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 FAITH-BASED MENTAL HEALTH PROFESSIONALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

Amici curiae are faith-based mental health professionals who work with minors on the topics of gender and sexuality. Each of these therapists follows traditional and theologically conservative Christian teachings surrounding gender identity and sexual orientation, and their deeply held convictions anchor them in their clinical practice. They submit this brief in support of Colorado's ban on licensed mental health professionals subjecting minors to "conversion therapy." Given their professional and religious backgrounds, *amici* have an interest in explaining how Colorado's law neither impedes freedom of speech nor hinders the ability to engage in effective, value-congruent therapeutic practices that honor patients' religious convictions while pursuing psychological wellness. To the contrary, the law protects youth and families from harmful practices that have been shown to be ineffective in accomplishing their stated goals.

Dr. Julia Sadusky, Psy.D., is a licensed clinical psychologist in Colorado and a Catholic Christian. She received her bachelor's degree from Ave Maria University and her doctorate from Regent University, where she participated in the Institute for the Study of Sexual Identity, a research institute run by Mark Yarhouse, a Christian psychologist specializing in sexual and gender identity. Now practicing in Colorado, Dr. Sadusky works primarily with religious

[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amici curiae* and their counsel, made any monetary contribution toward the preparation or submission of this brief.

individuals and families, and she specializes in the intersection of faith, sexual orientation, and gender identity. She offers professional treatment to patients in value-congruent ways, but without engaging in conversion therapy. Indeed, many of Dr. Sadusky's patients and their parents come to her after negative experiences with conversion therapy. Dr. Sadusky also offers professional trainings and consultations with religious leaders and faith-based mental health professionals and has written extensively in this area.

Dr. Michele Willingham, Psy.D., is a licensed clinical psychologist in California and an Evangelical Christian. She specializes in anxiety, depression, grief and loss, and LGBTQ and relationship issues. She received her doctorate from the California School of Professional Psychology, Los Angeles, and for the past 27 years she has served as a teaching faculty member, administrator, and counselor at two different private Christian universities in Southern California. She is active in the California Psychological Association and serves on the American Psychological Association Commission for Accreditation, which is the primary programmatic accreditor in the United States for professional education and training in psychology.

Dr. Nathan Willis, PhD, LMHC, CFHMHE, is a licensed mental health counselor in Florida and a Christian who believes in a traditional biblical sexual ethic. He has served as an adjunct faculty member at the University of South Florida and Liberty University. He holds a master's degree in professional counseling from Southeastern University and a Ph.D. in counseling and counselor education from the University of Florida, where he conducted research on

the moral decision-making processes of counselors. His primary research focus remains on counselor morality. In his practice, Dr. Willis works with clients on, among other topics, sexuality and gender. His work includes counseling children and teens as well as parents.

SUMMARY OF THE ARGUMENT

The practice of mental health treatment is governed by a wide range of state regulations and accreditation requirements. One such regulation, Colorado's Minor Conversion Therapy Law ("MCTL" or "Law"), bans "conversion therapy," a treatment aimed at causing a person to change their sexual orientation or gender identity. There is almost no evidence that this type of therapy is effective or helpful, and there is substantial evidence that it harms minor patients and their families.

As mental health providers and theologically orthodox Christians, *amici* support Colorado's law. Given the culture-war narratives that surround the development of sexuality and gender in youth, *amici* understand the concern that some laws in this area may conflict with First Amendment freedoms. But *amici* know from experience that the MCTL is not one of those laws. The MCTL leaves ample room for licensed therapists to counsel minor patients in a manner consistent with the therapist's and the patient's religious beliefs while providing critical protection for minors, including those with deeply held religious views.

I. The restrictions on conversion therapy in Colorado's law are appropriately limited. The Law prohibits, for minor clients, a specific mental health treatment that lacks evidentiary support—namely, treatment that sets as its goal or promises a change in sexual orientation or gender identity. But the Law stops there. It does not require mental health counselors to encourage minors to identify in any particular way, including as LGBTQ; to enter same-

sex relationships; or to transition. In other words, mental health practitioners need not (and typically should not) set as a goal of therapy *any* fixed outcome in terms of gender or sexuality. To the contrary, the Law expressly permits facilitation of "identity *exploration* and development," Colo. Rev. Stat. § 12-245-202(3.5)(b)(I) (emphasis added), which allows for a range of outcomes.

II. The Law thus leaves a broad range of mental healthcare treatments available to licensed practitioners, including methods that accommodate religious beliefs and are backed by evidence. *Amici* regularly work with theologically conservative Christian clients, including minors, who are experiencing same-sex attractions or gender dysphoria. There are therapeutic approaches available to such clients that allow them to explore their identities, beliefs, and values—and potential conflicts among them—without establishing as a goal any particular outcome in terms of sexual orientation or gender identity. *Amici* have witnessed firsthand how such approaches can improve minor patients' mental health, familial relationships, and personal faith.

III. The Law prohibits mental health professionals from offering conversion therapy because it is harmful and not evidence-based. *Amici*, who often meet with clients after negative experiences with conversion therapy, have witnessed how such approaches can harm the psychological wellbeing of youth. This harm is compounded by the damage conversion therapy can do to minors' relationships

with their parents, their faith, and access to future therapy.

IV. The Law is consistent with a wide range of regulations, licensure requirements, and common-law standards that govern the provision of professional mental health services. These legal restraints require *amici* and other licensed practitioners to adhere to a professional standard of care in their practices, even when that standard limits how they may "speak" when treating clients. Adopting Chiles's position here would call into question whether *any* requirement governing mental health professionals (or other professionals, such as lawyers, whose professional services consist of "speech") could survive First Amendment scrutiny.

ARGUMENT

I. Colorado's law does not require practitioners to pursue certain outcomes or prohibit them from expressing views about conversion therapy.

Contrary to the impression that may be left by Chiles's opening brief and many of the *amicus* briefs supporting her, the provisions of the Law challenged here are limited in scope. They prohibit mental health professionals who are licensed, registered, or certified in the state from providing conversion therapy to minors. *See* Colo. Rev. Stat. § 12-245-224(1)(t)(V). And they define "conversion therapy" as a practice or treatment "that attempts or purports to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attraction or feelings toward individuals of

the same sex." Colo. Rev. Stat. § 12-245-202(3.5)(a). The restriction is thus narrow: It applies only to therapies that set as a goal, or promise as a result of therapeutic intervention, a particular outcome—namely, a shift in attraction or a shift in gender expression and behaviors. And it governs only licensed mental health professionals.

The statute does not, however, go further than these restrictions. The MCTL does not, for example, require therapists or other mental health providers to encourage minors to embrace gender transition, initiate same-sex relationships, or identify as LGBTQ. *See* Resp. Br. 18 ("Just as a therapist may not pursue an *a priori* goal of making a minor patient heterosexual or cisgender, the law likewise prohibits them from seeking to make a minor gay or transgender."). Instead, the Law aims to protect identity exploration and development free from coercion by mental health professionals.

Confirming as much, the Law expressly permits a therapist to support and "facilitat[e]" a minor's "identity exploration and development." Colo. Rev. Stat. § 12-245-202(3.5)(b)(I). In other words, if a client chooses to no longer identify as gay or trans during the course of therapy, the Law permits supporting this. What the law prohibits is a licensed mental health provider setting as the *goal* of the treatment changing a minor's sexual orientation or gender identity. This is consistent with guidelines from a range of governing bodies and professional organizations, all of which indicate that effective therapy around sexual orientation and gender must not set as a goal a fixed

outcome in any direction.[2] *See* Resp. Br. 3 (noting the law "prohibits licensees' efforts to 'change' minor patients' sexual orientation or gender identity *in any direction*" (emphasis added)).

It is also important to note two further ways in which the Law leaves ample room for therapists with conservative religious beliefs to exercise their freedom of speech. First, nothing in the Law requires a therapist to express viewpoints that they might find objectionable—such as that same-sex sexual behaviors are morally licit or that sex differences are purely a social construct. Such a law would be misplaced not only because of the freedom of speech and religion concerns it would raise, but because it is rarely appropriate for mental health providers to offer such personal opinions—whatever they may be—while providing care. Rather than dictate expression, the Law even leaves covered providers free to express their (misguided, in *amici*'s view) beliefs about the

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[2] *See, e.g.*, Am. Psych. Ass'n, APA Resolution on Sexual Orientation Change Efforts 5 (2021) ("[T]he APA opposes any efforts by mental health professionals that aim at a specific, predetermined sexual orientation or gender-expression outcome …."); J.A. 136 (2009 APA Task Force Report) ("[T]he appropriate application of affirmative therapeutic interventions for those who seek SOCE involves therapist acceptance, support, and understanding of clients and the facilitation of clients' active coping, social support, and identity exploration and development, without imposing a specific sexual orientation identity outcome."); J.A. 571 (SAMHSA 2015 Report) ("Appropriate approaches support children and adolescents in identity exploration and development without seeking predetermined outcomes related to sexual orientation, sexual identity, gender identity, or gender expression.").

purported benefits of conversion therapy, so long as they do not professionally practice it on minors.

Second, the Law does not prohibit all efforts to change a minor's sexual orientation or gender identity—it only prevents licensed providers from offering professional mental health treatment aimed at or promising such a change. *See* Colo. Rev. Stat. § 12-245-101. The Law imposes no restrictions on such efforts by citizens not subject to the licensure regime. And it expressly specifies that its prohibition does not extend to people "engaged in the practice of religious ministry" who do not hold themselves out as licensed mental health providers. *Id.* § 12-245-217(1). The Law thus permits therapists to refer clients who seek a ministry-based approach to other individuals not covered by the statute. Rather than impose any bar on speech, the Law is one of many restrictions that govern mental health treatment offered by licensed mental health professionals. *See infra* Section IV.

Chiles's brief and those of her *amici* paint a different picture of the Law, but that picture is mistaken. She contends, for example, that she is "forced to deny to her clients … any counseling that fully explores sexuality and gender." Pet. Br. 18 (cleaned up). She also contends that she "has been unable to fully explore certain clients' bodily experiences around sexuality and gender and how their thoughts, beliefs, interpretation, and behaviors intersect." Pet. Br. 18–19 (cleaned up). Chiles's *amici* present a similarly catastrophizing view of the Law, arguing that the State "impos[es] penalties on counselors who, by their profession and expertise, recognize the value of open-ended, non-judgmental

conversation for youths who truly desire to understand and explore all sides of the internal conflict they are experiencing." *Amicus Curiae* Sexuality Research Scholar Amy E. Hamilton Br. 3; *see also, e.g.*, *Amici Curiae* American Association of Christian Counselors, *et al.* Merits Br. 19 (contending that the decision below means that "the state can bar discussions based on the religious beliefs of a mental health client").

But the Law, in fact, specifically *permits* facilitation of "identity exploration and development." Colo. Rev. Stat. § 12-245-202(3.5)(b)(I). Far from *penalizing* "open-ended, non-judgmental conversation," *Amicus Curiae* Sexuality Research Scholar Amy E. Hamilton Br. 3, the Law encourages it by banning a practice defined by a fixed goal. It thus does not prohibit the exploration of conflicts between attractions and religious beliefs. And there are effective, ethical, and legal therapeutic approaches to doing just that. *See infra* Section II.

Confirming that the MCTL does not prohibit therapy that is consistent with religious values and that explores important questions of faith and identity, the Law has never been enforced against *anyone* since it was enacted in 2019. *See* Pet. App. 12a. This litigation thus represents an effort to conjure an unconstitutional restriction where none exists. The Court should follow its ordinary practice of "avoid[ing] constitutional problems" where "fairly possible to do so" instead of mangling a state statute to create constitutional problems to address. *Boumediene v. Bush*, 553 U.S. 723, 787 (2008) (cleaned up).

II. Value-congruent and effective treatment methods exist and are permissible under Colorado's law.

The MCTL leaves plenty of room for religious practitioners to offer mental health treatment to minors that is consistent with theologically orthodox Christian values surrounding gender identity and sexual orientation. And there are alternative approaches that are fully consistent with the Law and respect a range of religious values. At their core, these licit practices allow minors to explore their sexual and gender identities, and any conflicts between those identities and their faith, without imposing on them a specific outcome goal in *any* direction. As Christian mental-health providers specializing in this area, *amici* practice such approaches regularly.

A. Long before the MCTL was passed, theologically conservative Christians recognized the need for faith-congruent therapy options that avoid the harm caused by conversion therapy. In the realm of sexual orientation, two such Christians, Mark Yarhouse and Warren Throckmorton, developed the Sexual Identity Therapy ("SIT") framework specifically to address that need. This framework and others like it allow for faith-congruent outcomes without the harms caused by conversion therapy.[3] One

[3] *See* J.A. 190–91 (2009 APA Task Force Report) (collecting host of "scholarly contributions" about "alternative frameworks" that "address the religious and spiritual needs of LGBT individuals from integrative and affirmative perspectives" and demonstrate "that religious faith and psychology do not have to be seen as being opposed to each other"); *see also* J.A. 288–91 (collecting sources).

of the developers of this approach describes it as a contrast to both "reorientation therapy"—that is, conversion therapy—and "gay affirmative therapy"—that is, "therapy [that] tends to assume that a person is gay, that they are discovering this about themselves," and that therapy "simply creates a safe place to discuss 'coming out.'"[4] There have also been other, related "attempts to envision alternate frameworks to address these issues." J.A. 204 (2009 APA Task Force Report) (collecting sources).

SIT is "a client-centered and identity-focused approach to navigating sexual identity questions or concerns."[5] Unlike conversion therapy, it is not oriented to a specific outcome in terms of sexual orientation, attractions, or behavior: "Sexual attractions or orientation may or may not change, but the overall emphasis is on identity."[6] In focusing on "weighted aspects of identity," therapists practicing SIT help clients work through conflicts between aspects of their identity—like same-sex attraction and their religious beliefs—and seek ultimately to help clients find congruence among their identities, behaviors, beliefs, and values.[7]

For issues concerning gender identity, *amicus* Dr. Sadusky and Dr. Mark Yarhouse (one of the developers of SIT) developed a related model known as

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[4] Mark Yarhouse, *Understanding Sexual Identity Therapy* (Mar. 10, 2010), https://tinyurl.com/2d49kau5.

[5] *Id.*

[6] *Id.*

[7] *Id.*

Gender and Religious Identity Therapy ("GRIT").[8] Like SIT, GRIT is "client-centered" and "allows clients to explore gender and religious faith and any conflicts between these two aspects of identity. The therapy emphasizes the exploration of gender identity without a fixed outcome, the attainment of coping skills, and the establishment of social support."[9] GRIT also works to help reduce parents' anxiety surrounding gender so that their fears do not negatively impact their children.

Notably, these and other forms of therapy allow Christian clients to set healthy, realistic, and faith-congruent goals that are not defined by specific sexuality or gender outcomes. One common goal is fostering acceptance. Another is clarifying forms of support and identifying ways to improve social support of the minor client, such as removing barriers to communication with parents, repairing hurt that sabotages connection, increasing involvement in church and youth groups, and buffering against bullying and peer rejection. These goals also prioritize treatment of general mental health concerns, like addressing trauma.

Unsurprisingly considering that this form of therapy is not geared toward pushing specific sexuality or gender outcomes, *amici* have witnessed a range of outcomes. Some teens start therapy identifying as heterosexual, despite attraction to the

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[8] *See* Mark A. Yarhouse & Julia A. Sadusky, Gender Identity and Faith: Clinical Postures, Tools and Case Studies for Client-Centered Care (2022).

[9] *Id.* at 45.

same sex, in the hope their attractions will change. Others begin therapy having adopted labels such as bisexual, confused, gay, or lesbian. And some avoid labels altogether out of fear of prematurely setting a trajectory for their lives that they feel unsure about. As therapy proceeds (along with life and natural development), some of these teens choose to identify with a different label and pursue a range of romantic and sexual relationships. Some maintain a label of heterosexual, especially if their same-sex attractions seem to subside in strength over adolescence, which is a time of immense evolution and attraction fluidity for some. Some teens pursue singleness and abstain from sexual behaviors in adolescence or permanently because of their deeply held convictions around marriage, sexual ethics, and morality. Still others enter into same-sex relationships, believing these are blessed by God, while others enter such relationships unsure about their values and beliefs around sexual ethics.

Amici have also witnessed various outcomes in the realm of gender. Some youth experience resolution of gender distress as therapy progresses, and some seek adaptive coping through changes in hairstyle and dress to manage distress around embodiment, while still aligning with their sex. Others make changes in social identity and adopt labels outside of the binary or adjust the names and/or pronouns that they use, while others have concerns about doing so. Some consider the use of puberty blockers and ultimately do not seek them; some consider the use of hormones and delay that step until they become adults; and some seek out referrals to hormonal treatments as minors, with parental support.

B. The current Colorado law does not impede this natural developmental process or foreclose any of these potential outcome possibilities for youth. It simply prevents clinicians from representing that they can manipulate attraction and identity through therapeutic intervention or offering potentially harmful therapeutic approaches that are not backed by evidence. Identity-focused and outcome-open approaches like those detailed above squarely align with Colorado's law, which permits treatment providing "[a]cceptance, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development." Colo. Rev. Stat. § 12-245-202(3.5)(b)(I). And they do so in a manner that is respectful of clients' (and clinicians') religious beliefs by seeking to foster those values as part of a holistic approach to identity development.

These approaches also are consistent with the American Psychological Association's 2009 report on this topic, on which Chiles mistakenly relies. That report endorses treatment methods that are "supportive of clients' identity development without an a priori treatment goal concerning how clients identify or live out their sexual orientation." J.A. 147–48; *see also* J.A. 171 ("[A] multiculturally competent affirmative approach aspires to understand the diverse personal and cultural influences on clients and enable clients to determine (a) the ultimate goals for their identity process; (b) the behavioral expression of their sexual orientation; (c) their public and private social roles; (d) their gender roles, identities, and expression; (e) the sex and gender of their partner; and (f) the forms of their relationships." (footnotes

omitted)). And it supports identity exploration, defined as "an active process of exploring and assessing one's identity and establishing a commitment to an integrated identity that addresses the identity conflicts without an a priori treatment goal for how clients identify or live out their sexual orientation." J.A. 316.[10] Critically, the APA also supports "an approach that respects religious values and welcomes all of the client's actual and potential identities by exploring conflicts and identities without preconceived outcomes," and that "does not prioritize one identity over another and may aide a client in creating a sexual orientation identity consistent with religious values." J.A. 324.

C. *Amici* have witnessed firsthand the value that these approaches offer Christian clients and their parents. There are many benefits of pursuing a religiously accommodative approach that does not seek to force identity or orientation change. These benefits include reduced depression, anxiety, and

[10] *See also* J.A. 147–48 (2009 APA Task Force Report) ("Given that there is diversity in how individuals define and express their sexual orientation identity, an affirmative approach is supportive of clients' identity development without an a priori treatment goal concerning how clients identify or live out their sexual orientation or spiritual beliefs."); J.A. 150 (2009 APA Task Force Report) ("The clinical and research literature encourages the provision of acceptance, support, and recognition of the importance of faith to individuals and communities while recognizing the science of sexual orientation. This includes an understanding of the client's faith and the psychology of religion, especially issues such as religious coping, motivation, and identity. Clients' exploration of possible life paths can address the reality of their sexual orientation and the possibilities for a religiously and spiritually meaningful and rewarding life.").

suicidality. In addition, one particular benefit of religiously accommodative approaches—and one that provides a stark contrast to conversion therapy—is worth noting: the fostering of a strong parent-child relationship.

The quality of a minor's relationship with their parents is a critical factor that impacts the mental health and wellness of youth, particularly those dealing with questions of sexual orientation and gender identity.[11] As detailed below, conversion therapy can gravely harm that relationship. *Infra* Section III. But so too can an approach that villainizes the minor's parents and their sincerely held religious beliefs. Fortunately, approaches like SIT and GRIT avoid these pitfalls and help to strengthen the crucial parent-child relationship.

One way that religiously accommodative therapy strategies can improve the relationship between Christian parents and their children is through the non-outcome-based goals noted above. Although every client is different, *amici* regularly work with Christian families who are hesitant to expose their child to conversion therapy—having heard of its harms—but still want a religiously accommodative approach to therapy that doesn't assume an outcome of transition or entering same-sex partnerships. Some of these parents have pursued conversion therapy despite such hesitation because they were desperate and believed

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[11] *See generally, e.g.*, Caitlin Ryan et al., *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 123 Pediatrics 346 (2009).

it was the only approach that would respect their religious beliefs. *Amici* have also met with teens whose parents requested conversion therapy to change their child's sexual orientation. In discussing with the parents, it was clear that they loved their child and were motivated by fear that the child's sexual identity would ultimately lead them to reject their faith. Explaining conversion therapy's ineffectiveness in changing orientation, and offering alternatives that respect clients' deeply held religious beliefs, often allows those parents to see the value in broader goals, such as reducing their child's panic attacks or other co-occurring mood symptoms; assisting in resolving value conflicts their teen has about sexual attractions; and improving family communication around many topics, including faith and sexuality.

Whether or not they initially seek conversion therapy, parents (and their children) regularly welcome alternative therapeutic approaches that provide faith-congruent goals that do not seek a fixed outcome. One such goal is acceptance of the reality of a child or teen's current experience. Christian parents often quickly come to a place of awareness that they do not want to signal that their acceptance or love of their child hinges on heterosexuality or a lack of gender dysphoria. They also do not want to suggest by "acceptance" of their child's current experience that they agree with or approve of every pathway for their child. In that way, they are like every other parent, who can love and accept their child while also having different perspectives on appropriate pathways. In refraining from the conversion therapy approach, *amici* facilitate conversations where parents speak

clearly to their minor child about their unconditional love that does not hinge on change in any direction, connecting this unconditional love to their faith. Conversations also allow space to articulate boundaries and concerns from a place of care and honesty.

Relatedly, repair of any previous harm that sabotages communication and connection between parent and child is another common goal. Christian parents often want to buffer against any hurt they may have caused their child, whether intentionally or not, by pushing conversion therapy or by interactions that have signaled rejection of their child. Taking accountability for intended and unintended hurt is often important to religious parents, who want to model virtues like humility and repentance as Christians and as mature adults.

Reducing a youth's shame about their experience is another common goal. *Amici* talk clearly about what support, compassion, and affirmation can look like, even in cases where parents are not comfortable with facilitating transition and/or are not comfortable with supporting same-sex partnerships. In doing so, *amici* work to reduce rejection of children and teens without requiring parents to necessarily change their own theological beliefs in the process.

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In short, the MCTL targets a particular form of mental health treatment. It does not prohibit therapy that is congruent with religious beliefs. Nor does it require that therapists abandon their faith in order to work as licensed counselors. There are evidence-based

treatment options that fully comply with the Law and with religious principles. The Law allows for these approaches; it only prohibits establishing attraction or identity change as a goal or promising it as a result.

III. Conversion therapy is frequently harmful and ineffective in achieving its purported goals.

In contrast to these sound therapeutic methods, conversion therapy is demonstrably harmful to minor patients. The legislative history highlights that Colorado was concerned with these harms when passing the statute here. One Senator, for example, stated that "all of the prevailing science and modern medicine tells us that not only does this practice [of conversion therapy] not work, but it ... actually harms young people." *See* Pet. App. 40a (quotation marks omitted). And indeed, the district court found that "Colorado considered the body of medical evidence regarding conversion therapy and sexual orientation change efforts—and their harms—when passing the Minor Therapy Conversion Law and made the reasonable and rational decision to protect minors from ineffective and harmful therapeutic modalities." Pet. App. 158a.

Conversion therapy increases negative outcomes. At the extreme, one study shows that lesbian, gay, or bisexual people who underwent conversion therapy were almost twice as likely to think about or attempt suicide as their LGB peers who did not participate in such therapy.[12] A wealth of research shows other

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[12] *See* John R. Blosnich et al., *Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation*

harms, including depression, anxiety, shame, guilt, self-hatred, worsening of family relationships, and loss of faith. *See* J.A. 61–74 (documenting harms and collecting sources).

Amici's experience with individuals who have undergone conversion therapy aligns with that body of research. Such minors often suffer in their psychological wellbeing, have a troubled relationship with therapy, and experience significant discomfort in their relationship with their parents. Moreover, conversion therapy can trigger a crisis of faith, causing many young people to walk away from their faith altogether.

Psychological Wellbeing. Conversion therapy—and its narrow focus on an outcome of changing one's sexuality or gender—can be counterproductive to a minor's overall psychological wellbeing. *Amici* have seen numerous Christian parents who bring a child to therapy only after the child discloses same-sex feelings or gender questions, even if the child has been demonstrating symptoms of depression or anxiety for some time. Particularly when these parents select conversion therapy, youth observe that their parents are willing to seek therapeutic support for them only to "correct" their sexuality or gender. Teens have repeatedly shared that this signals that sexuality or gender disclosures are the "worst thing" and the only thing worth "fixing." Young people then internalize the belief that they are broken, flawed, and in need of fixing, particularly by

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and Attempt Among Sexual Minority Adults, United States, 2016-2018, 110 Am. J. Pub. Health 1024, 1027 (2020).

virtue of their sexual attractions or gender exploration. Conversion therapy compounds these harms because minors are vulnerable and often see therapists—particularly therapists of similar faith backgrounds—as sources of authority. These therapists, who imply that heterosexual attraction or lack of gender dysphoria is the goal, can quickly come to represent what God is expecting of them to be able to grow in holiness. This drives even worse negative outcomes, including suicidality, when attractions or gender distress persist.

Relatedly, conversion therapy can increase shame in minors. It can instill in them a belief that they are flawed or defective by virtue of their very existence. The self-rejection that flows from this can lead minors to act out sexually in unsafe ways as a form of punishing themselves or distracting from emotional pain, and can also drive depression, anxiety, and other mental health issues.

Relationship with Parents. Worsening these impacts, conversion therapy also often harms the parent-child relationship. A critical factor that impacts the mental health and wellness of minors, particularly LGBT-identifying youth, is the quality of their relationship with their parents.[13] Too often, therapists and others villainize Christian parents without fully understanding their hopes and goals for their families. But conversion therapy approaches also alienate Christian youth from their parents, something that *amici* have seen far too often in their practice. For example, conversion therapy approaches

[13] *See* Ryan et al., 123 Pediatrics at 346.

often signal that attraction or gender can change by virtue of healing wounds with parents, which can have the counterproductive impact of alienating youth from their parents and causing resentment against them. This impact is worsened because the conversion-therapy theory itself often places blame on parents for their children's attraction patterns. And promising unrealistic outcomes not based in evidence to Christian parents only exacerbates these problems. There are plenty of established ways to improve parent-child relationships in therapy, and banning a practice that does the opposite is sound policy.

Faith. Conversion therapy can also impair minors' relationship with their faith and with God. *Amici* have met with teens and adults who went through conversion therapy at some point in their adolescence, stirred by conviction, a longing to be obedient to God and their faith community, and a desire to participate in Christian marriage. Their fervor at that time was profound. But many of these youth eventually rejected their faith altogether. Conversion therapy reinforced in them a misguided, unsupported belief that a loving God would change their attractions if they followed a protocol. This created a conditional experience of love of God that disillusioned them when their attractions did not change. They came to believe that they were not "doing it right" and "didn't want it enough" and blamed themselves for their continued attraction. These youth also became angry at God when their attractions or orientation did not change, coming to believe that, if a loving God exists, he did not care to help them despite their investment in conversion therapy. Self-blame, rage, and futility in the face of

enduring experiences are unsustainable, so these youth and adults who underwent conversion therapy eventually rejected God and faith altogether, believing that the only faith-congruent option was conversion. These clinical observations are consistent with research findings on the subject.[14]

Relationship with Therapy. Unsurprisingly given these problematic outcomes, minors' negative experiences with conversion therapy can often drive them away from mental health care altogether. Some young people wait significantly longer to seek therapy than they otherwise would have after a harmful experience with conversion therapy, fearing similarly unhelpful approaches. This translates into delaying much-needed care until it becomes desperate, worsening mental health symptoms such as depression, anxiety, and suicidality that otherwise could have been expediently addressed. So even where conversion therapy as such has not prompted worsened mental health, it can lead to worse outcomes by delaying much-needed mental health care later in life.

Relatedly, *amici* have experienced trouble building trust with clients who previously had negative experiences with conversion therapy. Trust is essential to effective mental health care. In fact, one of the top predictors of successful therapeutic outcomes is the strength of the therapeutic

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[14] *See* Timothy W. Jones et al., *Religious Trauma and Moral Injury From LGBBTQA+ Conversion Practices*, 305 Soc. Sci. & Med. 1, 7 (2022); *see also* J.A. 67–68 (Glassgold Declaration); J.A. 265, 277 (2009 APA Task Force Report).

relationship.[15] Understandably, youth who have been harmed by conversion therapy are often hesitant or scared to meet with a Christian provider because of fear that they will again be subjected to efforts to change their attractions, orientation, or gender expression. Colorado's law addresses these harms by reducing the likelihood of such practices and increasing youth confidence in therapy through the message that therapy will not seek to coerce an outcome.

IV. The MCTL is one of many restrictions that apply to ensure that therapeutic speech by licensed providers comports with professional ethics and the evidence-based standard of care.

Colorado's restriction on this harmful form of therapy falls squarely within a long history of restrictions on the practice of mental health professions—and indeed, a history of state regulation of professions more broadly. States have the prerogative to regulate the professional conduct of licensed medical professionals; and in the professional therapeutic context, such conduct necessarily manifests in speech. State regulation of such speech as professional conduct is generally unexceptional.

A. Licensed therapists and other mental health professionals are subject to a well-established licensure regime that places important restrictions on what providers may say to a client in therapy. Far

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[15] *See, e.g.*, Tori DeAngelis, *Better Relationships With Patients Lead to Better Outcomes*, 50 Monitor on Psych. 38 (2019), https://www.apa.org/monitor/2019/11/ce-corner-relationships.

from representing "a sharp break from historical counseling regulations," Pet. Br. 2, the MCTL is squarely in line with those restrictions on professional conduct.

There are two primary sources of restrictions on the practice of professional mental health care in Colorado (as in other states): the state licensing scheme, and malpractice law enforced through the tort system. Both provide important limits on what a licensed therapist may say to a client during counseling.

First, Colorado has a regulatory scheme under the Mental Health Practice Act that applies to anyone licensed, registered, or certified to practice in certain mental-health fields, like psychology, social work, and certain types of counseling and therapy. *See* Colo. Rev. Stat. § 12-245-101 *et seq*. If a covered practitioner engages in prohibited practices, they may face sanctions including probation, revocation or suspension of their license, or an injunction prohibiting them from practicing the profession. *See id.* § 12-245-225(1). The restriction on conversion therapy for minors operates within this scheme. *Id.* § 12-245-224(1)(t)(V). But the scheme is much broader—indeed, it covers any scenario where a licensed provider "[h]as acted or failed to act in a manner that does not meet the generally accepted standards of the professional discipline under which the person practices." *Id.* § 12-245-224(1)(g)(I).

Second, mental health providers may face liability for their professional conduct under tort law in malpractice actions. *See Fried v. Leong*, 946 P.2d 487, 488 (Colo. App. 1997). Professional malpractice

actions require showing that a defendant "failed to conform to the standard of care ordinarily possessed and exercised by members of the same [field] practiced by the defendant." *Day v. Johnson*, 255 P.3d 1064, 1069 (Colo. 2011). The Mental Health Practice Act contemplates malpractice as a concurrent method of regulating licensed therapists, stating that a "malpractice judgment of a court of competent jurisdiction is conclusive evidence that [an] act or omission does not meet generally accepted standards of the professional discipline." Colo. Rev. Stat. § 12-245-224(1)(g)(II); *see Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 521 (1992) (recognizing that legal duties can take the form of positive enactments or rules imposed by common-law damages actions).

The professional duty of care incorporated into the Mental Health Practice Act and the common-law rule against malpractice imposes restrictions on professional conduct, including in the realm of goal-setting, far beyond the ban on conversion therapy. A therapist could not, for example, encourage a client to die by suicide even if the therapist shared a secular or religious belief that this was an appropriate course of action. An atheist therapist could not push a client to walk away from the client's deeply held religious beliefs because the therapist deems the client's beliefs to be at odds with the therapist's personal values. Nor could a therapist encourage a client to stay married to an abusive partner at all costs, even if motivated by her and her client's beliefs in the sanctity of marriage. Conversely, mental health providers need not *encourage* divorce, just as they need not encourage identifying as LGBT, engaging in same-sex sexual activities, or transitioning gender. But they should

offer therapy that acknowledges a potential outcome of divorce, just as sexuality- and gender-related therapy should recognize the potential for a range of outcomes.

As one more example, it would likely violate the standard of care for a therapist working with a sexual assault survivor to establish as the treatment goal absolute forgiveness, defined as the elimination of any feelings of residual anger at the perpetrator. While this goal might, at first glance, align with Christian values of forgiveness, an aspect of treatment planning around forgiveness involves educating the client that they should expect periodic feelings of anger and hurt, even after they work through forgiveness in therapy.[16] This tempers unrealistic goals, even when the goals may, on some level, align with the therapist's values. The key to effective therapy is holding on to the value of forgiveness, rather than eradication of "negative" emotions completely.

The above examples would likely provide grounds for sanction or a malpractice suit because such treatment would "not meet the generally accepted standards" of the mental health profession. Colo. Rev. Stat. § 12-245-224(1)(g)(I); *see also Day*, 255 P.3d at 1069. They thus show that Chiles's claim that the statute "disrespects clients' autonomy to set their own

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[16] *See* Everett L. Worthington Jr. & Michael Scherer, *Forgiveness Is an Emotion-Focused Coping Strategy That Can Reduce Health Risks and Promote Health Resilience: Theory, Review, and Hypotheses*, 19 Psych. & Health 385, 387 (2004). Similarly, a competent therapist, when a client asks for therapy to eliminate same-sex attraction or gender distress, ought to provide education about the unlikelihood of this outcome.

goals," Pet. Br. 12, fails to account for the numerous ways that goal-setting and absolute client autonomy—and consequently, therapists' "speech"—are properly limited in the context of licensed, professional mental health treatment.

Limits on therapists' "speech" (or, more accurately, their professional conduct) are not confined to the goal-setting context. For example, the Act also imposes confidentiality requirements on therapists that prohibit them from speaking about their client conversations with third parties. Therapists are restricted from sharing identifying information (through speech) about their clients, even in cases where they may have value conflicts about not sharing confidential information. For example, in the case of an adult who is voluntarily in an emotionally abusive relationship, barring imminent harm to self or others, the therapist cannot report this without client consent according to Colorado law. *See* Colo. Rev. Stat. § 12-245-220. So too for issues of public concern—a therapist could not run to the papers with scandalous information about a political candidate that was revealed in therapy, even if the therapist had a firmly held belief that the candidate should not hold office based on what he had revealed. *See id.* And this applies even if the therapist's speech is religiously motivated. A therapist cannot, for example, call up her client's pastor to express concern about her client's questioning of her faith or engagement in morally problematic behaviors when these are disclosed in therapy.

Conversely, the Act imposes speech requirements in certain circumstances. Therapists are required by

law to break confidentiality in certain scenarios, like when a client has communicated a serious threat of imminent physical violence against a specific person. *See id.* §§ 13-21-117(2), 12-245-220(5). If a minor child seeks therapy services from a licensed therapist, the Act requires the therapist to encourage the child to notify the minor's parents or guardians. *Id.* § 12-245-203.5(3)(b). And the Act requires licensed practitioners to provide certain information to clients, including, for example, a statement indicating that "[a] client is entitled to receive information about the methods of therapy, the techniques used, [and] the duration of therapy, if known" and that "[i]n a professional relationship, sexual intimacy is never appropriate and should be reported." *Id.* § 12-245-216(1)(d).

B. This Court has acknowledged that the State plays an important role in regulating professional conduct, even when that conduct takes the form of speech. In *National Institute of Family & Life Advocates v. Becerra* (*NIFLA*)—a case heavily relied on by Chiles—the Court noted that "[l]ongstanding torts for professional malpractice" do not raise First Amendment concerns because they "'fall within the traditional purview of state regulation of professional conduct.'" 585 U.S. 755, 769 (2018) (quoting *NAACP v. Button*, 371 U.S. 415, 438 (1963)); *see also id.* at 769–70 (recognizing that the Court has upheld speech-mandating informed-consent requirements as regulations of professional conduct).

Chiles attempts to distinguish such regulations as "incidental to regulable conduct." Pet. Br. 32. But that distinction collapses when the "speech" at issue *is* the

conduct being regulated. Many licensed professions are practiced substantially or primarily through speech, and that speech is routinely regulated as professional conduct. An attorney can be sued for malpractice or face bar discipline based on the advice she provided or failed to provide. *See, e.g.*, *Boyd v. Garvert*, 9 P.3d 1161, 1162 (Colo. App. 2000). A doctor can face liability or discipline based on the diagnosis she gave. *See, e.g.*, *Williams v. Boyle*, 72 P.3d 392, 401 (Colo. App. 2003) (citing *McKay v. State Bd. of Med. Examiners*, 86 P.2d 232 (Colo. 1938)). And a licensed mental health professional can face licensure sanctions or malpractice liability for offering unproven and potentially harmful therapeutic modalities. *See supra* Section IV.A.

The Court recently held that States have leeway in regulating professional services that are untested and may pose serious harm. In *United States v. Skrmetti*, in the context of gender-related treatments for minors, the Court held that the Constitution "afford[s] States 'wide discretion to pass legislation in areas where there is medical and scientific uncertainty.'" 145 S. Ct. 1816, 1836 (2025) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)); *see also id.* at 1852 (Barrett, J., concurring) ("The question of how to regulate a medical condition such as gender dysphoria involves a host of policy judgments that legislatures, not courts, are best equipped to make."). There is no reason why that discretion should not apply equally to professional healthcare services that are provided through speech. And for the reasons *amici* have explained, the Colorado legislature exercised its discretion wisely here. *Supra* Section III.

C. If the Court were to adopt Chiles's position that strict scrutiny applies here, it would upend malpractice law and the regulation of professions that provide speech-based services. As this Court has repeatedly held, the First Amendment applies in the same manner to "state tort suits," like malpractice, as it does to traditional government regulation. *See Snyder v. Phelps*, 562 U.S. 443, 451 (2011); *see also Hustler Mag., Inc. v. Falwell*, 485 U.S. 46, 53 (1988). So if statutory or regulatory restrictions on the professional practice of licensed therapists trigger strict scrutiny under the First Amendment, so too does the entire regulatory and malpractice regime that governs other speech-based professional services.

Not only therapists but also lawyers, doctors, schoolteachers, financial advisors, real estate agents, and many others practice their regulated professions partly or entirely through their words. States regulate that "speech"—really, that professional conduct—to ensure those professions are practiced responsibly and to protect the public. Given that strict scrutiny is "fatal in fact absent truly extraordinary circumstances," *Free Speech Coal., Inc. v. Paxton*, 145 S. Ct. 2291, 2310 (2025), a ruling for Chiles here would mark a sea change in the regulation of professions in this country. *See also id.* ("Strict scrutiny therefore cannot apply to laws … which are traditional, widespread, and not thought to raise a significant First Amendment issue.").

* * *

As Christians, *amici* sympathize with Chiles's concerns about laws that target religious populations and impinge upon deeply held beliefs and values. But

the law here does not implicate those concerns. And adopting Chiles's position would not just undermine the Colorado law at issue here; it would call into question the entire regulatory regime for licensed therapists and other professionals that is critical to ensuring patient care and protecting the public.

CONCLUSION

The judgment below should be affirmed.

Respectfully submitted,

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