The Therapy Room Is Not the State's Territory

A Line the Supreme Court Finally Drew

Dr. Jeffrey E. Hansen, Ph.D.

For years now, there has been a slow and unmistakable encroachment into one of the most protected and sacred spaces in our culture, the therapy room. It did not happen all at once, and that is precisely why it was so easy to miss at first. It came gradually, almost quietly, advancing inch by inch. First as guidance. Then as regulation. And eventually as something far more concerning, far more intrusive, the attempt to control what therapists are allowed to say, what questions they are permitted to ask, and which directions of inquiry are deemed acceptable or unacceptable by forces outside the room.

And that is where the line was crossed.

On March 31, 2026, in **Chiles v. Salazar, the Supreme Court of the United States** stepped in and drew a line that should never have been crossed in the first place. In an 8 to 1 decision, the Court made it unmistakably clear that the government does not have the authority to dictate the content of therapy based on preferred viewpoints. That is not regulation. That is not benign oversight. That is overreach, and it is precisely the kind of overreach the Constitution exists to restrain.

This ruling did not merely resolve a legal question. It restored something that had been under

increasing pressure, something foundational, something that cannot be compromised without doing harm to the very people therapy is meant to serve. It restored the integrity of the therapeutic relationship.

How We Got Here

To understand the weight of that decision, you have to understand what was happening in Colorado. Under the stated goal of protecting minors, the state enacted a law that reached directly into the therapy room and began defining what licensed clinicians could and could not explore in conversations related to identity, particularly gender identity. On its surface, it sounded protective, even compassionate. It was framed in the language of care.

But in practice, it functioned as a constraint on clinical judgment. It replaced the nuance of individualized care with a predetermined boundary around what was considered acceptable exploration. It substituted the lived, relational, moment to moment discernment of a trained clinician with a rigid, externally imposed framework.

It did not trust the therapist.
It did not trust the patient.
It trusted the state.

The named respondent, **Patty Salazar**, served as the Executive Director of the Colorado Department of Regulatory Agencies, an administrative position responsible for oversight across a wide range of professions. It is a role rooted in policy, compliance, and enforcement. It is not a role grounded in psychotherapy. It is not shaped by years of sitting with patients, working through trauma, identity confusion, developmental struggles, attachment wounds, and the deeply human process of meaning making.

And yet, through that office, the state assumed the authority to define what constitutes appropriate therapeutic conversation.

That should give every clinician, every parent, and every citizen pause.

Because if that authority stands, the therapy room ceases to be a place of exploration and becomes a place of compliance.

When Regulation Becomes Control

Because the question in this case was never simply about protecting patients. Ethical clinicians are already bound, rigorously and rightly, to protect those they serve. We are accountable to ethical codes, licensing boards, professional standards, and most importantly, to the well-being of the human being sitting across from us.

The real question was whether the state could go further, whether it could begin to prescribe how therapy must unfold, what must be affirmed, what may not be questioned, and which avenues of exploration are effectively closed off, regardless of the patient's own stated goals, experiences, and internal conflicts.

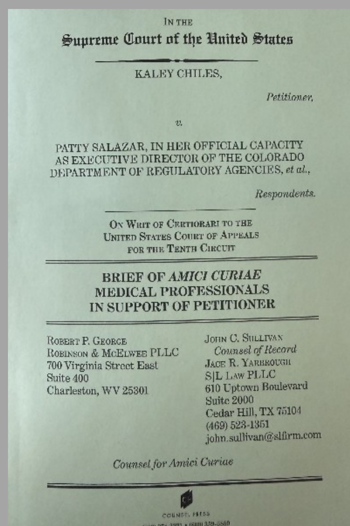
When that occurs, something essential begins to erode. The therapeutic space narrows, not because of clinical judgment, but because of externally imposed limits on what may be explored and understood.

At that point, therapy no longer functions as a process of discovery grounded in the patient's experience. It becomes, in effect, a state directed dialogue, shaped less by the needs of the individual and more by predetermined boundaries of acceptable thought.

That is a profound shift, and a dangerous one.

Why We Stepped Forward

This case drew national attention because many of us recognized what was at stake and chose not to remain silent. I had the privilege, and I would say the responsibility, of contributing to an amicus curiae brief, titled Amicus Curiae Brief of Medical Professionals in Support of Petitioner, alongside colleagues who are not abstract voices, but seasoned professionals with deep expertise across medicine, endocrinology, pediatrics, and clinical care.



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 *AMICI CURIAE* MEDICAL PROFESSIONALS IN SUPPORT OF PETITIONER

ROBERT P. GEORGE
ROBINSON & MCELWEE PLLC
700 Virginia Street East
Suite 400
Charleston, WV 25301

JOHN C. SULLIVAN
Counsel of Record
JACE R. YARBROUGH
S|L LAW PLLC
610 Uptown Boulevard
Suite 2000
Cedar Hill, TX 75104
(469) 523-1351
john.sullivan@slfirm.com

Counsel for Amici Curiae

COUNSEL PRESS

Among those who stood together in this brief were the distinguished and widely respected Michelle A. Cretella, M.D., Executive Director of the American College of Pediatricians; Michael K. Laidlaw, M.D., an endocrinologist and expert in hormone physiology; Quentin L. Van Meter, M.D., a pediatric endocrinologist and former president of the American College of Pediatricians; André Van Mol, M.D., a board-certified family physician and co-chair of the American College of Pediatricians' Committee on Adolescent Sexuality; and Maria Keffler, an author and public speaker focused on parental rights and child advocacy.

Alongside them, I contributed as a clinical psychologist, grounded in decades of work with adolescents, trauma, identity formation, and the layered psychological realities that unfold in the therapy room.

These are not theoretical voices. These are clinicians, physicians, and professionals who have spent their lives working with real patients, real families, and real suffering. These are individuals who carry responsibility, not just opinion.

And we stepped forward together, not because it was easy, but because it was necessary.

Because there are moments when silence becomes complicity.

And this was one of those moments.

The Critical Distortion

At the heart of our concern was a growing and deeply problematic conflation, one that has been repeated often enough that it has begun to take on the appearance of truth.

Historically, what has been called conversion therapy referred to coercive attempts to change sexual orientation. These practices were often ethically indefensible and, in many cases, harmful. They have been widely rejected, and rightly so. There is little disagreement on that point within the profession.

In recent years, however, the meaning of that term has expanded in ways that collapse fundamentally different forms of therapy into a single category. Exploratory therapy, which is careful, patient directed, and grounded in ethical clinical practice, has increasingly been drawn into that same label. In doing so, an important distinction has been lost.

This concern has been articulated clearly by **Debra Soh, Ph.D.,** a sexologist and former academic researcher whose work has been published in peer reviewed scientific journals, including research conducted at institutions such as York University. Though generally regarded as politically liberal leaning, she has been notably willing to challenge ideological overreach from within her own side. In her book *The End of Gender*, she describes how the term conversion therapy has been inflated through **conflation,** expanding beyond its original meaning in ways that erase critical distinctions. What follows is not simply imprecision, but a critical distortion of meaning that reshapes the conversation, misrepresents the nature of therapeutic work, and obscures the ethical boundaries that actually matter. This is not a minor semantic issue. It is a meaningful mischaracterization that carries real consequences for both clinicians and patients.

When a patient says, "*I do not want to move in a certain direction, but I need to understand why I feel this way,*" the ethical response is not to shut that down. It is not to redirect them toward a predetermined outcome or to foreclose exploration before it has even begun.

The ethical response is to engage the question fully and thoughtfully. It is to explore developmental history, trauma, relational patterns, identity formation, and the broader psychological landscape in which that experience has emerged. It is to remain grounded in the patient's stated goals while bringing clinical skill, curiosity, and care to the process.

That is not coercion. It is appropriate and responsible clinical care.
That is therapy.

What the Court Restored

The Court recognized this issue for what it truly is. It affirmed that therapy is, at its core, speech, deeply personal, exploratory, and meaning-making speech that unfolds in the context of trust and professional responsibility. To regulate that kind of speech based on viewpoint is not simply a matter of policy or preference; it crosses into unconstitutional territory by restricting the very process through which individuals come to understand themselves. In doing so, the Court drew an important line, one that protects not only clinicians, but the integrity of the therapeutic relationship itself.

For those of us who have spent our lives engaged in this work, the implications are both immediate and profound. Therapy is not a scripted exchange or a predetermined outcome. It is a process of discovery, often nonlinear and at times uncomfortable, where patients are given the space to examine their thoughts, emotions, beliefs, and experiences without coercion or constraint. When a patient sits down and says, *"Help me understand myself,"* they are not asking for direction imposed from the outside. They are asking for guidance in making sense of their own internal world, and that requires freedom, freedom to explore, to question, and to arrive at meaning in a way that is authentic to them.

This ruling restores and reinforces that freedom. It allows clinicians to practice ethically and responsibly, grounded in their training and professional judgment, without the fear that certain lines of inquiry are off-limits simply because they challenge prevailing viewpoints. It safeguards the therapeutic space as one where truth can be pursued, not prescribed, and where the goal is not ideological conformity, but genuine understanding and healing.

A Final Word

There is one final point that must be said, and it needs to be said without hesitation. What has unfolded in recent years is not merely a shift in clinical thinking. It reflects a bending of language, a collapsing of essential distinctions, and a movement away from the disciplined clarity that our profession depends on. When that clarity is lost, the consequences are not abstract. They are borne by patients.

We cannot afford that.

Words must mean what they mean if our work is to remain grounded and ethical. A practice rooted in coercion cannot be equated with a process rooted in exploration, and a framework built on predetermined outcomes cannot be confused with one grounded in patient autonomy. When a patient enters the room seeking to understand their own internal experience, the ethical obligation is not to narrow that path, but to walk it with them carefully

and thoughtfully, without imposing conclusions that are not their own. That is not coercion. That is therapy.

Therapy is not a tool of the state, nor is it a vehicle for ideology. It is a disciplined, relational, deeply human process that requires humility, restraint, and the courage to sit with complexity. It calls the clinician to respond to the individual in front of them, not to an abstract framework, not to a cultural mandate, and not to pressures that originate outside the room. When that freedom is constrained, even subtly, the work itself is compromised.

This moment also calls for reflection among the institutions that shape the field. The American Psychological Association, the American Academy of Pediatrics, the Endocrine Society, and others hold immense influence, and with that influence comes responsibility, to precision, to science, and to truth. When those anchors drift, the consequences do not remain theoretical. They show up in the therapy room, and they show up in the lives of patients.

To my colleagues, both those who have stepped forward and those who are watching carefully, this is a moment that requires clarity and courage. There is risk in being visible, and there is risk in attaching your name to positions that will be challenged, scrutinized, and at times opposed. But there is also responsibility, responsibility to the profession, responsibility to the science, and above all, responsibility to our patients. Some things are worth that risk.

We do not step forward because it is comfortable. We step forward because it is necessary, because truth requires it, because our profession depends on it, and because our patients deserve it.

And we must be willing to say plainly what is true. A rock is a rock. A tree is a tree. Exploratory therapy is not coercion. Inquiry is not harm. Listening is not abuse.

The therapy room belongs where it has always belonged, in the space between clinician and patient, grounded in trust, guided by ethics, and oriented toward truth, not the state, not ideology.

Truth.

And that is not something we will surrender.