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 SEXUAL ORIENTATION SCHOLARS IN SUPPORT OF PETITIONERS

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INTERESTS OF AMICI

Amici Dr. D. Paul Sullins and Dr. Jennifer Roback Morse are scholars with deep expertise in sociology, human sexuality, and the ethical responsibilities of counseling professionals.[1] They submit this brief to help the Court evaluate the scientific, psychological, and constitutional implications of Colorado's speech restrictions in therapeutic settings.

Dr. D. Paul Sullins is a Professor of Sociology (retired) at The Catholic University of America, President of the Leo Institute for Social Research and a Senior Research Associate at the Ruth Institute. Over the course of his career, Dr. Sullins has authored more than 150 peer-reviewed studies on topics ranging from statistical methodology to religion, mental health, and sexual orientation. His recent work directly examines sexual orientation change efforts (SOCE), the reliability of minority stress theory, and the presence of ideological bias in sexuality research. Dr. Sullins has testified as an expert witness in cases involving religious discrimination and mental health ethics, and his insights are grounded in both empirical rigor and decades of academic experience.

Dr. Jennifer Roback Morse is the founder and president of the **Ruth Institute**; a nonprofit organization focused on promoting lifelong married love, and healing trauma resulting from family instability, including

1. As required by Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici* or their counsel made such a monetary contribution.

protecting the rights of all people to seek counseling aligned with their life goals.

A former economics professor at Yale and George Mason University, Dr. Morse is a seasoned commentator on marriage, sexuality, and public policy. She has authored six books on marriage and family related topics. Through her research and advocacy, she has collaborated closely with individuals who have experienced harm from affirming-only therapy models, particularly those whose trauma, abuse histories, or religious convictions were dismissed or pathologized. Her work highlights voices often excluded from mainstream research and public discourse.

Together, your *amici* share a commitment to academic integrity, client-centered counseling, and constitutional protections for speech and conscience. They appear in this case to urge the Court not to let disputed science and professional orthodoxy justify the suppression of speech between counselors and their clients. At stake is more than policy, it is the freedom to think, to question, and to speak openly in pursuit of personal goals and truth.

SUMMARY OF ARGUMENT

Colorado's ban on change-oriented counseling speech is based on two assumptions that do not withstand scrutiny: scientific consensus and professional neutrality. The law censors only one side of a deeply contested issue: discussions between counselors and clients that explore whether, how, or why a person might wish to change sexual orientation or behavior. This is viewpoint-based censorship of core protected speech and violates the First Amendment.

First, the claim that all sexual orientation change efforts (SOCE) are inherently harmful lacks scientific support. Much of the research used to support such laws is based on non-representative, ideologically biased samples and excludes those who report benefit. By contrast, high-quality longitudinal studies have found no evidence of harm—and, in some cases, unmistakable evidence of improvement—for clients who voluntarily pursued change in alignment with their personal or religious values.

Second, the underlying rationale for banning this speech—that sexual orientation is innate and immutable—is also scientifically contested. A substantial body of research shows that sexual orientation, especially among youth, is fluid over time. Many individuals experience mixed sexual attractions and change the way they describe themselves. Clients who seek to align their behavior or identity with their deeper convictions are not denying reality; they are exercising agency.

Third, affirming-only therapy, which Colorado permits and endorses, is not without risks. There is no rigorous body of research proving that affirming therapy consistently improves outcomes or respects client autonomy. Case studies document situations where vulnerable individuals were misdiagnosed, pressured, or harmed by counselors who prioritized ideology over inquiry. Meanwhile, entire populations—such as detransitioners or desisters—are systematically excluded from the research used to justify these laws.

Finally, the Colorado law is a textbook example of unconstitutional viewpoint discrimination. It permits speech that affirms sexual minority identities while banning speech that affirms a client's desire to pursue

change. That is not neutral professional regulation; it is government-imposed orthodoxy. This Court has repeatedly rejected such efforts to control what individuals may say or hear in matters of conscience and identity. The counseling room should be no exception.

The First Amendment does not permit the state to silence private conversations merely because one side of the conversation offends prevailing cultural or political norms. For that reason, this Court should reaffirm the principle that viewpoint neutrality is not optional in the regulation of speech, even in professional contexts.

ARGUMENT

I. Colorado's Ban on Change-Oriented Counseling Speech Is Not Justified by Scientific Consensus

A. Social Science Data is notoriously unreliable.

Social science is amid a "replication" crisis. Courts deal with evidence, but the field of social science has been particularly beset with weak, unrepeatable studies making precarious claims. While good social science research can tell us things, there is a systematic bias toward overstated "effects" and "consensus" well before the data supports the claims.

In a recent article in Asterisk magazine, an associate professor at the University of Guelph, Ontario, made a striking assertion: "[W]ould the world actually improve if those in power consistently took social science evidence seriously? It brings me no joy to tell you that I think the

answer is usually 'no.'"[2] "The interaction between selection on significance and low power means that our published literature (in social science) is often not merely kind of wrong but wildly wrong." *Id.*

Briggs describes the problem of "low statistical power" studies, which claim to find a "statistically significant" result, but are not professionally designed to assess the strength of the effect in highly variable situations. This can have the effect of "wildly" overstating the claimed effect. Briggs also cites "selection significance," the bias created by only publishing "significant" results, and not hypotheses that do not produce meaningful results. This pressures academics to "search" for significant results and then report only successes. As a result, the literature is biased toward claims of significance, not toward true measures.[3]

Partisan or commercial interests often unduly influence worse, empirical studies. Addressing the commercialization of medical research, Dr. Marcia Angell of Harvard University, longtime editor of the New England Journal of Medicine, has concluded: "It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines."[4]

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2. Ryan C. Briggs, *Can We Trust Social Science Yet?*, Asterisk (May 19, 2025), https://asteriskmag.substack.com/p/can-we-trust-social-science-yet (last visited May 28, 2025).

3. *Id.*

4. Marcia Angell, *Drug Companies & Doctors: A Story of Corruption*, 56 N.Y. Rev. Books 8 (2009).

This is particularly true for clinical psychology, where disfavored theories have been systematically excluded from study. A prominent survey of eight hundred psychologists found that "[i]n decisions ranging from paper reviews to hiring, many [up to 38% of] social and personality psychologists said that they would discriminate against openly conservative colleagues."[5]

The APA has been especially prone to jettison scientific objectivity in favor of ideology. Former APA President Nicholas Cummings has written: "The APA has chosen ideology over science," explaining that since the mid-1970s "advocacy for scientific and professional concerns has been usurped by agenda-driven ideologues who show little regard for either scientific validation or professional efficacy," with the result that "topics that are deemed politically incorrect … are neither published nor funded."[6]

On top of the general issues pressuring social science literature to overstate findings, one of the most ideologically charged areas of research is the field of sexual orientation and gender identity.

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5. Yoel Inbar & Joris Lammers, *Political Diversity in Social and Personality Psychology*, 7 Persp. on Psychol. Sci. 496, 496-503 (2012), https://doi.org/10.1177/ 1745691612448792.

6. Rogers Wright & Nicholas A. Cummings eds., *Destructive Trends in Mental Health: The Well-Intentioned Path to Harm* xiv (Routledge 2005).

B. Biased and unrepresentative studies drive the harm story.

Most research cited to support SOCE bans relies on "convenience samples" drawn from gay-oriented media, events, or websites. These studies exclude individuals who do not identify as LGBT, including those who report successful change This introduces elevated levels of bias and undermines reliability.

Simply put, convenience samples cannot give anyone a meaningful measure of the general population.

Professor Ritch Savin-Williams, of Cornell University, has criticized the bias this introduces in the research, which is then ignored when characterizing the results:

> The importance of recruiting a representative sample of nonheterosexuals, as well as the costs (i.e., skewed findings and lack of generalizability) of failing to do so, is usually conceded in individual studies. Thereafter, however, these limitations are minimized or summarily dismissed. Yet it greatly matters how sexual orientation is defined and where participants are obtained. For example, a common strategy for recruiting nonheterosexuals is to mine gay organizations, websites, conferences, resource centers, and pride marches, *venues most sexual minorities do not frequent*"

(emphasis added).[7]

7. Ritch C. Savin-Williams, *Sexual Orientation: Categories or Continuum? Commentary on Bailey et al.* (2016), 17 *Psychol. Sci. Pub. Int.* 37, 39 (2016), https://doi.org/10.1177/1529100616637618.

In other words, individuals who frequent these gay-affirmative centers are not representative, even of the population of self-identified sexual minorities. They may be the most committed members of this population and so may be more likely to understate problems and overstate the advantages of being part of this community. At the very least, responsible research requires acknowledging this fact and attempting to correct for it.

The bias of convenience samples of sexual minorities is not a merely theoretical criticism. Instead, this bias has been concretely observed in studies where evidence from convenience samples of self-identified and self-selected gay populations has often reported lower psychopathology and higher unique stigma compared to evidence derived from population-representative data that include sexual minority persons. For example, a study using the U.S. National Household Survey of Drug Abuse, a large population-representative dataset, reported a higher-than-expected risk of major depression among homosexual men and alcohol abuse among homosexual women. The authors explained the difference by the fact that earlier studies "relied on convenience samples drawn from the visible lesbian and gay community."[8] The "convenience sample" studies had found "no increased risk [of psychopathology] in comparison with heterosexuals," masking the effects found in the more powerful study.[9]

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8. Susan D. Cochran & Vickie M. Mays, *Lifetime Prevalence of Suicide Symptoms and Affective Disorders Among Men Reporting Same-Sex Sexual Partners: Results from NHANES III*, 90 *Am. J. Pub. Health* 573 (2000), https://doi.org/10.2105/AJPH.90.4.573.

9. *Id.*

Likewise, a study that directly compared a general population sample of LGB persons with "a convenience sample recruited at LGB venues" in the Netherlands found that the convenience sample claimed "lower levels of internalized homonegativity," and claimed "more negative social reactions on their LGB status."[10] Once again, the convenience samples weren't useful measures of the wider population.

Convenience samples recruited through LGB community communications channels are particularly ill-suited to deciding whether sexual orientation therapy is efficacious, beneficial, or harmful. Clinical studies have found that most persons who have experienced substantial change in same-sex attraction or behavior following SOCE *no longer identify as gay or lesbian,* often noting their explicit "decision to disidentify with a gay identity and the persons and institutions that support gay identity."[11] Sampling from gay organizations and venues will exclude almost all such persons—that is, they exclude precisely the person likely to say SOCE was successful or beneficial. These studies have a bias toward "success exclusion." If we wanted to know about the efficacy or harm of a sobriety program, we would not recruit from bars. Yet this is precisely how many studies in sexual orientation change are conducted.

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10. Lisette Kuyper, Hanneke Fernee & Saskia Keuzenkamp, *A Comparative Analysis of a Community and General Sample of Lesbian, Gay, and Bisexual Individuals*, 45 *Arch. Sexual Behav.* 683 (2016), https://doi.org/10.1007/s10508-014-0457-1.

11. Stanton L. Jones & Mark A. Yarhouse, *A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change*, 37 *J. Sex & Marital Therapy* 404, 423 (2011), https://doi.org/10.1080/0092623X.2011.607052.

A 2023 review found that eighteen of the twenty major studies of SOCE since 2010 had made no attempt to include non-LGBT-identified persons, thus manifesting at least an implicit success exclusion bias.[12]

Eight SOCE studies formally *screened out* non-LGBT-identifying people, enacting an explicit bias against cases of SOCE success.[13]

The APA passed a resolution supporting SOCE bans in 2021. But all the studies cited in support of the claim that SOCE increases psychological harm or suicide derived from this group of highly biased studies.[14]

C. Studies that have NOT excluded non-LGB respondents contradict claims of inefficacy and harm.

When studies take the simple step of including non-LGB respondents, they tend to show some successful change along the homosexual-to-heterosexual continuum and strong net psychological benefit.

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12. Christopher H. Rosik, *A Wake-Up Call for the Field of Sexual Orientation Change Efforts Research: Comment on Sullins* (2022), 52 *Arch. Sexual Behav.* 869 (2022), https://doi.org/10.1007/s10508-022-02481-7.

13. *Id.* at 870.

14. Judith M. Glassgold *et al.*, *APA Task Force Report on Appropriate Therapeutic Responses to Sexual Orientation* (2009), https://doi.org/10.13140/RG.2.1.3075.8004.

Shidlo and Schroeder's early study[15] is often cited as evidence of harm from sexual reorientation therapy. The APA's 2021 Resolution[16] calling for a SOCE ban cites it this way three times; Glassgold's accompanying review in *The Case Against Conversion Therapy* [17] misleadingly asserts that the study only "found little evidence of change and documented harm."[18] In fact, Shidlo and Schroeder recounted that they began their study with a goal of documenting harm, but "[a]fter the first 20 interviews, we discovered that some participants reported having been helped as well as harmed." [19]

Many of the 202 participants interviewed reported both benefits and harm, in very different amounts depending on whether they considered their experience to have been a success or failure (13% of the sample reported successful change or management of unwanted homosexuality).[20] Not surprisingly, those who reported a "failure" in SOCE rated 51% of their clinical treatments were harmful and

15. Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumers' Report*, 33 *Prof. Psychol.: Res. & Prac.* 249 (2002), https://doi.org/10.1037/0735-7028.33.3.249.

16. American Psychological Association, *Resolution on Sexual Orientation Change Efforts* (Feb. 2021), https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf.

17. Judith M. Glassgold, Research on Sexual Orientation Change Efforts: A Summary, in *The Case Against Conversion "Therapy": Evidence, Ethics and Alternatives* 17 (Douglas C. Haldeman ed., Am. Psychol. Ass'n 2022).

18. *Id.* at 21-22.

19. Ariel Shidlo & Michael Schroeder, *supra* note 15 at 251.

20. *Id.* at 253.

48% as at least partially helpful. Whereas those reporting some "success" felt that 71% of their clinical treatment courses were helpful only and 29% were at least partially harmful.[21] Among the group reporting any success, all the treatments were rated somewhat helpful. No treatments were rated always harmful. These results contradict the claim that SOCE is always harmful, despite the way the APA framed the study in its Resolution.

Two studies by overlapping teams of researchers[22] examined distinct aspects of an online survey of 1,612 formerly or currently same-sex-attracted Mormons who had undergone sexual orientation therapy. The sample did not formally exclude respondents who identified as heterosexual, although the survey recruitment process—primarily through gay-affirmative organizations and "snowball sampling"[23]—may have suppressed their proportional participation. Once again, the APA 2021 Resolution's review cited these studies as evidence that SOCE is intrinsically harmful, when in fact they showed the opposite, reporting more benefit than harm from SOCE. The study by Bradshaw and others[24] reported that their study "documented a broad range of potential

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21. *Id.* at 257.

22. Kristin Bradshaw, *et al.*, *Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated with the Church of Jesus Christ of Latter-day Saints*, 41 *J. Sex & Marital Therapy* 391 (2015); John P. Dehlin *et al., Sexual Orientation Change Efforts Among Current or Former LDS Church Members*, 62 *J. Counseling Psychol.* 95 (2015), https://doi.org/10.1037/cou0000011.

23. Bradshaw, *et al., supra* note 22 at 396; Dehlin, et al., *supra* note 22 at 98.

24. *Id.*

benefits and harms ancillary to the goal of orientation change."

It continued:

> Many found therapy to be a helpful, even life-saving experience. … Of particular interest was the large number of individuals who reported decreased levels of depression and anxiety and improved feelings of self-worth. … As a general rule, … experiences of harm or iatrogenic distress were much less frequent than reports of benefit."[25]

Jones and Yarhouse[26] further presented compelling evidence that sexual reorientation therapy did not induce psychological harm, in a longitudinal study that followed fifty-eight sexual reorientation therapy participants for six years of annual assessment. At the last assessment, 53% of participants reported success in changing sexual orientation at least partially; 25% reported failure, most of these reverting to a gay identity; and 23% were continuing in sexual reorientation therapy or did not respond to the questions. Jones and Yarhouse measured psychological distress using the Symptom Checklist-90, a well-validated instrument for assessing psychological distress with a general index of distress and a measure of the intensity of distress.

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25. *Id.* at 406.

26. Stanton L. Jones & Mark A. Yarhouse, *A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change*, 37 *J. Sex & Marital Therapy* 404 (2011), https://doi.org/10.1080/0092623X.2011.607052.

Jones and Yarhouse reported average improvement in each of three measures of distress for each of two cohorts, regardless of outcome, from beginning to end of the observations.[27]

Jones and Yarhouse said their findings "contradict the commonly expressed view that sexual orientation is not changeable and that the attempt to change is highly likely to result in harm for those who make such an attempt."[28] The APA ignored the Jones and Yarhouse study in their 2021 Resolution supporting SOCE bans.[29]

Pela and Sutton[30] found small average changes in sexual attraction but a substantial increase in well-being from "reintegrative therapy." Reintegrative therapy is a form of therapy that does not attempt to change sexual attractions but treats early life trauma. But reintegrative therapy is often condemned along with so-called "conversion therapy" precisely because it produces reports of changed orientation. Over the course of the treatment participants "experienced significant improvement in their well-being" (p. 76)[31] as confirmed by an average before/after improvement in symptom distress,

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27. *Id.* at 418.

28. *Id.* at 425.

29. *See, e.g.*, American Psychological Association, *Resolution on Sexual Orientation Change Efforts* (Feb. 2021), https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf.

30. Carolyn Pela & Philip Sutton, *Sexual Attraction Fluidity and Well-Being in Men: A Therapeutic Outcome Study*, 12 *J. Hum. Sexuality* (2021), https://www.journalofhumansexuality.com/files/ugd/ec16e9d0708a0dc82e4da78e0258eb96dc1467.pdf.

31. *Id.* at 76.

interpersonal functioning and social role functioning of 23% (effect size of .80) on the Outcome Questionnaire 45.2, a widely used instrument for measuring psychiatric treatment outcomes.

Again, these studies have taken the simplest step of not excluding potential successes, either by sampling outside those with LGB identity, or by longitudinal data not subject to the problems of retrospective recall. Once "convenience sampling" is removed, studies report substantial success and a range of benefits for persons who voluntarily sought counseling support for change or management of their sexual orientation.

There is a difference in kind between the types of claims made against change-allowing exploratory therapy and the claims made in its favor.

The advocates of "therapy bans" make two sweeping claims: first that sexual orientation is immutable and no one can change. Second, the attempt to change is intrinsically harmful, always and everywhere for everyone. Logically, even a single counterexample of a person who changed sexual orientation or who was not harmed by therapy is sufficient to refute these sweeping claims.

By contrast, our hypotheses are much more modest. The case for counseling freedom only needs to show that some people change their patterns of attractions and behavior to some extent. We only need to claim that some people benefit from therapy in this process.

Banning all change-allowing therapy is an unjustifiably extreme response to the harms reported by a subset of "affirming" activists.

II. Sexual Orientation Is Not Immutable and Fixed—Individuals Retain Agency

A. Leading researchers acknowledge that sexual orientation can change.

Following a review of the evidence on sexual orientation change with co-author Clifford Rosky, Professor Lisa Diamond, co-editor of the APA's authoritative Handbook of Sexuality and Psychology,[32] concluded that "arguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attraction remain fixed over the life course."[33] The studies Diamond and Rosky reviewed "unequivocally demonstrate that same-sex and other-sex attractions *do* change over time in some individuals. The degree of change is difficult to reliably estimate, given differences in study measures, but the occurrence of change is indisputable" (emphasis in original).[34]

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32. *See* Lisa M. Diamond & Douglas L. Tolman, *APA Handbook of Sexuality and Psychology* (Am. Psychol. Ass'n 2014).

33. Lisa M. Diamond & Clifford J. Rosky, Scrutinizing *Immutability: Research on Sexual Orientation and U.S. Legal Advocacy for Sexual Minorities*, 53 *J. Sex Res.* 364 (2016), https://doi.org/10.1080/00224499.2016.1139665.

34. *Id.* at 363.

Diamond and Rosky summarized the results of one study[35] examining over 13,000 representative young adults in the Growing Up Today Study (GUTS) as follows: "Of the 7.5% of men and 8.7% of women who chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the women chose a different category by age 23. Among the same-sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual."[36]

These authors also summarized results from the National Longitudinal Survey of Adolescent to Adult Health (Add Health) with over 20,000 representative cases[37] this way: "[R]espondents were asked to describe themselves as 100% heterosexual, Mostly heterosexual, Bisexual, Mostly homosexual, or 100% homosexual. Of the 5.7% of men and 13.7% of women who chose one of the nonheterosexual descriptors at [age 22 on average], 43% of the men and 50% of the women chose a different sexual orientation category six years later. Of those who changed, two-thirds changed to the category 100% heterosexual."[38]

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35. Diamond & Rosky, *supra* note 33, *citing* M.Q. Ott *et al.*, *Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics*, 40 Arch. Sexual Behav. 519 (2011), https://doi.org/10.1007/s10508-010-9691-3.

36. Diamond & Rosky, *supra* at note 33, 369-70.

37. Ritch C. Savin-Williams & Zhana Vrangalova, *Mostly Heterosexual as a Distinct Sexual Orientation Group: A Systematic Review of the Empirical Evidence*, 33 *Dev. Rev.* 58 at 62-6 (Table 1) (2013), https://doi.org/10.1016/j.dr.2013.01.001.

38. Diamond & Rosky, *supra* note 33 at 369.

As these examples document, the number of persons who have changed from at least some homosexual behavior to solely heterosexual sex behavior, with or without the support of counseling, is substantial. The reviewed studies just noted are not based on retrospective recall of earlier states in convenience samples but employed true longitudinal time series measures of the same individuals at different ages in nationally representative samples. They thus present the best available objective scientific evidence for observing valid change in individuals over time. This compelling evidence is what justifies the definitive, strongly worded conclusions from prominent researcher Diamond, quoted above, that sexual orientation change is "indisputable" and that the claim that sexual orientation is immutable is "unscientific."

B. Most non-heterosexual people report mixed attractions, enabling scope for agency to pursue alignment with values and goals.

Arguments about counseling and the possibility of "change" in gender identity are often framed as though sexual orientation were a binary and a fixed-sum construct within which "change" would necessarily require turning off desires that the individual experiences and turning on desires that the individual does not experience. Empirically, this is extremely far from the truth. Instead, most men and almost all women who are not exclusively heterosexual report experiencing a mix of both homosexual and heterosexual attractions.

The Kinsey scale measures sexual attractions from 0 ("exclusively heterosexual") to 6 ("exclusively homosexual"), with values 1 to 5 reporting a mix of both

heterosexual and homosexual attractions. A review of Kinsey scale results on major population surveys[39] reported data revealing that the percentage of respondents not identified as heterosexual who nevertheless reported mixed sexual attractions in these surveys was, by sex:

- Men 61%, Women 93% — citing National Health and Social Life Survey (USA, age 18–59)

- Men 88%, Women 98% — citing National Survey of Sexual Attitudes and Lifestyles (UK, age 16–44)

- Men 72%, Women 95% — citing Add Health Wave 4 (USA, age 24–33)

- Men 80%, Women 95% — citing National Survey of Family Growth 2006–2008 (USA, age 18–44)

- Men 77%, Women 95% — citing Dunedin Multidisciplinary Health and Development Study (DMHDS, current sexual attraction) (New Zealand, age 26)

Recent research, moreover, has found the Kinsey scale's zero-sum assumption (that increased opposite-sex attraction correlates with reduced same-sex attraction)

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39. Ritch C. Savin-Williams & Zhana Vrangalova, *Mostly Heterosexual as a Distinct Sexual Orientation Group: A Systematic Review of the Empirical Evidence*, 33 *Dev. Rev.* 58 at 62-6 (Table 1) (2013), https://doi.org/10.1016/j.dr.2013.01.001.

to be false. A definitive 2019 study that directly examined the human genome found that "[i]ndividuals can be high on both same-sex and opposite-sex behavior or attraction (some bisexual individuals), and individuals can be low on both (asexual)."[40] The genome study called for discontinuing use of the Kinsey scale.

Keeping in mind that sexual orientation operates on three axes—attractions, behavior, and identity—these facts imply that individuals may "change" their lived sexual orientation not by working an extreme binary change in their sexual attractions, but by changing from one mix or intensity of attractions to both sexes to a different balance or mix of attractions to both sexes. Thus, "sexual orientation change" may not consist in a radical re-orientation but in more measured, incremental change. Individuals may also choose to act on or identify socially emphasizing either homosexual or heterosexual behavior or identity.

A recent examination of self-reports of sexual orientation changes by seventy-two highly religious men who had undergone SOCE found that most of them underwent this kind of change. Only two men reported a complete change from exclusively homosexual to exclusively heterosexual attractions, with most reporting incremental change among levels of mixed attractions. Despite only modest change in attractions, however, most men completely ceased homosexual behavior. The author

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40. Andrea Ganna *et al., Response to Comment on "Large-Scale GWAS Reveals Insights into the Genetic Architecture of Same-Sex Sexual Behavior*," 371 *Science* eaba5693 (2021), https://doi.org/10.1126/science.aba5693.

observed, "while …psychological scholars may assert that these men have not changed sexual orientation due to possible persistent same-sex desire, … these religious men may assert that they have changed sexual orientation because they are able to resist acting on any persistent same-sex desire."[41]

C. Denial of homosexual-to-heterosexual change is contradicted by simultaneous affirmation of heterosexual-to-homosexual and gender identity change.

The insistence that persons with homosexual attractions are unable to change any element of their sexual orientation is not consistent with the well-known experience and construction of sexual minority identity in other areas. For example, many children enter same-sex families by means of a parent who was previously in an opposite-sex sexual relationship.[42] Most such same-sex parents identify as gay or lesbian, not bisexual, and many are men. It must be acknowledged that men who have transitioned from a procreative opposite-sex sexual relationship to a same-sex sexual relationship have in some sense changed sexual orientation. Your *amici* are unaware of a single academic publication that questions the veracity of these men or argues that they have not really

41. D. Paul Sullins, *What Sexual Orientation Change Efforts Change: Evidence From a United States Sample of 72 Exposed Men*, 16 Cureus 13 (2024), https://doi.org/10.7759/cureus.68854.

42. Danielle Taylor, *Same-Sex Couples Are More Likely to Adopt or Foster Children*, U.S. Census Bureau (Sept. 17, 2020), https://www.census.gov/library/ stories/2020/09/fifteen-percent-of-same-sex-couples-have-children-in-their-household.html.

changed. In whatever sense it is understood and accepted that these men have transitioned from heterosexual to homosexual orientation, why is it not possible also to accept and understand that other men may transition from homosexual to heterosexual orientation?

As another example, it is widely affirmed that some persons experience a subjective gender identity that does not conform to their phenotypic birth sex. Such people transition from one gender identity to another, although their bodily sexual biological functions do not, or only change cosmetically. Many of the scholars and activists who reject change in orientation affirm a possibility of male to female (or female to male) change in the face of intractable biological reproduction patterns. In the same sense that one person can change gender identity without changing their underlying biological sex, there is no logical reason to exclude the possibility that another person can change sexual orientation without changing their underlying sexual arousal patterns.

These inconsistences suggest that the denial of any possibility of orientation change does not reflect an objective scientific conclusion; it can only be an ideological objection to a particular form of disfavored expression and activity.

III. Affirming-Only Therapy Is Not Evidence-Based and Can Also Cause Harm

A. "Affirming" therapy has not been demonstrated, only assumed by ideology.

Contemporary professional discourse—particularly within the American Psychological Association (APA)—imposes rigorous scrutiny only on therapy that permits sexual orientation change. Meanwhile, therapies described as "affirming" are presumed valid and exempted from equivalent empirical or ethical challenge. The APA has not substantiated the superiority of affirming-only therapy with replicable clinical data but assumes its legitimacy as an article of ideological faith.

For instance, an important review article from 2016 dismisses plausible causal connections between childhood sexual abuse and later same-sex attraction—despite empirical data that suggest such links warrant investigation. [43] This report, cited in the American Psychological Association's 2023 Resolution on Sexual Orientation Change Efforts,[44] acknowledges significantly higher rates of childhood sexual abuse among non-heterosexual adults yet preemptively rules out causality and instead attributes the correlation to the idea

43. J. Michael Bailey *et al.*, *Sexual Orientation, Controversy, and Science*, 17 Psychol. Sci. Pub. Int. 45 (2016), https://doi.org/10.1177/1529100616637616.

44. *See* Am. Psych. Ass'n, *Resolution on Sexual Orientation Change Efforts* (Feb. 2021) at 3, https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf).

that "gender nonconformity" invites predation. This interpretive leap is speculative and unaccompanied by dispassionate scientific evaluation. It reflects a broader trend: conclusions that affirm sexual minority narratives are elevated without evidentiary scrutiny, while contrary hypotheses are excluded from inquiry.

The ideological commitment to affirmation is so rigid that even discussing potential causality between traumatic childhood experiences and later sexual development is often stigmatized or legally constrained. Under such conditions, the role of therapy becomes validation, not investigation or helping. The result is a professional double standard: rigorous rejection of "change-allowing" therapy on empirical grounds, coupled with a refusal to apply those same standards to affirming therapy.

B. "Affirming" counselors can misdiagnose or pressure clients.

The professional double-standard is not merely academic. It puts real patients at risk.

When counselors are ideologically constrained to "affirm" a client's sexual orientation or gender identity, regardless of context, they are discouraged from exploring underlying trauma, confusion, or co-occurring psychological issues. Clients are left without access to truly comprehensive mental health care.

Concrete scenarios illustrate the danger:

If a young man presents with symptoms of trauma linked to childhood sexual abuse, an affirming-only approach may prohibit the counselor from examining

whether the abuse shaped the client's sexual arousal patterns. This is true even if the client himself raises the concern. If the abuser was male and the client now experiences same-sex attraction, the ideological imperative to affirm may compel the counselor to bypass meaningful inquiry into causality and coping. The State's imposition of affirming-only therapy, as in Colorado's law, thus silences legitimate therapeutic dialogue and ignores the client's right to self-determination.

Amicus Ruth Institute has interviewed patients damaged by these pressures and has released them as case studies.

For example, Nancy Charles sought help while navigating drug addiction and emotional instability, a profoundly vulnerable position. Ms. Charles' counselor in a rehabilitation facility diagnosed her with gender dysphoria within moments of meeting her, without any discussion or consent.[45] Charles had never heard the term before and was distressed by the counselor's 'diagnosis,' which was based solely on her appearance. When Ms. Charles objected, the counselor insisted that she was a "safe space" and persisted in offering gender transition as a valid path.[46]

Ms. Charles sought another counselor, only to find they were driven equally by ideology. Ms. Charles told her counselor that she, Ms. Charles, wanted to explore

45. *See, The Phrase I Wanted to Hear My Whole Life Was Actually Devastating to Hear | Nancy Charles Part 2*, YouTube (Ruth Inst., July 17, 2024), https://www.youtube.com/watch?v=GrWIe0ld2Nk&t=543s (at 9:03).

46. *Id.*

why she wanted to be a man.[47] Rather than being met with curiosity or clinical neutrality, she was told there was "nothing wrong" with her and that she was "perfect just the way she [was]."[48] The counselor immediately rejected *any* inquiry into causes of Charles' gender confusion because that would not be affirming enough. The counselor's ideology required blaming Ms. Charles' questions on internalized transphobia.

Ms. Charles left therapy feeling more isolated and hopeless, stating that she was at the brink of suicide. The affirming posture did not reassure her; it said her pain was illegitimate and blocked therapeutic engagement with her actual experience.

Broad definitions of "conversion therapy" further chill clinical judgment. By equating *all* change-allowing therapy with coercive or abusive practices, the profession deters nuanced treatment and vilifies counselors who simply listen, ask questions, or acknowledge complexity.

The result is systemic misdiagnosis by those who are indoctrinated that affirmation is harmless. In truth, ideologically driven therapy — whether under the guise of affirmation or prohibition — can harm clients by denying them the freedom to pursue therapeutic goals rooted in their own narratives, values, and experiences.

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47. *See My LGBT-Affirming Therapist Said THIS*, YouTube (Ruth Inst., July 12, 2024), https://www.youtube.com/watch?v=0cT6Tj7opQ4 (excerpt of recorded interview between Ruth Institute and Ms. Charles).

48. *Id.*

Charlene Cothran, a former lesbian activist and publisher, describes a similar journey, into and out of an LGBT identity. Cothran describes her life as shaped by childhood sexual abuse and a longing for safety and emotional connection. As she recounted, "[m]any gays and lesbians don't talk about [abuse] unless they're in their own little groups," but among themselves, "they admit... we all have been abused."[49] Cothran traced her decision to pursue same-sex relationships to her trauma. Her candid acknowledgment challenges the prevailing dogma that same-sex attraction is invariably inborn and immutable.

Later in life, Cothran felt convicted about her public role in promoting what she now describes as a "lie." At a pride event, she realized the magnitude of her influence, especially as younger women began telling her, "I want to be just like you." Her internal conflict intensified, prompting a spiritual reawakening. She renounced her former identity, crediting her transformation to faith-based approaches that allowed her to confront the root causes of her distress.[50]

Cothran is a black, Baptist, American woman. At the other end of the world, James Parker, a white Roman Catholic Australian man, offers a similar observation about the prevalence of childhood sexual abuse among those with same-sex attraction. For 15 years, Parker ran a support group in London for same-sex attracted persons

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49. *See Change is Possible | Cothran, Darrow, Sullins | Dr J Show ep. 136*, YouTube (Ruth Inst., June 10, 2022), https://www.youtube.com/watch?v=vTkZSh0MMJk&t=1209s (at 20:09).

50. *See, id.* at 00:24:00–00:28:00.

who desired to live chastely. Based on his experience with hundreds of people, he estimates that 80% had experienced childhood sexual trauma. [51]

Nancy Charles and Charlene Cothran are just two cases showing the wide-spread harm of "affirming-only" models that fail clients at their most vulnerable point. The literature reports other, similar situations where affirming therapy harms vulnerable people.

For example, Beckstead and Morrow reported that all of their sample of 50 very religious same-sex-attracted Mormons seeking sexual reorientation therapy "were willing to give up their sexual identities in return for religious and societal rewards because, as they stated, they felt their sexual identities were peripheral to their religious identities."[52] In a companion study, Beckstead elaborated further: "Because of the high stakes involved of losing family, friends, community, religious support, and eventually 'eternal exaltation,' participants felt that 'being gay' was not a valid choice for them."[53] The expectation of gay-affirmative therapy prompted sample members to frustration and despair.[54]

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51. *See* James Parker, *Fact is, You Can Change Your LGBT Identity*, YouTube.com (Ruth Inst., Mar. 4, 2024), https://youtu.be/xKcy76l_V2M?t=2252 (at 37:40).

52. A. Lee Beckstead & Susan L. Morrow, *Mormon Clients' Experiences of Conversion Therapy: The Need for a New Treatment Approach*, 32 Couns. Psychol. 651, 653 (2004).

53. A. Lee Beckstead, *Cures versus Choices: Agendas in Sexual Reorientation Therapy*, 5 J. Gay & Lesbian Psychotherapy 87, 97 (2002).

54. *Id.* at 98.

In a 2024 report by British Islamic authorities, an Australian Muslim man, Ahmed, recounted the traumatic effects of so-called "affirmative" therapy that disregarded his religious convictions.[55] Despite assurances that his values would be respected, the counselors presented only two options: misery, depression, and anxiety; or embracing a gay identity. The encounter triggered a severe emotional crisis, including panic attacks and hospitalization. Subsequent counselors similarly pressured him to affirm a gay identity, compounding his distress. He wrote:

> [M]y life was literally shattered before my very eyes. From that day onwards, I was in absolute panic. I cried in my car for more than four hours, the most intense tears that even soaked my clothing. The same day, I had a non-stop panic attack which felt as if it lasted forever. My parents took me to the hospital in the middle of the night because I was going insane."[56]

Ahmed's experience illustrates how ideologically constrained therapy can violate client autonomy, disregard deeply held beliefs, and result in significant psychological harm.

As these cases show, ideologically driven approaches do not necessarily relieve distress; often they increase distress, and sometimes catastrophically. Their experience of childhood trauma suggests strongly that people need more opportunities to discuss the impact of childhood

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55. British Board of Scholars & Imams, Muslim Council of Scot. & Muslim Council of Wales, *Conversion Therapy: What Should Muslims Know?*, 21–22 (Mar. 2024).

56. *Id.*

sexual abuse, not fewer. The State of Colorado is cruel to systematically preempt discussion of a possible link between childhood trauma and patterns of sexual desire and behavior.

IV. Viewpoint-Based Suppression of Counseling Speech Violates the Free Speech Clause.

A. Colorado's law singles out disfavored ideas for suppression.

Viewpoint discrimination constitutes a more "egregious" and "blatant" offense to the First Amendment than does an ordinary content-based restriction— "a law that singles out specific subject matter for differential treatment." *Reed* v. *Town of Gilbert*, 576 U.S. 155, 156 (2015).

Viewpoint discrimination is "uniquely harmful to a free and democratic society." *Nat'l Rifle Ass'n* v. *Vullo*, 144 S.Ct. 1316, 1326 (2024). Thus, if a law is "viewpoint-based, it is unconstitutional." *Iancu* v. *Brunetti*, 588 U.S. 388, 393 (2019); *accord Minn. Voters Alliance* v. *Mansky*, 585 U.S. 1, 11("prohibited"); *Matal* v. *Tam*, 582 U.S. 218, 243 (2017) ("forbidden").

"The state engages in viewpoint discrimination when the rationale for its regulation of speech is the specific motivating ideology or the opinion or perspective of the speaker." *Gerlich* v. *Leath*, 861 F.3d 697, 705 (8th Cir. 2017) (internal quotation omitted). Viewpoint discrimination constitutes a more "egregious" and "blatant "offense to the First Amendment than does an ordinary content-based restriction. *Reed* v. *Town of Gilbert*, 576 U.S. 155, 156 (2015).

The same principle applies even more when the public debate is about medical issues. For example, in *Conant* v. *Walters*, the federal government threatened to revoke physicians' DEA registrations if doctors, based on their professional judgment, recommended the use of marijuana. 309 F.3d 629, 632-33 (9th Cir. 2002). Conant recognized the "core First Amendment values of the doctor-patient relationship." *Id.* at 637. Candid, open, and honest conversation is paramount "in order to identify and treat disease; barriers to full disclosure would impair diagnosis and treatment." *Id.* at 636 (*quoting Trammel* v. *United States*, 445 U.S. 40, 51 (1980)). And so, naturally, doctors do not "surrender" their First Amendment rights simply by "[b]eing a member of a regulated profession." *Id.* at 637. In applying First Amendment scrutiny, the Ninth Circuit found that the government's policy did "not merely prohibit the discussion of marijuana" generally (a "presumptively invalid" content-based restriction), it "condemn[ed] expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient" (a viewpoint-based restriction). *Id.* Worse still, this viewpoint-based restriction "altered the traditional role of medical professionals by prohibiting speech necessary to the proper functioning of those systems." *Id.* at 638.

Similarly, a municipal ordinance banned therapists from offering any counseling hoping to change a minor's sexual orientation. *Otto v. City of Boca Raton*, 981 F.3d 854 (11th Cir. 2020). On review, the Eleventh Circuit concluded that the ordinance was an unconstitutional viewpoint-based restriction on speech. Though the city could promote its own "viewpoint about sex, gender, and sexual ethics," it had no right to "engage in bias, censorship, or preference regarding another speaker's point of view." *Id.* at 864. And that is what its law did:

speech affirming one's sexual orientation was permitted; disaffirming speech promoting sexual orientation change was not. Here, the 11th Circuit was correct, and this Court should make it the rule nationwide.

States simply have no right to deny admission to the "marketplace of ideas" for those ideas it disapproves. Between the dangers of suppressing information and the alleged dangers of misusing information, "the First Amendment makes [the choice] for us." *Va. State Bd. of Pharmacy* v. *Va. Citizens Consumer Council*, 425 U.S. 748, 770 (1976). It requires a ruling against suppression, and in favor of allowing individuals to judge the information for themselves. And professional counselors have just as much right to participate in that free exchange of views. *Nat'l Institute for Fam. and Life Advocates* v. *Becerra*, 138 S. Ct. 2361, 2371 (2018).

If governments have the power to dictate the professional views of private healthcare providers during contentious times, every view will be either banned or mandated, prohibited or required, compulsory or forbidden. *See, e.g.*, John T. Whitaker, *Italy's Seven Secrets*, SATURDAY EVENING POST, Dec. 23, 1939, at 53 (depicting the totalitarian principle at work in fascist Italy).

B. Colorado's law targets speech, not conduct.

This Court has long recognized that "it is no answer to say that the purpose of the regulation is merely to insure high professional standards and not to curtail free expression. For a state may not, under the guide of prohibiting professional misconduct, ignore constitutional rights." *NAACP* v. *Button*, 371 U.S. 415, 438-39 (1963).

Indeed, Mr. Justice Jackson nearly predicted this very case in 1945: "[T]he state may prohibit the pursuit of medicine as an occupation without its license, but I do not think it could make it a crime publicly or privately to speak urging persons to follow or reject any school of medical thought. *Thomas* v. *Collins*, 323 U.S. 516, 544 (1945) (Jackson, J., concurring). *Thomas* concerned an attempt to block union speeches using professional regulations. Justice Jackson rejected the attempt.: while the state "may regulate one who makes a business soliciting funds… for unions," that may not interfere with their protected speech. Thus, wrote Jackson, "I do not think it can prohibit one, even if he is a salaried labor leader, from making an address to a public meeting of workmen, telling them their rights as he sees them and urging them to unite in general or to join a specific union." Given Justice Jackson's prescient comments, long standing First Amendment rules prohibit states from using professional regulations to stifle any professional's ability to talk about "any school of medical thought."

And if there were any doubt, this Court's decision in *Nat'l Inst. of Fam. & Life Advocs.* v. *Becerra*, 585 U.S. 75 (2018), should have resolved the matter.

Yet the decision below claims to uphold NIFLA at the same time it would gut it. Citing NIFLA, Judge Hart's dissent observes:

> The approach of the majority opinion would "give [] the States unfettered power to reduce a group's First Amendment rights by simply imposing a licensing requirement. States cannot choose the protection that speech receives under the First Amendment, as that

> would give them a powerful tool to impose invidious discrimination of disfavored subjects."

Chiles v. *Salazar*, 116 F.4th 1178, 1228 (10th Cir. 2024) (Hartz, J., Dissenting).

Judge Hartz was correct about the dangers of Colorado's ban on speech. The First Amendment does not allow professional speech to be censored, and this Court's precedents compel a decision for Petitioner Chiles.

CONCLUSION

Colorado's law censors deeply personal, voluntary conversations between counselors and clients based solely on disfavored viewpoints. It rests on contested science, disregards the experience of those harmed by affirming-only practices, and violates the First Amendment's guarantee of viewpoint neutrality.

Your *amici* respectfully urge the Court to reverse the judgment below for the reasons stated in Petitioners' brief.

Respectfully submitted,

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