DAVID C. DINIELLI (SB No. 177904)
David.Dinielli@mto.com
LIKA C. MIYAKE (SB No. 231653)
Lika.Miyake@mto.com
BRAM ALDEN (SB No. 272858)
Bram.Alden@mto.com
MUNGER, TOLLES & OLSON LLP
355 South Grand Avenue, Thirty-Fifth Floor
Los Angeles, CA 90071-1560
Telephone: (213) 683-9100
Facsimile: (213) 687-3702

MICHELLE FRIEDLAND (SB No. 234124)
Michelle.Friedland@mto.com
MUNGER, TOLLES & OLSON LLP
560 Mission Street, Twenty-Seventh Floor
San Francisco, CA 94105-2907
Telephone: (415) 512-4000
Facsimile: (415) 512-4077

Attorneys for EQUALITY CALIFORNIA
Amicus Curiae and Proposed Intervenor

SHANNON MINTER (SB No. 168907)
SMinter@nclrights.org
CHRISTOPHER STOLL (SB No. 179046)
cstoll@nclrights.org
NATIONAL CENTER FOR LESBIAN RIGHTS
870 Market Street, Suite 360
San Francisco, CA 94102
Telephone: (415) 392-6257
Facsimile: (415) 392-8442

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

DONALD WELCH, ANTHONY DUK, AARON BITZER,

Plaintiffs,

vs.

EDMUND G. BROWN, JR., Governor of the State of California, in his official capacity, et. al,

Defendants.

CASE NO. 2:12-CV-02484-WBS-KJN

DECLARATION OF DOUGLAS C. HALDEMAN, PH.D., IN SUPPORT OF AMICUS BRIEF OF EQUALITY CALIFORNIA

Judge: Hon. William B. Shubb

Courtroom: #5

Date: December 3, 2012

Time: 2:00 p.m.

DECLARATION OF DOUGLAS C. HALDEMAN

I, Douglas C. Haldeman, Ph.D, declare as follows:

1. I have been retained by Amicus Curiae Equality California as an expert in connection with the above-referenced litigation. I have personal knowledge of the contents of this Declaration and, if called upon to testify, I could and would testify competently to the contents of this Declaration.

EXPERT BACKGROUND AND QUALIFICATIONS

2. My background and experience are summarized in my *curriculum vitae*, which is attached as Exhibit A to this Declaration. My *curriculum vitae* also includes a list of publications I have authored.

3. I am a licensed psychologist in the State of Washington. I have engaged in a full-time independent clinical practice in Seattle since 1983. The majority of my full-time clinical practice involves individual, couple, family and group counseling to the LGBT communities.

4. I received my Doctorate in Counseling Psychology from the University of Washington in 1984. Since 1988, I have served as a Clinical Instructor in the Department of Psychology at the University of Washington. In addition, I have been an active member of the American Psychological Association (APA) since 1985, and have served in a number of positions in APA Governance, including its Board of Directors and the Board of its Insurance Trust. I have also been a member of the Washington State Psychological Association (WSPA) since 1984, and have been involved in a number of the Association's committees.

5. One of the primary foci of my nearly 30 years of clinical practice has been to counsel men who have been harmed, both emotionally and physically, by undergoing "sexual orientation change efforts" ("SOCE"). For more than 20 years, I have written extensively about issues relating to SOCE, including more than 40 papers and chapters in scholarly journals and books. Those publications are summarized in my *curriculum vitae* (Exhibit A).

6. In preparing to write this Declaration, I have reviewed the declarations filed by the Plaintiffs in this matter.

SEXUAL ORIENTATION CHANGE EFFORTS

7. There is a consensus among mainstream mental health organizations and mainstream mental health providers and academics that SOCE is not an accepted therapeutic practice. This is because (1) there is no valid evidence that it works; and (2) there is significant and valid evidence that it can cause serious harm, including serious emotional consequences such as depression, suicide attempts, and suicide.

8. A review of the literature relating to SOCE reflects that the premise underlying treatments designed to change homosexual orientation is that homosexuality is a mental disorder that needs to be "cured." When homosexuality was declassified as a treatable mental disorder nearly 40 years ago, it was assumed by many that the popularity of treatments intended to change sexual orientation would come to an end. While some of the most notorious aversive change therapies have largely fallen into disfavor, including the application of electric shock to the hands and/or genitals, or nausea-inducing drugs, some practitioners have continued to engage in other types of SOCE premised on the unscientific belief that homosexual orientation is undesirable, pathological, and the result of learned behavior, which can be reconditioned through various means.

9. A review of hundreds of studies over many decades concludes that there is no reliable evidence to suggest that SOCE therapies are effective in changing a patient's sexual orientation (APA, 2009). The studies purporting to show the efficacy of SOCE are characterized by serious methodological flaws and conceptual weaknesses that make their results unreliable. Foremost among the methodological problems with these studies is sampling bias. Frequently, the participants in these studies have been selected by, or identified exclusively by referrals from, practitioners of SOCE therapy. In addition, these studies rarely include any effort to define what constitutes sexual orientation in the first place, or to place the study participants on any sort of spectrum reflecting their own individual sexual orientation. Similarly, the studies rarely include any effort to define quantitatively what constitutes a change of sexual orientation. Furthermore, these studies are also characterized by methodological flaws relating to "response bias": study participants, because of societal and/or religious pressures, typically hold strong views that

homosexuality is undesirable and therefore are likely to overstate their perceived success in changing their underlying orientations. Almost all such studies draw on a subject's retrospective analysis of the therapeutic experience, which is further influenced by pressures from family and social desirability generally linked to membership in a conservative religious community. Finally, few of the conversion therapy studies offer any follow-up data. This is particularly relevant given the fact that these studies frequently ignore extraordinarily high SOCE dropout rates. The failure of the studies to follow up with the participants who have dropped out serves to distort the results of the studies, because they do not take into account the large number of individuals for whom the treatment was, at best, ineffective, and, more likely, harmful. Indeed, it is worth noting that even in these tremendously flawed studies, proponents of SOCE report only a 30% success rate at best. Nevertheless, these studies are marketed as "scientific" to a public that is unable critically to evaluate them.

SOCE THERAPIES CREATE A SIGNIFICANT RISK OF HARM

10. When patients begin SOCE therapy, they frequently blame themselves for experiences of rejection or maltreatment rooted in society's devaluation of same-sex sexual orientation. SOCE therapy invariably involves validating and reaffirming this societal rejection, and imbuing it with the false appearance of scientific and medical acceptance. Those who report being harmed in SOCE therapies frequently report that their prior therapists attempted to frighten them into changing their sexual orientation by presenting images of gay men and lesbians as depraved, chronically miserable people, unproductive in life, and incompetent in meaningful relationships. Because SOCE therapy validates and reaffirms that devaluation, it frequently exacerbates the patient's distress and results in severe emotional harm. Harms from SOCE can manifest in the form of depression, guilt, anxiety, low self-esteem, intimacy avoidance, sexual dysfunction, suicidal ideation, and other negative consequences.

11. Additionally, a patient's recognition that SOCE has failed can cause further severe emotional consequences. LGB youth -- regardless whether they attempt to change their orientation through SOCE -- are at heightened risk of expulsion from family, loss of position in society, rejection from familiar institutions, loss of faith in and membership in the community,

and vulnerability to anti-gay biases. The failed attempt to change one's sexual orientation -- because it often is perceived to be a "failure" on the part of the patient -- exacerbates these risks. This in turn can cause additional negative emotional consequences like those described above: depression, guilt, anxiety, low self-esteem, intimacy avoidance, sexual dysfunction, suicidal ideation, and other negative consequences.

12. My own experience as a mental health provider confirms the harms that SOCE therapies cause. For nearly thirty years, I have been working with patients in my clinical practice who have suffered through a variety of efforts to change their sexual orientation and have been harmed as a result.

13. The harms associated with SOCE therapies are particularly significant as they relate to minors. Adolescents require a period of exploration and introspection in order to work through issues relating to sexual orientation and gender identity. Minors who have not had a chance to explore or know their sexuality can be particularly harmed by the bias and lack of accurate information inherent in SOCE therapies, where the proponents reinforce the message that homosexuality is a disorder that is to be avoided at all costs. The harms inflicted on minors who are exposed to SOCE therapies may be exacerbated by the fact that an individual's brain tissue in the pre-frontal cortex is still developing and changing rapidly during early adolescence and teenage years. These cellular changes in brain tissue leave the mid-brain (repository of emotional responses) much more vulnerable to the potentially traumatic effects of SOCE.

14. Minors are particularly susceptible to implicit or explicit coercion by family members and faith communities who disapprove of their sexual orientation. Parents often urge or compel minors to undergo SOCE, and minors often experience a desperate desire to gain the approval of their family and churches. Because of the stigma attached to being gay, minors may also even have difficulty separating what they want from what their families or therapists want, and SOCE may appear to some of these minors to provide a means to gain approval and to conform their identities and behaviors to familial and societal expectations and hopes. But minors often do not understand the risks, and may not understand that other therapeutic interventions could help them feel better and resolve conflicts between their sexual orientation,

their family expectations, and, where applicable, their own religious values without risking severe harm.

15. The potential consequences of SOCE, such as depression and suicide, are sufficiently grave that it is appropriate to erect a complete barrier between minors -- who deserve special protections from harmful practices -- and therapists who would offer them the false hope of changing their sexual orientation through SOCE.

16. "Informed consent" is appropriate only for therapies that offer at least some potential benefits, which SOCE does not. There are many potential benefits for LGB youth who seek therapy. Therapy can provide a safe place to discuss conflict, experience support, and develop hope. But none of these benefits derives from the practice of SOCE itself, but rather from universal techniques of psychotherapy. These basic benefits can be provided by culturally competent care, without creating the risks of harm caused by SOCE.

17. My conclusions regarding the harms caused by SOCE therapies have been reinforced in recent years. The Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation ("APA (2009)") concluded that SOCE interventions have no scientific basis. The APA Task Force Report undertook a comprehensive review of the relevant research literature and concluded that there was no reliable evidence to support the contention that SOCE therapies work. The APA Task Force Report also provided a detailed discussion and analysis of the harms associated with SOCE therapies.

18. After a peer review of the conclusions of the APA (2009) Task Force, the APA passed a resolution in 2009 declaring that "there is insufficient evidence to support the use of psychological interventions to change sexual orientation." In addition, the resolution points out that "the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation." As a result, the APA, like all the other major mental-health organizations, has resolved that SOCE therapies are unnecessary and potentially harmful, and therefore should not be promoted or offered.

19. The methodological flaws in the studies purporting to show the efficacy of SOCE therapies were recently underscored by Dr. Robert Spitzer, the author of what had been

considered to be the most well-known and authoritative study purporting to demonstrate that SOCE therapies may work for some individuals under certain circumstances. Earlier this year, Dr. Spitzer took the unusual step of recanting his 2001 study that had been published in the *Archives of Sexual Behavior*. Dr. Spitzer admitted that his study had been methodologically flawed and that there was no valid basis for his study's conclusion that SOCE therapies had succeeded in changing the sexual orientation of any study participants. Indeed, Dr. Spitzer issued a public apology for having made unproven claims regarding the efficacy of SOCE and subjecting individuals to the harms of SOCE interventions. An article from the New York Times detailing this retraction is attached as Exhibit B. Dr. Spitzer recently gave a brief videotaped statement for use in this case, explaining the methodological flaws in his prior study and explaining his current view that SOCE causes harm. A video of Dr. Spitzer's statement is available at http://youtu.be/TdOovBb2tqI and a transcript of that statement is attached hereto as Exhibits C.

SOCE DOES NOT ADVANCE CLIENT AUTONOMY

20. Competent, ethical psychologists respect a client's right to self-determination. That does not mean, however, that a psychologist is ethically required to defer to a client's stated goals, without regard to medical and ethical guidelines. Nor does that mean that a psychologist must provide a patient with whatever form of therapy the client wants, regardless of the therapy's efficacy or potential harm, or that clients should be permitted to demand such therapy. For example, if an anorexic patient asks for help in losing more weight, competent psychologists do not defer to this goal out of respect for the patient's self-determination.

21. Psychology remains a profession, not merely a service industry. Competent psychologists listen to a client's stated goals and experiences, and guide the client through the process of exploring the emotional basis for those goals and experiences using accepted therapeutic techniques. It is through this process that competent therapists assist clients in gaining understanding, and, based on that understanding, determining healthy and emotionally sound strategies for living their chosen lives.

22. SOCE necessarily runs counter to these accepted methods, because SOCE presupposes a preferred outcome -- generally a heterosexual or celibate orientation -- which typically is in direct conflict with the clients' actual emotional and physical experiences. Moreover, SOCE excludes any accurate and honest exploration of the basis for the desire to be heterosexual.

23. Professional guidelines and ethical principles admonish psychologists against the imposition of personal, religious, or idiosyncratic beliefs upon any patient. SOCE presupposes an unrealistic outcome, and is imposed on the minor client regardless of his or her own thoughts, desires, or personal exploration of sexual orientation and identity. In this way, SOCE *thwarts* client autonomy, rather than advances it.

24. Respecting client autonomy does not mean that clients with strong religious beliefs that include, for example, disapproval of homosexual behavior, should be permitted to elect to undergo SOCE. Regardless of a client's religious beliefs, it is inappropriate for a competent therapist to offer a purported "treatment" that does not work and creates a significant risk of serious harm. A competent therapist treating a client with strong religious beliefs assists the client in understanding the source and emotional consequences of any conflicts between experience and belief, and in negotiating a healthy life course in light of accurate knowledge about what can be changed and what cannot.

25. The APA (2009) Task Force Report reaches this same conclusion regarding the appropriate manner of respecting client autonomy: "We believe that simply providing SOCE to clients who request it does not necessarily increase self-determination but rather abdicates the responsibility of [mental healthcare providers] to provide competent assessment and interventions that have the potential for benefit with a limited risk of harm. We also believe that [mental healthcare providers] are more likely to maximize their clients' self-determination by providing effective psychotherapy that increases a client's abilities to cope, understand, acknowledge, explore, and integrate sexual orientation concerns into a self-chosen life in which the client determines the ultimate manner in which he or she does or does not express sexual orientation."

26. The concept of self-determination in relation to SOCE is particularly critical when it comes to minors. Minors are often forced into SOCE by their parents, who refuse to accept the fact that their child may be lesbian, gay, bisexual, or transgender. Unlike the discredited SOCE therapies, interventions or therapies that affirm a patient's sexual orientation and gender identity actually promote the patient's autonomy and self-determination, because true self-determination is accomplished when the patient's false assumptions are corrected and the individual is allowed to make truly informed decisions about his life.

CONCLUSION

27. SOCE therapies designed to change an individual's sexual orientation have not been empirically demonstrated to be either effective or safe. Indeed, such SOCE therapies needlessly expose patients to risk of serious harms. In fact, based on my 20 years of experience studying and writing about SOCE in textbook peer reviewed journals, as well as my 30 years of clinical observations, I am convinced that many individuals who attempted to change their sexual orientation have experienced considerable psychological pain and harm.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 19th day of November, 2012, at Seattle, Washington.

Douglas C. Haldeman, Ph.D