Diagnosis Gay:
The use of MRI brain scans to identify sexual orientation

“You’d better name yourself, because, if you don’t others will do it for you”

Audrey Lorde “A Black Feminist, Lesbian, Poet, Mother, Warrior”

When I was first introduced to this quote, I was immediately put off by its seemingly limited parameters; why would I want to be bound by what I could “name myself”? My attitude was perhaps emphasized by the fact that I was 14, and in the midst of my adolescent rebellion. As I got older, however, I began to view this quote differently. Our society is founded on labels, and we are all at risk of being limited not by ourselves, but by the names that others give us.

Each of us takes care in recognizing the characteristics that define ourselves as individuals. This act of self-classification is perhaps most important among the estimated 9 million lesbian, gay, bisexual, and transgendered (LGBT) people living in America today. However, this personal process may be threatened by new neurological studies that use MRIs to identify sexual orientation. These studies, while rooted in scientific correlation, do not provide a definitive diagnosis, and therefore pose the risk of incorrectly or prematurely labeling someone before they are given a chance to do so themselves. In a community committed to celebrating
diversity, every person has the right to define themselves without the fear of others doing it for them.

In the past decade, there has been an increase of neurological research focused on the differences between the homosexual and heterosexual brain. Imaging studies have found various structural differences between the brains of heterosexual and homosexual patients, including hemispheric ratios, amygdala connectivity, and the size of hypothalamus and anterior commissure. In each case, the brains of homosexual women (HoW) exhibit the same features as heterosexual men (HeM), and homosexual men (HoM) have brains structurally comparable to heterosexual women (HeW). Other studies have used MRI (magnetic resonance imaging) scans to map the brain’s response when the subject is shown male and female faces. The tests revealed activation of the reward pathway when the subject was shown images of their sexually desired gender, thereby determining one’s sexual orientation. It is important to note that current studies only indicate hallmarks of sexual orientation, not a definitive diagnosis. However, as research progresses these markers could be used in a clinical setting. Any new knowledge concerning human sexuality obligates a responsibility within the medical community to use caution in order to avoid labeling individuals before they have the chance to do so themselves.

The greatest concerns of patient autonomy are in situations involving a young patient. For children, the decision to undergo sexual orientation diagnosis would not be within their control. There could be a situation in which a parent, perhaps upset over social or behavioral differences in their child, would want an MRI performed to determine their child’s sexual orientation. In situations where the parents are not supportive of homosexuality, there are detrimental consequences to the well-being of the child. According to a study conducted by the American Academy of Pediatrics (2008), gay and lesbian adolescents who experienced rejection from
family members had overall poor health, and were at a much greater risk for taking part in unhealthy behaviors. Compared to youth in families accepting of their sexuality, those experiencing rejection are “8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, [and] 3.4 times more likely to use illegal drugs.”

Clearly, an accepting and inclusive home environment is essential for the wellness and safety of gay youth.

The question remains, could children benefit from this technology? One could argue that having information of a child’s sexual orientation could help parents understand potential social challenges their child may face, and therefore may plan accordingly to help the child reach their full potential. If this was the only outcome of clinical sexual orientation identification, then the use of MRIs in this fashion would be considered beneficent. However, the technology still removes autonomy from the self-labeling process. The importance of autonomy has been studied at great lengths. For example, according to an article published in Social Psychological and Personality Science (2012), gay and lesbian individuals were more likely to feel comfortable disclosing their sexual orientation when they were met with “autonomy support”, which the authors define “as interpersonal acceptance and support for authentic self-expression. In environments high in autonomy support, people feel accepted for who they are, are free to act and express themselves.”

The argument can be made that parents who are aware of their young child’s sexual orientation can prepare to provide a familial construct of “autonomy support”. While this may be in the child’s best interest, the very foundation of autonomy support emphasizes the importance of “authentic self-expression,” implying the need for the individual to make the personal identifications for themselves. Having a child’s sexual orientation identified for them is not
congruent with this principle. Parents could do more harm than good by raising their child under a perceived sexual orientation, and should instead foster an inclusive environment in which the child will feel respected and accepted, regardless of sexual orientation.

It is clear that the use of MRIs to clinically identify sexual orientation has extreme risks, as well as potential benefits. However, at the core of this debate stands the issue of autonomy, and recent studies involving MRI technology threatens to remove this autonomy from the LGBTQ population. The process of self-identification is important for all members of our diverse society. We do not need to fear labels, but instead ensure that we have the power to name ourselves.
Footnotes


