UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF MASSACHUSETTS

CIVIL ACTION
NO. 1:09-cv-10309

NANCY GILL & MARCELLE LETOURNEAU, MARTIN KOSKI & JAMES FITZGERALD, DEAN HARA, MARY RITCHIE & KATHLEEN BUSH, MELBA ABREU & BEATRICE HERNANDEZ, MARLIN NABORS & JONATHAN KNIGHT, MARY BOWE-SHULMAN & DORENE BOWE-SHULMAN, JO ANN WHITEHEAD & BETTE JO GREEN, RANDELL LEWIS-KENDELL, and HERBERT BURTIS,	)
Plaintiffs,	)
v.	)
OFFICE OF PERSONNEL MANAGEMENT, UNITED STATES POSTAL SERVICE, JOHN E. POTTER, in his official capacity as the Postmaster General of the United States of America, MICHAEL J. ASTRUE, in his official capacity as the Commissioner of the Social Security Administration, ERIC H. HOLDER JR., in his official capacity as the United States Attorney General, and THE UNITED STATES OF AMERICA, Defendants.	)

EXPERT AFFIDAVIT OF GREGORY M. HEREK, Ph.D.

I, Gregory M. Herek, Ph.D., hereby depose and say as follows:

PRELIMINARY STATEMENT

1. My professional background, experience, and publications are detailed in my curriculum vitae, which is attached as Exhibit B to this affidavit. I have been retained by counsel for Plaintiffs and by the Commonwealth of Massachusetts as a consultant in connection with both the above-referenced litigation ("*Gill*") and in *Commonwealth of Massachusetts v. United States Dept. of Health and Human Services, et. al*, Civ. A. No. 1:09-11156 JLT (D. Mass). I have actual knowledge of the matters stated in this affidavit and could and would so testify if called as a witness.

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

3. Two principal foci of my original empirical research program 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 95 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 85 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. My expertise extends beyond the specific areas addressed in my own empirical research program, encompassing theory and empirical research in multiple academic disciplines

on a variety of topics related to sexual orientation. A broad knowledge of this area has been a necessity not only for my own scholarship, but also for successfully completing my professional duties as a reviewer of academic journal and book manuscripts, as well as grant proposals. Over the past 25 years, I have reviewed manuscripts on topics related to sexual orientation for a large number of scientific and professional journals spanning a variety of disciplines, including psychology, sociology, political science, sexuality studies, gender studies, and public health. I currently serve on the editorial boards of nine professional journals and I am frequently invited to serve as an ad hoc peer reviewer for others. I am also the Executive Editor Emeritus of *Contemporary Perspectives on Lesbian, Gay, and Bisexual Psychology*, a book series dedicated to scientific and professional works on sexual orientation and related topics, which is published by the American Psychological Association. In that capacity I reviewed book proposals and edited manuscripts that addressed research on a variety of topics related to sexuality and sexual orientation. As a member of a peer review panel for the National Institute of Mental Health from 1992 to 1995, and as an ad hoc reviewer for NIMH and the National Science Foundation on multiple occasions since then, I have reviewed proposals requesting federal funding for projects addressing an array of research questions related to sexuality. From 1995 to 2007, I served as chairperson of the Scientific Review Committee of the American Psychological Foundation's Wayne F. Placek Award competition, which funded empirical research in the behavioral and social sciences related to sexual minorities and sexual orientation. In that capacity, I oversaw the review of more than 200 research proposals from a large number of academic disciplines. A broad understanding of the research literature on sexual orientation has also been essential for my teaching: At UC Davis, I regularly teach an upper-division undergraduate course on sexual orientation and have also taught graduate seminars on this and related topics. My successful work in these varied capacities has required me to possess a broad knowledge of theory and research on sexual orientation.

5. I am a member and Fellow of the American Psychological Association (APA), the Association for Psychological Science, and several other professional organizations. On two occasions, I have testified before the U.S. Congress about issues related to sexual orientation on

behalf of the APA and other professional societies. I have received several professional awards and honors, including the 1996 APA Award for Distinguished Contributions to Psychology in the Public Interest.

6. In this affidavit, I summarize the current state of scientific and professional knowledge about several issues relevant to sexual orientation and marriage. In preparing it, I have relied on the best empirical research available, focusing as much as possible on general patterns in the research literature rather than any single study. Whenever possible, I have relied on original empirical studies and literature reviews published in 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 consulted material published in academic books or technical reports released by individual scholars or research organizations. Recognizing that such work typically is not subjected to the same rigorous peer-review standards as journal articles, I have relied on these sources 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 have not relied upon studies merely because they support particular conclusions, nor have I excluded credible studies from consideration merely because they contradict particular conclusions. I have not attempted to provide an exhaustive review of the scientific literature on the topics addressed in this affidavit. Rather, I cite representative sources that illustrate or 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 Exhibit A. In preparing this Affidavit, I have also reviewed the Amended Complaint in *Gill* and the Complaint in the *Commonwealth of Massachusetts* case as well as the motions to dismiss in both cases.

I. Summary of Ultimate Conclusions

7. 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, or to functioning well in society. Such functioning

includes the capacity to form healthy and mutually satisfying intimate relationships, just as heterosexual persons do. The factors that cause an individual to become heterosexual, homosexual, or bisexual are not currently well understood. However, most lesbian and gay adults report that they do not experience their sexual orientation as a choice, and sexual orientation is highly resistant to change through psychological or religious interventions. Marriage confers a variety of psychological, social, and health benefits to spouses. Marrying a person of the other sex is not a realistic option for a gay or lesbian person, any more than marrying a person of the same sex is a viable option for a heterosexual man or woman. By refusing to recognize same-sex couples who are legally married, the Defense of Marriage Act denies the members of those couples the many federal benefits that heterosexual married couples receive. This denial is an instance of structural stigma. Structural stigma gives rise to prejudicial attitudes and stigmatizing actions against the members of stigmatized groups and thus has negative consequences for the entire population of those groups – in this case, the sexual minority population. Experiencing stigma is associated with heightened psychological distress among lesbians and gay men. To the extent that stigma prevents heterosexuals from establishing personal relationships with lesbians and gay men, it further reinforces antigay prejudice among heterosexuals.

II. Sexual Orientation

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

8. As commonly used, *sexual orientation* refers to an enduring pattern of 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] 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*).

9. Most social and behavioral research has assessed sexual orientation in terms of attraction, behavior, or identity, or some combination of these constructs. Which of these operational definitions is most appropriate for a particular study depends on the research goals. For example, studies of sexually-transmitted diseases among men who have sex with men would appropriately focus on sexual behavior. By contrast, for research on experiences stemming from one's status as an openly gay, lesbian, or bisexual individual, sexual orientation would be best operationalized in terms of identity.

10. Although social scientists conceive of sexual orientation as a complex, multi-faceted phenomenon and operationalize it in a variety of ways, most adults in the United States are able to report their own sexual orientation to researchers. When asked about their sexual orientation, nearly all participants in national survey studies are able to provide a response.[2] Among the small percentage of individuals who do not report their sexual orientation in response to a survey question, some may be unsure about their orientation or may be uncomfortable labeling it, but many are probably motivated by concerns about their personal privacy or, for those who are not heterosexual, fear of stigma.

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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.

2 Some heterosexual survey respondents are unfamiliar with terms such as "heterosexual" and "homosexual" but provide responses (e.g., "normal," straight") that indicate they identify as heterosexual (e.g., Laumann, Gagnon, Michael, & Michaels, 1994).

11. 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 sexual behaviors as well as actions that simply express affection, such as holding hands with or kissing another person.

12. 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 feelings of 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.

13. Mainstream mental health professionals and researchers have long recognized that homosexuality is a normal expression of human sexuality. Like heterosexuals, the vast majority of gay and lesbian people[3] function well in society and in their interpersonal relationships. Such functioning includes the capacity to form a healthy and mutually satisfying intimate relationship

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3 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. I also use the term "sexual minority" to refer collectively to gay, lesbian, and bisexual people. Throughout the affidavit, I focus mainly on persons with a homosexual orientation – i.e., gay men and lesbians – but much of the research I cite is applicable to bisexual as well as homosexual persons.

with another person of the same sex and to raise healthy and well-adjusted children. Being gay or lesbian bears no inherent relation to a person's ability to perform, contribute to, or participate in society, and poses no inherent obstacle to leading a happy, healthy, and productive life.[4]

14. To better appreciate the significance of contemporary attitudes toward homosexuality in the mental health profession, it is useful to understand its historical background. Reflecting widespread popular attitudes during much of the 20th century, psychiatrists and psychologists once assumed that homosexuality was a mental illness. Indeed, the American Psychiatric Association initially classified homosexuality as a disorder in 1952 when it published its first *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[5] However, that classification was subjected almost immediately to critical scrutiny in research funded by the National Institute of Mental Health.[6] Over time, as empirical research results consistently failed to provide an empirical or scientific basis for the labeling of homosexuality as a mental disorder, professionals in medicine, mental health, and the behavioral and social sciences reached the conclusion that the classification 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 of individuals whose

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4 See, e.g., the various resolutions addressing issues related to sexual orientation that have been passed by the American Psychological Association (http://www.apa.org/pi/lgbc/policy/pshome.html), and the American Psychiatric Association's official positions on these issues (http://www.healthyminds.org/More-Info-For/GayLesbianBisexuals.aspx).

5 American Psychiatric Association, 1952.

6 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 concluded from her data that homosexuality is not inherently associated with psychopathology and that "homosexuality as a clinical entity does not exist" (Hooker, 1957, p. 30). Hooker's findings were subsequently replicated and amplified by numerous studies using a variety of research techniques which similarly concluded that homosexuality is not inherently associated with psychopathology or social maladjustment (see, e.g., Gonsiorek, 1991).

conduct brought them into the criminal justice system. The American Psychiatric Association removed homosexuality from the *DSM* 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.[7]

15. The fact that the mental health profession now recognizes that homosexuality is a normal expression of human sexuality does not mean that gay men and lesbians do not experience psychological problems. Like heterosexuals, lesbians and gay men benefit psychologically from being able to share their lives with and receive support from their family, friends, and other people who are important to them. In many studies, 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 identity based on it, and have integrated it into their lives by disclosing it to others (such disclosure is commonly referred to as "coming out of the closet" or simply "coming out").[8] 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[9] and are also at risk for physical health problems.[10]

16. Moreover, like heterosexuals, gay people can be adversely affected by high levels of stress. The link between experiencing stress and manifesting symptoms of psychological or physical illness is well established in human beings and other species. To the extent that a minority group is subjected to additional stress beyond what is normally experienced by the

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7 The text of the 1975 American Psychological Association resolution can be found at http://www.apa.org/pi/lgbc/policy/discrimination.html and in Conger, 1975.

8 Herek & Garnets, 2007; Pachankis, 2007.

9 Meyer, 2003; Herek, 1996.

10 Cole, 2006; Strachan, Bennett, Russo, & Roy-Byrne, 2007.

population at large, it may, as a group, manifest somewhat higher levels of illness or psychological distress.[11] Much of the difference in levels of stress experienced by the heterosexual population and the sexual minority population is attributable to the societal stigma directed at the latter.[12] As one researcher noted after reviewing the relevant scientific literature, lesbian, gay, and bisexual individuals "are exposed to excess stress due to their minority position and . . . this stress causes an excess in mental disorders."[13] In experiencing such excess stress, sexual minorities are comparable to other minority groups that face unique stressors due to prejudice and discrimination based on their minority status.[14] Given the unique social stressors to which they are subjected, the noteworthy fact is that the vast majority of lesbian, gay, and bisexual people effectively cope with these challenges and lead happy, healthy and well-adjusted lives.

C. The Origins and Enduring Nature of Sexual Orientation.

17. The factors that cause an individual to become heterosexual, homosexual, or bisexual are not currently well understood. Widely differing sources for adult sexual orientation have been proposed 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

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11 Consistent with this observation, several studies suggest that, compared to the heterosexual population, a somewhat larger proportion of the homosexual and bisexual population may manifest certain psychological symptoms (Herek & Garnets, 2007).

12 I define the construct of stigma and discuss it at length below.

13 Meyer, 2003; see also Herek & Garnets, 2007.

14 Meyer, 2003, pp. 675-76, 690. In addition, lesbian, gay, and bisexual people face other stressors. For example, because the AIDS epidemic has had a disproportionate impact on the gay male community in the United States, many gay and bisexual men have experienced the loss of a life partner, and gay, lesbian, and bisexual people alike have experienced extensive losses in their personal and social networks resulting from the death of close friends and acquaintances; bereavement related to multiple losses is linked to higher levels of depressive symptoms (see Folkman, Chesney, Collette, Boccellari, & Cooke, 1996; Martin, 1988).

being shaped by a complex interaction of biological, psychological, and social forces. They often differ, however, on the relative importance they attach to each.

18. Most adults 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, a substantial number 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.[15] More recent studies have reported similar findings.[16]

19. The vast majority of gay men and lesbians report that they experience no choice or very little choice in their sexual orientation. In a 2005 national survey conducted with a probability sample[17] of more than 650 self-identified lesbian, gay, and bisexual adults, 95% of

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15 In interviews with a nonprobability sample of 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 after the onset of adolescence were heterosexual or homosexual (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). However, regardless of whether or not Kinsey's findings accurately describe the current distribution of heterosexuals, homosexuals, and bisexuals in the general population, they document the existence of a sizable number of individuals whose history of sexual attractions and behaviors is exclusively or almost entirely to one sex.

16 E.g., Laumann et al., 1994.

17 Researchers distinguish between probability and nonprobability samples. In a *probability* sample, all members of the population under study have some calculable chance of being included in the sample, and individual sample members are chosen through a process that includes some element of randomization. Probability samples are sometimes referred to colloquially as *representative* samples, reflecting the fact that statistical procedures can be applied to them to estimate their level of sampling error. In *nonprobability* samples, by contrast, some members of the population have no chance of being included in sample. For example, if a study relies solely on data from volunteers who respond to a newspaper advertisement, it inevitably excludes members of the population who didn't see the ad; this would be a nonprobability sample. To confidently describe the prevalence or frequency with which a phenomenon occurs in the population at large, it is necessary to collect data from a probability sample. By contrast, simply to document that a phenomenon ever occurs, case studies and nonprobability samples are often adequate. For comparisons of different populations, probability samples drawn from each group are desirable but not necessary and are often not feasible. Hence, researchers often rely on nonprobability samples that have been matched on relevant characteristics (e.g., educational level, age, income). Some groups are sufficiently few in number – relative to the entire population – that locating them with probability sampling methods is extremely

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the gay men and 83% of the lesbians reported that they experienced "no choice at all" or "very little choice" about their sexual orientation (fully 88% of the gay men and 68% of the lesbians reported "no choice at all").[18] I am not aware of empirical studies in which heterosexual men and women have been 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 do not experience their own heterosexuality as a choice.

20. Sexual orientation is highly resistant to change through psychological or religious interventions. Interventions aimed at changing an individual's sexual orientation have not been demonstrated by empirical research to be effective or safe. Moreover, because homosexuality is a normal variant of human sexuality, the major mental health professional organizations do not encourage individuals to try to change their sexual orientation from homosexual to heterosexual. Indeed, 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.[19]

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expensive or practically impossible. In the latter cases, the use of nonprobability samples is often appropriate.

18 Herek, Norton, Allen, & Sims, 2009. Similarly, in a survey conducted during the 1990s with a nonprobability sample of more than 2,200 gay, lesbian, and bisexual adults in the greater Sacramento (CA) area, 87% of the gay men and 70% of the lesbians reported that they experienced "no choice at all" or "very little choice" about their sexual orientation (Herek, Gillis, & Cogan, 2009).

19 Although some psychotherapists and religious counselors have reported changing their clients' sexual orientation from homosexual to heterosexual, empirical data are lacking to demonstrate that these interventions are either effective or safe. Most of the published empirical research that has claimed to demonstrate the efficacy of techniques intended to change a person's sexual orientation can be criticized on methodological grounds. In response to public debates about these techniques, the American Psychological Association created a Task Force on Appropriate Therapeutic Responses to Sexual Orientation which reviewed the relevant research literature. The Task Force reported that it found "serious methodological problems in this area of research, such that only a few studies met the minimal standards for evaluating whether psychological treatments, such as efforts to change sexual orientation, are effective" (American Psychological Association, 2009a, p. 2). Based on its review of the studies that met these standards, the

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21. For these reasons, no major mental health professional organization has sanctioned efforts to change sexual orientation and virtually all of them have adopted policy statements cautioning the profession and the public about treatments that purport to change sexual orientation. 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.[20]

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Task Force concluded that

> "enduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE [sexual orientation change efforts] and did not report significant change to other-sex attractions that could be empirically validated, though some showed lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE" (pp. 2-3).

In addition, the Task Force found evidence to indicate that some individuals experienced harm or believed they had been harmed by these interventions. The Task Force report provides a detailed discussion of this topic and an extensive review of relevant research. It is available at: http://www.apa.org/pi/lgbc/publications/therapeutic-response.pdf.

20 In response to the 2009 report of its Task Force on Appropriate Therapeutic Responses to Sexual Orientation, the APA passed a resolution that stated, in part, "the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation" and "the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation" (American Psychological Association, 2009b). See also the relevant policy statements by the American Psychiatric Association, the National Association of Social Workers, and the American Counseling Association. These policy statements are compiled in a publication titled *Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*, which is available

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IV. Marriage Confers Benefits.

22. The belief that being married bestows benefits on wedded couples is widespread in the United States and the positive consequences of being married are well documented. Married men and women who are satisfied with their relationships generally experience better physical and mental health than their unmarried counterparts.[21] This outcome does not result simply from being in an intimate relationship, as indicated by the fact that otherwise comparable heterosexuals who are in cohabiting couples generally do not manifest the same levels of health and well-being as married individuals.[22] Nor does it appear to be simply a product of self-selection by healthy and happy individuals into marital relationships.[23] Of course, marriage is not a panacea. Empirical data and common experience show that it is a better option for some than for others.[24] People who are unhappy with their marriages often manifest lower levels of well-being than their unmarried counterparts, and experiencing marital discord and dissatisfaction is often associated with negative health effects.[25] Nevertheless, happily married couples are generally better off than the unmarried.

23. The positive health effects of marriage result, in part, from the tangible resources and protections that society accords to spouses. For example, federal and state statutes accord married partners many financial benefits – including those deriving from tax laws, employee benefits, death benefits, and entitlement programs – which provide the couple with greater economic and financial security than unmarried individuals. Such security is an important

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on the American Psychological Association's Web site: http://www.apa.org/pi/lgbc/publications/justthefacts.pdf

21 Diener, Suh, Lucas, & Smith, 1999; Gove, Style, & Hughes, 1990; Johnson, Backlund, Sorlie, & Loveless, 2000; Ross, Mirowsky & Godsteen, 1990; Simon, 2002; Stack & Eshleman, 1998.

22 Brown, 2000; Nock, 1995; Stack & Eshleman, 1998; but see Ross, 1995.

23 Gove et al., 1990; but see Huston & Melz, 2004.

24 E.g., Huston & Melz, 2004.

25 Gove, Hughes, & Style, 1983; Kiecolt-Glaser & Newton, 2001; Williams, 2003.

predictor of mental and physical health. In addition, married couples enjoy special rights and privileges that buffer them against the psychological stress associated with extremely traumatic life events, such as the death or incapacitation of a partner. Married couples' legal status also enables them to exercise greater control over their lives when stressful situations arise and to avoid some types of stressful situations entirely. These include, for example, being compelled to testify against one's spouse in court, having a noncitizen spouse deported, and having one's relationship or joint parental status challenged outside one's home state.[26]

24. Marriage also provides other benefits and protections. Compared with the unmarried, for example, married adults tend to receive more social support from other people, especially from their parents, and such support contributes to individual well-being.[27] Indeed, social support and integration are central to the institution of marriage: Marital relationships differ from nonmarital intimate relationships, in part, by requiring a lifelong commitment that is publicly affirmed, typically in the presence of family members, friends, and civil or religious authorities. This public aspect of marriage can be understood as increasing each relationship partner's sense of security that the relationship will endure. In the words of one scholar, "The public commitment and the involvement of friends and relatives create an enforceable trust that is not present in cohabiting unions. It allows couples to have more confidence that their investments in the union will be recouped."[28]

25. Although these conclusions are derived from studies of heterosexual couples, it is reasonable to assume that same-sex couples who choose marriage will generally benefit from it, like their heterosexual counterparts.

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26 See generally Herek, 2006.

27 Cooney & Uhlenberg, 1992; Nock, 1995; Sprecher, 1988; Umberson, 1992.

28 Cherlin, 2000, p. 136; Cherlin, 2004. For a more detailed discussion of the points in this section, see Herek, 2006.

V. Marrying a Person of the Other Sex Is Not a Realistic Option for Gay Men and Lesbians.

26. As explained above, a person's sexual orientation defines the universe of persons with whom they are likely to find the satisfying and fulfilling relationships that, for many individuals, comprise an essential component of personal identity. For individuals who are exclusively heterosexual, such relationships are with a person of the other sex. For individuals who are exclusively lesbian or gay, such relationships are with a person of the same sex.[29] Thus, marrying a person of the other sex is not a realistic option for a gay or lesbian person, any more than marrying a person of the same sex is a viable option for a heterosexual man or woman.

27. This is not to say that gay men and lesbians never marry a person of the other sex. In the fairly recent past, before the emergence of visible gay communities in the United States, many gay women and men married heterosexually for a variety of reasons, including social and family pressures, a desire to avoid stigma, and a perception that such marriages were the only available route to having children. Sometimes individuals have recognized their homosexuality or bisexuality only after they married a person of the other sex.[30] In these situations, the heterosexually married gay, lesbian, or bisexual individual's eventual recognition or disclosure of his or her sexuality has typically been highly disruptive for the entire family. Not all such marriages have ended in divorce or separation, but many have.[31] Given these negative

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29 For example, in the previously-cited national survey that I conducted with a probability sample of more than 650 lesbian, gay, and bisexual adults, approximately 76% of lesbians and 40% of gay men were currently in a committed relationship, the vast majority of them cohabiting. Only two of these respondents were in a heterosexual relationship, both of them married to a person of the other sex (Herek et al., 2009).

30 E.g., Higgins, 2006. Owing to the difficulty of obtaining probability samples that include large numbers of gay men and lesbians, reliable estimates of the proportion of gay and lesbian adults who have been heterosexually married have not been available. However, a recently published analysis of responses to a 2003 survey of California adults found that approximately 9% of gay men and 25% of lesbians 18-59 years of age reported having ever been married, most of them presumably to a person of the other sex (Carpenter & Gates, 2008, Table 3).

31 E.g., Bozett, 1982.

consequences, pressuring gay men and lesbians to marry a person of the other sex is not in the best interests of the individuals involved or of society.

VI. Denying Federal Recognition to Gay Men and Lesbians Who Are Legally Married Stigmatizes Them.

28. Denying federal recognition to married same-sex couples devalues and delegitimizes their relationships. It conveys the government's judgment that committed intimate relationships between people of the same sex – even when those relationships are recognized as legal marriages by the couple's state – 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.[32]

29. *Stigma* refers to an enduring condition, status, or attribute that is negatively valued by society, that fundamentally defines a person's social identity, and that consequently disadvantages and disempowers those who have it.[33] Social scientists have long recognized that stigma is not inherent in a particular trait or membership in a particular group; rather, society collectively identifies particular characteristics and groups, and assigns negative meaning and value to some of them, thereby "constructing" stigma. Thus, a classic work in this area

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32 In 2004, based on its review of the relevant scientific research concerning marriage and same-sex relationships, the American Psychological Association passed a *Resolution on Sexual Orientation and Marriage*, in which it resolved "That the APA believes that it is unfair and discriminatory to deny same-sex couples legal access to civil marriage and to all its attendant benefits, rights, and privileges" and that the "APA encourages psychologists to act to eliminate all discrimination against same-sex couples in their practice, research, education and training" (American Psychological Association, 2004). Similarly, in 2005, the American Psychiatric Association adopted a *Support of Legal Recognition of Same-Sex Civil Marriage* position statement, resolving that "In the interest of maintaining and promoting mental health, the American Psychiatric Association supports the legal recognition of same-sex civil marriage with all rights, benefits, and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities" (American Psychiatric Association, 2005).

33 See, e.g., Goffman, 1963; Link & Phelan, 2001.

characterized stigma as "an undesired differentness."[34] Exactly which differences are important, and which ones are designated as undesirable, is socially constructed and can change over time as social norms and mores change.

30. Social psychological research indicates that "differentness," to the extent that it creates perceptions of ingroups and outgroups, is associated with biased perceptions and differential treatment of individuals according to whether they are considered "us" or "them." People tend to hold positive feelings and display favoritism toward members of their own group, even in situations when group membership is based on completely arbitrary criteria, such as the flip of a coin.[35] To the extent that laws differentiate majority and minority groups and accord them differing statuses, they highlight the perceived "differentness" of the minority and thereby promote and perpetuate stigma.

A. Homosexuality Remains Stigmatized, and this Stigma Has Negative Consequences.

31. Homosexuality remains stigmatized today in the United States: Significant portions of the heterosexual public harbor negative feelings and hostile attitudes toward sexual minorities.[36] Such stigma can be observed both in the institutions of society and among its individual members. In the former, stigma-derived differentials in status and power are legitimated and perpetuated in the form of *structural stigma*. As a product of sociopolitical forces, structural stigma "represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups."[37]

32. By legitimating and reinforcing the "undesired differentness" of sexual minorities and by according them inferior status relative to heterosexuals, structural stigma gives rise to prejudicial attitudes and individual acts against them, including ostracism, harassment,

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34 Goffman, 1963, p. 5.

35 See, e.g., Devine, 1995; Dovidio & Gaertner, 1993.

36 E.g., Herek, 2002; Herek & Capitanio, 1999; Schafer & Shaw, 2009.

37 Corrigan et al., 2005; see generally Link & Phelan, 2001.

discrimination, and violence. Large numbers of lesbian, gay, and bisexual people experience such acts of stigma because of their sexual orientation. For example, in my national survey of lesbian, gay, and bisexual adults, 21% of the respondents reported having been the target of a physical assault or property crime because of their sexual orientation since age 18. Gay men were the most likely to report they had been the targets of such crimes; 38% had experienced an assault or property crime because of their sexual orientation.[38] In the same survey, I found that 18% of gay men and 16% of lesbians reported they had experienced discrimination in housing or employment because of their sexual orientation.

33. Research indicates that experiencing stigma and discrimination is associated with heightened psychological distress.[39] Being the target of extreme enactments of stigma, such as an antigay criminal assault, is accompanied by greater psychological distress than is experiencing a similar crime not based on one's sexual orientation.[40] Fear of being a target for stigma makes some gay and lesbian persons feel compelled to conceal or lie about their sexual orientation. As noted above, experiencing barriers to integrating one's sexual orientation into one's life (e.g., by being able to disclose it to others) is often associated with heightened psychological distress and has negative implications for physical health.

34. In addition, to the extent that the threat of being stigmatized motivates some lesbians and gay men to remain in the closet, it further reinforces anti-gay prejudices among heterosexuals. Research has consistently shown that prejudice against minorities, including gay people,[41] is significantly lower among members of the majority group who knowingly have

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38 Herek, 2009a; see also Herek, Gillis, & Cogan, 1999; Herek & Sims, 2008.

39 E.g., Meyer, 2003; Mays & Cochran, 2001.

40 Herek et al., 1999.

41 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.

contact with minority group members.[42] Consistent with this general pattern, empirical research demonstrates that having personal contact with an openly gay person is one of the strongest and most consistent correlates of heterosexuals' tolerance and acceptance of gay people. Anti-gay prejudice is significantly less common among members of the population who report having a close friend or family member who is gay or lesbian.[43] Indeed, an extensive analysis of empirical studies examining the association between prejudice and personal contact between a wide range of stigmatized and nonstigmatized groups found that the link is stronger for sexual minorities than for other types of groups, including those defined by race, ethnicity, and mental illness.[44] Prejudice tends to be lower when a lesbian or gay friend or family member has directly disclosed her or his sexual orientation to a heterosexual person, compared to when the former's sexual orientation is known but has not been directly discussed.[45]

B. The Defense of Marriage Act Reflects and Reinforces This Stigma.

35. Just as sexual orientation is inherently about relationships, so is the stigma associated with homosexuality. Although sexual stigma is often enacted against individuals (e.g., through ostracism, discrimination, or violence), it is based on those individuals' relationships (actual, imagined, or desired) with others of their same sex. Sexual minority individuals are stigmatized not only because their private desires are directed at people of their same sex, but

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42 A meta-analysis of more than 500 studies of contact and prejudice based on sexual orientation, nationality, race, age, and disability found a highly robust inverse relationship between contact and prejudice. That analysis also found that more rigorous studies (based on observed contact rather than reported contact) yielded greater effects, that contact changed attitudes towards the entire outgroup (not just towards those individuals with whom subjects had contact), and that majority group participants experienced greater changes in attitude than minority group members (Pettigrew & Tropp, 2006).

43 Herek & Capitanio, 1996; Herek & Glunt, 1993; Familiarity encourages acceptance, 2000; Vonofakou, Hewstone, & Voci, 2007.

44 Based on their meta-analysis, Pettigrew & Tropp reported that ". . . the magnitudes of the contact–prejudice effect sizes vary in relation to different target groups. The largest effects emerge for samples involving contact between heterosexuals and gay men and lesbians . . . . These effects are significantly larger than are those for the other samples combined . . . ." (Pettigrew & Tropp, 2006, p. 763, statistics omitted).

45 Herek, 2009b; Herek & Capitanio, 1996.

also because of the nature of their intimate relationships (i.e., because their sexual or romantic partner is of their same sex). Indeed, a person's homosexuality or bisexuality often becomes known to others only when she or he enters into a same-sex relationship, regardless of whether that relationship involves a single sexual act or a lifelong commitment to another person. Consistent with this observation, psychological research has shown that heterosexuals' reactions to same-sex couples are typically more negative than their reactions to heterosexual couples, and this bias is often outside their conscious awareness or control.[46]

36. Because it restricts the opportunities of sexual minorities relative to heterosexuals, the Defense of Marriage Act is, by definition, an instance of structural stigma. It conveys the government's judgment that, in the realm of intimate relationships, a legally married same-sex couple possesses an "undesired differentness" and is inherently less deserving of society's full recognition through the provision of federal marriage-linked benefits than are heterosexual couples. This according of disadvantaged status to the members of one group relative to another is the crux of stigma. By thus devaluing and delegitimizing the relationships that constitute the very core of a homosexual orientation, the federal government compounds and perpetuates the stigma historically attached to homosexuality. This stigma affects homosexual and bisexual persons as a group, not only those who are married to a person of the same sex.

Signed under the pains and penalties of perjury under the laws of the United States this 13th day of November, 2009.

/s/ Gregory M. Herek

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Gregory M. Herek, Ph.D.

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46 E.g., Dasgupta & Rivera, 2006; Jellison, McConnell, & Gabriel, 2004.

Certificate of Service

I hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on November 19, 2009.

/s/ Gary D. Buseck
Gary D. Buseck