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 THE AMERICAN PSYCHOLOGICAL ASSOCIATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, AND TWELVE OTHER MENTAL HEALTH AND MEDICAL PROFESSIONAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae the American Psychological Association,[2] American Psychiatric Association, the Colorado Psychiatric Society, the Colorado Child & Adolescent Psychiatric Society, the National Association Of Social Workers, the American Association For Marriage and Family Therapy, the American Counseling Association, the American Academy of Pediatrics, the American Academy of Pediatrics, Colorado Chapter, the American Medical Association, the Colorado Medical Society, the Colorado Psychological Association, Society for Adolescent Health and Medicine, and Society for Sexual, Affectional, Intersex, and Gender Expansive Identities submit this brief to provide the Court with information about the professional nature of therapy and the state of scientific knowledge about the safety and effects of sexual orientation and gender identity change efforts ("SOGICE").

Amici are leading scientific organizations whose members specialize in psychology, psychiatry, social work, marriage and family therapy, and counseling, and serve as frontline clinicians who treat youth at all stages of their development. *Amici* are deeply concerned about

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[1] Pursuant to Rule 37.6, counsel for *amici curiae* state that no counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief.

[2] The APA gratefully acknowledges the assistance of the following psychologists in the preparation of this brief: R. Abreu, Ph.D.; S. Budge, Ph.D.; M. Grey, Ph.D.; T. Hart, Ph.D.; and F. J. Sánchez, Ph.D.

the effects of SOGICE, especially on minors. *Amici* and their members have rejected the use of SOGICE as ineffective and potentially harmful. For example, from 2007 to 2009, an American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation conducted a systematic review of the peer-reviewed studies on sexual orientation change efforts ("SOCE"), which culminated in a comprehensive Report on the state of the scientific literature (the "2009 Report"). J.A. 131-398.[3] Given Petitioner's mischaracterizations of the American Psychological Association's key findings in its 2009 Report, and of SOGICE's potential harms, *amici* have a distinct interest in this case.

SUMMARY OF ARGUMENT

At the center of this case are (1) the science of therapeutic practice; and (2) the state of scientific evidence regarding SOGICE's safety and efficacy. *Amici* respectfully submit this brief to explain that the scientific, professional nature of therapy[4] justifies the state's regulation of professional conduct and to describe the scientific evidence of the harms that conversion efforts cause.

To begin, therapy consists of evidence-based treatments and not mere "conversations" as Petitioner suggests. Pet'r Br. 3. Strict licensure regimes under which professionals who provide therapy operate

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[3] Dr. Jack Drescher, a psychiatrist, served on the Task Force.

[4] As used in this brief, "therapy" refers specifically to psychotherapy, professional counseling, and mental or behavioral health treatments.

require that practitioners maintain not just baseline competence, but also knowledge of safe and effective treatments. Therapeutic practices produce measurable outcomes for patients' quality of life, psychological symptoms, and brain functioning.

SOGICE—efforts to alter a patient's sexual orientation, gender identity, or gender expression—do not meet the criteria of a legitimate therapeutic treatment. SOGICE are potentially harmful, discredited practices, and are not supported by credible scientific evidence.

Before issuing its 2009 Report, the American Psychological Association Task Force conducted a comprehensive multi-year survey of the scientific literature on SOCE. The 2009 Report reached two key conclusions. *First*, it found SOCE ineffective at changing sexual orientation. *Second*, the 2009 Report raised significant concerns that SOCE can pose a risk of harm to individuals who undergo them. *See* J.A. 141-42. In 2021, the American Psychological Association updated its findings to reflect the most recent research and issued the American Psychological Association Resolution on Sexual Orientation Change Efforts and the American Psychological Association Resolution on Gender Identity Change Efforts, which reaffirmed that SOGICE lack sufficient bases in scientific principles.[5]

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[5] American Psychological Ass'n, *Resolution on Sexual Orientation Change Efforts* (Feb. 2021) ("SOCE Resolution"), https://www.apa.org/about/policy/resolution-sexual-orientation-change-efforts.pdf; American Psychological Ass'n, *Resolution on Gender Identity Change Efforts* (Feb. 2021) ("GICE Resolution"),

Indeed, the most recent research supports the American Psychological Association's conclusions that SOGICE are not helpful therapeutic interventions but rather ineffective and potentially harmful practices that reinforce stigma.[6] These recent studies highlight that exposure to SOGICE is associated with a range of negative outcomes, including "loneliness, regular illicit drug use, suicidal ideation, and suicide attempt[s]" as well as "severe psychological distress."[7] Especially so for minors, for whom "conversion therapy increases the risk of attempting suicide . . . and running away" by a significant percentage.[8]

In asserting that the research shows no evidence of harm and supports SOGICE's efficacy, Petitioner mischaracterizes the 2009 Report's key findings and disregards more recent evidence that affirms its

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https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[6] *See* SOCE Resolution, *supra* note 5, at 4-5; GICE Resolution, *supra* note 5, at 2-4.

[7] Travis Salway et al., *Prevalence of Exposure to Sexual Orientation Change Efforts and Associated Sociodemographic Characteristics and Psychosocial Health Outcomes Among Canadian Sexual Minority Men*, 65 Can. J. Psychiatry 502, 502 (2020); Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA Psychiatry 68, 69 (2020).

[8] Travis Campbell & Yana van der Meulen Rodgers, *Conversion Therapy, Suicidality, and Running Away: An Analysis of Transgender Youth in the U.S.*, 89 J. Health Econ. 102750, at 2 (2023).

conclusions. *Amici* urge this Court to reject Petitioner's mischaracterizations of the scientific evidence and affirm the decision below.

ARGUMENT

I. Therapy is Evidence-Based Mental Health Treatment.

To portray therapy as something other than mental health treatment, Petitioner repeatedly characterizes sexual orientation and gender identity change efforts ("SOGICE") as "speech-only," "talk therapy," "conversations," and the like. Pet'r Br. 3, 12, 21, 32, 45. But the fact that therapy is delivered verbally (an approach common to many evidence-based techniques) does not alter its status as a regulated form of professional mental health care. That is clear from the extensive licensure and other requirements under which licensed mental health professionals ("LMHPs") practice, as well as the evidence that therapy produces measurable psychological and physical benefits for patients.

A. Therapy is Practiced by Highly Trained, Licensed Professionals According to Rigorous Standards of Care.

Therapy is distinct from speech in that it is a mental health practice conducted by professionals subject to regimented training, licensure, and standard of care requirements.[9]

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[9] *Amici* acknowledge that some practitioners hold sincere religious beliefs about gender identity and sexual orientation. The standards at issue in this case do not regulate individuals' private religious

LMHPs who provide therapy—including psychologists, psychiatrists,[10] licensed clinical social workers, and professional counselors—must obtain a state license, which entails significant training requirements set by state licensure boards.[11] In Petitioner's state of Colorado, for example, a licensed psychologist must earn a doctoral degree in psychology—typically five to seven years of schooling—from a program accredited by the American Psychological Association or an equivalent approved by the state licensure board. Colo. Rev. Stat. § 12-245-304. Colorado psychologists must also complete a minimum of 1,500 hours of postdoctoral clinical practice experience under the supervision of a licensed psychologist or psychiatrist and pass two licensure exams. 3 Colo. Code Regs. § 721-1.14.

Likewise, licensed Colorado psychiatrists must earn a medical degree, complete four years of psychiatry

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beliefs, but instead establish professional obligations to provide evidence-based care and avoid practices known or believed to cause harm within licensed practice.

[10] American Psychiatric Ass'n, *Resource Document on Psychotherapy as an Essential Skill of Psychiatrists* (July 2014), https://www.psychiatry.org/getattachment/753c5589-3658-4572-88cc-3ce4b6341f61/Resource-2014-Psychotherapy-Essential.pdf.

[11] *See e.g.*, American Psychological Ass'n, *State Licensure and Certification Information for Psychologists*, https://www.apaservices.org/practice/ce/state/state-info (last updated Apr. 2022).

residency training, and obtain passing scores on licensure exams. Colo. Rev. Stat. § 12-240-110.[12]

Licensed professional counselors in Colorado, for their part, must complete a master's degree in professional counseling from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs ("CACREP") or a state-approved equivalent. 4 Colo. Code Regs. § 737-1:1.14. Colorado further requires at least 2,000 hours of practice experience supervised by a licensed practitioner as well as passing two licensure exams. *Id.*

Licensed clinical social workers in Colorado must hold a master's degree in social work from a program accredited by the Council on Social Work Education or a state-approved equivalent. Colo. Rev. Stat. § 12-245-403(1). Colorado also requires at least two years of post-degree supervised clinical practice as well as passing the Association of Social Work Boards clinical exam. Colo. Rev. Stat. § 12-245-404(2)(c), (d).

Finally, licensed marriage and family therapists in Colorado must obtain a master's or doctoral degree from an accredited program in marriage and family therapy, or state-approved equivalent. Colo. Rev. Stat. § 12-245-504(1). Under Colorado law, they must also complete two years of post-master's practice or one year of post-

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[12]*See* Accreditation Council for Graduate Medical Education, *Program Requirements for Graduate Medical Education in Psychiatry* (2025), https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/400_psychiatry_2025_reformatted.pdf ("ACGME Requirements").

doctoral practice. Marriage and family therapists must also pass a state-approved clinical exam and a jurisprudence exam. *Id.* In short, no matter a therapy provider's title, strict licensure regimes apply.

Licensure requirements are not—as Petitioner suggests—merely competence requirements divorced from instruction on safe and effective therapeutic interventions. *See* Pet'r Br. 9-10. Such instruction is integral to any accredited institution's required curricula. Because "science is at the core" of psychology, the American Psychological Association accredits only those programs that "demonstrate that they rely on *the current evidence-base* when training students," and that their students "demonstrate a fundamental understanding of and competency in . . . *evidence-based professional practice*."[13] Likewise, under Accreditation Council for Graduate Medical Education guidelines, psychiatry residents "must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health," including "managing and treating patients using . . . psychotherapies."[14] Similarly, CACREP requires that "*evidence-based* counseling strategies"—defined as "[t]he use and application of the best available current research to inform decision-making and practice"—must

[13] American Psychological Ass'n, *Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures*, at 9-10 (2015), https://www.apa.org/ed/accreditation/standards-of-accreditation.pdf (emphases added).

[14] ACGME Requirements, *supra* note 12, at 22.

be a component of its "foundational counseling curriculum."[15] Licensure and accreditation standards are designed to ensure that LMHPs begin practice with a clear understanding of what is, and what is *not*, an evidence-backed therapeutic method.

This is an ongoing commitment. *See* Colo. Rev. Stat. §§ 12-240-130.5, 12-245-307, 12-245-606, 12-245-506. For instance, Colorado state licensure boards require at least 30-40 hours of board-approved continuing education every two years to renew licenses to practice as a psychologist or psychiatrist. Colo. Rev. Stat. §§ 12-240-130.5, 12-245-307. For licensees to receive credit under many licensing regimes, continuing education programs must be accredited by organizations like the American Psychological Association and the Accreditation Council for Continuing Medical Education, which use evidence-based standards. Colo. Rev. Stat. §§ 12-240-130.5, 12-245-307.[16] American

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[15] Council for Accreditation of Counseling and Related Educational Programs, *2024 CACREP Standards*, at 14, 33 (2024), https://www.cacrep.org/wp-content/uploads/2024/04/2024-Standards-Combined-Version-4.11.2024.pdf.

[16] American Psychological Ass'n, *Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists* at 2-7 (Aug. 2015), https://www.apa.org/about/policy/approval-standards.pdf (American Psychological Association- approved continuing education programs "must be grounded in an evidence-based approach" and enable LMHPs "to keep pace with the most current scientific evidence"); *see also* Accreditation Council for Continuing Medical Educ., *The ACCME Accreditation Requirements* at 11 (2021), https://accme.org/wp-content/uploads/2018/04/626_20211221_accreditation_requirements.pdf (continuing

Psychological Association-approved continuing education programs are intended to promote "consumer protection," including discouraging harmful or discredited treatments.[17]

Extensive and ongoing licensure requirements, which include education on which treatments are evidence-based, set the practice of therapy apart from mere "speech."

B. Therapy Produces Measurable Benefits for Patients.

Valid, evidence-based therapeutic techniques are also shown to—unlike mere "conversations"—have measurable impact on patients' global quality of life, overall psychological functioning, and physical health.[18]

For example, in Cognitive Behavioral Therapy ("CBT"), a therapist helps a patient identify "negative automatic thoughts," with the goal of

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education content must "support[] safe, effective patient care" and "be based on current science, evidence, and clinical reasoning").

[17] American Psychological Ass'n, *Quality Professional Development and Continuing Education Resolution*, https://www.apa.org/about/policy/improving-quality/ (last updated Feb. 2025).

[18] *See* K. Kamenov et al., *The Efficacy of Psychotherapy, Pharmacotherapy and Their Combination on Functioning and Quality of Life in Depression: A Meta-Analysis*, 47 Psych. Med. 414, 418 (2017); Spyros Kolovos et al., *Effect of Psychotherapy for Depression on Quality of Life: Meta-Analysis*, 209 Brit. J. Psychiatry 460, 465 (2016).

"modification of [those] automatic thoughts."[19] Research shows that CBT produces significant benefits when administered to patients with a range of psychological disorders, including post-traumatic stress disorder, depression, and various anxiety disorders.[20] CBT has even been shown to reduce clinical pain in fibromyalgia patients.[21] Studies have found that CBT's effects can continue for *years* after treatment ends.[22] Another example is Psychodynamic Therapy, which has been found to improve panic-related symptoms in patients with panic disorder.[23] In fact, psychotherapies have

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[19] Benjamas Prukkanone et al., *Cost-Effectiveness Analysis for Antidepressants and Cognitive Behavioural Therapy for Major Depression in Thailand*, 15 Value Health S3, S4 (2012).

[20] Eva A. M. van Dis et al., *Long-Term Outcomes of Cognitive Behavioral Therapy for Anxiety-Related Disorders: A Systematic Review and Meta-Analysis*, 77 JAMA Psychiatry 265, 270 (2020) ("CBT was associated with moderate symptom reductions up to 12 months after treatment. Longer effects were still significant for GAD, SAD, and PTSD[.]"); Ruth von Brachel et al., *Long-Term Effectiveness of Cognitive Behavioral Therapy in Routine Outpatient Care: A 5-to 20-Year Follow-Up Study*, 88 Psychotherapy & Psychosomatics 225, 225 (2019) ("The results point to the long-term effectiveness of CBT under routine conditions for a wide array of problems[.]").

[21] Asimina Lazaridou et al., *Effects of Cognitive-Behavioral Therapy (CBT) on Brain Connectivity Supporting Catastrophizing in Fibromyalgia*, 33 Clinical J. Pain 215 (2017).

[22] Von Brachel, *supra* note 20, at 232.

[23] Manfred E. Beutel et al., *Changes of Brain Activation Pre- Post Short-Term Psychodynamic Inpatient Psychotherapy: An fRMI Study of Panic Disorder Patients*, 184 Psychiatry Rsch.: Neuroimaging 96, 101 (2010) (finding "moderate to large effect sizes").

been shown to yield effects comparable to, and in some cases greater than, pharmacological treatments—particularly in improving quality of life.[24]

Research has further shown that therapy affects the very functioning of a patient's brain. Observed brain function changes include normalized connectivity between certain parts of the brain[25] and normalized activation patterns within certain parts of the brain associated with psychological distress.[26] Again, these

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[24] Kamenov, *supra* note 18, at 418 (meta-analysis found that psychotherapy was more effective than pharmacotherapy in reducing depression symptoms).

[25] L. Mason et al., *Brain Connectivity Changes Occurring Following Cognitive Behavioural Therapy for Psychosis Predict Long-Term Recovery*, 7 Translational Psychiatry e1001, at 1 (2017) (CBT for psychosis affected connectivity between the dorsolateral prefrontal cortex and amygdala); Lazaridou, *supra* note 21 (finding association between CBT and altered connectivity between S1 and anterior/medial insula).

[26] Beutel, *supra* note 23, at 96 (Psychodynamic Therapy found to normalize fronto-limbic activation patterns in patients with panic disorder); Anna Buchheim et al., *Changes in Prefrontal-Limbic Function in Major Depression After 15 Months of Long-Term Psychotherapy*, 7 *PloS One* e33745, at 1 (2012) (Psychodynamic Therapy found to reduce activation in medial prefrontal cortex in patients with major depressive disorder, which was associated with improvement in depression symptoms); *see also* Alessio Barsaglini et al., *The Effects of Psychotherapy on Brain Function: A Systematic and Critical Review*, 114 Progress Neurobiology 1, 3 (2014) (finding that psychotherapy can normalize brain function in OCD patients by reducing orbitofrontal cortex and caudate nucleus metabolism).

neurobiological changes can be comparable to those that pharmacological treatments produce.[27]

In short, therapy is conducted by highly trained professionals because—no matter its mode of delivery—therapy is not merely engaging in conversations; it is mental health treatment designed to improve patients' psychological functioning. As discussed *infra*, SOGICE does not qualify as legitimate therapy under this rubric.

II. SOGICE Are Illegitimate, Ineffective, and Can Cause Harm, Especially to Minors.

A. SOGICE Are Illegitimate, as *Amici* Have Recognized.

SOGICE are not legitimate therapeutic practices because they do not target any underlying mental illness or disorder.

Sexual Orientation Change Efforts ("SOCE") developed in the mid-nineteenth century to cure homosexual desires, which were then viewed as a mental illness. J.A. 191-92. Like SOCE, Gender Identity Change Efforts ("GICE") arose from a belief that nonconforming gender identity or expression is pathological.[28] Over the decades, overwhelming evidence has demonstrated that these were faulty premises and that variances in human sexuality, gender identity, and gender expression are normal and not mental health disorders. By 1973, the American Psychiatric Association removed homosexuality from

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[27] *See* Barsaglini, *supra* note 26, at 3.

[28] *See* GICE Resolution, *supra* note 5, at 1-2.

the *Diagnostic and Statistical Manual of Mental Disorders II* ("DSM-II"), and in 1975, the American Psychological Association adopted a policy reflecting the same conclusion. J.A. 161-62.

Over the next several decades, professional medical and mental health organizations increasingly adopted the view that homosexuality is "a normal variant of human sexuality." J.A. 165 (footnote omitted). In 1990, the World Health Organization removed the diagnosis of homosexuality from the 10th edition of the International Classification of Disease ("ICD-10").[29] Similarly, health organizations today recognize that an "incongruence between sex and gender in and of itself is not a mental disorder,"[30] and that "gender diversity is present throughout the lifespan and has been present throughout history."[31] By 2000, mental health organizations—including the American Counseling Association, the American Psychiatric Association, and the American Psychoanalytic Association—adopted

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[29] Geoffrey M. Reed et al., *Disorders Related to Sexuality and Gender Identity in the ICD-11: Revising the ICD-10 Classification Based on Current Scientific Evidence, Best Clinical Practices, and Human Rights Considerations*, 15 World Psychiatry 205, 216 (2016).

[30] GICE Resolution, *supra* note 5, at 1.

[31] American Psychological Ass'n, *Policy Statement on Affirming Evidence-Based Inclusive Care* at 1 (Feb. 2024), https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.pdf.

resolutions opposing SOGICE because "such efforts were ineffective and potentially harmful." J.A. 164.[32]

Building on these early findings, the American Psychological Association Task Force spent two years conducting an extensive systematic review of the literature on SOGICE's safety and efficacy and published a 130-page Report in 2009.[33] A systematic

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[32] *See, e.g.*, Am. Counseling Ass'n, *Resolution on Reparative Therapy/Conversion Therapy/Sexual Orientation Change Efforts (SOCE) as a Significant and Serious Violation of the ACA Code of Ethics* (Dec. 19, 2017), https://www.counseling.org/docs/default-source/resolutions/reparative-therapy-resoltution-letter--final.pdf?sfvrsn=d7ad512c_4. Likewise, the National Association of Social Workers ("NASW"), American Association for Marriage and Family Therapy ("AAMFT"), the American Medical Association, and the American Academy of Child & Adolescent Psychiatry adopted such positions. *See* NASW, *Sexual Orientation Change Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender Persons* (May 2015), https://www.utah.gov/pmn/files/517781.pdf; Am. Med. Ass'n, *Advocating for the LGBTQ Community*, https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community (last visited Aug. 18, 2025); AAMFT, *Position Statement on Nonpathologizing Sexual Orientation* (approved Sept. 2004), https://www.aamft.org/AAMFT/About_AAMFT/Position_Statements.aspx#anchor5; Am. Acad. of Child & Adolescent Psychiatry, *Conversion Therapy* (approved Feb. 2018), https://www.aacap.org/aacap/Policy_Statements/2018/Conversion_Therapy.aspx.

[33] This review considered only peer-reviewed empirical research on treatment outcomes from 1960 to 2009. For this brief, the American Psychological Association has made a good-faith effort to review the findings of all valid, empirical studies published on SOGICE since the 2009 Report. Significant studies, discussed in detail *infra*, have corroborated the 2009 Report's findings with reliable data. The 2009 Report also conducted narrative reviews of the larger body of studies on SOCE. These studies are useful in understanding the

review is the use of "scientific methods to identify, select, assess, and summarize the findings of similar but separate studies."[34] The Report reviewed "aversive" techniques to change sexual orientation—which have historically included inducing nausea and paralysis; electric shock therapy; shame-aversion therapy; and "systematic desensitization,"—as well as "non[-]aversive" approaches like assertiveness and dating trainings, "affection training with physical and social reinforcement," and hypnosis. J.A. 195. The Report concluded that both SOCE variants were ineffective and associated with harm and thus recommended ending their use. J.A. 141-42, 151.

In 2021, the American Psychological Association reviewed the research on SOCE published since the 2009 Report and passed two new resolutions reaffirming and strengthening its opposition to SOGICE as ineffective and harmful, *especially* when used on minors.[35] Accordingly, the American Psychological Association opposes training psychologists in SOGICE

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experiences of those who have experienced SOCE, but they are not valid bases for conclusions regarding whether SOCE can change sexual orientation. The results of such studies will be reported in this brief when they are pertinent to other important questions.

[34] Inst. of Med., *Finding What Works in Health Care: Standards for Systematic Reviews* 1 (Jill Eden et al. eds., 2011). Petitioner incorrectly characterizes the product of this rigorous technique as "pronouncements of [a] professional association[]." Pet'r Br. 47.

[35] SOCE Resolution, *supra* note 5, at 1-2; GICE Resolution, *supra* note 5, at 1-2.

or otherwise teaching SOGICE as part of an education in psychology.[36]

In light of this evidence, the American Psychological Association and other health organizations have established practice guidelines, informed by empirical research and professional consensus, that encourage clinicians to use gender-affirming practices—called affirmative therapy—when addressing gender identity issues, rather than GICE.[37] The same is true of SOCE: "mainstream mental health professional associations [currently] support affirmative approaches that focus on helping sexual minorities cope with the impact of minority stress and stigma," rather than SOCE. J.A. 202. Affirmative therapy "addresses the influence of social inequities on the lives of LGBQ clients; fosters autonomy, enhances resilience, coping, and community building, [and] advocates to reduce systemic barriers to mental, physical, relational, and sexual flourishing."[38] Importantly, affirmative therapy—unlike SOGICE—does not aim to change an individual's identity.

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[36] SOCE Resolution, *supra* note 5, at 8; GICE Resolution, *supra* note 5, at 1-4.

[37] *See* GICE Resolution, *supra* note 5, at 2-3; American Psychological Ass'n, *Guidelines for Psychological Practice with Sexual Minority Persons* 13 (Feb. 2021), https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf ("American Psychological Association Guidelines").

[38] Tiffany O'Shaughnessy & Zachary Speir, *The State of LGBQ Affirmative Therapy Clinical Research: A Mixed-Methods Systematic Synthesis*, 5 Psych. Sexual Orientation & Gender Diversity 82, 83 (2018).

Today, mental health organizations and practitioners widely agree that any therapeutic practice that actively seeks to change one's gender identity or sexual orientation is not clinically appropriate and raises serious ethical concerns.[39] For instance, one publication has recently taken steps to identify historical studies requiring "prominent advisory information" that "the SOGICE practices tested or described in these papers are inconsistent with modern standards."[40] Although being a person of diverse sexual orientation and/or gender identity may leave an individual more vulnerable to stigma and discrimination,[41] it is not a mental disorder, and any attempts to "treat" normal variations in human sexuality and gender identity are flawed and amount to unethical conduct.[42] Moreover, as demonstrated below, these practices are ineffective,

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[39] *See* United States Joint Statement Against Conversion Efforts (Aug. 23, 2023) https://usjs.org/wp-content/uploads/2023/10/USJS-Final-Version.pdf (featuring 28 major U.S. medical and psychological professional association signatories).

[40] Jonathan S. Comer et al., *Reckoning With Our Past and Righting Our Future: Report From the Behavior Therapy Task Force on Sexual Orientation and Gender Identity/Expression Change Efforts (SOGIECEs)*, 55 Behav. Therapy 649, 650 (2024).

[41] *See generally American Psychological Association Handbook of Sexuality and Psychology* (Deborah L. Tolman & Lisa M. Diamond eds., 2013).

[42] *See* SAMHSA, *Moving Beyond Change Efforts: Evidence and Action to Support and Affirm LGBTQI+ Youth*, 11 (2023); Melissa Grey et al., *Review of U.S. Public Policy, Legislative, and Judicial Work on Conversion Efforts, in The Case Against Conversion "Therapy": Evidence, Ethics, and Alternatives* 195 (Douglas C. Haldeman ed., 2022).

potentially harmful, unethical, and the overwhelming scientific consensus has rejected them.

B. Studies Show that SOGICE Are Ineffective.

SOGICE are ineffective. That is the conclusion of leading professional and scientific organizations based on decades of research. The 2009 Report found that "enduring change to an individual's sexual orientation is uncommon and that a very small minority of people in the [early SOCE] studies showed any credible evidence of reduced same-sex sexual attraction[.] . . . Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life." J.A. 255. The American Psychological Association and social scientists have similarly found no scientifically valid empirical evidence that GICE are effective or safe practices for changing gender identity.[43]

The 2009 Report acknowledged that some individuals reported that they had benefitted from SOCE, as Petitioner notes. Pet'r Br. 14. But those responses did not suggest that the individuals' sexual orientation or same-sex attraction had changed, only that they had benefitted from aspects of the treatment not unique to SOCE, like the solidarity offered by mutual support groups. J.A. 143-44. The Report

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[43] *See* GICE Resolution, *supra* note 5, at 2-3; *see also* American Psychiatric Ass'n, *Position Statement on Conversion Therapy and LGBTQ+ Patients* (2024), https://www.psychiatry.org/getattachment/3d23f2f4-1497-4537-b4de-fe32fe8761bf/Position-Conversion-Therapy.pdf ("[L]eading professional health care bodies have concluded that conversion therapies lack efficacy and may carry significant risks of harm.").

indicated that such benefits "can be provided within an affirmative and multiculturally competent framework, which can mitigate the harmful aspects of SOCE." J.A. 144. In other words, the Report discussed no evidence of benefits derived specifically *from SOCE*, much less evidence of efficacy.[44]

The "multiple clinical studies" that Petitioner newly claims on appeal "reported successful change . . . and strong net psychological benefit" from SOGICE do not call the 2009 Report's conclusions into question. Pet'r Br. 15.[45] To start, several lack validity. The author of one such paper Petitioner relies on later wrote that he "judged the major critiques of the study as largely correct," and retracted his support for its findings.[46] Another relied in large part on that study's now-retracted data-measurement techniques, utilized a nonrepresentative self-selected sample, and stated outright that the study's "purpose . . . was not to . . . establish the efficacy" of SOCE and that its "implications speak more to reported changes in sexual feelings and behavior than it does to actual changes in

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[44] American Psychological Association Guidelines, *supra* note 37, at 13 ("Any reported benefits noted in the literature (e.g., finding community) are not universal, and are also achieved with other safe and scientifically-based approaches that do not attempt sexual orientation change." (internal citations omitted)).

[45] Citing Decl. of D. Paul Sullins ¶¶ 99–112, *Bury v. City of Kansas City*, No. 4:25-cv-00084 (W.D. Mo. Apr. 14, 2025), ECF No. 31-2.

[46] Robert L. Spitzer, *Spitzer Reassesses His 2003 Study of Reparative Therapy of Homosexuality*, 41 Archives Sexual Behav. 757 (2012).

sexual orientation, per se."[47] Yet another suffers from serious methodological flaws, including that it had a high attrition rate; lacked a baseline measure representing a state of being untreated; had inconsistent assessment intervals; had significant variations among participants in terms of the length of exposure to treatment, the nature of treatment, and the amount of time between a person's initial and subsequent assessments; and failed to explain significant gaps in data regarding participants.[48]

Other studies on which Petitioner relies as showing "strong net psychological benefit" find, at most, minimal reports of ancillary psychological benefits (alongside harm), which, as the 2009 Report addressed, often stemmed from aspects of treatment not specific to SOGICE, J.A. 144, or else derived from accepting one's identity because SOGICE had proven ineffective.[49]

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[47] Elan Y. Karten & Jay C. Wade, *Sexual Orientation Change Efforts in Men: A Client Perspective*, 18 J. Men's Stud. 84, 86, 89-90, 99 (2010).

[48] *See* Stanton L. Jones & Mark A. Yarhouse, *A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change*, 37 J. Sex & Marital Therapy 404 (2011).

[49] *See* Ariel Shidlo & Michael Schroeder, *Changing Sexual Orientation: A Consumers' Report*, 33 Pro. Psych.: Rsch. & Prac. 249, 249 (2002) ("A minority [of participants] reported feeling helped, although not necessarily with their original goal of changing sexual orientation."); *id.* at 256 (participants' reported psychological benefits included "relief from just talking"; "general psychological insight"; "coping strategies"; and for some, "a sense of relief from the pressure to change" because SOGICE "demonstrated to them that change was not possible"); John P. Dehlin et al., *Sexual Orientation Change Efforts Among Current or Former LDS*

Indeed, since the 2009 Report, social scientists have deemed many of the existing studies that have ostensibly shown benefits from SOCE to be methodologically and statistically flawed. A 2021 paper by reviewers at Case Western University found that dozens of research studies deeming SOCE effective suffered from "biased recruitment, retrospective study designs, lack of generalizability, reliance on samples of bisexual individuals rather than those who are predominantly homosexual, and the use of sexual or social behavior (*e.g.*, engaging in sex with or marrying an individual of a different gender) as the outcome instead of sexual orientation."[50]

Church Members, 62 J. Counseling Psych. 95, 95 (2015) ("While some beneficial SOCE outcomes (such as acceptance of same-sex attractions and reduction in depression and anxiety) were reported, the overall results support the conclusion that sexual orientation is highly resistant to explicit attempts at change and that SOCE are overwhelmingly reported to be either ineffective or damaging by participants."); Kate 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, 391, 406 (2015) (reporting that "less than 4% [of participants] reported any modification of core same-sex erotic attraction" and noting that "individuals who reported decreased levels of depression and anxiety and improved feelings of self-worth" were often those who had "accepted same-sex attraction").

[50] Amy Przeworski et al., *A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts*, 28 Clinical Psychol.: Sci. & Prac. 81, 83, 92-93 (2020); American Psychological Association Guidelines, *supra* note 37, at 13 ("[T]hose who report success from SOCE tend to describe changes to how or whether they act on their sexual attractions, instead of changes to their sexual minority orientation.").

Nor does the Department of Health and Human Service's ("HHS") recently published report undermine the conclusion that SOGICE are ineffective. Petitioner claims that the report's approval of therapy for conditions that commonly co-occur with gender dysphoria evinces likely efficacy of SOGICE for gender dysphoria itself. Pet'r Br. 13. But nothing in the HHS Report or the studies it cites suggests that SOGICE are proven to "resolve" gender dysphoria by aligning individuals' gender identity with their sex assigned at birth. The two reviews HHS deems valid on this issue either find that SOGICE is harmful or do not address SOGICE at all.[51] One review found that SOGICE was associated with higher suicidality and produced no benefits.[52] The other review examined the efficacy of *non*-SOGICE therapeutic approaches, including ones

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As an example, one paper released after the 2009 Report was published purports to show SOCE led to shifts in sexual orientation with no harmful side effects. *See* Paul L. Santero et al., *Effects of Therapy on Religious Men Who Have Unwanted Same-Sex Attraction*, Linacre Q., July 2018, at 1. But that study was retracted by the publishing journal due to statistical flaws. *See Retraction Notice*, 87 Linacre Q. 108 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7016425/pdf/10.1177_0024363919854842.pdf.

[51] *See* Dep't Health & Hum. Servs., *Treatment for Pediatric Gender Dysphoria*: *Review of Evidence and Best Practices* 88 n.36, 252 & n.78 (May 1, 2025), https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf ("HHS Report").

[52] *See* Alex R. Dopp et al., *Interventions for Gender Dysphoria and Related Health Problems in Transgender and Gender-Expansive Youth: A Systematic Review of Benefits and Risks to Inform Practice, Policy, and Research*, RAND, at 30 (2024), https://www.rand.org/pubs/research_reports/RRA3223-1.html.

with a stated aim of "prepar[ing] [patients] for gender transitions."[53]

Relatedly, Petitioner's assertion that SOGICE save patients from the harms of gender affirming medical care—even assuming such harms exist—is a red herring. *See* Pet'r Br. 16-17. Petitioner sets up a false choice between SOGICE and medical intervention that leaves out LGBTQ-affirmative therapy, described *supra* at 16, for which there is a "growing evidence base."[54]

Finally, Petitioner wrongly suggests that the range of sexual orientations and gender identities—as well as possible naturally occurring identity shifts over time—show that SOGICE can be effective. *See* Pet'r Br. 6-8. That contention lacks scientific basis. Natural identity shifts are simply not the same as shifts purportedly produced by SOGICE.[55] As the American Psychological

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[53] Claire Heathcote et al., *Psychosocial Support Interventions for Children and Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review*, 109 Archive Disease in Childhood S19, S25-S27 (2024).

[54] American Psychological Association Guidelines, *supra* note 37, at 14; Julian Burger & John E. Pachankis, *State of the Science: LGBTQ-Affirmative Psychotherapy*, 55 Behav. Therapy 1318, 1322-23 (2024) (describing studies of LGBTQ-affirmative CBT finding "improvements across outcomes, including depression, anxiety, and substance use"); Shelley L. Craig et al., *Efficacy of Affirmative Cognitive Behavioural Group Therapy for Sexual and Gender Minority Adolescents and Young Adults in Community Settings in Ontario, Canada*, 9 BMC Psych. 1, 11 (2021) (similar study "reported significantly reduced depression and threat appraisals and improved coping and hope" for LGBTQ participants).

[55] The only study Petitioner cites for the notion that "counselling" helps those with gender dysphoria ultimately "live consistent with

Association's 2021 SOCE Resolution put it, "Rather than willful shifts in sexual orientation, fluidity describes changes in awareness, attractions, behaviors, and identities that unfold over time. However, that sexual orientation can evolve and change for some does not mean that it can be altered through intervention or that it is advisable to try."[56]

C. Studies Show that SOGICE Can Cause Harm.

In addition to lacking legitimate clinical aims and evidence of efficacy, SOGICE pose serious risks to patients. As the 2009 Report explained, there is "evidence to indicate that individuals experienced harm from SOCE." J.A. 142. With respect to aversive SOCE therapies, studies show "negative side effects include[] loss of sexual feeling, depression, suicidality, and anxiety." J.A. 370. Even for "non[-]aversive" SOCE, research reports published at the time of the Report "indicate[d] that there are individuals who perceive [that] they have been harmed." J.A. 142. The evidence of harm available today is even more conclusive.

Based on its exhaustive review of the SOCE literature, the 2009 Task Force ultimately concluded that the best available evidence suggested "attempts to

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their sex," Pet'r Br. 6-7, did not address that at all, as it was "beyond the scope of [the] article" to even "describe" the "quite variable" treatments received by the study participants, much less trace identity changes to particular treatments. Devita Singh et al., *A Follow-Up Study of Boys with Gender Identity Disorder*, 12 Frontiers in Psychiatry 632784, at 13-14 (2021).

[56] SOCE Resolution, *supra* note 5, at 3 (internal citation omitted).

change sexual orientation may cause or exacerbate distress and poor mental health in some individuals, including depression and suicidal thoughts." J.A. 255. The 2009 Task Force also described in detail "studies that report perceptions of harm," noting those studies "represent[] a serious concern." *Id.*

The 2009 Report also noted that studies "document that there are people who perceive that they have been harmed through SOCE." J.A. 253. In those studies, "the reported negative social and emotional consequences include[d] self-reports of anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation, self-hatred, and sexual dysfunction." J.A. 253-54.[57] Participants in these studies also described "decreased self-esteem and authenticity to others"; "increased self-hatred"; "an increase in substance abuse and high-risk sexual behaviors"; and a variety of harms to their

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[57] *See* A. Lee Beckstead & Susan L. Morrow, *Mormon Clients' Experiences of Conversion Therapy: The Need for a New Treatment Approach*, 32 Counseling Psych. 651 (2004); Glenn Smith et al., *Treatments of Homosexuality in Britain Since the 1950s—An Oral History: The Experiences of Patients*, 328 Brit. Med. J. 427 (2004); Shidlo & Schroeder, supra note 49; Michael Schroeder & Ariel Shidlo, *Ethical Issues in Sexual Orientation Conversion Therapies: An Empirical Study of Consumers*, 5 J. Gay & Lesbian Psychotherapy 131 (2001); Joseph Nicolosi et al., *Retrospective Self-Reports of Changes in Homosexual Orientation: A Consumer Survey of Conversion Therapy Clients*, 86 Psych. Rep. 1071 (2000); Kim W. Schaeffer et al., *Religiously-Motivated Sexual Orientation Change*, 19 J. Psych. & Christianity 61 (2000).

relationships, including hostility towards their parents and the loss of friends and potential romantic partners. J.A. 276-77.

More recent research confirms the Report's findings. For instance, one 2020 study documented the harms of SOCE, concluding from a survey of over 8,000 sexual minority men in Canada that "[e]xposure to SOCE was positively associated with loneliness, regular illicit drug use, suicidal ideation, and suicide attempt."[58] Other recent studies have likewise found that experiencing SOCE was "independently associated with suicidal ideation, suicide planning, and suicide attempts," even adjusting for adverse child experiences,[59] and have noted that such SOCE-related harms "may compound" experiences of "stigma, heterosexism, violence, and discrimination."[60]

Research shows that GICE likewise lead to adverse outcomes such as emotional distress, loss of relationships, and low self-worth. In a study of 27,715 transgender adults in America, the authors found GICE were "significantly associated with increased odds of severe psychological distress during the previous month and lifetime suicide attempts compared with transgender adults who had discussed gender identity

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[58] Salway, supra note 7, at 502.

[59] John R. Blosnich et al., *Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016-2018*, 110 Am. J. Pub. Health 1024, 1027 (2020).

[60] Przeworski, *supra* note 50, at 95.

with a professional but who were not exposed to [GICE]."[61] Another study from 2015 reported that individuals who had experienced GICE in the past were "[f]ar more likely to currently be experiencing serious psychological distress" than transgender individuals who did not experience GICE.[62]

In addition to *direct* harms, SOGICE also have the potential to cause *indirect* harms like loss of time, energy, and money. *See* J.A. 325.[63] Moreover, some

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[61] Turban, *supra* note 7, at 69; *see also* Amy E. Green et al., *Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018*, 110 Am. J. Pub. Health 1221, 1224 (2020) (identification as transgender or nonbinary was one of the strongest predictors of increased suicidality associated with exposure to SOGICE).

[62] *See* Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey*, Nat'l Ctr. for Transgender Equality at 110 (Dec. 2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. These results match findings on the harmful effects of coercion toward gender nonconformity from other sources, including peers and family. *See* Tara E. Smith & Campbell Leaper, *Self-Perceived Gender Typicality and the Peer Context During Adolescence*, 16 J. Rsch. Adolescence 91, 101 (2006); Maggi Price et al., *A Developmental Perspective on Victimization Faced by Gender Nonconforming Youth, in Handbook of Children and Prejudice: Integrating Research, Practice, and Policy* 447 (Hiram E. Fitzgerald et al. eds., 2019).

[63] *See also* Anna Forsythe et al., *Humanistic and Economic Burden of Conversion Therapy Among LGBTQ Youths in the United States*, 176 JAMA Pediatrics 493, 494 (2022) (finding the "total annual cost of SOGICE among 4,554,300 LGBTQ youths in the US is estimated at $650.16 million, with associated harms, such as substance abuse and suicide attempts, totaling an estimated total economic burden of $9.23 billion").

SOGICE recipients may suffer an indirect harm in the form of disappointment or psychological damage from the ineffectiveness of a therapy they thought would be effective. Indeed, the 2009 Report found "[i]ndividuals who failed to change sexual orientation, while believing they should have changed with such efforts, described their experiences as a significant cause of emotional and spiritual distress and negative self-image." J.A. 143; *see also* J.A. 276-77 (some participants in SOCE studies reported "anger at and a sense of betrayal by SOCE providers" or "blamed themselves for the failure" of SOCE to work as expected).

Petitioner does not cite any methodologically sound research dispelling the 2009 Report's finding that harm is associated with SOGICE. Petitioner claims that "recent evidence analyzing a randomly selected group of 1,518 people from across the country concluded that [SOGICE] 'do[ ] not result in higher suicidality . . . and may sharply reduce subsequent suicide attempts.'" Pet'r Br. 15 (quoting D. Paul Sullins, *Sexual Orientation Change Efforts Do Not Increase Suicide: Correcting a False Research Narrative*, 51 Archives Sexual Behav. 3377, 3377 (2022), perma.cc/H2QH-U92H). But the study underlying this claim has been widely critiqued as lacking scientific validity due to "glaring methodological flaws."[64] Its "fatal flaw" was in "presuming information that does not exist in the

[64] Adovich S. Rivera & Lauren B. Beach, *Unaddressed Sources of Bias Lead to Biased Conclusions About Sexual Orientation Change Efforts and Suicidality in Sexual Minority Individuals*, 52 Archives Sexual Behav. 875, 875 (2023) (concluding that study contained "failed to properly account for temporal relationships").

dataset" it analyzed regarding the relative timing of suicide and SOCE exposure, thus reaching conclusions "predicated on a fabricated" timeline.[65]

D. Studies Show that Minors Are Particularly Vulnerable to Harm from SOGICE.

Importantly, there are considerable ethical issues with providing SOGICE to minors in particular. *See* J.A. 334-62. In the absence of scientifically valid studies showing the safety of SOGICE and in the presence of retrospective reports of harm, the potential for SOGICE to harm minors is of great concern to *amici*. Those same concerns animate the Colorado ban on SOGICE.

SOGICE may present unique threats to youth. Studies show minors who have been subjected to SOGICE report more suicide attempts than those who have not.[66] A 2022 study underscored that minors are especially vulnerable to the adverse effects of SOGICE. It found that "conversion therapy increases the risk of attempting suicide . . . and running away" by a

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[65] John R. Blosnich et al., *Correcting a False Research Narrative: A Commentary on Sullins (2022)*, 52 Archives Sexual Behav. 885, 885, 887 (2023).

[66] *See, e.g.*, Green et al., *supra* note 61, at 1221 (youth who "under[went] SOGICE were more than twice as likely to report having attempted suicide and having multiple suicide attempts" than youth who did not); *see also* Caitlin Ryan et al., *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*, 67 J. on Homosexuality 159, 167-68 (2018); GICE Resolution, *supra* note 5, at 2-3; SOCE Resolution, *supra* note 5, at 5-6.

significant percentage, and that these "effects are largest when exposure to [SOGICE] occurs at a young age (11-14)."[67] In fact, the American Psychological Association's 2021 SOCE Resolution found that SOCE "may be understood as an adverse childhood experience."[68]

These findings support the 2009 Report's original conclusions regarding SOGICE for youth. Generally, it reported, youth may be "particularly vulnerable" to the potential harms of SOGICE because they have been exposed to negative messages about sexual minorities but have not yet developed the maturity to reject those messages.[69] Given the increased risk of harm and that "[t]here is no research demonstrating that providing SOCE to children or adolescents has an impact on adult sexual orientation," J.A. 377, the 2009 Report recommended that LMHPs provide "client-centered therapies" to children and adolescents, "rather than SOCE," J.A. 361-62. Ultimately, the 2009 Task Force concluded that it had "concerns that [SOGICE-type] interventions may increase self-stigma and minority stress and ultimately increase the distress of children and adolescents." J.A. 145.

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[67] Campbell & van der Meulen Rodgers, *supra* note 8, at 2; *see also* Turban, *supra* note 7, at 73 ("[E]xposure to GICE before age 10 years was significantly associated with several measures of suicidality, including lifetime suicide attempts.").

[68] SOCE Resolution, *supra* note 5, at 1-2.

[69] *See, e.g.*, SOCE Resolution, *supra* note 5, at 5.

Petitioner states that she counsels only minor clients who are "internally motivated" to undergo SOGICE. Pet'r Br. 4. However, "[first] do no harm" has long been foundational to the practice of healthcare professionals.[70] For this reason, an ethical practitioner should not offer treatments that would harm the patient's health, or for which no evidentiary basis exists to satisfy a patient's request; for example, a physician would decline to prescribe antibiotics for a viral infection—even if the patient insists. After all, in this context, a patient's request may be guided by an inaccurate understanding of SOGICE's efficacy or by external pressures, even if presented as internally motivated.

Accordingly, the GICE Resolution notes, "[P]rofessional consensus recommends [LGBTQ]-affirming therapeutic interventions for transgender and gender nonbinary adults who request that a therapist engage in GICE, and for trans youth whose parents/guardians or other custodians (*e.g.*, state, foster care) request that a therapist engage in GICE."[71] Similarly, "the [American Psychological Association] urges psychologists to assist patients seeking SOCE to understand the dangers of SOCE, the lack of research showing efficacy, the societal contexts of heterosexism

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[70] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, at General Principles A (Jan. 1, 2017), https://www.apa.org/ethics/code; *see also* American Counseling Ass'n, *Code of Ethics*, at 4 (2014), https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf.

[71] GICE Resolution, *supra* note 5, at 3.

and monosexism, and the internalized stigma that results from these contexts, and to use acceptance, support, comprehensive assessment, active coping, social support, and identity exploration and development."[72]

E. Petitioner Misrepresents the 2009 Report's Statements About the State of the Research.

Petitioner mischaracterizes key aspects of the American Psychological Association's 2009 Report and the scientific research on SOGICE; downplays the possibility of harm from SOGICE; and ignores more recent evidence underscoring these harms. Specifically, Petitioner wrongly claims that the 2009 Report endorses the conclusion that there is no scientific consensus on the harms of SOGICE. Pet'r Br. 45-47. That is incorrect for several reasons.

First, Petitioner ignores the reasons behind any methodological issues the 2009 Report acknowledged in the then-published research on SOCE: numerous researchers and LMHPs have concluded that SOGICE should neither be studied nor provided precisely ***because SOGICE may cause harm to patients***. *See* J.A. 393.[73] Petitioner also relies on a "recent [American

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[72] SOCE Resolution, *supra* note 5, at 8.

[73] *See also, e.g.*, Gregory M. Herek, *Evaluating Interventions to Alter Sexual Orientation: Methodological and Ethical Considerations*, 32 Archives Sexual Behav. 438 (2003); Gerald C. Davison, *Homosexuality: The Ethical Challenge*, 44 J. Consulting & Clinical Psych. 157 (1976).

Psychological Association]-published book," to support the notion that there is no empirical basis showing the harm of SOGICE. Pet'r Br. 13. But the chapter cited by Petitioner merely notes this same difficulty of *expanding* the research base due to ethical considerations.[74]

Second, Petitioner ignores more recent research confirming that SOGICE expose recipients to considerable risk of psychological harm. Though the 2009 Report acknowledged that scientifically valid empirical research on SOCE was limited, J.A. 253, it also discussed a body of research finding some participants in SOCE retrospectively reported harms stemming directly from their exposure to SOCE. Newer research on SOGICE harm, moreover, has confirmed this point with stronger empirical evidence, particularly as to minors. *See supra* § III.C, D.

Third, even if there were a wholesale lack of evidence on this topic, that would not counsel in favor of permitting the use of an unvetted therapeutic technique. *Amici* support rigorous evaluation of therapeutic modalities. The American Psychological Associations' standards for creating practice guidelines, for instance, state that such guidelines must "take into account the best available sources on current theory, research, ethical and legal codes of conduct, and/or practice within existing standards of care so as to provide a defensible

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[74] *See* David Rivera & Seth Pardo, *Gender Identity Change Efforts*, *in The Case Against Conversion "Therapy"* 51, 62 (D.C. Haldeman ed., 2022).

basis for recommended conduct."[75] Treatments must be borne out by data and experience to warrant a place in accepted therapeutic practice.

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request that this Court affirm the decision below.

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Respectfully submitted,

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[75] American Psychological Ass'n, *Criteria for Practice Guideline Development and Evaluation*, , 57 Am. Psych. 1048, 1049 (2002), https://www.apa.org/practice/guidelines/criteria.pdf.