional to the patient (except in cases of foreseeable immediate harm to self, others, and/or grave disability, depending on the definitions of the jurisdiction of practice and public safety requirements). Instead, all therapeutic endeavor is a collaborative development that depends equally on the therapist's expertise and on the patient's willingness, receptivity, openness, and readiness for change.

The process is based almost exclusively on talking. Even in instances when the therapist suggests self-help resources (e.g., books, articles, etc.) or other activities (e.g., journaling, personal daily logs, etc.), the primary activity is still speech. The conversation that flows between the therapist and client is the primary mode of activity, and it is designed to promote better and deeper self-reflection

patterns in the client. This is the key agent of improvement and change. There are no other ways to address thinking, feeling, and acting than through speech.

There are multiple theoretical types of therapy, spanning from psychoanalysis to behaviorism. The term "talking cure"—later, "talk therapy"—originates from the report of treatment of a patient suffering from hysteria (today's somatoform disorder) and published jointly by Joseph Breuer and Sigmund Freud.[5] The relevant feature of this treatment was recognized by both physicians as the beginning of the verbal treatment later termed "psychoanalysis" (i.e., psychological analysis) and paved the way for all forms of verbal therapy that we practice today. "Talk therapy" is in contradistinction to material forms of care, such as medications or mechanical interventions (e.g., surgery).

Talk therapy became popular to the public and academia after the proliferation of psychoanalysis at the turn of the twentieth century, first in Europe and then to North America and other parts of the world. It has branched out in a number of principal ways. While psychoanalysis continued in its original path of the exploration of the unconscious, in the United States behaviorism offered its own theory and practice of therapy by focusing on observable behavior and techniques for change in the present, disregarding the internal motivations. These methods boasted fierce proponents

5. Joseph Breuer and Sigmund Freud, "Case histories: Case 1, Fräulein Anna O. (Breuer)" (1895) in James Strachey, Anna Freud, Alix Strachey, and Alan Tyson (eds.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (London: The Hogarth Press, 1955), 21-47.

and equally fierce detractors, giving rise to a middle ground with the emergence of cognitivism based on the human information processing paradigm. Instead of focusing on unconscious contents (psychoanalysis) or observable behavior (behaviorism), cognitivists research psychological functions: types of memory, visual and auditory cognition, attention, perception, problem-solving, and higher executive functions.[6] Cognitive-behavioral therapy was born as the result of transferring the experimental findings into the therapeutic session. In the years since, human information processing has been bolstered by neuropsychological research on the correspondence of the nervous system to observed behavior and consciousness. Alongside, interpersonal, humanistic, and experiential modes of therapy emerged mid-20th century and are still prominent today. They

6. Ulric Neisser, *Cognitive Psychology* (New York: Psychology Press, 1967). Psychiatric research gave rise to the first wave of typical psychotic medications that became popular in the 1950's. These medications were the first pharmacological attempt at addressing severe disorders, such as schizophrenia and manic-depressive psychosis—later renamed Bipolar Disorder, Type I and II. The second wave of atypical antipsychotics in the 1980's and 1990's brought new possibilities for these diseases that alleviated some of the most complex and difficult side effects of the typical antipsychotics. At the same time, new classes of medications became available, such as antidepressants and anxiolytics. They have become more and more ubiquitous in treatment of mental disorders, with or without talk therapy. When this situation occurs, the prescription of medication is not within the purview of therapists, who continue to practice talk therapy. The prescribers (usually, psychiatrists, psychiatric advanced registered nurse practitioners, or family physicians), if not engaging in talk therapy, are, in most cases, different professionals than therapists as addressed here.

focused mostly on an understanding that relationships are powerfully formative of the human personality and psychological functioning. Interpersonal therapists focus in therapy on relational patterns in the patient's life as well as how the relationship between patient and therapist unfolds in real time. The humanistic movement in therapy focused on human dignity and freedom with a firm belief in the potential for growth and flourishing possessed by each person. Humanistic therapists emphasize a non-directive, empathetic, and respectful stance. Experiential therapists blend aspects of these various approaches with an understanding that therapy can provide a corrective emotional experience that has the power to heal old wounds and open new forms of growth for the patient. They focus on experience and exploration of emotion in a vivid way in session.

In the 1950's marriage and family therapy publications started to appear on the integration of the individual within his or her family system. Theories of systems influenced the study of human development from the family as the most intimate system to the larger community of neighborhood, school, local associations, all the way to the culture at large. Multiculturality began its influence in the 1980's with the rise of awareness of patients coming from multiple cultural and ethnic backgrounds with differing attitudes toward the exposition of private thoughts to a stranger, albeit a credentialed one. As well, sensitivity to concepts of psychopathology in non-Western cultures began to grow.

In summary, many different talk therapy modalities are now practiced. This has also given rise to eclecticism, i.e., practitioners borrowing elements from different modalities based on the patient's symptoms.

III. Therapists Rely First and Foremost on Speech

As these therapy modalities have developed, the initial and constant element has remained the same: speech. The main instrument of every therapist is talking, i.e., the verbal history-gathering from the patient (and/or family members), the formulation and expression of clinical conception and the proposed treatment, and the session-after-session feedback and verbal interventions. The patient is encouraged by the therapist to express perceived needs and problems openly. The nature of self-reflection requires that there be no thought restrictions and, therefore, no verbal restrictions on content. Everything the patient says—rational, irrational, coherent, incoherent, broad, narrow, including halting, disorganized speech and even silence—is part of therapy. Therapy works precisely because it gives the patient the opportunity to work through thoughts and, with the assistance of a trained professional, to place them in a coherent order that produces realistic self-understanding to live as a healthy and productive member of one's community. Therapeutic speech can also be used to help patients explore and integrate parts of the self that are in conflict, thereby enhancing their ability to live according to their goals and values.

In this treatment, the therapist must be free to respond as appropriate to the patient's utterances and to speak in ways that are of benefit to the patient and further the goals of treatment. Anything and everything is open for discussion and being seen from different angles, including various layers of emotions. In this way, therapy becomes an extended activity of assisted, self-reflective discernment. Eventually, this leads to better adaptation,

better decision making, better relationships, and overall higher levels of personal well-being.

Therapy and speaking cannot be separated. Speech is necessary and external manifestation of therapeutic work, and the connection between thought and speech applies to both therapy participants. Both must be free to think and speak within the therapeutic dialogue. A therapist that is not free to think about certain areas that are germane to the patient is also not free to speak and is reduced to parroting prescribed scripts, for better or, especially, for worse. When therapists cannot speak freely, they are reduced to state-approved messages, undermining the collaborative essence of therapy and stripping the clients of therapeutic choice. Therapists are placed in a double bind: either affirm state-mandated norms and violate patient autonomy or respond to patient distress with honesty and risk losing their license.

The de-pathologizing of homosexuality in the last decades (homosexuality was listed as a diagnosis in the second edition of the DSM (1968), removed from the third edition (1980), and additionally removed from the tenth edition of ICD (1992)), the recent dramatic increase in cases of the so-called "gender-affirming care," and the rising phenomenon of de-transitioning have created a complex and difficult atmosphere for therapists who have been generally cautious in exploring cases of these types.[7] Their normal exploration of a patient's distress

7. DHHS, *supra* note 2, *Treatment for pediatric gender dysphoria*, at 245-266, regarding the mischaracterization of psychotherapy as "conversion therapy" when it is intended as a means of exploration, diagnosis, and treatment. *Cf.* Roberto D'Angelo, "Do we want to know?" *Int'l J. of Psychoanalysis* 106,

has become hampered by the fear of potential ethical complaints or law suits, backed by laws passed in various states such as Colorado.

What should a therapist do when patients *want* to explore their sexual orientation? What if they don't wish to take it at face value but instead want to trace its existence and meaning alongside all areas of their life? What if the patient wishes to challenge the status quo and consider change? Anti-conversion statutes restrict the therapist's therapeutic exploration as sought by the patient or at least put the therapist at risk of an ethics complaint, law suit, and loss of license. If the therapist, facing these risks, decides not to follow the patient on this path, the therapist may be harming the patient by inhibiting self-reflection and perhaps even inducing shame in the patient for wanting to explore these issues.

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no. 1 (2025), 82-108. He comments: "Our current health care system and popular discourse have increasingly rejected the notion that psychotherapeutic exploration is an essential aspect of the clinical response to young people with trans identities. The frequently cited treatment guidelines produced by the World Professional Association for Transgender Health eschew the need for psychotherapeutic exploration before any medical intervention and consider this a form of "gatekeeping." Even routine psychological assessment is increasingly being conflated with gatekeeping. Gender health care for those 18 and over in the USA is increasingly moving towards a model based on 'informed consent' which requires no psychological evaluation before starting treatment. Advocates of this approach recommend that it should also be considered for adolescents. Even when psychological exploration is required, it often involves perfunctory evaluations and only a handful of sessions, with the goal of 'affirming' a young person's self-declared identity." *Id.* at 88-89 (citations omitted).

As a result, the therapist is presented with a professional and moral conflict. He or she should do what is best for his or her patients at all times and in all cases based upon his/her professional judgment, including when the patient wishes to explore and possibly work through his or her sexual orientation and/or gender dysphoria conflicts. But if we followed the resolutions of some academic institutions, professional associations, accrediting bodies, state anti-conversion legislation,[8] and now largely discredited "evidence,"[9] the only acceptable response by the therapist would be to affirm the patients' current feelings as unquestionably representative of their true selves and their highest good, even if this is in direct contradiction to the interests of the patients, undermines their autonomy, violates the therapist's understanding of the whole person, and restricts the therapist's speech.

IV. Psychotherapy Has Proven Benefits and Minimal Risks

The benefits of all types of psychotherapy are typically measurable in the diminishment of anxiety, depressive states, and a general increased level of adjustment to life and its challenges. The goal of therapy is not the

8. E.g., APA Resolution on Sexual Orientation Change Efforts, Feb. 2021; APA Topics: Orientation and Gender Identity Change Efforts, undated, found at https://www.apa.org/topics/lgbtq/sexual-orientation-change (last visited Apr. 29, 2025).

9. D. Paul Sullins, "Sexual orientation change efforts do not increase suicide: Correcting a false research narrative," *Archives of Sexual Behavior*, 51 (2022), 3377-3393; Peter Sprigg, "Are sexual orientation change efforts (SOCE) effective? Are they harmful? What the evidence shows," *Family Research Council*, Sept. 2018.

change of material reality, but, rather, the change of one's ways of approaching, understanding, and living in reality. Its benefits are usually measured by the person's ability to adapt. When the client no longer reports feeling overwhelmed or fearful of what is to come and symptoms have diminished or resolved fully, therapy comes to an end.

Patients often return to therapy on occasion of stressful events or setbacks. This suggests that the previous experience was helpful. They value what therapy provides: a relational setting where they can talk and bring up everything they need to work through. This upholds the benefits of exploring oneself within a relational and verbal context, building upon previous experience.

There is generally minimal risk in engaging in a therapeutic process, as the main activity is conversation. The typical and most frequent risk is feeling emotionally uncomfortable, although that is typically just a function of facing the emotional difficulty the patient is already experiencing. For example, a patient that describes a marital conflict may feel a fair amount of discomfort (e.g., anxiety, anger, irritation, uncertainty) in the course of ordinary presentation and exploration of the conflict.

Proponents of bans on so-called "conversion therapy" (or the umbrella term "sexual orientation change efforts" (SOCE)[10]) allege that therapy that fails to uniformly

10. Am. Med. Ass'n and Health Professionals Advancing LGBTQ Equality, "Issue brief: Sexual orientation and gender identity change efforts (so-called "conversion "therapy")," found at https://www.ama-assn.org/system/files/conversion-therapy-issue-brief.pdf (last visited Apr. 29, 2025); Am. Psychiatric Ass'n, "Commission on Psychotherapy by Psychiatrists (COPP):

affirm a person's sexual orientation and gender identity "pathologizes" those behaviors; they assert that any therapeutic analysis that questions the appropriateness of them for the patient is ineffective and harmful. However, more reasoned research throws significant doubt on these conclusions.[11] To quote the researchers in just one comprehensive analysis of the studies supposedly supporting surgical and pharmaceutical interventions with minors, "[W]e are deeply alarmed that these therapies, treatments, and surgeries seem disproportionate to the severity of the distress being experienced by these young people, and are at any rate premature since the majority of children who identify as the gender opposite their biological sex will not continue to do so as adults."[12]

Proponents of the Minors' Conversion Therapy Law (MCTL) cite studies claiming sexual orientation change efforts (SOCE) cause harm, like depression or suicidality.

Position statement on therapies focused on attempts to change sexual orientation (reparative or conversion therapies)," *Am. J. of Psychiatry*, 157, no. 10 (2000) 1719–1721; Am. Psychological Ass'n, Task Force on Appropriate Therapeutic Responses to Sexual Orientation, "Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation" (2009), found at http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html (last visited Apr. 29, 2025); Am. Psychological Ass'n, "Resolution on Sexual Orientation Change Efforts" (2021), found at https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf (last visited Apr. 29, 2025).

11. Sullins, *supra* note 9.

12. Lawrence S. Mayer, M.B., M.S., Ph.D. Paul R. McHugh, M.D., "Sexuality and Gender Findings from the Biological, Psychological, and Social Sciences," *The New Atlantis* 50 (Fall 2016), Conclusion.

See Am. Psychological Ass'n, Task Force Report (2009). Yet, these often focus on coercive, outdated methods (e.g., aversion therapy), not modern, voluntary talk therapy. Recent research counters these claims: Sullins (2022) found no link between SOCE and increased suicide risk, and Sprigg (2018) reported effectiveness with minimal harm when client-driven. The MCTL's broad ban ignores this distinction, sweeping in safe, speech-based therapy without evidence of widespread harm.

Finally, it is important to highlight psychotherapy's relative safety compared to medical approaches. The latter involve making direct chemical, hormonal, or surgical changes to the body with the goal of alleviating mental distress. These approaches are highly invasive, come with many risks and side effects, and, in some cases, are irreversible. The experimental nature of these interventions and the yet unclear long-term harms of them make truly informed consent by the patient impossible to achieve. By comparison, talk therapy is a much safer alternative to addressing mental health concerns and helping patients not only feel better but also grow in self-knowledge and personal agency. This is especially true for minors, who may not have the mental and emotional maturity to make major decisions with lifelong consequences. Psychotherapy avoids the regret many de-transitioners have experienced, as it does not impact any part of the body and does not change the functionality of any organ.

Psychotherapy is designed to provide a place where all the individual's symptoms are open for discussion and treated. A therapist will always be available to work with a depressed, anxious, or suicidal patient, before or after a gender transition, with or without a patient's regret. The

availability and effectiveness of the therapist depends in large part on the freedom to work with the needs the individual patient articulates, without being hampered by the fear of ethics complaints or law suits.

V. "Anti-conversion" Statutes Are Premised on Views of the Person Contrary to Christian-informed Psychotherapy and Thereby Restrict Speech

The motivating philosophy behind the anti-conversion therapy statutes is that the "real" person can be divorced from the person's physical, sexed body, colloquially expressed as a person may be born in the "wrong" body. Your *Amici*, as medical, bioethical, and psychological professionals and Catholic Christians, find this to be wrong and harmful. Thus, for this reason as well their speech is hampered and their practices threatened by these statutes.

A. A Person Is an Undivided Unity of Body and Soul

The Christian worldview at large and the Catholic reflection in particular is firmly centered on the Trinity—the Father, the Son, and the Holy Spirit—and it is animated centrally by Jesus Christ, the Son of God, who was born of the Virgin Mary and became man.[13] The crucial events of the incarnation of Christ, his Passion, and especially his Resurrection (the Resurrection of the *body*, and not an alternate form of life[14]) enliven the Christian

13. *Cf.* Nicene Creed, 325 AD.

14. Benedict XVI, *Jesus of Nazareth: Holy Week from the entrance into Jerusalem to the Resurrection* (San Francisco: Ignatius Press, 2011).

view of the person as an undivided unity of body and soul. The centrality of Christ in Christian faith and for the purposes of this brief rests on two main points. The first is Christ's physical existence (incarnation and birth) and the miracles that would not be possible without physicality (healing the sick, restoring sight to the blind, even walking on water). The second is his teachings expressed in human language to promote human understanding through human dialogue.[15]

Christian teaching has always recognized that the material existence of the body and the immaterial existence of the soul together form the person as an irreducible unity.[16] Largely discarded in modernity, the soul played a key role in the grand theological syntheses of Augustine of Hippo (354-430 AD) and Thomas Aquinas

15. "He said to them, 'But who do you say that I am?' Simon Peter said in reply, 'You are the Messiah, the Son of the living God.' Jesus said to him in reply, 'Blessed are you, Simon son of Jonah. For flesh and blood has not revealed this to you, but my heavenly Father'" (Matthew 16:15-17).

16. Select bibliography on the development of the meaning of person in the Catholic intellectual tradition through an ontological lens: Joseph Ratzinger, "Concerning the notion of person in theology," *Communio* 17 (1990), 439-454; W. Norris Clarke, "Person, being, and St. Thomas," *Communio* 19 (1992), 601-618; D. L. Schindler, "Norris Clarke on person, being and St. Thomas," *Communio* 20 (1993), 580-592; Kenneth L. Schmitz, *At the center of the human drama: The philosophical anthropology of Karol Wojtyła/Pope John Paul II* (Washington, DC: Catholic Univ. of Am. Press: 1993); Edmund Hill, *Augustine: The Trinity* (New York: New City Press, 2015); Karol Wojtyła, *Person and Act and Related Essays*, trans. G. Ignatik (Washington, DC: Catholic Univ. of Am. Press, 2021); Nicholas J. Healy, "The Christian personalism of John Paul II," *Communio* 51 (2024), 419-435.

(1225-1274 AD), the two most central authorities in the Catholic intellectual tradition. Both of these Doctors of the Church offered an ordered view of the human person by outlining the sensitive (i.e., body-founded) and intellective (i.e., knowledge-seeking) components of the soul. In his study of the Trinity, St. Augustine outlined the sensitive part of the soul that gives life to the physical body and the rational part of the soul (akin to the contemporary concept of consciousness) that capacitates the person to seek knowledge and ultimately to develop wisdom, or the contemplation of God's Eternal Truth.

Thomas Aquinas deepened the Augustinian formulation, delivering a more complex and detailed understanding of the soul, composed of vegetative, sensitive, and intellective powers. "By arguing that the spiritually subsistent soul is nothing less than the form of the body, Thomas Aquinas makes of the human being a microcosm of creation, constituting the embodied, knowing, and free boundary between the spiritual and corporeal realms."[17]

St. Thomas's synthesis offers an important insight for today's work of psychotherapy. The enlivening principle of the soul on the body means that, for the Christian believer and therapist, the schism between body and soul is incoherent and ontologically impossible. The soul's animating power gives dignity to the body as a living being and raises the human person, via the intellect, above all other created beings. The human person—our human patient—is a body-soul composite. The therapist's

17. John Finley, "The metaphysics of gender: A Thomistic approach," *The Thomist* 79, no. 4 (2015), 585-614, at 585.

understanding and the patient's self-understanding are foundationally dependent on the existence of the body-soul unity.

In the Thomistic view, intellection and rational knowledge are oriented towards the discovery of the truth—"You will know the truth and the truth will set you free" (John 8:32). St. Thomas argues that the truth is the correspondence between reality and intellect,[18] that is, the thinking person's proper understanding of reality (including corporeal reality) as it exists by naturally seeking to know, learn, and understand.[19] It leads to personal and interpersonal *awareness*, *knowledge* via senses/physicality and thinking/understanding, and the use of *language* to express oneself and reflect on one's own thoughts.[20]

The Catholic Church formally adopted the Aristotelian-Thomistic metaphysics of the unity of body and soul at the Council of Vienne (1312 AD). The Church teaches that "the soul is the 'form' of the body: i.e., it is because of its spiritual soul that the body made of matter becomes a living, human body; spirit and matter, in man, are not two natures united, but rather their union forms a single

18. Thomas Aquinas, *Summa Theologiae*, I, q. 16, a. 1-2; *De Veritate*, q. 1., a. 1.

19. *Cf.* Réginald Garrigou-Lagrange, *Thomistic common sense: The philosophy of being and the development of doctrine*, trans. M. K. Minerd (Steubenville, OH: Emmaus Academic: 2021).

20. Étienne Gilson, *The Christian philosophy of St. Thomas Aquinas* (Bend, IN: Univ. of Notre Dame Press, 1956).

nature."[21] "The Church teaches that every spiritual soul is created immediately by God—it is not 'produced' by the parents—and also that it is immortal: it does not perish when it separates from the body at death, and it will be united with the body at the final Resurrection."[22]

Therefore, physicality and spirituality are inextricably and bidirectionally linked together in the human person. Material reality is understood spiritually as a coherent whole that is oriented towards the good, the beautiful, and the true, while spiritual reality finds its expression in the ordered creation and recognizes its goodness, beauty, and truth.

B. The Advancement of Scientific Evidence of Sex/Gender and Corporeality Is Included in the Contemporary Catholic-Christian Understanding of the Person As an Undivided Unit

Sexual identity has traditionally been determined by the presence of external genitalia. The discovery of human sex chromosomes in 1923 added a molecular component to the identification of the human beings as either male (XY) or female (XX). An additional discovery occurred in 1959 with the identification of the *Sry* (sex determining region of the Y chromosome) gene, the presence of which determines the male sex and the absence of the female sex by targeting the *Sox9* gene, creating a cascading

21. Catholic Church, *Catechism of the Catholic Church*, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 2019), ¶ 365 (hereafter "CCC").

22. CCC, *supra* note 21, ¶ 366.

regulation of downstream target genes and ordering the developing organism into male or female, starting around the sixth week of gestation.[23]

The system's perspective that holds that the whole is always larger than the sum of its parts—the human body is more than the sum of its atoms and molecules, in that it replaces its atoms nearly every two years, while the individual remains the same person throughout his/her life—is consistent with the Church's Thomistic metaphysics. The body-soul unity accounts for the sameness of the individual even though his/her atoms change many times during an average lifespan. Its male-female complementarity is larger than the sexual identity taken by itself, and it is systemically oriented toward procreation.[24]

C. The Modernist Schisms Between Body/Soul and Sex/Gender Violate Catholic-Christian Understandings of the Person

Along the unfolding of the Western history of thought, the Catholic intellectual tradition paid special attention to modern tendencies in philosophy that separated the body from the soul, thereby reducing the human person's dignity, warning that it would lead to what Pope John

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23. Nicanor Pier Giorgio Austriaco, "The specification of sex/gender in the human species: A Thomistic analysis," *New Blackfriars*, 94, no. 1054 (2013), 701-715; at 702 and 713. Your *Amici* recognize, of course, that on rare occasions there are genetic abnormalities.

24. *Id.*

Paul II termed the "pulverization" of the person.[25] The schism between body and soul is especially complicated in the matters of sex and sexuality with the rise of the concept of "gender" (as distinct from physical sex) in the second half of the twentieth century. This distinction undermines the body-soul unity by suggesting (and eventually mainstreaming) that one's perception of gender is or could be separate and separated from the biological reality of sex. Therefore, sexual existence and identity become based more upon one's perception and/or desires than on given material reality. This diminishes and even eliminates the (sexed) body from rational consideration; a person's identity is separated from material existence. Gender confusion and dysphoria suggest such separation.

In cases of homosexual attraction, the separation is not as pronounced because the sexual component is regarded as an intrinsic and especially intimate aspect of one's identity as a human being. However, procreation presupposes the sexed body and sex complementarity. Sexuality plays a critical role in the promotion of the human species as created by God ("male and female he created them" (Gen. 5:2)), and it is the final and highest attainment of the ordered universe.[26] In other words, the sexual distinction of male and female derives its meaning from the reproductive roles of each. Homosexuality

25. John F. Crosby, *The personalism of John Paul II* (Steubenville, OH: The Hildebrand Project, 2019), at ix.

26. John Paul II, *The Theology of the body: Human body in the divine plan* (Boston, MA: Pauline Books and Media, 1997); Paul C. Vitz (ed.), *The complementarity of women and men: Philosophy, theology, psychology, and art* (Washington, DC: Catholic Univ. of Am. Press, 2021).

can thus be seen—alongside gender dysphoria—as a movement away from this proper orientation toward fatherhood and motherhood.

D. Catholic Practitioners Do Not Divide the Human Person into Physiological, Emotional, and Spiritual Components That Can Be Treated Separately

It follows that, in the Christian context, talk therapy addresses all parts of a person—body, soul, and spirit—as a fully integrated whole. The goal of therapy is helping the client harmonize these aspects into a healthy, functioning, well-integrated person. Christian therapists do not consider as separate the emotional-perceptive and physical-material aspects of the patient. They further recognize that every individual has dignity as a son or daughter of God, with the freedom to make his or her own decisions.

Freedom is exercised in relationships between human beings. Every human person, created in the image of God, has the natural right to be recognized as a free and responsible being. All owe to each other this duty of respect. The *right to exercise of freedom*, especially in moral and religious matters, is an inalienable requirement of the dignity of the human person. This right must be recognized and protected by civil authority within the limits of the common good and public order.[27]

The Catholic Church recognizes the right of exercise of freedom, as outlined in the Second Vatican Council's

27. CCC, *supra* note 21, ¶ 1738.

declaration on religious freedom, *Dignitatis Humanae*. As the name of the declaration itself expresses, it urges Catholics to respect the dignity of the human person, promotes the use of responsible freedom, and acknowledges that the human person cannot discharge these obligations without psychological freedom.[28]

The Christian worldview holds that the human being, created in the two complementary forms of male and female, is an intimate and inextricable part of creation. The Catholic-Christian view of the human person is underlain by three large components: theological, philosophical, and psychological.[29] As we have outlined thus far, the interweaving of these components yields a multifaceted understanding of the human person that is not merely an agglomeration of features, but, rather, a principled organization of ontological and methodological layers. The person is: (1) *Created* by God in his image and likeness, with goodness and dignity, and understands his/her life as a gift of love. This leads to an existence based on communion with God and one another, embedded in the natural order of creation. (2) *Fallen* as a consequence of sin, experiencing sin, weakness, and death. (3) *Redeemed*

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28. Declaration on religious freedom *Dignitatis Humanae* on the right of the person and of communities to social and civil freedom in matters religious promulgated by His Holiness Pope Paul VI, Dec. 7, 1965.

29. Craig Steven Titus, Paul C. Vitz, William J. Nordling, and the DMU Group, "Theological, philosophical, and psychological premises for a Catholic Christian Meta-Model of the Person," in Paul C. Vitz, William J. Nordling, and Craig Steven Titus (eds.), *The Catholic Christian Meta-Model of the Person: Integration with psychology and mental health practice* (Sterling, Va.: Divine Mercy Univ. Press, 2020), 20-44.

through Christ's incarnation and resurrection that restores the communion with God through faith, hope, and love. The human person lives his/her life fortified by participation in sacraments, prayer, and a vocational commitment, in single life, married life, or through religious orders. (4) *A personal unity* with human dignity on the body-soul composite, either male or female, with multiple capacities (organic, cognitive, and affective), that are expressed in outward behaviors and actions, culturally, historically, and ecologically located. (5) *Fulfilled through vocation* intended as the human flourishing with a purposeful development (teleology) towards personal goodness and holiness through vocational service. (6) *Fulfilled in virtue* by expanding the understanding of the human flourishing to include remediating the downfalls and sufferings from trauma, misdirected choices, unsuitable practices, and damaged relationships. (7) *Interpersonally relational* by virtue of naturally seeking relationships and being receptive to them, both with God and with other humans through marriage, family, friends, and communities. (8) *Sensorily-perceptually-cognitively endowed* to flourish through the capacities of linguistic, interpersonal, and moral dimensions. (9) *Emotional* in a person's capacity to establish and nourish self-understanding, interpersonal relations, moral actions, and spiritual life, within the differences of being created as man or woman based on biological predispositions and rooted in experience. (10) *Rational* in the individual's expression of intelligence and knowledge actively seeking truth and freedom. And (11) *Volitional and free* as subject of moral action, capable of responsible will and free choice.[30]

30. *Id.* at 21-42.

From this, it is clear that the Christian therapist listens and observes a patient's distress and self-reflection through multiple lenses. Themes of prayer and Christian worldviews are often discussed. For example, a patient asked one of your *Amici* to formulate her interventions specifically through Biblical references. The patient reasoned that his self-reflections in parallel to his Biblical interests would be more beneficially presented through two simultaneous lenses. In other cases, patients explicitly ask that the therapist pray with them to address a specific issue. The relational and verbal natures of therapy emerge simultaneously. Asking the therapist to pray or to formulate interventions in familiar language aids the patient in continuously integrating various aspects of personality. This is a desired and desirable outcome. Informed by the Catholic Christian Meta-Model of the Person, therapists treat clients as unified wholes, not fragmented parts. See Titus *et al.*, Catholic Christian Meta-Model (2020). When a minor expresses distress over sexual orientation or gender identity, therapists explore underlying causes—e.g., trauma, unmet developmental needs—with consent. Catholic clinicians offer not just a religious, but a constitutionally protected, multicultural framework. Their therapeutic understanding of harm includes psychological and spiritual dimensions often ignored by other therapists. The client's religious worldview, including their anthropology of sex and gender, is central to their well-being and must be respected under professional ethics codes. The MCTL bars this, denying the chosen path to healing.

It emerges from the foregoing that, by considering the person through these multiple, related lenses, a Christian therapist would not blindly affirm someone's professed

sexual orientation or gender identity if that individual reports anxiety or distress. Instead, a Christian therapist would explore potential underlying causes for those feelings, both in the present and historically, through the multiple and simultaneous lenses outlined above. For example, the therapist, with the patient's consent and active involvement, would explore potential underlying issues such as unmet developmental needs; emotional wounds; internal conflicts; past trauma; issues of identity and self-worth, meaning, and purpose; blockages to connection and belonging; and more. Throughout this process, the therapist would attempt to help the patients integrate various aspects of self into a unified, coherent whole such that the patients can experience greater internal harmony and freedom to love according to their chosen values.

It also follows that Christian therapists discharge their professional duties with respect for the individual's autonomy and choices even if the counselor disagrees with those choices. It is vital to the therapeutic endeavor that the patient and therapist achieve a strong consensus on the goals and tasks of therapy. The basis of this is some joint understanding of what health actually is. In some cases, the therapist and patient may have disparate views and may, therefore, identify conflicting goals of therapy. Therapists must have the freedom to decline to continue talk therapy if they sincerely believe the patient's therapeutic goals are not healthful. (In such circumstances, the therapist does not abandon the patient but can transfer the care of the patient to a provider freely chosen by the patient.) Conversion therapy bans severely limit therapists' freedom of speech on such topics when sex and gender identity are involved.

Christian counselors provide a safe and supporting environment in which patients feel comfortable expressing their concerns and feelings; they do so in an atmosphere of psychological freedom that manifests itself in the verbal expression of the two parties. Hence, the freedom to explore and venture into all areas of clinical interest is central. Without it, therapy ceases to exist and becomes a prescription of rules that may not be much different than an AI-generated "dialogue" between a person in the flesh (the patient) and the therapeutic lists provided by the non-human agent.

Laws like Colorado's forbid helping a person with unwanted feelings of sexual attraction or gender confusion align their feelings with the teachings of their faith. They encourage an unsustainable dualism that separates body, mind, and soul, creating contradictions and conflict. By enforcing a non-Christian philosophy through restricting counseling from a Christian viewpoint, such laws not only violate the free speech of therapists but harm the individuals in need of their assistance to form whole, fully integrated persons.

CONCLUSION

Psychotherapy is speech, not conduct, relying on free dialogue to explore and address clients' needs. Catholic therapists integrate faith and psychology to help clients harmonize body, soul, and spirit. Colorado's MCTL restricts this speech, imposes secular values, and harms clients and therapists by limiting autonomy and faith-based care. It seeks by imposition of extreme professional penalties to impel Catholic therapists to become partisans in healthcare and to split the standard of care based on diagnosis, rather than upholding a unified ethical practice for the entire profession. This violates the First Amendment's Free Speech and Free Exercise Clauses. This Court should reverse the Tenth Circuit and strike down the MCTL to protect these fundamental rights.

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APPENDIX

TABLE OF APPENDICES

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