IN THE IOWA DISTRICT COURT
FOR POLK COUNTY

KATHERINE VARNUM, PATRICIA HYDE VARNUM; DAWN BARBOUROSKE and JENNIFER BARBOUROSKE, individually and as next friends of MCKINLEY and BREEANNA BARBOUROSKE, minor children; JASON MORGAN, CHARLES SWAGGERTY; DAVID TWOMBLEY, LAWRENCE HOCH; WILLIAM M. MUSSER, OTTER DREAMING; INGRID OLSON, and REVA EVANS, individually, and as next friend of JAMISON OLSON, a minor child, Plaintiffs, v. TIMOTHY J. BRIEN, in his official capacities as the Polk County Recorder and Polk County Registrar, Defendant.	CASE NO. CV5965 **AFFIDAVIT OF GREGORY M. HEREK**

GREGORY M. HEREK certifies as follows:

1. I know the facts stated herein of my own personal knowledge, except those facts known on information and belief, and if called as a witness I could and would testify competently thereto.

2. I am a tenured Professor of Psychology at the University of California at Davis. In 1983, I received my Ph.D. in Psychology, with an emphasis in Personality and Social Psychology, from the University of California at Davis. I was a Post-Doctoral Fellow in Social Psychology at Yale University from 1983 to 1985. I subsequently served as a Lecturer and Visiting Assistant Professor at Yale University and as an Assistant Professor at the City University of New York Graduate Center in the Program in Social and Personality Psychology. I returned to the University of California at Davis in 1989 as an Associate Research Psychologist, and was appointed a full Professor in 1999.

3. Two principal foci of my original empirical research are societal stigma based on sexual orientation and the social psychology of heterosexuals' attitudes towards lesbians, gay men, and bisexuals. As reflected in my curriculum vitae (Exhibit B), I have published more than 85 papers and chapters in scholarly journals and books, most of them related to sexual orientation, HIV/AIDS, or attitudes and prejudice. I also have edited or coedited five books and two special issues of academic journals on these topics,

and I have made more than 80 presentations at professional conferences and meetings. I have received numerous federal and state grants for my research with combined budgets totaling more than $5 million.

4. I am a Fellow of the American Psychological Association and the Association for Psychological Science and a member of several other professional organizations. On two occasions, I have testified before the U.S. Congress about issues of sexual orientation on behalf of the American Psychological Association and other professional societies. I have received several professional awards and honors, including the 1996 American Psychological Association Award for Distinguished Contributions to Psychology in the Public Interest.

5. I currently serve on the editorial boards of six professional journals and routinely serve as an ad hoc reviewer for many others. Over the past three years, I reviewed manuscripts for approximately 15 different scientific and professional journals in the fields of psychology, sociology, political science, sexuality studies, gender studies, and health studies. I am the Executive Editor of a book series published by the American Psychological Association, *Contemporary Perspectives on Lesbian, Gay, and Bisexual Psychology*, whose titles include scientific and professional books on a variety of topics related to sexual orientation. I was a member of a peer review panel for the National Institute of Mental Health from 1992 to 1995, and have served as an ad hoc reviewer for the Institute on several occasions since completing my three-year term on that committee. Since 1995, I have served as chairperson of the Scientific Review Committee of the Wayne E. Placek Award competition, sponsored by the American Psychological Foundation, which annually funds empirical research in the behavioral and social sciences related to sexual orientation. At the University of California, Davis, I regularly teach an upper-division undergraduate course on sexual orientation and also have taught graduate seminars on this and related topics. My successful service in these varied capacities has required me to possess a broad multidisciplinary knowledge of theory and empirical research on a wide variety of topics related to sexual orientation. Thus, I have expertise on sexual orientation that crosses academic disciplinary boundaries and extends beyond the specific areas addressed by my own empirical research.

I. Summary of Ultimate Conclusions

6. Mainstream mental health professionals long have recognized that homosexuality is a normal expression of human sexuality. Being gay or lesbian poses no inherent obstacle to leading a happy, healthy, and productive life. Gay and lesbian persons have the capacity to contribute to society and to form lasting, committed, healthy, and mutually satisfying intimate relationships, just as heterosexual persons do. When the State treats the committed relationships of gay men and lesbians differently from those of heterosexuals, it has the effect of perpetuating the stigma historically associated with homosexuality. Such stigma has negative consequences for all gay, lesbian, and bisexual people regardless of their relationship status and regardless of whether or not they wish to marry.

II. The Nature of Scientific Evidence

7. In this affidavit, I summarize the current state of scientific and professional knowledge about several issues relevant to sexual orientation. At the outset, I wish to note three important, interrelated points concerning the nature of scientific evidence in the social and behavioral sciences.

8. First, scientific knowledge is cumulative. Scientists continually try to replicate their own findings and those of their colleagues by collecting new data from new samples using a variety of methods. Scientists place greater confidence in conclusions that are supported by multiple studies employing different methods with different samples than in conclusions derived from a single study.

9. Second, scientific research cannot prove a negative. We cannot conclusively demonstrate that a particular phenomenon never occurs or that two variables are never related to each other. However, as increasing numbers of independent studies fail to establish the existence of a phenomenon or fail to show a relationship between two variables, we become increasingly convinced that, in fact, the phenomenon does not exist or the variables are unrelated. If a researcher wishes to argue that two phenomena are correlated despite repeated failures to prove that they are, the burden of proof is on that researcher to demonstrate empirically that the relationship exists.

10. Third, no empirical study is perfect in its design and execution. Scientists continually critique their own research and that of their colleagues in order to advance scientific knowledge. Thus, when a scientist identifies limitations or qualifications to a published study's findings (whether the scientist's own research or that of a colleague), or when she or he notes areas in which additional research is needed, this should not itself be interpreted as a dismissal or discounting of the research. All scientific studies can be constructively criticized.

11. In preparing this affidavit, I have relied on the best empirical research available, focusing as much as possible on general patterns rather than any single study. Whenever possible, I have relied on original empirical studies and literature reviews published in the most highly respected peer-reviewed journals in the behavioral and social sciences. Not every published paper meets this standard because academic journals differ widely in their publication criteria and the rigor of their peer review. In some cases, I have used technical reports and material published in academic books although they typically are not subjected to the same rigorous peer-review standards as journal articles. I have done so only when, in my judgment, they meet the criteria of employing rigorous methods, having credible researchers as authors, and accurately reflecting professional opinion about the current state of knowledge. In assessing the scientific literature, I neither have relied upon credible studies merely because they support, nor excluded credible studies from consideration merely because they contradict, particular conclusions.

12. Although this affidavit, in my judgment, accurately summarizes the scientific literature on the topics it addresses, I have not attempted to provide an

exhaustive review of that literature. Rather, I cite representative sources that elaborate on my main points or provide additional evidence for the conclusions I have reached. The full bibliographic citations for the sources I cite in this affidavit are listed in Appendix A.

III. Sexual Orientation

A. The Nature of Sexual Orientation and Its Inherent Link to Intimate Relationships.

13. As commonly used, *sexual orientation* refers to an enduring pattern or disposition to experience sexual, affectional, or romantic desires for and attractions to men, women, or both sexes. The term is also used to refer to an individual's sense of personal and social identity based on those desires and attractions, behaviors expressing them, and membership in a community of others who share them. Although sexual orientation ranges along a continuum from exclusively heterosexual to exclusively homosexual, it is usually discussed in terms of three categories: *heterosexual* (having attraction primarily or exclusively to members of the other sex), *homosexual* (having attraction primarily or exclusively to members of one's own sex), and *bisexual* (having a significant degree of attraction to both men and women).[1]

14. Sexual orientation is distinct from other components of sex and sexuality, including *biological sex* (the anatomical, physiological, and genetic characteristics associated with being male or female), *gender identity* (the psychological sense of being male or female), and *gender role orientation* (the extent to which one conforms to cultural norms defining feminine and masculine behavior; also referred to as *sex role orientation*).

15. Sexual orientation is commonly discussed as a characteristic of the *individual*, like biological sex, gender identity, race, or age. Although this perspective is accurate insofar as it goes, it is incomplete because sexual orientation is always defined in *relational* terms and necessarily involves relationships with other individuals. Sexual acts and romantic attractions are characterized as homosexual or heterosexual according to the biological sex of the individuals involved in them, relative to each other. Indeed, it is by acting with another person – or expressing a desire to act – that individuals express their heterosexuality, homosexuality, or bisexuality. This includes actions as simple as holding hands with or kissing another person.

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[1] For elaboration on the definition of sexual orientation, see the entries I wrote on "Homosexuality" for *The Encyclopedia of Psychology* (Herek, 2000) and *The Corsini Encyclopedia of Psychology and Behavioral Science* (Herek, 2001). See also Gonsiorek & Weinrich, 1991. In this affidavit, I focus specifically on persons with a homosexual orientation – gay men and lesbians – and on how prohibiting marriage rights for same-sex couples affects that group and their children. It should be noted that some research I cite (for example, the research on stigma discussed below) is applicable to bisexual as well as homosexual persons. Moreover, many bisexual persons are involved in committed same-sex relationships and, to the extent that they are, many statements in this affidavit apply with equal force to them.

16. Thus, sexual orientation is integrally linked to the intimate personal relationships that human beings form with others to meet their deeply felt needs for love, attachment, and intimacy. These bonds encompass not only sexual behavior, but also nonphysical affection between partners, shared goals and values, mutual support, and ongoing commitment. Consequently, sexual orientation is not merely a personal characteristic that can be defined in isolation. Rather, one's sexual orientation defines the universe of persons with whom one is likely to find the satisfying and fulfilling relationships that, for many individuals, comprise an essential component of personal identity.

B. Homosexuality Is a Normal Expression of Human Sexuality.

17. Mainstream mental health professionals and researchers have long recognized that homosexuality is a normal expression of human sexuality; that being gay or lesbian bears no relation to a person's ability to perform, contribute to, or participate in society; that being gay or lesbian poses no inherent obstacle to leading a happy, healthy, and productive life; and that the vast majority of gay and lesbian people function well in society and in their interpersonal relationships.[2] Such functioning includes the capacity to form a healthy and mutually satisfying intimate relationship with another person of the same sex and to raise healthy and well-adjusted children.

18. Empirical research conducted since the 1950s consistently has failed to provide any empirical or scientific basis for the once common view of homosexuality as a mental disorder or abnormality.[3] While the American Psychiatric Association initially classified homosexuality as a disorder in 1952 when it published its first *Diagnostic and Statistical Manual of Mental Disorders*,[4] that classification was subjected almost immediately to critical scrutiny in research funded by the National Institute of Mental Health.[5] As empirical research results accumulated, professionals in medicine, mental

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[2] In this affidavit, I use "gay" to refer collectively to men and women whose social identity is based on their homosexual orientation, that is, their sexual, affectional, or romantic attraction primarily to members of their own sex. I use "gay man" to refer to men in this group, and "lesbian" to refer to women in this group. In some instances, I use the phrase "gay and lesbian" to clarify that I am referring to both gay women and men.

[3] A mental disorder is "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (American Psychiatric Association, 2001).

[4] American Psychiatric Association, 1952.

[5] In what is now considered a classic study and one of the first methodologically rigorous examinations of the mental health status of homosexuality, Dr. Evelyn Hooker administered a battery of widely used psychological tests to groups of homosexual and heterosexual males who were matched for age, IQ, and education. The men were recruited from nonclinical settings; none of the men was in therapy at the time of the study. The heterosexual and homosexual groups did not differ significantly in their overall psychological adjustment, as rated by independent experts who were unaware of each man's sexual orientation. Hooker determined that homosexual and heterosexual men could not be distinguished from one another on the basis of the psychological testing, and that a similar majority of the two groups appeared to be free of psychopathology. She concluded from her data that homosexuality is not inherently associated

health, and the behavioral and social sciences reached the conclusion that the classification of homosexuality as a mental disorder was in error. They recognized that it reflected untested assumptions based on once-prevalent social norms as well as clinical impressions from unrepresentative samples of patients seeking therapy and individuals whose conduct brought them into the criminal justice system.

19. The American Psychiatric Association removed homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders* in 1973, stating that "homosexuality *per se* implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." The American Psychological Association adopted the same position in 1975, and urged all mental health professionals to help dispel the stigma of mental illness that had long been associated with homosexual orientation.[6]

C. The Origins and Enduring Nature of Sexual Orientation

20. The factors that cause an individual to become heterosexual, homosexual, or bisexual are not currently well understood.[7] Irrespective of the origins of sexual orientation, I have found in my own research that the vast majority of gay men and most lesbians report having either no choice or very little choice in their sexual attraction to members of their own sex.[8] This finding is consistent with research showing that most people report having sexual attractions to and experiences with the members of only one sex. In the Kinsey studies of the 1940s and 1950s, for example, substantial numbers of respondents reported they had experienced sexual attraction to the members of only one sex, that is, they experienced either heterosexual or homosexual attractions, but not both.[9]

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with psychopathology and that "homosexuality as a clinical entity does not exist" (Hooker, 1957, p. 30). Hooker's is only one study. However, her findings have subsequently been replicated and amplified by numerous studies, using a variety of research techniques, which have similarly concluded that homosexuality is not inherently associated with psychopathology or social maladjustment. (For reviews, see Gonsiorek, 1991; Riess, 1980; Hart et al., 1978.)

[6] The text of the 1975 Psychological Association resolution can be found on the Internet at http://www.apa.org/pi/lgbc/policy/discrimination.html and in Conger, 1975. The Psychological Association's other resolutions addressing issues related to sexual orientation are posted at http://www.apa.org/pi/lgbc/policy/pshome.html. The Psychiatric Association's official positions on those issues is posted at http://healthyminds.org/glbissues.cfm .

[7] Various theories have proposed widely differing sources for adult sexual orientation but no single theory enjoys unequivocal empirical support. Given the current lack of definitive knowledge about why some individuals develop a heterosexual orientation and others become homosexual, most social and behavioral scientists regard sexual orientation as being shaped by a complex interaction of biological, psychological, and social forces. They often differ, however, on the relative importance they attach to each.

[8] e.g., Herek, Cogan, Gillis, & Glunt, 1998. I have also collected data on this point from a nationally representative sample of gay, lesbian, and bisexual adults, which I am currently preparing for publication.

[9] In interviews with more than 10,000 adults, Alfred Kinsey and his colleagues categorized respondents according to the extent to which their sexual behaviors and emotional attractions and fantasies were heterosexual or homosexual after the onset of adolescence (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953).The extent to which the percentages reported by Kinsey and his colleagues can be generalized to the current U.S. population has been a topic of controversy (e.g., Michaels, 1996). Whether or not Kinsey's findings accurately describe the current distribution of heterosexuals, homosexuals, and bisexuals in the general population, however, they document the existence

More recent studies have reported similar findings.[10] I am not aware of empirical studies in which heterosexual men and women were directly asked whether or not they chose to be heterosexual. If such a study were to be conducted, however, I believe it is likely that most heterosexuals would report that they have always been attracted to the other sex and that they do not experience their heterosexuality as a choice.

21. Sexual orientation is highly resistant to change through therapeutic or religious interventions. Interventions aimed at changing an individual's sexual orientation have not been demonstrated by empirical research to be effective or safe.[11] Moreover, such interventions are ethically suspect because they can be harmful to the psychological well-being of those who attempt them. Clinical observations and self-reports indicate that many individuals who unsuccessfully attempt to change their sexual orientation experience considerable psychological distress.[12] For this reason, virtually all of the major mental health professional associations have adopted policy statements cautioning the profession and the public about treatments that purport to change sexual orientation.

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of a sizable number of individuals whose history of sexual attractions and behaviors is exclusively or almost entirely to one sex.

[10] e.g., Lauman et al., 1994.

[11] Although some therapists have reported changes of sexual orientation from homosexual to heterosexual in their clients, critics have detailed numerous ambiguities and problems with their methods and results. (For a review, see Haldeman, 1994.) For example, in many reports of "successful" conversion therapies, the participants' initial sexual orientation was not adequately assessed; thus, many bisexuals have been mislabeled as homosexuals with the consequence that the "successes" reported for the conversions actually have occurred among bisexuals who were highly motivated to adopt a heterosexual behavior pattern. An additional problem is that "success" usually has been defined as suppression of homoerotic response or mere display of physiological ability to engage in heterosexual intercourse; neither of these should be equated with adopting the complex set of attractions and desires that constitute sexual orientation. Many interventions aimed at changing sexual orientation have succeeded only in reducing or eliminating homosexual behavior rather than in creating or increasing heterosexual attractions; they have, in effect, deprived individuals of their capacity for sexual response to any partner, regardless of gender. Another problem is that even these inadequate operational definitions of change often have been assessed only through therapists' impressions or participants' self reports rather than through objectively verifiable indicators.

In 2003, a highly controversial paper was published in the *Archives of Sexual Behavior*, which reported the results of interviews with individuals who claimed to have changed their sexual orientation as a result of various interventions. The study's author concluded that the interviewees, most of whom were recruited through conservative religious organizations and groups that promote conversion therapies, had indeed changed their sexual orientation from homosexual or bisexual to the direction of heterosexual (Spitzer, 2003). The study drew a sufficient amount of criticism that an entire issue of the *Archives* was devoted to commentary on it, and a separate book was published with those commentaries and additional ones (Drescher & Zucker, 2006). I wrote one of the commentaries, in which I noted inadequacies in the measurement of key variables and problems with biased sampling procedures. I also noted that, because homosexuality is not a pathology, efforts to change the sexual orientation of people who are gay or lesbian should be considered suspect. And I pointed out that the study design did not permit conclusions to be drawn about the reasons why changes occurred in the participants' sexual orientation (to the extent that they did, indeed, occur). I concluded that the study amounted to little more than a collection of testimonials from individuals who are strongly dedicated to promoting the notion that homosexuals can and should try to become heterosexual (Herek, 2003).

[12] Haldeman, 2001; Shidlo & Schroeder, 2002.

These include the American Psychiatric Association, American Psychological Association, American Counseling Association, and National Association of Social Workers. In addition, reflecting the fact that adolescents are often subjected to such treatments, the American Academy of Pediatrics has adopted a policy statement advising that therapy directed specifically at attempting to change an adolescent's sexual orientation is contraindicated and unlikely to result in change.[13]

D. Stigma and Denial of Access to Marriage.

22. Denying same-sex couples the right to marry conveys a societal judgment that committed intimate relationships with people of the same sex are inferior to heterosexual relationships, and that the participants in a same-sex relationship are less deserving of society's recognition than heterosexual couples. It perpetuates power differentials whereby heterosexuals have greater access than nonheterosexuals to the many resources and benefits bestowed by the institution of marriage. These elements are the crux of *stigma*, which refers to an enduring condition, status, or attribute that is negatively valued by society, fundamentally defines a person's social identity, and consequently disadvantages and disempowers those who have it.[14]

23. Stigma gives rise to prejudice, discrimination, and violence against people based on their sexual orientation. Research indicates that being a target of stigma and discrimination is associated with heightened psychological distress among gay men and lesbians. Experiencing extreme enactments of stigma, such as antigay criminal assault, is associated with greater psychological distress than experiencing a similar crime not based on a stigmatized aspect of identity.[15]

24. Fear of stigma makes some gay, lesbian, and bisexual persons feel compelled to conceal their sexual orientation, and this forced concealment can have deleterious consequences for the individual. Like heterosexuals, lesbians and gay men benefit to the extent that they are able to share their lives with and receive support from their family, friends and other people who are important to them. For example, lesbians and gay men have been found to manifest better mental health to the extent that they hold positive feelings about their own sexual orientation, have developed a positive sense of personal identity based on it, and have integrated it into their lives by disclosing it to others (commonly referred to as "coming out of the closet" or simply "coming out"). By contrast, lesbians and gay men who feel compelled to conceal their sexual orientation tend to report more frequent mental health concerns than their openly gay counterparts, and may even be at risk for physical health problems.[16]

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[13] The text of the relevant policy statements are available on the American Psychological Association's Web site; http://www.apa.org/pi/lgbc/publications/justthefacts.html#2.

[14] e.g., Goffman, 1963; Link & Phelan, 2001; Crocker, Major, & Steele, 1998.

[15] e.g., Herek et al., 1999; Meyer, 2003.

[16] Herek, 1996; Herek & Garnets, 2007. *See generally* Meyer, 2003.

25. To the extent that stigma motivates some gay and lesbian people to remain in the closet, it further reinforces anti-gay prejudices among heterosexuals. Research consistently has shown that prejudice against minorities, including gay people,[17] decreases significantly when members of the majority group knowingly have personal contact with minority group members.[18] Consistent with the general pattern, empirical research demonstrates that having contact with an openly gay person is one of the most powerful influences on heterosexuals' tolerance and acceptance of gay people. Anti-gay attitudes are significantly less common among heterosexuals who report having a close friend or family member who is gay or lesbian; their prejudice tends to be lower when a lesbian or gay friend or family member has directly disclosed her or his sexual orientation to them, compared to when the former's sexual orientation had not been directly discussed.[19] To the extent that stigma prevents heterosexuals from interacting with openly gay people, it also reinforces and perpetuates heterosexuals' antigay prejudice.

26. Thus, by denying same-sex couples the right to marry legally, the State devalues and delegitimizes the relationships that are at the very core of a homosexual orientation and thereby expresses, compounds, and perpetuates the stigma historically attached to homosexuality. Such stigma negatively affects not only the members of same-sex couples who seek to be married and any children they may have, but all homosexual and bisexual persons, regardless of their relationship status or desire to marry.[20]

27. It is my understanding that Dr. Michael Lamb has submitted an affidavit for the present case in which he describes the relevant research on children raised by lesbian and gay parents. Without duplicating Dr. Lamb's discussion, I would like to briefly address the specific issue of the stigma such children may experience in the absence of legal recognition for their parents' relationship.

28. Such stigma can derive from various sources. The children born to same-sex couples in Iowa are accorded a status historically stigmatized as "illegitimacy" and "bastardy."[21] Although the social stigma attached to illegitimacy has declined in recent decades, being born to unmarried parents is still widely considered undesirable. Indeed, opponents of marriage rights for same-sex couples have argued that the stigma attached to unwed parentage serves a valuable social function and should be perpetuated.[22] This stigma is likely to be extended to the children of unmarried same-sex couples. As a result, children of parents who are not married may be stigmatized by others, such as peers or

[17] Although the specific content of prejudice varies across different minority groups, the psychological dynamics of prejudice are similar regardless of the group toward which that prejudice is directed.

[18] A meta-analysis of more than 500 studies of intergroup contact and prejudice based on sexual orientation, nationality race, age, and disability found a highly robust inverse relationship between contact and prejudice (Pettigrew & Tropp, 2006).

[19] Herek & Capitanio, 1996; Herek & Glunt, 1993.

[20] Herek, 2006.

[21] e.g., Witte, 2003.

[22] Gallagher, 2004.

school staff members. The children of same-sex couples will not be subjected this stigma of illegitimacy when those couples can legally marry.

29. In addition, children of same-sex couples may be secondary targets of stigma directed at their parents because of the parents' sexual orientation. The effects of such stigma may be indirect, as when lesbian or gay parents experience greater strain on their relationship as a result of not receiving social support to the same extent as heterosexual couples, which has consequences for the child. The effects may also be direct if the children of lesbian and gay parents, like children from other minority groups, experience teasing at the hands of other children. Empirical research has *not* found that the children of lesbians differ from the children of heterosexual parents in the quality of their peer relationships.[23] However, lesbian and gay parents and their children are generally aware of the potential for stigma and may take specific steps to avoid it.[24] Thus, the threat of stigma represents a burden with which families headed by same-sex couples must cope and it is reasonable to predict that children will benefit by having even the threat of such stigma removed from their lives.

I certify under penalty of perjury and pursuant to the laws of the State of Iowa that the preceding is true and correct.

DATED this 23rd day of January, 2007

[signed]
Gregory M. Herek

[23] e.g., Stacey & Biblarz, 2001; Patterson, 2000.

[24] e.g., Patterson, 2004; Tasker & Golombok, 1997.

APPENDIX A

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