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.

On Writ of Certiorari to
the United States Court of Appeals
for the Tenth Circuit

BRIEF OF *AMICUS CURIAE* THE AMERICAN COLLEGE OF PEDIATRICIANS IN SUPPORT OF PETITIONER

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INTRODUCTION AND INTEREST OF *AMICUS CURIAE*[1]

The number of American children presenting with gender-related psychological distress has surged in recent years. Most of the medical community has responded by stepping back and reevaluating best practices, exemplified in England's comprehensive Cass Review (2024) and the U.S. Department of Health & Human Service's (HHS) Treatment for Pediatric Gender Dysphoria report (2025). Colorado has chosen not to reassess, but to entrench its preferred approach by banning dissent.

Colorado generally permits the practice of psychotherapy—guided conversations between a licensed mental-health professional and a client, which clinicians rely on every day to treat anxiety, depression, PTSD, eating disorders, and countless other concerns. But under the Colorado Minor Conversion Therapy Law, the State prohibits even client-initiated, exploratory psychotherapy if the client's goal is to feel at peace with their biological sex. When children who are distressed with thoughts (i.e. "gender identities") not aligned with their bodies (i.e. biological sex) present to a counselor, this statute forbids the counselor from resolving that distress by affirming their bodies and exploring the underlying reasons their thoughts are at odds with their bodies.

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

The harms of Colorado's statute are especially evident here as (1) the majority of youth with gender dysphoria also suffer from pre-existing underlying mental health conditions such as anxiety, depression, trauma, or autism, and (2) between 80-95% of youth with gender dysphoria will naturally desist as they age—*if* they are not affirmed in false ideas of sexual identity. Yet Colorado bans client-directed speech that treats depression or trauma in youth *when* that speech opposes the State's view of gender. The law is based on the State's preferred ideology, not evidence.

This approach is of great concern to the American College of Pediatricians (the College or ACPeds), one of the Nation's leading, science-oriented medical organizations. The College is a national organization of nearly 500 board-certified pediatricians or related specialists with active practices in 46 different states, all dedicated to the health and well-being of children. Formed in 2002, the College is a scientific medical association committed to producing policy recommendations based on the best available scientific research. The College strives to ensure that all children reach their optimal physical and emotional health and well-being.[2]

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[2] In keeping with these objectives, the American College of Pediatricians, other medical organizations representing over 75,000 physicians and healthcare providers, and over 5,600 individual signatories, recently issued a declaration—the Doctors Protecting Children Declaration—stating that "Medical decision making should respect biological reality and the dignity of the person by compassionately addressing the whole person. * * * [Yet,] [g]ender ideology seeks to affirm thoughts, feelings and beliefs, with puberty blockers, hormones, and surgeries that harm healthy bodies, rather than affirm biological reality."

Amicus's members provide high-quality medical services to children and other patients without discrimination based on sex or any other characteristic prohibited by law. In doing so, *Amicus*'s members cannot harm or lie to their patients. Based on their commitment to scientific integrity and the ethical obligation to do no harm, *Amicus*'s members cannot engage in the "affirming-only" model that Colorado dictates. The College has a direct interest in the outcome of this case because it threatens to impose professional sanctions on medical professionals employing best practices.

Amicus submits this brief to show how the Colorado law muzzles medical professionals despite lacking an evidentiary foundation that talk therapy harms youth with gender dysphoria. While this brief concentrates on counseling regarding gender dysphoria, the First-Amendment analysis and the faulty support for the Court of Appeals' conclusions regarding change-allowing talk therapy applies equally to counseling about sexual orientation.

Decl., Doctors Protecting Children (2024), https://doctors protectingchildren.org/.

SUMMARY

Psychotherapy, often in the form of change-allowing talk therapy, is a well-accepted method of addressing psychological distress, including anxiety, depression, and other mental health conditions. Colorado recognizes the value of such therapy in general yet, without evidentiary basis, bans its use when a clinician pursues a patient's self-selected goal in addressing unwanted same-sex attraction or gender dysphoria. In doing so, the State prohibits licensed therapists from helping patients, especially minors, pursue their personal mental health goals. The Tenth Circuit's decision upholding this ban should be reversed.

I. Psychotherapy is a critical tool for treating minors with gender dysphoria who often present with other mental health conditions such as depression or anxiety. Further, psychotherapy is needed to address child abuse and other adverse childhood events that are common in children with gender dysphoria. This is because issues of gender incongruence are issues of the mind and not the body, and because substantial evidence shows that most youth with gender-related distress will naturally desist if not socially or medically transitioned. Accordingly, treatment should be for the mental health distress and not altering a perfectly healthy body. But the exact opposite is true in Colorado: the law mandates "affirmation" of a psychological identity at odds with biological reality, regardless of the patient's needs or goals, while barring helpful therapy that treats comorbid mental health conditions or other trauma contributing to the child's distress.

II. Colorado's law imposes sweeping restrictions on ethical, client-directed psychotherapy by banning speech because it does not align with the State's preferred conception of gender. The Tenth Circuit acknowledged as much. Pet. 50a. In doing so, the panel drastically understated the law's reach. In practice, the statute prohibits therapists from offering basic diagnostic assessments or engaging in exploratory discussions *if* those actions might "change behaviors or gender expressions[.]" Colo. Rev. Stat. § 12-245-202(3.5)(a). Through its interaction with other laws, such as Colorado's child abuse statute, the therapy ban exposes even good-faith referrals made in a clinician's professional judgment to criminal liability.

III. Colorado and the Tenth Circuit present no credible evidence that discussions of gender distress between a patient and therapist are harmful. The studies it relies on are both irrelevant and suffer from serious methodological flaws. By contrast, the most comprehensive review to date—England's Cass Review—found either benefit or no change from such therapy while finding no evidence of harm. The absence of demonstrable harm is underscored by the complete lack of disciplinary action against therapists for providing change-allowing talk therapy.

While banning well established and beneficial therapy techniques, Colorado promotes intrinsically harmful and experimental hormonal and surgical interventions for gender dysphoric youth. By Colorado only allowing "affirming" therapies, children are pushed onto a tragic and invasive medical pathway that only increases mental and physical harms to

these children. Thus, Colorado undermines its asserted interest in preventing unproven or harmful practices by permitting (and mandating insurance coverage for) a range of harmful "gender-affirming" interventions. To know what Colorado allows or bans, one merely asks if the practice supports the State's ideology.

In short, Colorado silences certain speech not to protect children, but to enforce an ideology. The Tenth Circuit's decision upholding that ban should be reversed.

ARGUMENT

Best-practice forms of talk therapy can relieve mental health conditions like anxiety, trauma, and depression, which often present with a minor patient experiencing gender dysphoria. It can also assist in addressing childhood trauma such as abuse or familial mental health issues gender dysphoric children have experienced. But Colorado has banned that speech if either the client's or therapist's goals do not align with the State's preferred gender ideology.

Licensed counselors, including pediatricians, "do[] not begin counseling with any predetermined goals other than those that the clients themselves identify and set." Pet.207a, ¶85. Yet the Court of Appeals upheld a law that outlaws any attempt to reduce gender incongruence, even if client-directed. The law bans or mandates outcome specific speech-based care in cases where:

- A girl says she wants to feel comfortable being a girl;

- A teen says "I want to talk about why I feel this way and where it's coming from" when those feelings include same-sex attraction or gender incongruence; or
- A parent says "we're worried this started after abuse."

The state's ban rests on political preferences, not evidence. This Court has recognized that regulating the content of professionals' speech "poses the same 'risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.'" *National Inst. of Fam. & Life Advocs.* v. *Becerra*, 585 U.S. 755, 757 (2018) (quoting *Turner Broad. Sys., Inc.* v. *F.C.C.*, 512 U.S. 622, 641 (1994)). The Colorado law is thus a content-based speech restriction: "the 'conduct' being regulated here is speech itself, and it is being regulated because of disapproval of its expressive content." Pet. 88a (Hartz, J., dissenting).

To help the Court evaluate how the State's law targets speech and fails to advance its stated interests of protecting children, ACPeds will focus on (a) the medical evidence concerning youth gender dysphoria and the impact the law has on best-practices care; (b) Colorado's failure to demonstrate a compelling interest for its talk therapy ban; and (c) Colorado's undermining of any purported compelling interest by allowing harmful and unproven medical interventions that align with the State's preferred ideology.

I. Colorado's Therapy Ban Outlaws Speech that Allows Youth to Address Gender Dysphoria in Context of Biological Reality.

To understand why Colorado's therapy ban is both unscientific and dangerous, it is helpful to clarify the proper terminology and summarize what is known about the psychological nature of gender dysphoria in children.

A. Sex is an Immutable Biological Characteristic While Gender Identity is Psychological.

Biological sex is immutable. It is "almost always easily identifiable at birth (if not before) based upon phenotypic expression of chromosomal complement [XX for female, and XY for male]. * * * To describe sex as 'assigned at birth' is inaccurate and misleading."[3]

But some individuals suffer from a condition where their mental state cannot accept or feels marked discomfort with their biological sex. This condition, recognized by almost every psychological association, is known as gender dysphoria: "a psychological condition in which they experience marked incongruence between their experienced gender and the gender associated with their biological sex. They often express the belief that they are the

[3] Am. Coll. of Pediatricians (ACPeds), *Mental Health in Adolescents with Incongruence of Gender Identity and Biological Sex* 2 (2024) ["ACPeds, *Mental Health*"] (citing extensive scientific research), https://tinyurl.com/49pbypk9.

opposite sex."[4] Crucially, gender identity is *psychological* while sex is *biological*:

> *[G]ender identity* is psychological, made up of expectations and self-perceptions. Gender does not exist in the body or in any bodily structure or process. This is in contrast to *sex*, which is determined exclusively by bodily data: genitals and chromosomes.[5]

This background is necessary given the confusing title of Colorado's "Minor Conversion Therapy Law." When a patient presents with incongruence between the youth's biological sex, and the youth's experienced gender, Colorado mandates that mental health professionals "affirm" the incongruent identity. The critical role of non-"affirming" talk therapy, the very therapy prohibited by Colorado, is evident in the fact that, as noted below, gender dysphoria in children is strongly associated with underlying mental health conditions, adverse childhood experiences, autism spectrum disorder, and family dysfunction—factors that usually *precede* the onset of gender-related distress. The very change-allowing talk therapy banned by Colorado is well recognized to relieve such mental health disorders and resolve gender-related discomfort.

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[4] *Gender Dysphoria in Children*, Am. Coll. of Pediatricians (Nov. 2018), https://tinyurl.com/2cnt7jh3 ["ACPeds, *Gender Dysphoria*"] (citing Am. Psych. Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) ["DSM-5"]).

[5] David Schwartz, *Clinical and Ethical Considerations in the Treatment of Gender Dysphoric Children and Adolescents: When Doing Less Is Helping More*, 20 J. Infant, Child & Adolescent Psych. 439, 439 (2021).

Yet, Colorado adopts a "gender-affirming care" model. This is a misnomer, as it does not treat any conditions related to gender; rather it *entrenches* a mental health condition of gender incongruence or dysphoria. By requiring mental health professionals to promote the adoption of an incongruent gender identity when addressing a child's distress over his/her sex, Colorado is effectively *mandating* "conversion therapy." This is so because unless the gender incongruence is affirmed, the overwhelming majority will desist by adulthood as noted below, while those "affirmed" almost always persist in their incongruence and seek more invasive and dangers medical interventions. Accordingly, based on the evidence below, Colorado's ban essentially forces transition by prohibiting licensed counselors from helping a child understand his or her feelings of distress or discomfort with that child's sex.

B. Gender Dysphoria Reflects Psychiatric Distress Best Addressed Through Psychotherapy.

As noted above, gender dysphoria is a psychiatric condition, not a disorder of the body.[6] This means that children with gender dysphoria do not have a disordered body—even though they feel as if they do.[7] Thus, treatment should be psychological, often through change-allowing talk therapy designed to alleviate feelings of gender incongruence (or same-sex attraction) and the associated distress associated with such feelings.

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[6] See *Gender Dysphoria*, DSM-5, at 452-459.

[7] ACPeds, *Gender Dysphoria*.

Adequate treatment requires acknowledging this fact, along with the fact that gender dysphoria is frequently comorbid with anxiety, depression, autism spectrum disorder, and trauma.[8] For instance:

- Finland's Gender Identity Services found 75% of adolescents they saw were or had been undergoing psychiatric treatment for reasons other than gender dysphoria.[9]
- A four nation European study found almost 70% of people with gender identity disorder had "a current and lifetime diagnosis" other than gender dysphoria.[10]
- A Kaiser-Permanente study gleaned from electronic medical records of 8.8 million members in Georgia and California found prevalence ratios in the six months before first findings of gender non-conformity compared to gender congruent peers: psychological disorders 7 times higher overall, psychological hospitalizations 22-44

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[8] Pien Rawee et al., *Development of Gender Non-Contentedness During Adolescence and Early Adulthood*, 53 Archives of Sexual Behav. 1813, 1822 (2024) (internal citations omitted); see also ACPeds, *Mental Health*, at 3 ("Using five independent cross-sectional datasets consisting of 641,860 individuals, researchers found 'transgender and gender-diverse individuals have, on average, higher rates of autism, other neurodevelopmental and psychiatric diagnoses'").

[9] Riittakerttu Kaltiala-Heino et al., *Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development*, 9 Child & Adolescent Psych. & Mental Health 1, 1, 6-7 (2015).

[10] Gunter Heylens et al., *Psychiatric characteristics in transsexual individuals: multicentre study in four European countries*, 204 Brit. J. Psych. 151, 152-153 & tbl. 2 (2014).

times higher, self-harm 70-144 times higher, and suicidal ideation 25-54 times higher.[11]

- A parental survey of minors with Rapid Onset Gender Dysphoria found 62.5% of gender dysphoric adolescents had "a psychiatric disorder or neuro-developmental disability preceding the onset of gender dysphoria," 48.4% had experienced a traumatic or stressful prior event.[12]

Accordingly, youth presenting with gender dysphoria frequently have another underlying mental health condition that *can* be treated and "many psychological therapies have a good evidence base for the treatment in the general population of conditions that are common in this group, such as depression and anxiety."[13]

Best practices for a mental health practitioner, then, will often involve treating a youth with gender dysphoria for his or her underlying anxiety or depression. But if doing so also addresses gender incongruence, Colorado prohibits the therapy, only allowing it if the practitioner simultaneously assists with an impossibility, "gender transition."

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[11] Tracy A. Becerra-Culqui et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 Pediatrics e20173845, at 2, 5, 6 & tbls. 3, 4 (2018).

[12] Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria,* 13 PLoS ONE e0202330, at 13 (2018).

[13] Hilary Cass for NHS England, The Cass Review, Final Report 30 (as amended Dec. 2024), https://tinyurl.com/3mzfckv2 ["Cass Review"].

C. Most Youth with Gender Dysphoria Naturally Desist Without Affirmation While Affirmed Youth Proceed to More Invasive Intervention.

The natural resolution of gender dysphoria in most youth underscores *why* it is so important to address the underlying mental health conditions that so often accompany it. The high desistance rate into adulthood is striking, with studies finding the overwhelming majority of youth will no longer suffer from gender discomfort as adults:

- DSM-5 reports that 70 to 97.8% of natal males and 50 to 88% of natal females desist by adulthood.[14]
- The Endocrine Society Guidelines, a notable proponent of an affirmation-only approach admit that "the large majority (about 85%) of prepubertal children with a childhood diagnosis [of GD] did not remain GD/gender incongruent in adolescence[.]"[15]
- A 2021 study that constituted the "largest sample to date of boys clinic-referred for gender dysphoria" found an 87.8% desistance rate.[16]

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[14] DSM-5, at 454-455.

[15] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology Metabolism 3869, 3879 (2017).

[16] Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Frontiers in Psych. 632784, at 1, 8 (2021).

- Another study found 80–95% of gender dysphoric pre-pubertal children desist by the end of adolescence.[17]

While *desistence* is natural, when following Colorado's "affirmation only" approach a minor almost always *persists* in an incongruent gender identity.[18]

Because "[s]ocial transition is associated with the persistence of GD [gender dysphoria]/gender incongruence as a child progresses into adolescence,"[19] the APA has recommended that "[p]remature labeling of gender identity should be avoided. Early social transition (i.e., change of gender role * * *) should be approached with caution to avoid foreclosing this stage of (trans)gender identity development."[20] That is because while natural desistence predominates, children in such studies on gender dysphoria who socially "transitioned"[21] in early childhood were more

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[17] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893, 1895 (2008).

[18] William Byne et al., *Report of the APA Task Force on Treatment of Gender Identity Disorder*, 169 Am. J. Psych., Suppl., 1, 4 (2012) (The American Psychiatric Association observed that "only a minority" of those diagnosed with childhood gender identity disorder "will identify as transsexual or transgender in adulthood (a phenomenon termed *persistence*), while the majority will become comfortable with their natal gender over time (a phenomenon termed *desistance*)."); Rawee et al., note 8, at 1818.

[19] Hembree et al., *Endocrine Treatment,* at 3879.

[20] Bockting, at 744.

[21] Social transitioning "consists of first affirming the child's false self-concept by instituting name and pronoun changes, and facilitating the impersonation of the opposite sex within and outside of the home." ACPeds, *Gender Dysphoria*.

likely to have persisting feelings of gender dysphoria.[22] Such affirmation efforts also significantly increase the likelihood of a medical pathway that fails to address the child's mental health while permanently harming their developing bodies.[23] The evidence-based approach is therefore to simply allow a child to grow up without being "affirmed" in an incongruent gender identity.

D. Psychotherapy Is an Important Tool for Treating Minors Suffering from Gender Dysphoria.

The evidence consistently supports the use of psychotherapy to treat youth with gender-related distress, particularly by targeting the underlying mental health issues that commonly accompany gender dysphoria.

> All mental health professionals recognize the ability of therapy to treat some mental health conditions. Indeed, HHS has recently recognized a key contradiction when gender dysphoria is at issue: "psychotherapy is both recognized as an important tool but is also stigmatized if its aim is the resolution of GD."[24] Similarly, the Cass Review observed

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[22] Rawee et al., at 1814 (citation omitted); see also ACPeds, *Mental Health*, at 7; ACPeds, *Gender Dysphoria* (study of 70 pre-pubertal candidates to receive puberty suppression showed that every child "eventually embraced a transgender identity and requested cross-sex hormones"); Cass Review, at 176.

[23] Cass Review, at 31.

[24] U.S. Dep't Health & Hum. Servs., Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices 88 (as corrected 2025) ["HHS Report"], https://tinyurl.com/2x4enzkn.

> the harmful results of demonizing therapeutic approaches to resolving gender dysphoria as Colorado has done here.[25]

Even commentators supportive of affirmation now acknowledge that it is improper to "mis-categorize[] ethical psychotherapies that do not fit the 'affirmation' descriptor as conversion therapies" and that "[s]tigmatizing non-'affirmative' psychotherapy for GD as 'conversion' will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress."[26]

This polarization has chilled research into treating gender dysphoria, contributing to the current situation in which "the certainty of evidence was very low."[27] Yet as the HHS Report concluded, "no harms were reported" from therapy for youth with gender dysphoria.[28] Similarly, the Cass Review found that "[m]ost analyses of mental health, psychological and/or psychosocial outcomes showed either benefit or no change, with none indicating negative or adverse effects."[29]

But there *is* robust evidence that youth with gender dysphoria benefit when their other underlying mental conditions are treated through therapy. A recent report shows "there is available evidence to

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[25] Cass Review, at 150.

[26] Roberto D'Angelo et al., Letter to Editor, *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Arch. Sexual Behav. 7, 7 (2020).

[27] HHS Report, at 88; accord Cass Review, at 30.

[28] HHS Report, at 88.

[29] Cass Review, at 5.

support the role of psychotherapy in treating children and adolescents with other mental health problems, including depression, anxiety, eating disorders, self-harm, and suicidality."[30] And as the Cass Review found, "we know that many psychological therapies have a good evidence base for the treatment in the general population of conditions that are common in [youth with gender dysphoria], such as depression and anxiety."[31] When considered in light of the strong natural desistance and lack of evidence to support the State's mythical harms from change-allowing talk therapy, treating a child's underlying mental health concerns through standard psychotherapy will often assist in resolving a child's gender dysphoria—the very result Colorado opposes, so it bans the one means of actually helping such vulnerable children.[32]

II. Colorado's Law Bans Ethical, Client-Directed Psychotherapy.

It is against this backdrop that Colorado's ban on "conversion therapy" must be evaluated. In reality, the statute outlaws and chills a wide swath of therapeutic

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[30] HHS Report, at 89.

[31] Cass Review, at 30.

[32] Tatiana Brandsma et al., *A Pilot Study on the Effect of Peer Support on Quality of Life of Adolescents with Autism Spectrum Disorder and Gender Dysphoria*, 54 J. Autism Dev. Disorder 997, 1006 (2024) (study on such treatment of youth with gender dysphoria "found that participating in a specific peer support group increased psychological well-being and decreased psychological complaints in these adolescents with [Autism Spectrum Disorder] and [Gender Dysphoria], thereby increasing their quality of life").

speech that aligns with clinical best practices and respects patient autonomy.

A. Colorado's Statute Enforces the State's Preferred Ideology by Banning Beneficial Speech.

The Therapy Ban prohibits "any 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[.]" Colo. Rev. Stat. § 12-245-202(3.5)(a). But the statute carves out the State's preferred speech encouraging the lie that a person's sex is not what it is. *Id.* § 12-245-202(3.5)(b)(II). In as much as gender identity is sexual identity, affirming that a male is not a male or a female is not a female entrenches a false concept of sex. Yet that is what this statute does.

The statute bans disfavored speech to implement the "[a]ffirmative model" addressing gender dysphoria, "which affirms a young person's subjective gender experience[.]"[33] In an Orwellian twist, the "conversion therapy" law that purportedly bans efforts to "change an individual's * * * gender identity" expressly encourages a boy to falsely think he is a girl by helping him impersonate a girl, but it prohibits helping him accept that he is male.

The result is a ban on beneficial, ethical, and truthful speech that mental health professionals commonly use to diagnose clients and reduce their distress. The ban even silences counseling initiated and directed by the client. Colorado forbids

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[33] Cass Review, at 235. This approach "originated in the USA" and spread "across the Western world." *Id.*

practitioners from helping "clients with 'same-sex attractions or gender identity confusion' who 'prioritize their faith above their feelings and are seeking to live a life consistent with their faith,'" even when the clients' false sexual identity led to "'internal conflicts, depression, anxiety, addiction, eating disorders and so forth.'" Pet.14a (quoting Compl. ¶111 [see Pet.214a-215a]). The Tenth Circuit agreed that such speech plainly falls within the statute's prohibition. See Pet. 23a.

The statute further bans a wide range of evidence-based, best-practices speech. For instance:

- **Pediatric Client A** presents with gender dysphoria and tells her therapist she hopes her gender will align with her biological sex. The therapist may only administer a diagnostic assessment to determine if client suffers from gender dysphoria if done to promote "gender transition" and not to help the client align her gender identity with her sex.
- **Adolescent Client B**, who has socially and medically "transitioned," comes and expresses discomfort and dismay. She says she would like to discuss whether she should explore detransitioning. The therapist evaluates the client and determines that detransitioning is in the client's best interest. Colorado, however, prohibits such a conversation, only allowing the therapist to promote the "gender transition" rejected by the client.
- **Adolescent Patient C**, undergoing puberty, expresses distress over his sudden growth in body

> hair and deepening voice. The therapist employs a "watchful waiting" approach, and asks gender exploratory questions to diagnose the patient: When did you first feel distressed by your sexed body? Do you feel safe in your body? This method, which recognizes the reality that most patients desist over time, violates the statute merely by leaving open the path to desistance for helping the patient reflect on his body in a healthier way "change[s] * * * behaviors or gender expressions" in violation of the law.

Each of these examples involves speech that aligns with patient goals, reflects sound clinical judgment, and follows established standards of care. Yet Colorado prohibits it, *because* it might help youth reach better mental health outcomes and desist from an incongruent gender identity. So, to promote its ideology, Colorado silenced opposing speech.

B. The Statute's Breadth Sweeps in Far More Speech than the Tenth Circuit Acknowledged.

The Tenth Circuit accepted that the law "abridged" Ms. Chiles's speech but upheld it because she still had the right to say other things. See Pet. 50a. That is emphatically *not* how this Court has interpreted the First Amendment. See *Schneider* v. *New Jersey*, 308 U.S. 147, 163 (1939) ("[O]ne is not to have the exercise of his liberty of expression in appropriate places abridged on the plea that it may be exercised in some other place."). And the extent of the "abridgement" is seen in how Colorado's Therapy Ban interacts with other state law to criminalize much more speech than the Tenth Circuit recognized.

For instance, the Tenth Circuit asserted that "Ms. Chiles may * * * share with her minor clients her own views on conversion therapy, sexual orientation, and gender identity." Pet. 47a. But consider a minor patient who presents with gender dysphoria seeking help. The therapist responds by helping the child become more comfortable in his/her body and provides the child's parents with evidence documenting the long-term harms of medical transition, along with statistics on natural desistance. Has the therapist made an "effort[] to change behaviors or gender expressions" in violation of the law? *Contra* Colo. Rev. Stat. § 12-245-202(3.5)(a). On the face of the statute, the answer is clearly yes.

The panel also suggested that Ms. Chiles "may refer her minor clients to service providers outside of the regulatory ambit who can legally engage in efforts to change a client's sexual orientation or gender identity." Pet. 47a. But that is not at all clear. First, referring a patient to an *unlicensed* mental health practitioner may very well expose her to malpractice liability. Further, referring a patient for such therapy likely constitutes an "effort[] to change behaviors or gender expressions[.]" Contra Colo. Rev. Stat. § 12-245-202(3.5)(a). Of course, the "safe harbor" provision for religious ministers only covers the religious minister; it offers no protection for licensed practitioners. Colo. Rev. Stat. § 12-245-217(1)

And the risks for clinicians under Colorado law extend far beyond professional discipline. Because the State has declared that non-affirming talk therapy is "harmful," such therapy may expose providers to criminal child abuse liability. See Colo. Rev. Stat. § 18-

6-401(1)(a). Given the State's ideological commitments, a referral falls squarely within the statute's scope. The Therapy Ban does not merely chill protected speech; it criminalizes it.

III. No Compelling Interest Justifies Colorado's Ban on Speech.

The State justifies its actions by claiming "conversion therapy" is ineffective and harms patients. But there is no evidence to support this claim. The most comprehensive studies available conclude that talk therapy either *benefits* patients suffering from gender dysphoria or causes them no adverse effects. Meanwhile, the studies cited by the State and its *amici* suffer from fundamental design flaws: they rely on self-selected samples, confuse correlation with causation, and exclude subjects for whom therapy may have been *effective*. Meanwhile, the State undermines any claimed compelling interest by permitting harmful interventions—including hormone therapy and surgery—for minors with gender dysphoria, because they further the State's preferred ideology, not because they help kids.

A. Talk Therapy Causes No Harm to Youth Suffering from Gender Dysphoria.

The Tenth Circuit, applying rational basis, held that the Therapy Ban serves a "legitimate and important interest[]" in "protect[ing] minors from ineffective and harmful therapeutic modalities." Pet. 61a, 72a. Like Colorado's statute as a whole, the claim that talk therapy causes harm to youth with gender dysphoria rests on ideology, not evidence.

The most comprehensive analysis of the question to date was a systematic literature review and narrative synthesis commissioned by the Cass Review.[34] While the review acknowledged that "[m]ost studies were of low quality," the authors concluded that "[m]ost analyses of mental health and psychosocial outcomes showed either benefit or no change, *with none indicating negative or adverse effects*."[35]

At the same time, the review found that the studies evidenced improvement of mental health comorbidities through the use of change-allowing talk therapy, what Colorado calls "conversion therapy", by finding improvements in depression, anxiety and suicidality.[36]

In short, "there is no reliable evidence to suggest that psychotherapy for GD is harmful[.]"[37]

B. Colorado's Proffered Studies Lack Scientific Rigor and Fail to Show that Therapy Harms Youth with Gender Dysphoria.

The core studies that the State offered, and the Tenth Circuit relied on, each suffer from fundamental flaws. Most obviously, none of them specifically analyze the issue of *talk therapy* to *minors* suffering

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[34] See Cass Review, at 53.

[35] Claire Heathcote et al., *Psychosocial support interventions for children and adolescents experiencing gender dysphoria or incongruence: a systematic review*, 109 Arch. of Disease in Childhood s19, s19 (2024) (emphasis added).

[36] See Cass Review, at 153 (discussing Heathcote et al.).

[37] HHS Report, at 251-252.

from *gender dysphoria*. The studies also suffer from two key design flaws. First, each study or report suffers from a retrospective design without longitudinal controls, which means the design cannot establish causation, and therefore cannot show whether therapy caused harm.[38] Second, all rely on convenience sampling, which is notorious for bias.[39] Indeed, the studies Colorado cites drew its participants from LGBTQ platforms and organizations, ensuring that the studies systematically exclude those who do not self-identify as a member of those groups.[40] And, of course, the 2015 report by the Substance Abuse and Mental Health Services Administration (SAMHSA), a subagency of HHS, stands discredited with HHS now warning all readers that the report "is extremely

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[38] See, *e.g.*, Jae W. Song & Kevin C. Chung, *Observational Studies: Cohort and Case-Control Studies,* 126 Plastic & Reconstructive Surgery 2234, 2234 (2010) ("Because the temporal relationship between disease occurrence and exposure cannot be established, cross-sectional studies cannot assess the cause-and-effect relationship.").

[39] Lior Gideon, *Handbook of Survey Methodology for the Social Sciences* 66 (2012) ("[c]onvenience sampling is to be avoided *always* in survey research" because one "cannot make statistical generalizations from research that relies" on it).

[40] Amy E. Green et al., *Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018*, 110 AJPH Open-Themed Rsch. 1222 (2020) [Green et al. (2020)]; Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. Adolescent Health 643 (online 2021, print 2022) [Green et al. (2022)]; Am. Psych. Ass'n (APA), *Report of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation* at 34 (2009), https://tinyurl.com/y9vwd7s5 (Jt. App'x 131-517).

inaccurate" and that "this Department rejects it."[41] Indeed, the more recent and better-evidenced guidance from SAMHSA recommends that dialectical behavior therapy (DBT) is an effective treatment to reduce suicidality and self-harm in adolescents—conditions that frequently co-occur with gender dysphoria.[42]

C. The Absence of Disciplinary Action Shows the Harms Are Purely Speculative.

Besides the empty research dossier, the "danger" of therapy bans is belied by the complete lack of disciplinary actions against mental health professionals employing therapy for youth with gender dysphoria.

The First Amendment forbids restricting rights based on speculative harms. Indeed, this Court has "never accepted mere conjecture as adequate to carry a First Amendment burden[.]" *Nixon* v. *Shrink Mo. Gov't PAC*, 528 U.S. 377, 392 (2000). Yet when it comes to documented, real-world cases of harmful therapy, that is all that Colorado has offered.

Complaints of harmful practices or clinician misconduct are handled by state licensing boards comprised of appointed, licensed mental health

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[41] Off. Disease Prevention & Health Promotion, U.S. Dep't Health & Hum. Servs., About this resource, *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* (Feb. 14, 2025).

[42] See SAMHSA, PEP20-06-01-002, Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth 18-20 (2020).

professionals. So if "conversion therapy" were a scourge on the safety of America's youth, one would expect a record of documented disciplinary actions in this tightly regulated profession.

Indeed, even critics acknowledge there is no documented harm. A 2016 article in the *Journal of Medical Regulation*—authored by a group broadly hostile to change-allowing therapy—acknowledged: "As of this writing, to our knowledge, there have been no formal actions by a regulatory body against a provider for engaging in conversion therapy."[43] Nor have Colorado or its *amici* provided any evidence of such action in the years since that publication.

D. Colorado Undermines Its Purported Interest by Allowing Ineffective and Harmful Gender Practices that Align with the State's Ideology.

Tragically, Colorado bans treatments that are likely to help a child experiencing gender dysphoria while promoting hormonal and surgical efforts to "transition" a child that are not simply without any long-term benefits to a child but actually harm the child's long-term mental and physical health. While desistence is typical, Colorado's mandated "affirmative" approach pushes children toward hormonal treatment and, often, surgery.

"[A] 'law cannot be regarded as protecting an interest of the highest order, and thus as justifying a restriction on truthful speech, when it leaves appreciable damage to that supposedly vital interest

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[43] Jack Drescher et al., *The Growing Regulation of Conversion Therapy*, 102 J. Med. Regul. 7, 10 (2016).

unprohibited[.]'" *Reed* v. *Town of Gilbert*, 576 U.S. 155, 172 (2015) (quoting *Republican Party of Minn.* v. *White*, 536 U.S. 765, 780 (2002)).

Here, Colorado *says* it bans "conversion therapy" because it is unproven and harmful. But Colorado allows unproven and demonstrably harmful treatments when those treatments align with the State's preferred ideology. This demonstrates the ban lacks a compelling interest.

1. Colorado Allows Ineffective and Harmful Practices that Align with Its Preferred Ideology

The Court of Appeals concluded that Colorado has an interest in banning medical practices that are "harmful to minors" and therapies that are "ineffective." Pet. 63a-67a. But the State allows more ineffective and permanently harmful practices to facilitate a "gender transition" because they align with its ideological commitments. That contradiction undercuts any asserted interest in preventing ineffective services.

The Cass Review's extensive analysis found that the most promoted interventions for gender-dysphoric youth, the use of puberty blockers, cross-sex hormones and surgical efforts, which Colorado promotes, were *not* proven to be effective.[44] The Cass Review further observed that, "[t]he adoption of a treatment with uncertain benefits without further scrutiny is a significant departure from established practice."[45] But

[44] Cass Review, at 13, 75-76.

[45] *Id.* at 25.

in Colorado, it is ideology, not evidence, that determines whether a treatment is banned outright or mandated by law for insurance coverage.

Puberty Blockers. Puberty blockers suppress the natural development of secondary sex characteristics, impairing normal brain, bone, and reproductive development. "[B]locking this experience [of puberty] means that young people have to understand their identity and sexuality based only on their discomfort about puberty and a sense of their gender identity developed at an early stage of the pubertal process."[46]

And it relies on unproven drug treatments. The principal puberty-blocking agents—gonadotropin-releasing hormone agonists (GnRHa) such as leuprolide and histrelin—are not FDA-approved for use in treating gender dysphoria.[47] These drugs have long-term effects when used for "gender transition," a purpose that is "very different" from their original (and approved) use in treating precocious puberty.[48] When used for precocious puberty, blockers "allow the child to experience normative psychosocial development alongside same-age peers."[49] But when used for "gender transition," puberty blockers maintain patients "in a prepubertal or early pubertal

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[46] *Id.* at 178.

[47] Ainhoa Gomez-Lumbreras & Lorenzo Villa-Zapata, *Exploring Safety in Gender-Affirming Hormonal Treatments: An Observational Study on Adverse Drug Events Using the Food and Drug Administration Adverse Event Reporting System Database*, 58 Annals of Pharmacotherapy 1089, 1092 (2024).

[48] Cass Review, at 173.

[49] HHS Report, at 110.

stage while their peers developmentally progress."[50] This results in psychological, social, and developmental harms. "There is some evidence of a detrimental impact of pubertal suppression on IQ in children," and there is "no evidence that cognitive effects are fully reversible following discontinuation of treatment."[51]

The drugs also have serious, harmful physical side-effects: "In addition to preventing the development of secondary sex characteristics, GnRH agonists arrest bone growth, decrease bone accretion, prevent the sex-steroid dependent organization and maturation of the adolescent brain, and inhibit fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment."[52]

Hormonal development makes puberty a pivotal time for the accrual of bone mass. Puberty blockers followed by cross-sex hormones (which are administered to roughly 90% of the patients that undergo puberty blockers) shorten or skip that key period. The result is that "patients may never reach

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[50] *Id*.

[51] Sallie Baxendale, *The impact of suppressing puberty on neuropsychological function: A review*, 113 Acta Paediatrica 1156, 1156 (2024).

[52] ACPeds, *Gender Dysphoria* (citing Lauren Schmidt & Rachel Levine, *Psychological Outcomes and Reproductive Issues Among Gender Dysphoric Individuals,* 44 Endocrinology & Metabolism Clinics N. Am. 773 (2015); Sheila Jeffreys, *The transgendering of children: Gender eugenics*, 35 Women's Stud. Int'l F. 384 (2012); Sara B. Johnson et al., *Adolescent Maturity and the Brain: The Promise and Pitfalls of Neuroscience Research in Adolescent Health Policy,* 45 J. Adolescent Health 216 (2009)).

the peak bone density they otherwise would have achieved."[53]

Unsurprisingly, the use of puberty blockers also harms fertility. A recent analysis of nine systematic reviews that assessed the treatment effects of puberty blockers concluded "[t]here is high certainty evidence that PBs * * * often cause infertility" when followed by cross-sex hormones.[54]

Cross-sex Hormones. Cross-sex hormones such as testosterone and estrogen are administered at supraphysiologic levels to minors to induce the secondary sex characteristics of the opposite sex. The dosages are striking. Among adult females, "typical serum testosterone levels range between 2-45 ng/dL," yet cross-sex hormones are typically administered in doses "between 320-1000 ng/dL, comparable to, or exceeding levels found in endocrine disorders."[55]

These drugs are likewise unapproved by the FDA for the treatment of gender dysphoria in children.[56] The adverse drug reactions are serious: "injury, poisoning, and procedural complications," "psychiatric disorders" consisting of "anxiety," "depression," and "suicidal ideation," as well as "nervous system disorders" such as "idiopathic intracranial

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[53] HHS Report, at 111.

[54] *Id.* at 85.

[55] *Id.* at 116 (citing Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 23 Endocrine Prac. 1437 (2017)).

[56] Gomez-Lumbreras & Villa-Zapata, at 1092.

hypertension" and "neoplasms * * * with breast cancer being the most common[.]"[57]

Patients receiving cross-sex hormones continue to suffer from serious mental health issues. Indeed, one recent "comprehensive data review of all 3,754 trans-identified adolescents in US military families over 8.5 years showed that cross-sex hormone treatment leads to increased use of me[n]tal health services and psychiatric medications, and increased suicidal ideation/attempted suicide."[58] A comprehensive Danish national register-based study of adults, children, and young people that had undergone cross-sex hormones found that transgender persons (who were already "five times more likely than controls to have mental health disorders") increased the need for mental health prescriptions from "less than 20% at baseline to more than 30% during follow-up."[59]

"Transition" surgeries. Colorado also permits irreversible surgical procedures on minors, including double mastectomies, hysterectomies, orchiectomies, vaginoplasties, and phalloplasties. Yet, these so-called "gender transition" surgeries are even more harmful

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[57] *Id.* at 1091-1092.

[58] ACPeds, *Mental Health*, at 9, 16 & n.48 (discussing Elizabeth Hisle-Gorman et al., *Mental Healthcare Utilization of Transgender Youth Before and After Affirming Treatment*, 18 J. Sexual Med. 1444 (2021).

[59] Cass Review, at 185 (discussing Dorte Glintborg et al., *Gender-affirming treatment and mental health diagnoses in Danish transgender persons: A nationwide register-based cohort study*, 189 Eur. J. Endocrinology 336 (2023)).

to children, resulting in permanent sterilization and carry high complication rates.[60]

Each of these procedures removes healthy tissue and body parts and constitutes a surgery for which there is no medical justification. Just as a surgeon should not perform liposuction for anorexia, so also surgery to "transition" a child's sex should be considered unethical, unscientific, and malpractice.

And it goes without saying that "transgendered individuals who undergo sex reassignment surgery and have their reproductive organs removed are rendered permanently infertile."[61] This too inflicts permanent, irreversible harm on a child's future possibilities of biological parenthood.

As a result, it is no surprise that, in July 2024, the American Society of Plastic Surgeons (representing 90% of board-certified plastic and reconstructive surgeons in the United States and Canada) cautioned that there is "considerable uncertainty as to the long-

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[60] Paulette Cutruzzula Dreher et al., *Complications of the Neovagina in Male-to-Female Transgender Surgery: A Systematic Review and Meta-Analysis with Discussion of Management*, 31 Clinical Anatomy 191, 193-194 & tbl. 1 (2018) (review of 125 articles on vaginoplasty revealed a complication rate of 32.5%); Jonathan P. Massie et al., *Predictors of Patient Satisfaction and Postoperative Complications in Penile Inversion Vaginoplasty*, 141 Plastic Reconstructive Surgery 911e, 915e-916e & tbl. 2 (2018) (The largest single-surgeon experience in vaginoplasty reported a total complication rate of 70%); Hans Veerman et al., *Functional Outcomes and Urologic Complications After Genital Gender Affirming Surgery With Urethral Lengthening In Transgender Men*, 204 J. Urology 104, 104, 107 (2020).

[61] ACPeds, *Gender Dysphoria* (citing Schmidt & Levine; Jeffreys; Johnson et al.).

term efficacy for * * * chest and genital surgical inventions" for youth."[62] And Dr. Steven Williams, the president of the American Society of Plastic Surgeons has recently publicly stated that he would not "even entertain" surgically transitioning minors because there is a lack of data to support it.[63]

2. Such Interventions Do Not Improve Mental Health or Reduce Suicide Risk.

In addition to these serious health risks, the scientific evidence does not support a claim that such interventions actually help children with gender dysphoria. For example, addressing this very issue, the Cass Review did a detailed analysis of studies on the relationship between gender dysphoria and suicide finding that the studies did not support a claim that a "medical pathway * * * [of] gender-affirming treatment reduces suicide risk."[64]

To the contrary, it is by now well established that, as ACPeds has elsewhere summarized, "over 90 percent of people who die of suicide have a diagnosed mental disorder. There is no evidence that gender-dysphoric children who commit suicide are any different. Therefore, the cornerstone for suicide prevention should be the same for them as for all children: early identification and treatment of

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[62] Leor Sapir, *A Consensus No Longer*, City J. (Aug. 12, 2024).

[63] Rich McHugh, *'No Good Evidence' for Teen Gender Surgery: Plastic Surgeons Head,* NewsNation (Sept. 2, 2024).

[64] Cass Review, at 186; see generally *id.* at 186-187.

psychological co-morbidities."[65] Yet, if treating these co-morbidities is designed to address gender incongruence, Colorado forbids the treatment.

This point was illustrated in a recent Finnish study among a population of 2,083 "gender clinic referred adolescents," which revealed that the suicide rate in these adolescents was equal to the suicide rate in 16,643 controls when the groups were matched for underlying mental disorders.[66] In other words, the underlying mental disorder was the cause of the suicide.[67] And, as the Cass Review concluded, "Tragically deaths by suicide in trans people of all ages continue to be above the national average, but there is no evidence that gender-affirmative treatments reduce this. Such evidence as is available suggests that these deaths are related to a range of other complex psychosocial factors and to mental illness."[68]

Further, studies show that puberty blockers, for example, do not address these issues, but may actually make them worse. Indeed, in evaluating an experimental trial of puberty blockers in the U.K.,

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[65] ACPeds, *Gender Dysphoria*(footnote omitted); Matthew K. Nock et al., *Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement*, 70 JAMA Psych. 300 (2013); Jonathan Cavanagh et al., *Psychological autopsy studies of suicide: a systematic review*, 33 Psych. Med. 395 (2003).

[66] Cass Review, at 96.

[67] See Sami-Matti Ruuska et al., *All-cause and Suicide Mortalities Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services In Finland In 1996-2019: A Register Study*, 27 BMJ Mental Health 1, 3 & tbl. 1 (2024).

[68] Cass Review, at 195.

Oxford University Professor Michael Biggs wrote, "[T]here was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and that girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria."[69]

Additionally, in the long term, "sex reassignment" surgery "does not result in a level of health equivalent to that of the general population"—with studies finding "considerably lower general health and general life satisfaction" and that "the rate of suicide among post-operative transgender adults was nearly twenty times greater than that of the general population."[70]

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[69] Michael Biggs, *Tavistock's Experimentation with Puberty Blockers: Scrutinizing the Evidence,* Transgender Trend:Blog (Mar. 5, 2019) (citation omitted).

[70] ACPeds, *Gender Dysphoria* (citing Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoSOne e16885 (2011); Annette Kuhn et al., *Quality of Life 15 years after sex reassignment surgery for transsexualism*, 92 Fertility & Sterility 1685 (2009)); see also, Dhejne et al., *Long-Term Follow-Up*, at e16885; ACPeds, *Mental Health*, at 9-10 ("Sex-reassigned persons * * * had an increased risk for suicide attempts * * * and psychiatric inpatient care" with risks "increasing substantially by 15 *years* after surgical reassignment. At 30 years of follow up, the suicide rate was 19 times that of age-matched controls.").

Sadly, Colorado bans the only treatment option likely to help a child experiencing gender dysphoria while not just *allowing* these dangerous and harmful procedures but *mandating* that insurer provides no-cost coverage of "[h]ormone therapy," "[b]reast or chest augmentation, reduction, or construction," and "[g]enital and nongenital surgical procedures." H.B. 25-1309, § 1, 75 Gen. Assemb., 1st Reg. Sess. (Colo. 2025), codified at Colo. Rev. Stat. §§ 10-16-104(30)(I)(A), (M), (N). This fatally undermines any supposed interest in preventing change-allowing talk therapy to youth with gender dysphoria.

CONCLUSION

Colorado's law does not protect children; it protects a narrative. It rests not on evidence, but ideology, an ideology that traps vulnerable youth in a false and dangerous mindset by denying them treatment that addresses what is, at root, a psychological condition.

The judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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