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Who has a problem with chemsex? Identity as a missing link in support services for men who engage in problematic use of psychoactive substances for sexual purposes

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Summary

As the social consent for seeking help in the area of psychosexual health increases, specialists observe the current socio-cultural changes and the new phenomena they give rise to reflected in their patients. One of these relatively new phenomena is chemsex. It is a distinct form of combining highly specific psychoactive substances and sexual activity, practised almost exclusively by men. Due to the increased health risks, associated both with the drugs used and the frequent lack of protection during sexual activity, international public health institutions consider chemsex a health problem of men who have sex with men (MSM). Although the introduction of MSM as a category in the 1990s – mainly in the context of HIV – was based on important epidemiological premises (the behavior, not the identification, is what is important in the context of risk), it is neglecting sexual identity that may be one of the missing links in the intersectional understanding and appropriate addressing of problematic chemsex.

Key words: chemsex, sexual identity

Introduction

Although combining psychoactive substance use and sexual activity is by no means a new social phenomenon, until recently it was not an area of special interest for clinicians. Psychiatric literature mentions it under the labels of risky behavior, acting-out, non-adaptive emotion regulation strategies and/or attachment disorders in adolescence, borderline personality disorder, or mania episode in bipolar disorder [1–4]. The psychoactive substances most commonly cited in those cases are alcohol, MDMA (ecstasy), amphetamine, and cocaine, and the sexual activity undertaken under their influence is thought to be a side effect of lowered control rather than a result of

premeditated action. Recently, however, sexualized drug use (SDU), that is intentional use of substances before or during sexual activity aimed at facilitating its initiation or enhancing the experience, has emerged as a new topic of discussion. It is a specific form of combining psychoactive substances and sex where the aim is intense and uninhibited sexual contact, and the drug is to guarantee – or at least facilitate and catalyze – effective realization of this aim.

Chemsex is a relatively new phenomenon in this area, with noticeably growing prevalence. It narrows the term SDU to using specific psychoactive substances for specific purposes by people belonging to a specific social (sub)group. Men who engage in it (described as the MSM population) are more and more often looking for specialized help, and their own definition of the problem is often the key according to which they select the specialist. Those who expect alleviation of the side effects of the drugs they use consult psychiatrists, those who have problems with, e.g., erectile dysfunctions, anxiety about excessive frequency of sexual contacts or inability to have sex when sober, seek help from sexologists, those who feel they are losing control talk to addiction therapists, and psychotherapists often see patients with all of the above, who also need to be understood without judgement.

We have decided to write on the subject of chemsex not only because it is still virtually absent from Polish psychiatric literature, but, above all, because it is described in professional literature all over the world from a highly reductionist – in our opinion – behavioral-epidemiological perspective, limited to problematic behaviors and risks to public health. The United Nations [5] reports an alarming increase in HIV infections among men, identifying chemsex as one of the most powerful accelerators of this increase. Chemsex has thus become a social problem primarily because of its epidemiological consequences. We ask the question about the reasons for this phenomenon, and attempt to give at least a partial answer to it because, although the phenomenon itself is new, the problem seems to be old and, like anything associated with sexuality, influenced by the cultural context, social polarization, and politics (including health politics). In search of the answer, we touch on the subject of complex post-traumatic stress disorder (cPTSD) and the new concept of intraminority stress. We also consider the hypothesis that in this specific case the category of declared/assumed identity/sexual orientation may turn out to be more important (and more useful for therapy) than the more frequently applied category of MSM. We believe that understanding why specific actions may be especially attractive for a specific group of people will contribute to more appropriate and effective response to the patients' needs.

Characteristics of chemsex

The word chemsex was first used in 2001 by David Stuart [6], and describes using methamphetamine and/or synthetic cathinones (3-MMC or 4-MMC) and/or GHB or GBL (gamma-hydroxybutyrate/gamma-butyrolactone) specifically for reducing

inhibitions and enhancing sexual pleasure by men who have sex with men (MSM) [6]. In our opinion, there are at least four reasons why this particular combination requires an approach that would be different from the established models of description, understanding and treatment of people who use psychoactive substances problematically, or psychotherapy of sexual dysfunctions in hypersexual men. The first reason is the effects of the above-mentioned substances, the second – the population who uses them, the third – the motivations for the abovementioned practices, and the fourth – following the Aristotelian understanding of the whole as something more than the sum of its individual parts – the unique interaction of all of the above, the understanding of which seems to be key for appropriate response to the patients' needs.

Substances used

The drugs used in chemsex – cathinones (including mephedrone), GHB/GBL (gamma-hydroxybutyrate/gamma-butyrolactone) and methamphetamine – are characterized by a particular action mechanism absent from drugs which have been "on the market" longer and are therefore better known. In the population using chemsex, cathinones are the most frequently used and most readily available drugs [7, 8]. Mephedrone, like other synthetic cathinones, has psychoactive and sympathomimetic action similar to amphetamine, and a stronger entactogenic effect, causing increased sensory sensitivity, sexual arousal and disinhibition [9]. Its potential and duration depend on the way in which it is administered [10]. If orally, it produces moderate effects after about 30 minutes, which last from three to five hours; intranasally – it produces effects after 10 minutes, which last about two hours, and with intravenous administration the effects are instantaneous, especially strong, and last up to 45 minutes [11]. Intranasal and intravenous administration are especially dangerous since the instant and intense effects result in the urge to repeat the dose. Mephedrone contributes to the increase in extracellular levels of dopamine, noradrenaline and serotonin by inhibiting their reuptake [8]. As a consequence, dependency is formed (relatively quickly), and the side effects include loss of appetite, insomnia or sleep disorders, agitation, anxiety, psychosis, impulsiveness, aggression, dehydration, hypertension, tachycardia, and tremors [12].

GHB and GBL are depressants of the central nervous system, in appropriate concentrations causing disinhibition, described as particularly sexually stimulating. What is more, they have analgesic effect and relax smooth muscles. They are usually administered orally, in form of drops added to small amounts (between 0.5 and 1 ml) of non-alcoholic drinks [9]. Maintaining the desired effect while avoiding overdose requires careful tracking of concentration of individual doses and intervals between them. Using mephedrone and/or methamphetamine and/or alcohol at the same time, combined with the fact that GHB/GBL accumulates, means that dosage control is significantly impaired or removed. An overdose results, among others, in memory

loss, loss of motor control, loss of consciousness, or respiratory failure, which is an immediate threat to life. In one of the studies [9], most respondents reported overdosing GHB/GBL at least once in the previous year.

Methamphetamine, although a derivative of amphetamine, differs from it by the stronger effects on the central nervous system, producing more intense and longer-lasting experience [13]. Like mephedrone, it causes a sudden release of dopamine and noradrenaline. It produces strong feelings of intimacy, closeness and emotional connection, increases confidence and self-perceived sexual attractiveness, lowers inhibitions, unblocks desires and fantasies, and enhances stimulation, allowing for longer and more intense contacts [1]. It is administered intranasally, orally, smoked or injected, with the latter two ways of administration guaranteeing extremely strong effects within 1–2 minutes. Negative effects vary from individual to individual and, apart from cardiovascular and cerebral-vascular complications, include a range of cognitive deficits, episodes of anxiety and depression, psychotic decompensation, as well as suicide ideation and attempts [13]. In a shorter perspective, days immediately after using methamphetamine bring states of anxiety and depression because of the extreme serotonin deficiency. The literature suggests that in the case of methamphetamine harm for mental health, especially in the form of psychotic episodes, depends less on how long the substance has been used for, and more on the size of individual doses [14]. Additionally, each of the substances listed above causes – in various intensity – increased confidence, sexual arousal and interest in sex, as well as lowers the ability to delay gratification. Apart from the health harms resulting from using or overusing those substances, whether individually or in combinations, the literature also mentions simultaneous and excessive use of sildenafil with the aim of enhancing duration of erection [15]. A dose of 100 mg of sildenafil combined even with a very small quantity of GHB can result in a sudden drop in blood pressure, tachycardia and respiratory distress.

Key population

In response to the growing popularity of the phenomenon, and primarily because of the worries associated with it, several research projects focused on men practicing chemsex have appeared in recent years. Based on their results, a description of an "average user" can be produced, with full awareness of its simplification. Descriptions produced through the prism of population allow for a synthetic view of the studied phenomena and a reasonably adequate insight into its scale and regularities, but at the cost of overlooking the subtle, though sometimes crucial, individual differences.

Among the studies conducted so far, the most comprehensive was The European MSM Internet Survey (EMIS) carried out in 2010 and 2017 [16, 17]. In the first edition, the anonymous internet survey was distributed in 25 languages, in 38 European countries, through 230 online social networking and dating services, and complete

data were obtained from 160,952 men who had had sexual contact with a man and/or felt sexual interest in other men in the previous year. From among the sample, 55,446 participants were divided into 44 groups, based around big European cities (if the number of respondents from the city was over 400), and the remaining participants were grouped as other – United Kingdom (8,291), other – Europe (60,606), and, because of the large number of respondents from Germany, other – Germany (36,606). The study also included data collected from 818 respondents from Warsaw [16]. Half of all respondents were aged between 25 and 39, while the other age groups were almost equal, with about 40,000 respondents below 25, and about 40,000 respondents above 40.

Around 20% of all the respondents declared engaging in chemsex in the previous four weeks. The numbers of men using ketamine, mephedrone, GHB/GBL, and methamphetamine for sexual purposes were the highest in Brighton, Manchester, London, Amsterdam, Barcelona, Madrid, and Valencia. Men who attended private sex parties had high rates of chemsex in the previous four weeks – as high as 50% in Amsterdam and London. The authors of the study point out that the place of residence, specifically the city, is the strongest predictor of using chemsex. For obvious reasons, capitals and other large urban centers offer easier access to drugs, people and opportunities.

The second edition of EMIS in 2017 [17] had similar scope, and it is worth noting here some results from the Polish part of the sample, comprising 4,025 respondents. In this group, 11.9% men reported they had taken psychoactive substances at least once to enhance sexual stimulation and the duration of sessions (in the whole sample this rate was 15%). 8% of the respondents reported that all or almost all of their sexual contacts with men within the previous 12 months had taken place under the influence of alcohol or other substances. Demographically, like in other European countries, around 42% of the respondents were aged between 20 and 39. In total, 41% of men who had used chemsex were not sure, disagreed, or definitely disagreed that their sexual contacts were always as safe as they want, while as many as 18% reported that they had been pushed, hit, kicked, or beaten at least once in their lives because somebody knew or suspected they were attracted to men [17][1].

In 2018, Hibbert et al. [18] conducted a survey among men living in Great Britain, receiving responses from 1,649 participants. They were asked about their identification, and as many as 86% selected the option gay/homosexual man. More than half of the respondents had higher education, and 4% knew they were HIV-positive. SDU, operationalized here in terms of using any psychoactive substance (except nicotine and alcohol) before or during sexual activity, was reported by 670 men, among whom

[1] It is worth noting here that so far two big studies have been conducted in Poland on this subject. One of them was organized by the Polish National Institute for Public Health with funds from the National Bureau for Drug Prevention. The general aim of the project was to assess the scale of chemsex in Poland and the prevalence of STDs among its users, as well as identifying the needs in terms of infectious disease prevention, addiction treatment and preventative interventions, including the identification of acceptable interventions in this sphere. The studies were both qualitative and quantitative.

6% reported using chemsex. Using psychoactive substances (especially cathinones, GHB/GBL and methamphetamine) for sexual purposes correlated with more frequent engagement in condomless anal sex. It seems worth noting here that men using chemsex reported lower overall satisfaction with life, and higher satisfaction with sex life.

Higher rates of unprotected sex among men who use psychoactive substances for sexual purposes were also reported by Gonzalez-Baez et al. [19] and Puffal et al. [20]. In the group of 742 patients of HIV treatment clinics in Madrid [19], as many as 60% had had condomless anal sex in the previous six months, and 29% used chemsex within the previous year. 62% had a history of at least one sexually transmitted infection other than HIV. As many as 88% of the participants in this study used geolocation-based mobile apps for sexual purposes, and 32% of this group organized their sexual contacts exclusively through these apps. An extended analysis of the data gathered from the above-mentioned 29% of participants (216 individuals) who engaged in chemsex was also published [21]. Among those participants, 64% had higher education, and almost 71% had a monthly income of 1,000 EUR or more. The median age was 38 years. Compared to non-injecting chemsex users, the 34 respondents who administered drugs through injections engaged in higher risk sexual behaviors, had more frequent diagnoses of sexually transmitted infections and experienced more severe short – and long-term effects of the substances they used, including primarily loss of consciousness, psychotic symptoms and suicidal behaviors [21]. The authors focused the analysis mainly on the injecting users, based on the earlier reports of the significant rise in the rates of MSM administering drugs this way between 2000 and 2015. Administering psychoactive substances through injections results not only in faster and more intense desired effects but also in more severe side effects and stronger dependency.

Puffal et al. [20] put forward the hypothesis that chemsex and other forms of using psychoactive substances for sexual purposes are partly responsible for the rise in HIV and other sexually transmitted infections among MSM in England and Wales, and perhaps also in a large part of Europe. The researchers used the Positive Voices survey, collecting data from all 30 HIV treatment clinics in the United Kingdom. A representative sample of 4,350 people (around 20% of all HIV-positive patients in the UK) was selected. They were sent or handed questionnaires on chemsex. Ultimately, 777 responses were gathered, from among which 392 MSM were included in the study. In the previous 12 months, 29.5% of them had engaged in chemsex. Most of the 29.5% were aged between 18 and 44 and lived in London. As many as 72.3% of the respondents reported condomless anal sex, and 40% had a history of another STI.

Bourne and Weatherburn [22] note that comparing studies on psychoactive substance use among men is made more difficult or even impossible not only by the fact that virtually every study operationalizes problematic substance use differently, both in terms of frequency and the substances used, but also, more importantly, by the fact that some studies use the category of behavior (MSM), while others use the category of identity (homo – and bisexual men). As a matter of fact, the authors of

this observation themselves repeat the very mistake they criticize by comparing MSM with heterosexual men.

Motivations

In studies of men who engage in chemsex, motivation is a rarely discussed subject [16, 19]. Authors are much more likely to focus on the demographic characteristics of the population, physical and (less often) mental health, the frequency of use of individual substances, as well as the forms of sexual contacts and the risk of infections associated with them. Some quantitative studies include scales of motivation created for their purposes, but they only allow participants to express their position on specific items. For example, in the survey conducted by Hibbert et al. [18] among men from Great Britain who engage in chemsex (*n* = 99), other forms of SDU with poppers (colloquial name for nitrites – mainly amyl nitrites – which, when inhaled, cause relaxation of smooth muscles and increase sexual pleasure), ecstasy, cannabis, cocaine, and sildenafil (*n* = 570), or sexual contacts under the influence of alcohol (*n* = 548), the participants were asked about their motivations for the above-mentioned activities. Among chemsex users, 72% agreed or definitely agreed that chemsex provides intense sexual pleasure (SDU – 42%, alcohol – 9%), 59% reported they engaged in activities they would not engage in when sober (SDU – 34%, alcohol – 43%), for 58% it resulted in longer sessions (SDU – 25%, alcohol – 6%), 43% were more likely to forego condom use (SDU – 21%, alcohol – 29%), negative effects were experienced by 17% (SDU – 6%, alcohol – 7%), and as many as 83% reported that this form gives them more pleasure from sex and does not limit their control (SDU – 89%, alcohol – 86%). In another study, MSM from the Netherlands who engage in chemsex (*n* = 209) reported increased stimulation and longer sessions (almost 80%) and lower inhibition and increase of pleasure (over 70%) [23].

Bourne and Weatherburn [22] analyzed narrations in literature across the fields of public health, psychology and sociology relating to motivations for using psychoactive substances and alcohol among MSM (or homo – and bisexual men) and determined three main themes: strengthening the sense of belonging, coping with difficulties and enhancing pleasure. The authors note that the substances – initially mainly alcohol and tobacco – have been inextricably linked to meetings of non-heterosexual men since the 1970s, when the only (relatively) safe places where the community could meet were limited to bars and clubs, whose income depended mainly on alcohol sales. Although, as a result of decriminalization and depathologization of homosexuality, spaces for gay socializing have become significantly more diverse, alcohol and other substances are still easily available and widely accepted in those communities. Coping with everyday difficulties and lowered self-esteem with the use of psychoactive substances is well documented in literature on addiction therapy, but Bourne and Weatherburn pay special attention to the specificity of the experience of non-heterosexual persons in this regard

as minority stress may also prompt homo – and bisexual men to use psychoactive substances. The central element here may be the combination of the negative experiences of stigmatization and victimization with the need to conceal one's identity, leading to internalized homo – and biphobia. Such intuitive self-medication is used to temporarily free oneself from painful affect states, from the conflict between revealing or concealing one's sexuality, or even to allay the fear of HIV infection. The pleasure achieved this way is, as the authors note, the least frequently discussed subject, both in the broadly defined research on substance use and in the research on chemsex – which seems to result in an incomplete and one-sided view of these phenomena.

The missing links

As demonstrated above, most authors of studies on men engaging in chemsex focus on physical health risks and epidemiology of infections, ignoring the mental health aspects with all the complexity of intrapsychic and interpersonal factors [18, 19, 22, 24]. It is true that engaging in chemsex correlates with a larger number of sexual partners, higher alcohol consumption and increased propensity for risky behaviors. In people living with HIV, it lowers adherence and increases viral load to detectable levels, weakening the effects of antiretroviral drugs and creating the risk of transmission, while in people who are HIV-negative, the lowered control caused by intoxication facilitates engaging in unprotected sex [18]. The above observations, supported by a number of studies, are, undoubtedly, necessary for planning harm reduction programs. Nevertheless, as they do not go beyond descriptions of behavior, they overlook the complexity of motivations, experiences and feelings, reducing men to the category of "problematic users," who generate "epidemiological risks" and "public health harms." The concentration on "risk-takers," the absence or marginalization of the social context, and the superiority of public health over individual health are the three main areas of interest of critical epidemiology, described in more detail, e.g., by Edelman [25]. The cause-and-effect narration around chemsex, presenting substance abuse which leads to an increase in the number of sexually transmitted infections in the population through disinhibition and loss of control, overlooks the complexity of the phenomenon, at the same time promoting epidemiological reductionism, which only slightly contributes to solving the problem. Based solely on this perspective, it is impossible to form recommendations for prevention, guidelines for psychotherapy, or for other interventions which would involve the interested party themselves, that is men who practice chemsex.

Rejected by the rejected. Intraminority stress and risky behaviors

The higher prevalence of depression and anxiety disorders among gay and bisexual men compared to heterosexual men, confirmed by numerous studies [see 26–28], is

usually explained on the basis of minority stress theory [29]. There is no doubt that experiencing discrimination, lack of social privileges, hiding one's identity, fear of rejection, and internalized homo – and biphobia constitute a burden for mental health. However, whether the minority stress theory explains to a sufficient degree the considerable differences clearly visible in the population of men [e.g., 30] has been called into question in recent years. To fill this gap, Pachankis et al. [31] developed the concept of intraminority stress, suggesting that the mental health of non-heterosexual men may be endangered not only by external, culturally conditioned stressors but also by oppressive influence of one's own community. According to the authors, these tensions rise, among others, because close relations, including sexual relations and romantic relationships, among men are formed within the group which, because of biological and cultural conditions, is at the same time competitive, focused on socio-economic status, concentrated on sex and excluding diversity. The tendency towards competition among men, biologically conditioned and strengthened by culture (e.g., in terms of the axiology of capitalism), in the case of gay men, paradoxically, becomes a source of additional stress. Men who see themselves as having lower social status because of their age, economic situation, physical attractiveness or serological status will experience, apart from the typical minority stress, rejection or fear of rejection by other non-heterosexual men, that is within their own group of reference. Moreover, it has been determined [32] that the tensions within the gay community are a largely overlooked element of social stress, and, consequently, also of the behavioral risk in homo – and bisexual men. In light of the above, it may be expected that sexual rejection is more likely to result in attempts to regain status in the same context, also through behaviors with potentially dangerous consequences, which – especially among men – are a tried and tested way of gaining the acceptance of peers. Additionally, rejection by other men belonging to the same minority is experienced more frequently by those seeking sex through mobile apps. Their users may experience multiple rejections by potential sexual partners before they finally meet to have sex, and it is those earlier experiences that may influence their behaviors to a much higher degree than the socio-cultural factors. These propositions were partly confirmed by research in 2020 [32].

Complex post-traumatic stress disorder (cPTSD)

Ever since the diagnosis of post-traumatic stress disorder started to dominate the understanding and description of psychological effects of traumatic events such as wars, catastrophes, accidents, or assaults, it has been argued that PTSD is not sufficient for description of all patients who experience chronic stress for a number of years [33]. It has been observed that adult patients who have experienced prolonged exposure to verbal, physical, or sexual violence, or functioned in constant fear for their safety, health, or life, not only develop symptoms similar to PTSD but also show additional, deeper problems. That is why the World Health Organization has proposed a new diagnostic

unit for the eleventh version of ICD –cPTSD (complex post-traumatic stress disorder) [34]. While the category of PTSD in ICD-11 encompasses three symptom clusters: re-experiencing the traumatic situation, active avoidance of elements resembling the trauma and a constant sense of threat, cPTSD also includes three more symptom clusters, which are to reflect self-regulation disorders. These are: affect dysregulation, negative self-concept and interpersonal problems [35]. In this understanding, chronic trauma in one's closest environment, especially during childhood and adolescence, can disrupt emotional development and the ability to self-regulate, strengthening non-adaptive beliefs about self and leading to problems with interpersonal functioning in adulthood. The WHO's proposal has brought about a number of clinical studies whose results overwhelmingly support both the correctness of the cPTSD construct and the validity of its distinction from PTSD [36, 37]. Exposure to traumatic stressors such as violence, harassment, bullying (including by peers), when extended in time, repeated and varied, when it is impossible or difficult to escape it, significantly increases the risk of cPTSD [36]. Emotional dysregulation should be understood as increased reactivity, violent outbursts of anger, self-destructive behaviors, and irritability. The negative self-image is reflected in low self-esteem, helplessness, feelings of worthlessness, shame, and guilt. Interpersonal problems may concern instability, changeability, isolation, and withdrawal.

The concept of the mind as an object protected by a shield, which is selectively permeable and protects the mind from the deluge of outside stimuli, has an established tradition [37]. Psychological trauma, just as a mechanical injury does, breaks the integrity of tissues and produces a breach in the shield, through which more stimulus reaches our mind than we are able to work through and integrate. Trauma is also an experience of loss of established ideas about the world and its predictability, as well as of protective defense mechanisms, especially those of the higher order, such as intellectualization, rationalization, repression, or sublimation, in favor of defenses of the lower orders. A defense mechanism of this group, often associated with PTSD and cPTSD is dissociation [38, 39]. A detailed description of the operationalization of dissociation and research on its co-occurrence with PTSD and cPTSD can be found in Hyland et al. [39]. For now, it is enough to assume that, in the broadest understanding, dissociation refers to the loss of access to mental processes (and loss of control over them), which, under normal conditions, remain available to conscious awareness and self-attribution [40]. In the context of the present analysis, it is especially worth noting the possible two-fold understanding of dissociation, as a state and as a trait. The state of dissociation, being a smaller harm, results “only” in a temporal loss, appearing as a reaction to a traumatic event and subsiding shortly after, while dissociation as a trait has a long-term, chronic character. Furthermore, it seems that the state of dissociation co-occurs with PTSD more often, and dissociation as a trait is a consequence of longstanding cPTSD [39].

Problematic chemsex is not a surprising phenomenon

The knowledge of action mechanisms of substances used for chemsex and of the character of the population of non-heterosexual men makes it possible to understand why it is mephedrone, GHB/GBL and methamphetamine, and not other substances used for decades in the social context, that is preferred in this group. It seems that chemsex seen from this perspective can be treated as intuitive self-medication, induced dissociation, whose aim is to temporarily suppress negative thinking about one's sexuality and cope with feelings of rejection. Mephedrone and GHB/GBL are useful here for suppressing trauma and feelings of guilt, while methamphetamine effectively produces the illusion of closeness and intimacy. The plausibility of this interpretation is additionally strengthened by the increasingly charged cultural atmosphere, where growing aversion to non-heterosexual persons has become an important element in recent years. Societal attitudes towards homosexuality, especially male homosexuality, reduced by church hierarchs and politicians solely to physiological dimensions, can effectively undermine self-respect, sabotage self-acceptance and escalate ambivalence towards one's orientation, as a consequence limiting the ability to experience pleasure from sexual contacts. The aversion and disgust towards male non-heterosexuality induced in the society can be internalized and, as a result, cause inability to engage in sexual activity without simultaneous use of psychoactive substances. The insecurity caused by actual or anticipated rejection by one's family, as well as the experience of dehumanization, humiliation and exclusion (possible also within one's minority community) may generate the need to seek not only community and closeness, even illusory, but also reduction of stress, immediate relief and a break from reality regardless of costs and risks.

Because of the socio-cultural context, non-heterosexual men face loneliness and difficulties with creating lasting relationships more often than heterosexual men. Dating/hook-up apps have considerable potential to increase rather than alleviate loneliness since they create a reality where it is not the person and their identity that matters, but the body as a commodity which must adhere to specific "marketing" criteria in order to sell it. For men who feel lonely and isolated, both from society at large and their group of reference, chemsex may be a chance to regain the sense of belonging. The source of numerous psychological and physical problems among non-heteronormative people lies in the fact that the only way for them to gain social acceptance, and with it the sense of belonging, is resignation from revealing their sexual identity. This essentially selective and conditional offer of approval only serves to consolidate the sense of shame about one's orientation, and at the same time increases the processes of self-control with regards to what one says and how one behaves to ensure the orientation is not publicly revealed. It is a banal truth, though easily forgotten, that, as human beings, we want to be accepted fully, with all the characteristics we think are important elements of our identity. In this situation of conflict, chemsex seems to constitute an attractive

option as it offers a quick – although temporary – escape from internalized shame, at the same time ensuring intense emotional and sexual experience.

Challenges for comprehensive psychiatric and psychotherapeutic care

The construct of syndemic, developed by anthropologist Merrill Singer in the 1990s [41] is still the perspective which most comprehensively describes the extensiveness and complexity of health problems in socially marginalized groups. A syndemic is a situation when two or more health problems aggregate in a population because of the additional adverse factors of biological, behavioral, intrapersonal, and/or societal (cultural) character. It appears wherever there are inequalities in access to medical care, stigmatization, stress, and structural violence. It is this type of social circumstances that is responsible for the emergence of specific conditions/health problems, their aggregation, and their spread. Thus – within this construct – it is a mistake to identify individual difficulties as risk factors, e.g., identifying minority stress as a risk factor for depression, or chemsex as a risk factor for HIV infection, without establishing the manner in which societal and environmental factors contribute to the intersectional overlapping of behavioral problems, as well as mental and physical health issues.

It should be noted that the group of chemsex users is diverse, encompassing both men who only engage in the practice sporadically and those who do it more often and problematically, and it is the latter who usually need and/or seek help. Psychoeducation and broadly understood prevention turn out to be sufficient for most men who use chemsex occasionally, as an addition to sexual activity undertaken when sober. Psychiatric and psychotherapeutic interventions are justified and desirable in case of problematic chemsex use, even though the distinction between problematic and non-problematic use seems to be – no pun intended – problematic, as it creates space for possible abuse and misinterpretation. On the one hand, the user may deny the difficulties or underestimate them, not noticing the scale of harms they experience. On the other hand, the clinician may arbitrarily decide that any instance of combining sexual activity and psychoactive substances requires treatment. An approach which may not be perfect but is a form of compromise seems to be emphasizing the patient's agency by giving him the responsibility for naming the problem and expressing the will to seek help.

Men who use chemsex problematically consult specialists only rarely for at least two main reasons. The first of them is shame about one's non-heterosexual orientation, using illicit substances for facilitating sex (including group sex), the loss of control which accompanies it, and sometimes also about the HIV-positive status. The second is the limited availability of psychiatrists, psychotherapists and sexologists familiar with the subject and willing to work with this group of patients. Moreover, the fact that chemsex can produce strong negative emotions also among the specialists is not without consequence. This is because individual elements and effects of chemsex, such as disinhibition, losing control and crossing boundaries can seem to many of us – including

specialists – difficult to accept. Concentration on the behavioral aspects, harms to the individual and to the public health, or epidemiological risk can seem to the potential patient a tool of control, judgement and punishment, and the fear of it may significantly influence their decision not to seek specialized help. Moreover, homo – and bisexual men are statistically more likely to find themselves treated by heterosexual specialists, which is an effect of the distribution of sexual identities in the population. Therefore, it is highly probable that the confrontation with the content brought in by the patient is an emotional and cognitive challenge for the specialist, requiring the latter to work through their own attitudes, prejudices, inhibitions, and defense mechanisms. Flores-Aranda [42] notes that one of the missing elements in support services for chemsex users is the aspect of pleasure stemming from both the substance-enhanced sexual act and the temporary acceptance of one's preferences, behaviors, and identity. For many, the decision to have sex when sober means resignation from the above, and, with no alternatives, it is a difficult decision to make without feelings of regret and loss. The specialist must then find in themselves a readiness to understand the patient's situation in this way, which often requires crossing one's own boundaries.

Complex problems do not always require complex and highly specialized tools. Evans [43] writes that chemsex is a container for community trauma, so perhaps a question should be asked what other container can be built for this group of patients. A psychotherapeutic or psychiatric relationship where the patient is heard, understood and not judged, where he experiences interest and care, is also one where the perspective of risky behaviors and harms becomes less prominent. Thus, it becomes less important *what* the problem is, but *who* seeks help for it. Paradoxically, the perspective of identity, so readily rejected in public health studies in favor of the non-stigmatizing category of MSM, may turn out to be the key to most symptoms and problems the patient seeks help with. It is worth noting here that the acronym MSM was created in 1994 [44], at the central moment of the HIV epidemic. Its legitimacy was based, it seems, mainly on epidemiological premises. A term was needed which would be neutral in terms of identity and free from social and political connotations, and which would describe the population solely in terms of the behaviors they engage in, as it is the behaviors, and not self-identification, that is linked with the risk of infection. Therefore, the category of MSM was supposed to weaken the attribution of HIV solely to non-heterosexual and bisexual men, which translated then (and still does) into stigmatization of and violence against the entire LGBT community. This behavioral category, although undoubtedly useful in the field of public health and in harm reduction models, seems to have significant drawbacks from the point of view of therapy, to the point of making effective intervention impossible. This is because it overlooks the extremely important fact that the genesis of the behavior can lie primarily in the identity. One could risk concluding, paraphrasing Thomas Szasz's famous statement on insanity, that chemsex is an "understandable" reaction of sensitive non-heterosexual men to the social practices of rejection and stigmatization which make their sexual orientation – after all, impos-

sible to abandon – impossible to accept by themselves. Under these circumstances, their identity can only be experienced when all the intrapsychic factors associated with self-knowledge, self-esteem and self-control which make this experience more difficult or impossible are weakened or eliminated – even if only temporarily. Chemsex, although potentially threatening with serious consequences for physical and mental health, appears in this light as an attractive tool for realizing this possibility. Judging its form and consequences for health (as well as its ethical and esthetic aspects), one should keep in mind that a significant part of responsibility for this and other similar practices lies with the culture we all co-create and we all are a part of. The preventative and therapeutic interventions are important, but awareness-raising and educating the broadly defined public opinion about the complexity and numerous determinants of mental health phenomena is also essential.

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