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 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* OUR DUTY–USA, LUKE HEALY, ARI, CHLOE BROCKMAN, SOREN ALDACO, AND KAYLA LOVDAHL SUPPORTING PETITIONER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases ..... **Page(s)**

Statutes

INTRODUCTION AND INTEREST OF *AMICI CURIAE*[1]

Our Duty–USA is a secular nonprofit whose members from all fifty states have varied political backgrounds, ethnicities, and sexual orientations but share the experience of raising former and current trans-identified children. Our Duty members are located in states with "anti-conversion therapy" laws. These laws make it nearly impossible to engage professionals who are willing to explore the root cause of a child's rejection of his or her body. Because of these laws, parents of dysphoric children are often presented with a dilemma. Either they forego professional assistance and be forced to personally address severe mental health issues, such as anorexia, self-harm, and autism. Or they risk that a provider will uncritically affirm their child's gender identity while treating companion mental issues as secondary.

Our Duty approaches this subject with personal knowledge that their children's distress is genuine. However, the adoption of transgender identities is a maladaptive coping mechanism stemming from internalized homophobia, exposure to pornography, trauma, sexual abuse, and other mental health ailments.

Our Duty believes that the transgender movement targets children who would likely be same-sex attracted as adults, do not fit the regressive

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[1] This brief was not authored in whole or in part by counsel for any party and no person or entity other than *amicus curiae* or its counsel has made a monetary contribution toward the brief's preparation or submission.

stereotypical roles for their sex, or have mental health issues. Our Duty does not believe that same-sex attraction is a mental health ailment.

Luke Healy, Ari (last name withheld), Chloe Brockman, Kayla Lovdahl, Soren Aldaco, and Elle Palmer rejected their natural bodies and adopted transgender identities as minors. Their mental health providers affirmed their identities, while relegating the acute and conspicuous companion mental health issues as ancillary. Because their providers gave one treatment plan – affirm and transition – they were set on a course of body modification interventions that irreversibly harmed them.

The gender-affirmative care model, which is required in states with "anti-conversion" therapy laws, almost invariably leads to permanent medicalization of a false sense of self that places hormone administration and surgeries above all else, in an impossible quest to change one's sex.

SUMMARY OF ARGUMENT

Colorado's Minor Conversion Therapy Law (MCTL), Colo. Rev. Stat §§ 12-245-224(1)(t)(V) and 12-245-202(3.5)(a), (b)(I), and (II) prohibit mental health professionals from attempting to change a minor client's sexual orientation or gender identity. Conversely, it requires professionals to affirm their minor clients' trans-identity and support and assist in any sex-trait modification procedures (STMP). MCTL hurts children, many of whom would likely be same-sex attracted as adults, as well as the vast majority of children who, if given the appropriate mental health

treatments and time, would return to being comfortable in their sexed bodies.

No scientific evidence suggests that attempting to help a child realign with his or her body is harmful. To the contrary, amici's stories demonstrate that professionals who seek to explore the root causes of their clients' dysphoria are often able to heal their clients without damage to their bodies, while professionals who affirm their patients' gender identity end up causing permanent, life-altering harm.

Finally, it is incontrovertible that talk therapy is speech, and relabeling it conduct to avoid strict scrutiny for content and viewpoint restrictions is an affront to the First Amendment.

ARGUMENT

Thomas Jefferson, an architect of the First Amendment, wrote: "truth is great and will prevail if left to herself; . . . she is the proper and sufficient antagonist to error, and has nothing to fear from the conflict unless by human interposition disarmed of her natural weapons, free argument and debate . . . ."[2] This founding principal is in grave peril if states are permitted to restrict the speech of professionals who attempt to help the rapidly growing number of minors who suffer from gender dysphoria.[3]

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[2] Thomas Jefferson, A Bill for Establishing Religious Freedom (June 18, 1779) *in* The Papers of Thomas Jefferson, Volume 2: January 1777 to June 1779, 545-53 (Julian P. Boyd ed.,1950).

[3] See Brief for Amicus Curiae Our Duty-USA Supporting Respondents and Affirmance at 8–15, *U.S. v. Skrmetti*, No. 23-477 (2024) [hereinafter Our Duty's *Skrmetti* brief].

I. Sexual Orientation and Gender Identity Are Entirely Unrelated Terms; One Is Generally Understood and the Other Is Recently Invented.

Despite being often conflated, sexual orientation[4] and gender identity are two entirely distinct concepts.[5] While "sexual orientation" currently has a concrete, well-understood definition (best described as a person's enduring personal pattern of romantic or sexual attractions to persons of the opposite sex or same sex), "gender identity" is a circular and ill-defined concept.[6] For example, the APA defines "gender identity" as:

> [A] component of gender that describes a person's psychological sense of their gender. Many people describe gender identity as a deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or a nonbinary gender (e.g., genderqueer, gender-

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[4] MCTL does not define "sexual orientation." Caution is warranted as Colorado greatly expands the traditional definition in Colo. Rev. Stat §24-34-301. Further, there is a movement underway to de-pathologize pedophilia with lexicon changes, such as minor attracted persons, turning a paraphilia into a sexual orientation ripe for new civil rights claims. See Christina Farmer, et al., *A Review of Academic Use of the Term "Minor Attracted Persons"*, 25 Trauma, Violence, & Abuse, 40784078-89. (2024). For purposes of this brief, "sexual orientation" is defined as heterosexual, same-sex attracted, and bisexual.

[5] See *Gender*, Am. Psychol. Ass'n (Oct. 2024), https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/gender.

[6] Am. Psychol. Ass'n, *Understanding Sexual Orientation and Homosexuality* (2008), https://www.apa.org/topics/lgbtq/orientation.

> nonconforming, gender-neutral, agender, gender-fluid) that may or may not correspond to a person's sex assigned at birth.[7]

Notably, the APA's definition repeats "gender" multiple times without defining what "gender" is or how it differs from "sex" or sex stereotypes, as well as introducing a series of undefined "identities."

"Gender identity" is a concept recently introduced to the mainstream and arises from queer theory.[8] A quasi-religious concept, it theorizes that humans have an internal "gendered" soul, which only the individual can feel or see, that is both detached from the body and can change throughout life (even daily or minute-to-minute).[9] Its disciples also believe that gender identity is more important than one's actual sex.[10] The number of possible gender identities is infinite.[11]

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[7] *Id.*

[8] See Logan Lancing & James Lindsay, *The Queering of the American Child* 16, 36-37, 188 (2024) (explaining that queer theory "seeks to explode rigid normalizing categories.").

[9] *Id.*

[10] See Brief of Amicus Curiae Society for Evidence-Based Gender Medicine (SEGM) in Support of No Party but Suggesting Affirmance at 9–10, *U.S. v. Skrmetti*, No. 23-477 (2024).

[11] See, *An Interview with Diane Ehrensaft, Author of Gender Born, Gender Made*, The Experiment (Jan. 11, 2012), https://theexperimentpublishing.com/2012/01/an-interview-with-diane-ehrensaft-author-of-gender-born-gender-made/ (arguing that no two gender identities are the same); Diane Ehrensaft, "*I'm a Prius*": *A Child Case of a Gender/Ethnic Hybrid*, 15 J. of Gay & Lesbian Mental Health 46, 46-57 (2010) (describing the potential range of a child's gender identity as "transgender,

The other differences between sexual orientation and gender identity are that sexual orientation is generally static, is not a mental health disorder in the Diagnostic and Statistical Manual for Mental Disorders, and it relies on the established binary of biological male and female (concrete human distinctions).[12]

There is also a crucial difference between same-sex attracted minors and trans-identified ones: profit motive. Trans-identified persons who undergo medical interventions are permanent medical patients as they need cross-sex hormones for life and often have multiple surgeries (and follow-ups due to complications from those surgeries). Detransitioners often also have lifelong medical complications requiring expensive, ongoing care.[13] This financial

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gender fluid, proto-gay, Prius-like, or his or her own creative tapestry of gender"); E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, *Version 8*, 23 Int'l J. of Transgender Health S1, S88–S89 (2022) (explaining that eunuch is a valid identity for children and adolescents). See also, *A Pediatrician's Guide to an LGBT+ Friendly Practice,* Am. Acad. of Pediatrics (Jun. 01, 2021) (https://www.aap.org/en/patient-care/lgbtq-health-and-wellness/a-pediatricians-guide-to-an-lgbtq-friendly-practice/ containing a form for minor patients with a "write in" option for the child's self-created gender).

[12] *See* Am. Psychiatric Ass'n, *Gender Dysphoria* (2013) (classifying gender dysphoria as a "mental disorder" when there is "clinically significant distress associated with the condition."); *Bostock v. Clayton Cnty., Georgia*, 590 U.S. 644, 709–10 (2020) (Alito, J., dissenting) (describing homosexuality's gradual removal from the DSM).

[13] See *infra* Section V; see also Elie Vandenbussche. *Detransition-Related Needs and Support: A Cross-Sectional*

interest creates perverse incentives for medical providers and pharmaceutical companies to facilitate a child into a trans-identity rather than encouraging self-acceptance by a child who may not conform to sex-based stereotypes, be uncomfortable with pubertal changes, or believe that he should be the opposite sex because of his same-sex attraction.[14] No such financial motive exists for the case of a child who evidences predictive behaviors that point to adulthood homosexuality.

II. The Pro-Trans/Gender Affirmation Lobby Has a Huge Impact on Proto-Gay Children.

Pediatric gender medicine began with experiments on same-sex attracted children. Researchers in the Netherlands opened the flood gates of altering children's bodies with their experiments on minors. They tested the efficacy of puberty blockers

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Online Survey, 69 Journal of Homosexuality 1602 (2022); Kinnon MacKinnon et. al., *Health Care Experiences of Patients Discontinuing Reversing Prior Gender-Affirming Treatments*, 5 JAMA Network Open 1, 1 (2022).

[14] See *Gender Reassignment Surgery Market Size & Share Analysis - Growth Trends & Forecasts (2025 - 2030),* Mordor Intelligence, https://www.mordorintelligence.com/industry-reports/sex-reassignment-surgery-market (predicting the gender reassignment surgical market to grow to $2.51 billion in 2030.); See also, Amanda Prestigiacomo, '*Huge Money Maker': Video Reveals Vanderbilt's Shocking Gender Care Threats Against Dissenting Doctors*, DailyWire, (Sept. 20. 2022) https://www.dailywire.com/news/huge-money-maker-video-reveals-vanderbilts-shocking-gender-care-threats-against-dissenting-doctors.

and cross-sex hormones on a cohort of 70 children, 68 of whom expressed same-sex attraction.[15]

The Dutch protocol led to a shocking prevalence of same-sex attracted adolescents seeking treatment for distress over their sexed bodies. This naturally resulted in an over-representation of proto-gay children among those seeking to transition.[16] In 2012, 90% of the United Kingdom's Gender Identity Development Service's (GIDS) female adolescent subjects reported that they were same-sex attracted and 80.8% of the males reported the same.[17] In Lisa Littman's 2021 study of detransitioners, she noted that only 18 of 100 participants claimed to be purely heterosexual.[18] This is strong evidence that many minors' adoption of transgender identity is driven by rejection of homosexual feelings.[19]

Likewise, evidence has shown that most children who "desist" (i.e., return to accepting their sexed bodies and foregoing trans medicalization) end up gay

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[15] See Dep't. of Health and Human Serv., *Treatment for Pediatric Gender Dysphoria, Review of Evidence and Best Practice*, Department of Health and Human Services 50–55 (2025).

[16] See *id.*

[17] See Hannah Barnes, *Inside the Collapse of the Tavistock Centre*, The New Statesman (Mar. 20, 2024) https://www.newstatesman.com/politics/health/2024/03/inside-the-collapse-of-the-tavistock-centre.

[18] Lisa Littman, *Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners* 50 Archives of Sexual Behaviors 3353, 3353–69 (2021).

[19] Vandenbussche, *supra* note 12.

or bisexual as adults.[20] Trans-identification has been tied to a history of victimization from homophobic bullying as well as negative parental attitudes toward nonconformity or same-sex attraction.[21]

Thus, by medicalizing gender-confused minors, professionals have been "trans'ing the gay away" turning same-sex attracted persons into artificial straight people.[22] The U.S. Department of Health and Human Services has given voice to this concern, reporting: "Given the medical profession's history of pathologizing and medicalizing same-sex attraction, serious justice-related concerns are raised by the overrepresentation of gay, lesbian, and bisexual adolescents among patients receiving unproven interventions that adversely impact fertility and sexual function."[23]

Rather than promoting the civil rights of an oppressed group, the U.S. is maiming and sterilizing a large proportion of a generation of gay, lesbian and bisexual individuals through the medicalization of trans-identified children.

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[20] See *id.* at 44; see also, Devita Singh, et al., *A Follow-Up Study of Boys with Gender Identity Disorder,* 12 Frontiers in Psychology 1; (2021); Jiska Ristori & Thomas D. Steensma, *Gender Dysphoria in Childhood*, 28 Int'l Rev. of Psychiatry 13–20 (2016).

[21] See Dep't of Health and Human Serv., *supra* note 12 at 254–59; Ristori & Steensma *supra*, note 18.

[22] Iran follows this despicable practice where homosexuals can face execution but can live as trans-identified woman without punishments. See Allyson Socha, *Myth vs. Fact: Homosexuality & Gender Assignment in Iran*, Am. Iran Council (Nov. 21, 2021) https://www.us-iran.org/resources/2021/7/15/homosexuality-gender-assignment-in-iran.

[23] Dep't of Health and Human Serv., *supra* note 12 at 213–25.

III. There is a Lack of Consensus Among the Medical Community On How Best to Treat Children With Gender Dysphoria.

Justice Thomas, in his dissent for writ of certiorari in *Tingley v. Ferguson*, astutely wrote that "[t]here is a fierce debate over how best to help minors with gender dysphoria." 144 S. Ct. 33 (2023) (*Tingley III*).

Since that dissent was written, the debate surrounding how to care for gender dysphoric minors has reached a fever pitch. More countries, including the United States, have begun re-evaluating whether they should have ever dispensed with the "wait and see approach," which allowed children time to come to terms with their sexed bodies before engaging in irreversible medical interventions. Many children with gender dysphoria who are seeking treatment also come with a whole host of other issues, such as autism, a history of sexual abuse, or other mental health issues that deserve exploration and treatment.

A. A Child-Directed Health Care Model for Gender-Related Issues is Not Ethical Medicine.

It is not health care to affirm a gender identity that does not align with a minor's sexed body, nor to funnel the minor through STMP. It is unprecedented to have a model of care where practitioners do not exercise their own good judgment and instead rely entirely on the self-diagnosis and directed treatment protocols of minor patients. The World Professional Association of Transgender Health (WPATH), which

almost all medical associations in the U.S. follow, recommends this extraordinary health care model for adolescents.[24] There is no other context in which children lead medical professionals in diagnosis and treatment determinations.

Even parents are powerless in many cases to make health decisions different than what their child demands. In states with anti-conversion therapy laws, parents cannot engage counselors who will not affirm their child's transgender identity. Washington and Oregon permit minors to make unilateral decisions related to STMP. See, e.g., Wash. Rev. Code § 71.34.530; Or. Rev. Stat. § 109.640. Parents are often psychologically coerced to agree to STMP because professionals will state, without evidence, that the parent can "choose between a trans child or a dead child."[25] A non-consenting parent often risks losing custody of his or her child. See, e.g., *Kolstad v. Baillargeon*, 1:24-cv-00055-SPW (D. Mont. May 20, 2024) (transferring a non-affirming parents' child to state where STMP is legal); *Blair* v. *Appomattox Cnty. Sch. Bd.*, No. 6:23-cv-47 (W.D. Va. Jun. 25, 2024) (involving a district attorney who refused to return sex-trafficked child to parents who did not refer to daughter as male); *Doe* v. *Children's Nat'l Hosp.*, No. 8:24-cv-00754 (D. Md. Mar. 14, 2024) (revoking parents' custody of their autistic son for refusing to

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[24] See E. Coleman et al., *supra* note 10 at S48, S61.

[25] See DeShanna Neal, *'Do You Want a Happy Little Girl or a Dead Little Boy?': My Choice as a Mother*, Vice, (Apr. 17, 2017, 2:00 PM) https://www.vice.com/en/article/do-you-want-a-happy-little-girl-or-a-dead-little-boy-my-choice-as-a-mother/; See also *infra* Section V.

transition him); see also, Our Duty's *Skrmetti* Brief, *supra* note 3, at 17-19.

This "minor-led" treatment model is exemplified by Dosomethingidentities.com, a website that facilitates minors obtaining the medicalization that they want with little gate-keeping.[26] This website boasts that therapists will write authorization letters to get hormones or surgery after a single one-hour session.[27] One Our Duty member tested this claim, receiving dozens of offers for approval letters for the removal of her 16-year-old daughter's breasts after a single mental health session, with one commenting that the first session will also be the last.[28]

Recently, Dr. Karla Solheim, MD, an OB-GYN and self-proclaimed member of the LGBT community, published an article stating that she "delighted" in performing hysterectomies on trans-identified females.[29] She wrote: "I would joke to my assistant, a gender affirming hysterectomy referral was 'my

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[26] Annie Slatz, *Health Care Providers Offering 'Gender Affirming' Letters for Surgery, HRT in One Hour*, Reduxx. (Apr. 23, 2022), https://reduxx.info/health-care-providers-offering-gender-affirming-letters-for-surgery-hormones-in-one-hour/ (detailing an affiliated spreadsheet that contains contact information of medical providers who have "committed to what is effectively 'no questions asked' gender affirmation.").

[27] *Id.* ("Affiliated with the Do Something Identity(ies) Conference's site, an entire page is dedicated to clinicians who can provide letters for hormones and surgery in a single session").

[28] *Id.*

[29] Karla Solheim, *It's Time for Liberal Physicians to Rethink American Gender Medicine*, The OB/GYN Power Project (May 27, 2025), https://www.obgynpower.com/blog/its-time-for-physicians-to-rethink-american-gender-medicine.

easiest consult of the day.' They came in knowing what they wanted."[30]

Dr. Johanna Olson-Kennedy, a researcher on the NIH-funded study,[31] was asked if she worries that she might "transition" a child who is not really "trans." Her flippant response was: (1) since non-transgender children do not have fragility, it's not so horrible; (2) being "trans" isn't the worst possible outcome and it was just part of their "gender journey"; and perhaps most outrageously, (3) "at the end of the day who is responsible for that? The person [child] that made that decision."[32]

Dr. Jason Rafferty, the author of the American Academy of Pediatric's transgender treatment protocol,[33] echoes Dr. Olson-Kennedy's sentiments. He states that doctors must affirm what the child says he or she is and provide the treatments requested. Dr. Rafferty also claims that cessation of gender treatments are "not treatment failures if that's what's affirming"[at that moment in time.][34]

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[30] *Id.*

[31] Diane Chen et al., *Psychosocial Functioning in Transgender Youth After 2 Years or Hormones*, 388 New England J. Med. 240 (2023).

[32] *Treating Trans Youth with Dr Johanna Olson-Kennedy, GenderGP* (Jan. 17, 2019), https://www.gendergp.com/gender-affirmative-johanna-olson-kennedy/.

[33] Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics 1, 1-2 (2018).

[34] Dep't of Health and Human Serv., *supra* note 12 at 184.

B. There is Little Evidence Regarding the Efficacy of Talk Therapy for Minors in Part Because of "Anti-Conversion Therapy" Laws.

In May of 2025, the HHS published its review of Treatment for Pediatric Gender Dysphoria,[35] evaluating the available evidence for best practices for treating minors with distress related to their sexed bodies. The HHS noted that there is a dearth of evidence on the effect of psychotherapy on distress over one's sex, likely because of "a conflation of psychotherapy with 'conversion therapy."[36] There is significant pressure on therapists "to assume —often without critical evaluation—that mental health issues co-occurring with [gender dysphoria] are primarily the result of minority stress [experiences of transphobia]."[37]

Mental health professionals may overlook the possibility that companion mental health issues are the primary issues and are the cause of the disconnection with the body.[38] "The practice of reflexive assumption contravenes fundamental principles of the psychotherapeutic approach, which emphasizes curiosity and consideration of *all* factors that may have contributed to the patient's problems."[39] The Cass Review, a comprehensive systematic review of the evidence of pediatric gender medicine,[40] also noted that divisive

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[35] See generally *id.*

[36] *Id.* at 88.

[37] *Id.* at 255.

[38] See *id.*, at 254–59.

[39] *Id.* at 256. Reflexive assumptions include beliefs that affirmation is supporting civil rights, moral righteousness or progressiveness. *Id.*

[40] See *id.* at 22.

conversion therapy rhetoric interferes with the therapeutic process.[41]

Despite assertions to the contrary, treating gender dysphoric children with cross-sex hormones and puberty blockers does *not* alleviate their mental health issues. An NIH-funded study of adolescents who were given hormones had two suicides in a cohort of 315 with another eleven reporting suicidal ideation in the first year, and there were little to no improvements in mental health.[42] Likewise, the recently published second half results of an NIH study dedicated to puberty blockers demonstrated no improvements in the child's mental health resulting from administration of blockers.[43]

Amici is unaware of any studies that track the mental health of a child or adolescent who undergoes mental health treatments to address his or her distress with his or her body, in which the child is *not* affirmed. Studies of desistence in which the earlier onset gender dysphoric children are not affirmed are the closest comparison. The results? Upwards of 97.5%

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[41] See Hilary Cass, *Independent Review of Gender Identity Services for Children and Young People: Final Report* 150 (2024).

[42] See Jesse Singal, *The New, Highly Touted Study on Hormones For Transgender Teens Doesn't Really Tell Us Much of Anything*, Singal-Minded, (Feb. 7, 2023) https://jessesingal.substack.com/p/the-new-highly-touted-study-on-hormones (noting that a recent study on transgender youth inexplicably dropped 6 out of the 8 study variables, including gender dysphoria, self-harm and quality of life).

[43] See Johanna Olson-Kennedy et al., *Mental and Emotional Health of Youth After 24 Months of Gender-Affirming Medical Care Initiated with Pubertal Suppression* 13–14 (May 16,2025) (unpublished manuscript) (on file with medRxiv).

desist.[44] A 15-year Netherlands' study demonstrates that close to 75% of youth ages 11-26 outgrow their discomfort with their sex by age 26, with the desistence rate increasing the more time passes from trans-identification.[45] A German study shows that 60% of youth ages 5-24 lose their gender dysphoria diagnosis within five years.[46] The rational conclusion is that not affirming what may be a transient identity is justified.

C. Reliance on The APA's Task Force Reports Is Misplaced As Applied to Gender Identity.

The courts, including the Tenth Circuit, rely heavily on the APA's Task Force Report on *Appropriate Therapeutic Responses to Sexual Orientation* to uphold anti-conversion statutes that proscribe professionals from using talk therapy to try to return a child to comfort with their natural body.[47] See, *Pickup v. Brown*, 740 F.3d 1208, 1231-32 (9th Cir. 2014); *King v.*

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[44] See *Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence*, Soc'y for Evidence-Based Gender Med. (May 6, 2022), https://segm.org/early-social-gender-transition-persistence.

[45] See P. Rawee I. *Development of Gender Non-Contentedness During Adolescence and Early Adulthood,* 53 Archives Sex Behavior 1813, 1813-1825 (May 2024).

[46] See *The Gender Dysphoria Diagnosis in Young People Has a "Low Diagnostic Stability," Finds a New German Study*, Soc'y for Evidence-Based Gender Med. (July 19, 2024), https://segm.org/gender-dysphoria-diagnosis-desistance-germany.

[47] See Am. Psych. Ass'n, *Appropriate Therapeutic Repsponses to Sexual Orientation* (2009).

Governor of New Jersey, 767 F.3d. 216, 224 (3d. Cir. 2014), (both abrogated by *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755 (2018) (*NIFLA*) for using intermediate rather than strict scrutiny). But the Task Force Report specifically states that it is inapplicable to conversion efforts related to gender identity. [48]

IV. Strict Scrutiny is Applicable to MCTL.

A. Colorado's Statute Burdens Speech.

MCTL prohibits and punishes mental health professionals who dare utter words that may help their struggling patients accept their natural bodies. MCTL only permits words to be spoken that accept, support, and assist a child to undergo SMTP. Put in simple terms, the professional cannot encourage the child to believe that she is perfect just the way she was born. Rather, professionals *must* affirm to the child that her body is wrong, but medical treatments are available to "fix" her.

Professional speech is afforded First Amendment protections. *NIFLA*, 585 U.S. at 767 ("Speech is not unprotected merely because it is uttered by 'professionals.'"). Indeed, "professional speech may be entitled to the strongest protection our Constitution has to offer." *Conant v. Walter* 309 F.3d 629, 637 (9th Cir. 2022) (citation omitted) (holding that the act of a physician recommending marijuana to patients is speech).

"[V]erbal communication is the quintessential form of 'speech' as the term is commonly understood."

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[48] *Id*. at 9.

King, 767 F.3d. at 224. Talk therapy that seeks to change a minor's sexual orientation or gender identity is speech, not conduct. *Id.; Otto v. City of Boca Raton* 981 F.3d 854, 861 (11th Cir. 2020). Disfavored speech or writings cannot be relabeled as "conduct" in order to more easily censor them. Allowing courts to do so is "unprincipled" and creates a judicial standard "susceptible to manipulation" by those seeking to avoid heightened scrutiny. *Wollschlaeger v. Governor, Fla.*, 848 F.3d 1293, 1308 (11th Cir. 2017) (quoting *King*, 767 F.3d at 228); see also, *Holder v. Humanitarian L. Project*, 561 U.S. 1 (2010) (holding that legal training and advice is speech as it is communicating a message, and its categorization does not change based upon the function that the communications serve).

The attempts in *King* and *Pickup* to create a new standard that affords intermediate scrutiny to professional speech were properly rejected. *NIFLA*, 585 U.S. at 767. The Ninth Circuit, now joined by the Tenth Circuit, is trying a new tactic, accepting what is clearly speech by labeling it "conduct" or "speech incidental to conduct." See *Chiles v. Salazar*, 116 F.4th 1178, 1214 (10th Cir. 2024); accord *Tingley v. Ferguson*, 47 F.4th 1055 (9th Cir. 2022)(*Tingley I*).

This is an unworkable test that subjects free speech rights to the whims of the judiciary. There is no discernable distinction between the speech and the conduct, and therefore, the whole should be viewed as simply speech. See *Tingley v. Ferguson*, 57 F.4th 1072, 1078-1079, 1083 (9th Cir. 2023) ("*Tingley II*") (en banc rehearing denied); *Cf. Nat'l Ass'n for Advancement of Psychology*, 228 F.3d 1043 (9th Cir. 2000) (rational basis review applied to licensing qualifications for psychoanalysts that did not involve control of speech

between professional and patient.) The court in *Tingley I* attempted to salvage this test by proffering two additional bases to avoid strict scrutiny for Washington's anti-conversion therapy law: (1) when speech may risk physical or psychological harm or (2) when expert organizations recommend the restrictions. See *Tingley II,* 57 F.4th at 1078-1079 . This legerdemain cannot stand. "[A] legislature cannot evade First Amendment scrutiny simply by labeling therapeutic speech as conduct, and the First Amendment's protections continue to apply even when a state legislature exercises its traditional police power." *Id*. at 1083. Nor does the First Amendment hinge on the recommendations of "expert organizations." Rather, "speech is speech[.]" *King*, 767 F.3d at 229.

MCTL would not have passed strict scrutiny if the Tenth Circuit had properly classified therapeutic speech as speech instead of conduct. Instead, the Tenth Circuit (and its sister courts) invented new bases to convert pure speech into supposed "conduct." This extraordinary reworking facilitated the unconstitutional suppression of therapeutic speech. This had and continues to have devastating consequences for minors never permitted to hear any other speech but "affirmation" and STMP.

B. MCTL is content and viewpoint-based.

"As a general matter, [content-based] laws 'are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests.'" *NIFLA*, 585 U.S. at 766 (quoting *Reed* v. *Town of Gilbert*, 576 U.S. 155, 163 (2015)). Whether a law is content-based is determined by examining whether the expressed message or idea is restricted. *Reed*, 576 U.S. at 163.

Government discrimination among viewpoints—or the regulation of speech based on "'the specific motivating ideology or the opinion or perspective of the speaker'—is a 'more blatant' and 'egregious form of content discrimination.'" *Reed*, 576 U.S. at 168. This Court warned that "regulating the content of professionals' speech 'poses the inherent risk that the Government * * * [will] suppress unpopular ideas or information.'" *NIFLA*, 585 U.S. at 755 (quoting *Turner Broadcasting System Inc. v. FCC,* 512 U.S. 622, 641 (1994)).

MCTL is limited to a category of professionals and prohibits a particular message – talk therapy that attempts to change a minor's gender identity. See *Otto*, 862 F.3d. at 863. The professional can counsel about changing the patient's outlook on life, e.g., whether her self-belief that she is fat is real, whether the voices in her head are real. But the professional cannot discuss whether she is really a boy trapped in a female body, nor whether that belief is tied to past trauma or internalized homophobia.

MCTL mandates a singular viewpoint: that the patient's gender identity (regardless of the absurdity of that gender identity) is valid and sufficiently static to merit irreversible STMP. The viewpoint that gender identities are not real and that the rejection of the natural body is harmful is banned. MCTL further compels professionals to assert that STMP—an ideology roiling in controversy— is the correct treatment, while banning any talk that would return the child to comfort in their natural body. This mandate is unconstitutional. *NIFLA*, 585 U.S. at 755.

V. Amici's Testimonials Illustrate the Dangers of Imposing Speech Restrictions on Mental Health Professionals.[49]

The following personal accounts show the devastating results of professionals supporting a minor patient's gender identity and the benefits of exploratory therapy. Affirming transgender identities precludes appropriate therapeutic processes that unearth the causality of feelings and companion mental issues, permitting treatment protocols that address the anguish of the mind, rather than altering the physical body.

A. Parents Unable to Find Non-Affirming Mental Health Providers

1. G.L., California

G.L., a recent recipient of a master's degree in clinical psychology. Her daughter W.L., at age 12, before having any romantic relationship, announced that she was pan-sexual (attracted to all sexes regardless of gender identity). Later, W.L. declared that she was "queer," or transgender. W.L. began self-harming.

W.L.'s transgender identity adoption was inorganic. She had developed feelings for a female peer, who had begun identifying as a boy. On the heels of her school's "diversity week," which focused exclusively on gender, W.L. announced that she was

[49] Some pseudonyms are used to protect families from the animus often directed at detransitioners and those who resist the pressure of supporting transgender identities.

"really a boy." G.L discovered that W.L. was obsessively watching YouTube videos of trans influencers, looking at trans-centric Pinterest boards and performing hundreds of google searches about transgenderisms, gender dysphoria, and suicidal ideation while isolating in her room.

W.L. began wearing three sports bras simultaneously to mask her female shape and instructed friends to call her "him/he." W.L. self-diagnosed herself as gender dysphoric based upon conversations with schoolmates, an online personality test, and contact with a purported professional on an anonymous online chat room. W.L. was convinced she had a male brain, and rewrote her history asserting that she always felt like a boy despite a heteronormative childhood.

G.L. intervened in a clandestinely scheduled meeting between W.L. and teachers, many of whom had secretively supported W.L.'s transgender identity. Despite G.L.'s directive to cease treating W.L. as a boy, several teachers not only affirmed W.L.'s male identity, but instilled fear into W.L. by asking her if she was "safe" with her parents. This created a schism between G.L. and her child

Following her adoption of a transgender identity, W.L.'s mental health imploded, and she attempted suicide. In her search for a therapist, G.L. was referred to the Gender Center, an organization then-led by Dr. Aydin Olson-Kennedy, the trans-identified spouse of Dr. Johanna Olson-Kennedy, the Medical Director of the Center for Transyouth Health and Development at Children's Hospital Los Angeles. The

Gender Center therapist, C.C., who had never met W.L., instructed G.L. to follow her then-13-year-old's lead and purchase her a breast compression binder. C.C. was uninterested in W.L.'s childhood history or mental health issues. G.L. later learned that C.C. hosts camps for gender-confused kids ages 6-12 that include recommending medical transition treatments available at Children's Hospital.

G.L.'s search for an exploratory therapist resumed. G.L. contacted at least 20 potential providers who either hung up on her, declined because of fear violating California's "anti-conversion" therapy law,[50] or informed her that her "son would kill himself." She was surprised at the extreme coercive approach – affirm the transgender identity or risk suicide.

G.L. located two providers who were willing to "acknowledge the possibility of a social contagion." Both took a neutral approach – neither affirming or negating W.L.'s transgender identity. Because of their willingness to explore without affirming, W.L. is thriving having completed her second year of college, with her natural body intact and her mental health issues well-managed.

2. Rebecca Whitney, California

Rebecca's daughter, L. was in 6th grade when California public schools shut their doors because of Covid-19. L.'s school had introduced her to the "born in the wrong body concept" and "sex/gender is merely a construct" two years prior. L. spent most of

[50] Cal. Bus. & Prof. Code § 865.1.

lockdown "surfing" the internet with transgender themes.

L., along with one of her female friends, both adopted new identities. L. chose lesbian then moved to transgender. Rebecca was unaware of these new identities, but did notice alarming changes in L. L.'s moods sunk and she started cutting. She dyed her hair to an unnatural hue and replaced her clothes with oversized, masculine, mostly black garb, accented with metal-studded jewelry. L. also practically stopped communicating with Rebecca and moved in with her father. Later, Rebecca learned that L. was warned online that Rebecca would abandon her when Rebecca discovered L.'s transgender identity.

During this period, unbeknownst to Rebecca, L.'s father engaged a therapist for L. This therapist affirmed L.'s transgender identity. L.'s father terminated the therapist with Rebecca still not knowing L.'s had adopted a trans-identity. The second therapist also affirmed L.'s rejection of her immutable female self, but Rebecca learned about it. Rebecca did not reject her daughter. Rebecca did try to find a mental health provider who would not support L.'s self-rejection, but she found none in her "anti-conversion therapy" state.

Rebecca employed the "wait and see" method, while refusing to medicalize L. However, Rebecca lived in constant fear because L. had sent her parents a Christmas wish list asking for hormones and surgeries with a warning that there is a high suicide rate for refusal. Having to choose between raising a child with suicidal ideation with no professional help or engaging

a mental health provider who affirms her child's misplaced gender identity is not something Rebecca would wish on her worst enemy.

After years of being committed to her transgender identity, L. shed her transgender and lesbian identities completely.

3. Erin Friday, California

Erin's daughter, P., was just eleven when, following the sex-ed class at school, P. and her entire friend group each chose a new identity. P. shifted from pansexual to lesbian and finally landing on transgender when she was thirteen. Her friends' identities likewise morphed.

During lockdowns, P. had secretly spent hours on pornography-filled websites and in communication with trans-identified adults and older minors who advised P. that her mental anguish was because she was a "transboy." P. consumed a steady stream of transgender-themed videos, including those that counseled minors to reject non-affirming parents. P. ran away several times and offered her parents emancipation papers.

Erin engaged a therapist who assured her that she would explore the causality of P.'s out-of-the-blue proclamation. That therapist counseled Erin to affirm P.'s male identity, call her a male name, dress her as a boy, and even informed Erin that all of the memories of P. as a child were concocted by P. to comply with normative female behavior until P. was ready to reveal her authentic self, a boy. She also warned that Erin's failure to affirm P. would lead to P.'s suicide.

Erin searched for other mental health providers in California, and found none willing to address the co-morbid mental health issues instead of placing P. on the STMP conveyor belt.[51]

Erin turned to a non-California provider. At significant out-of-pocket costs, Erin was able to engage a psychiatrist and therapist willing to explore the root cause of P.'s distress with her body. P. stopped identifying as a boy. Free to engage in body-modification interventions now that she is an adult, P. has opted for her natural body, a body P. was so confident needed irreversible changes.

4. January Littlejohn,[52] Florida

January's daughter, A.G. suffers from ADHD. At the age of 13, the midst of her puberty, A.G. became very anxious during COVID-19 lock-downs. Online instruction was arduous for her. In 2020, a few of A.G.'s close friends announced that they were non-binary or transgender. A.G. then asked her parents to call her by a different name and said that she was a "they/them."

January reached out to A.G.'s homeroom teacher via email in the fall of 2020 and told her A.G. was suddenly experiencing distress over her sex, that

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[51] One psychiatrist did agree to treat P.'s depression and anxiety but would not address the gender issue. Erin believes that this was an indicator of a non-affirming provider but she did not understand at the time that California providers were terrified of revealing that they would not blindly follow the affirmative model.

[52] See *Littlejohn v. School Board of Leon County*, 132 F.4th 1232 (11th Cir. 2025) (petition for en banc rehearing pending).

they had elicited the help of a counselor, and were not using the name A.G. requested at home. Without parental consent, the school created a secret social transition plan for A.G. in which the school would treat A.G. as "nonbinary." A.G.'s mental health collapsed, as the school caused A.G. to distrust her own parents. January removed A.G. from public school and provided the appropriate therapy that addressed the underlying issues that led A.G. to reject her biology. Today, A.G. is a confident female with no identity issues.

5. Rob Viola, New York

Rob Viola has a daughter T. T. identified as transgender for three-plus years. T.'s struggles began in early grade school, as she had issues with emotional regulation and anger management, lacked social skills, and subsequently, was very isolated with few friends. T. was diagnosed with attention-deficit disorder and disruptive mood dysregulation disorder.

As instructed by the Child Mind Institute clinicians who had been treating T. prior to her gender confusion, Rob affirmed and supported T.'s LGBT exploration that arose concurrently with her online presence on Tumblr. The therapists instructed Rob that to prevent suicide, he needed to accept all of T.'s vacillating identities from male, lesbian and others. Despite embracing T.'s identities, she worsened.

T. was violent, engaged in cutting, and developed suicidal ideations with multiple trips to the psychiatric wards, in-patient hospitalizations, and a suicide attempt. After delving deep into the studies, T.'s parents decided to reverse course.

It was nearly impossible to find a non-affirming therapist because of the "anti-conversion" law in their state, but Rob eventually located one who addressed T.'s autism as the primary issue.[53] T. abandoned her transgender identity more than two years ago, has stabilized mentally, and has her natural body intact.

B. Detransitioners Who as Minors Were Only Affirmed in Their Trans-identities.

1. Luke Healy, California

Luke is a male who lived as a woman for half a decade, having been intermittingly treated with estrogen. Luke returned to his male identity and is in a heteronormative relationship.

Luke grew up in a loving family. Luke learned about transgenderism through on-line interactions. At around age 10, older men enticed him to cross-dress for them and later seduced him for meet-ups. This caused acute distress and shame. Luke started to hate his body. He was ridiculed by on-line predatory communities while simultaneously being lauded for his female impersonation behaviors. Luke's self-esteem disappeared and he turned to self-harm, cutting, and alcohol. Convinced by his groomers that he was really a girl, Luke informed his parents. Neither parent supported Luke's belief.

Luke's parents took him to Kaiser Permanente in 2013, the year California's "anti-conversion therapy" bill passed, for mental health help.

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[53] N.Y. Educ. §§ 6531-a, 5409-e.

The first therapist initially tried to unravel the situation of Luke's abrupt personality shift and identity adoption, but did not question his identity declaration. However, the psychiatrist and medical doctor not only affirmed the transgender identity but also separated Luke from his mother in the appointment, while informing him that he *needed* puberty blockers and hormones. They also coached him to tell his mother that he would commit suicide without them. Luke's mother was individually pressured to consent, but she was unflappable. Luke grew to resent his parents for forbidding the "life-saving" STMP, and at age 18, he left home.

Luke's struggles worsened as did his substance abuse. He joined what he describes as a "trans-commune" where his abuse continued. After a successful stay in a rehabilitation program and talk therapy that addressed his shame from his childhood abuse, Luke returned to comfort in his male body. Had he received appropriate mental health treatments for the childhood trauma, Luke believes that he would not have adopted a trans identity.

2. Ari, Washington

Ari is a gay man, who lived as a woman for more than a decade. Ari's childhood set the stage for his self-loathing. He was sexually assaulted from the age of 4 until 12, and witnessed abuse to his mother. Ari is waif-like, with delicate features and effeminate mannerisms. His homosexuality was fodder for school bullies. His acute shame for his childhood trauma and belief that he was too feminine to be a man or attract a man, combined with early independence from his

mother and unstable housing, opened him up to more abuse. He was thrown into the hands of additional predacious men. He tried to find solace at an LGB center where the older homosexual men preyed on him. There he received therapy that convinced him that he was really a woman. The therapist did not explore the abuse or his internalized homophobia.

He underwent a "back alley" orchiectomy paying cash to a surgeon who would perform the operation regardless of Ari's pre-existing condition that made the procedure extremely risky. Necrosis set in and he was in agony for months. Later, Ari had vaginoplasty (penis inverted to create a faux vagina) and facial feminization surgery. Throughout each step, he had mental health providers unquestionably supporting his "transition." When he brought up the sexual abuse, his therapist told him that these discussions were interfering with his journey as a transwoman.

Ari finally found a mental health provider who helped him realize that his past led him to his false persona. Ari stopped identifying as a woman, and embraced his even more effeminate appearance.

3. Chloe Brockman, California

Chloe is a 21-year-old female, who was failed by every mental health provider who treated her. Chloe, at age 12, wrote her parents a letter that she wanted to be treated as a boy. This request stemmed from exposure to transgender themes on social media. Chloe worried that her muscular, curveless body was not "feminine enough" for her to be a woman. Additionally, she gravitated to

stereotypically male activities and male friendships, perceiving women to be judgmental.

Her parents did as any parents would have done and they took her to a mental health provider. This psychologist, in the initial visit, affirmed that Chloe was a transgender boy with no hesitation or exploratory inquiries as to causality. Essentially "the 12-year-old child said she was transgender and so she is." This pattern of blind affirmation continued with every subsequent mental health provider she saw as she careened towards an irreversible medical pathway that forever altered her body. The mental health providers were either disinterested in Chloe's reports of anxiety and depression, or counseled that "transitioning" would resolve her mental health issues. The medical providers employed the now well-known coercive tactic to Chloe's hesitant parents claiming that Chloe was at increased risk for suicide if she did not transition. Therefore, Chloe's parent agreed to the recommended STMP.

By age 15, Chloe had her healthy breasts removed leaving her with chest numbness and disfigurement, she had been on puberty blockers and was regularly taking testosterone that changed her body frame and facial structure, deepened her voice, caused body and facial hair growth, and resulted in urinary tract issues. The interventions left permanent and irreversible changes and did not resolve her mental health issues. None of the interventions would or could turn Chloe into a boy. The treatments exacerbated her mental anguish to the point of suicidal ideation. Chloe detransitioned at age 17.

4. Kayla Lovdahl, California

Kayla suffered from an array of complex mental health symptoms from childhood. They included: depression, anxiety, panic attacks, mood fluctuations, suicidal ideation, self-harm, oppositional and defiant disorder, dysregulated eating – symptoms indicative of bipolar disorder, a possible disorder raised by her mother to Kayla's mental health and medical providers.

Kayla was isolated and turned to the internet for comfort, where at the age of 11, she was captivated by transgender influencers. Kayla soon announced that she was transgender. Kayla's parents, desperate to relieve her pain, sought gender medicines at Kaiser, believing that "transition" would be the cure for their long suffering child. The doctors did not disavow Kayla's parents of the incorrect assumption.

Kayla's psychologist affirmed and supported her transgender identity, as did her medical doctors, which led to puberty blockers, testosterone use and a double mastectomy shortly after her 13th birthday.

The therapists and doctors, despite having access and knowing Kayla's well-documented acute mental health issues, set aside their obligation to treat Kayla based upon science, as opposed to through the lens of an unwell child. Kayla, as she reached adulthood, detransitioned.

5. Soren Aldaco, Texas

Soren had a tumultuous childhood. Her biological father was not in her life,. She was teased and bullied at school and did not fit in with her peers. Her breasts developed early which added to the ridicule. Soren grew more self-conscious and did not like her body as she compared herself to other females on the internet. She was deeply depressed and anxious.

She toyed with the idea of adopting a transgender identity like some in her friend group and as she had seen on the internet, but she had not committed, and was coming to terms with the fact she was just a female who gravitated towards typical male interests and was "gender nonconforming."

By tenth grade her mental health issues were acute, and she experienced a psychiatric episode. This led to a three-day hospitalization where a psychiatrist repeatedly prompted Soren to talk about identity, against Soren's wishes.

The relentless prodding coerced her to state that she was transgender. The psychiatrist had what he needed to ignore the glaring comorbid mental health issues, and blame *all* of her mental health on being transgender. The vulnerable Soren glommed onto his words and began believing that she was a man trapped in a girl's body.

Soren was subsequently diagnosed with Major Depressive Disorder, ADHD, and autism, all which were missed or unexplored by the coercive psychiatrist. Armed with a simple explanation for her

suffering, Soren embraced her transgender identity, and at age 17 sought out and found testosterone. It was prescribed to her, on the first visit, by a nurse who attended transgender support groups for youth, recruiting patients from the other attendees. This provider did not receive consent from Soren's parents, nor was he interested in Soren's extant mental health issues.

Subsequent mental health providers also did not attempt to connect her mental health issues to her struggles with identity, strictly following the affirmation model. When Soren experienced side-effects from the hormone usage, they were treated without any suggestion that she halt testosterone. Since her mental health issues continued, Soren took the next step in the "gender journey", again believing that transition was the elixir. She easily received the required mental health letter for a double mastectomy. Then breastless, the promise of comfort in her body did not materialize. Soren realized her body was not the problem, but her internalized homophobia, comorbid mental issues, and society that affirms and celebrates people's self-loathing. Soren no longer identifies as trans.

6. Elle Palmer, Montana

Elle is a 25-year-old female. Puberty at eleven brought unwanted changes to her body and an onslaught of mental health issues: suicidal ideation, anxiety, obsessive compulsive behavior, agoraphobia, internet addiction, insomnia, anorexia, ADHD, and depression. These ailments led to a range of drugs including anti-psychotics. Elle was addicted to the

internet where she was preyed upon by older men asking for nudes and sending photographs of their penises to her.

She found transgenderism, and the "cure" for her problems. She was not a bisexual girl or an atypical female, but a man trapped in the wrong body. None of the bad feelings and interactions with men would have happened if she were a man. She followed the script presented to her by her older transgender "friends" on line and told her parents that she was trans. Within the year, at age 16, she went to Planned Parenthood where she received testosterone on demand.

Despite Elle's known mental health issues, not one of her many mental health providers tried to stop her hormone usage or slow down the process. Her therapist was more excited about her transgender interventions than Elle, and he pressured her to "call that surgeon to schedule that hysterectomy."

By age 18, Elle had chest hair, a beard, a receding hairline and a baritone voice. She did not recognize herself – she was neither man nor woman. She detransitioned, but her body is forever changed.

Elle was a child; her requests should not have been followed. Her mental health history was cast aside when she said those magic words: "I am trans".

* * *

Each of these detransitioners were failed by their mental health providers who blindly supported their identities, leaving them disfigured with more

mental distress. If mental health providers are required to "support" and not question or try to lead a child to become comfortable with their natural bodies, the number of children irreversibly harmed will continue to climb.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation in Rule 33.1(h) because it contains 6973/8000 words, excluding those parts of the brief exempted by Rule 33.1(h).

This brief also complies with the typeface requirements under Rule 33.1(b) because it has been prepared in proportional 12-point sans-serif Century Schoolbook font using Microsoft Word.

s/*Daniel J. Cragg*
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CERTIFICATE OF SERVICE

I certify that on June 13, 2025, I electronically filed the foregoing with the Clerk of Court for the United States Supreme Court using the CM/ECF system. I also certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

s/*Daniel J. Cragg*
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