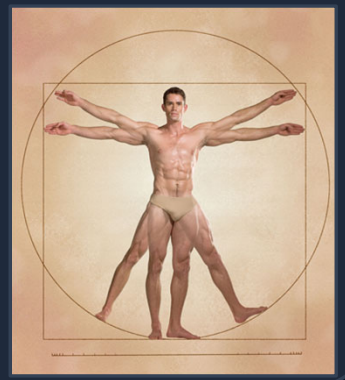
CLINICAL KEYNOTE

Beyond Prevention and Risks:

Integration, Psychological Flexibility, and Healing in Sexual Health Care for Gay, Bi, and Queer Men

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Framework: Chaos vs. Rigidity

Systemic Extremes in Behavioral and Relational Adaptation

Chaos 🔥

Unpredictable, wild, and reactive systemic dynamics.

SUBJECT / CASE

"Richie"

THE OPPORTUNITY

Integration

Flexible, adaptive, and clinically grounded relational healing space.

CLINICAL SPACE

The Exam Room

Rigidity ⛓

Over-controlled, austere, and unyielding pattern structure.

SUBJECT / CASE

"Sammy"

KEYNOTE OVERVIEW

Today’s Keynote: The Ingredients of Integration

01 Framework: Chaos - Integration - Rigidity

02 Awareness of the here and now

03 Context: Where We’ve been

04 Sexual/Erotic Literacy

05 Sexual Erotic Fluence

06 Sexual Erotic True North

07 Psycholgoical Flexibiity

We've Come a Long Way

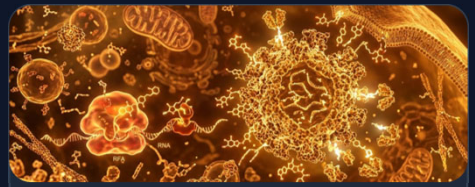
Major advances in HIV & STI prevention, treatment, and clinical diagnostics



PrEP



PEP



ART / U=U



Vaccination



STI Testing



Doxy-PEP



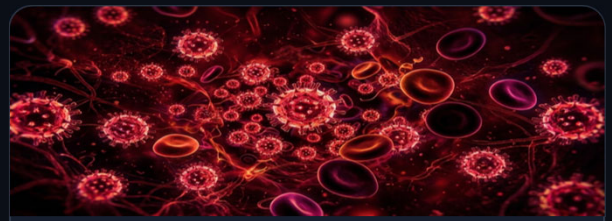
Highly Sensitive Diagnostics

CDC now recommends doxy-PEP discussion and shared decision-making for certain gay, bisexual, and other men who have sex with men and transgender women with recent bacterial STI histories; the CDC also explicitly situates doxy-PEP inside a broader comprehensive sexual-health approach.

Slide citation: *(Bachmann et al., 2024)*

But we’re still suffering

Key health disparities and systemic challenges impacting gay, bisexual, and MSM populations



70% HIV

Gay & bisexual men account for ~70% of new HIV infections in the U.S. *(CDC, 2024)*



High Rates STIs

Disproportionately high rates of syphilis & gonorrhea among MSM. *(CDC, 2024)*



31% Mental Health

Sexual-minority men experience mental illness annually at higher rates. *(SAMHSA, 2023)*



Elevated Suicide Risk

Significantly higher rates of suicidal thoughts & attempts reported. *(CDC, 2024)*



1 in 3 Substance Use

Nearly 31.9% of LGB+ adults met criteria for substance use disorder. *(SAMHSA, 2023)*



22% Chemsex

Meta-analysis estimates ~22% of gay, bisexual, & MSM engage in chemsex. *(Georgiadis et al., 2025)*

FUCK TO FEEL.
DRUG TO NOT FEEL.

—**Hide to survive.**

—**Perform to belong.**

—**Disconnect to endure.**

—**Disavow parts of the self to remain acceptable.**

—***And sometimes, disappear when being known feels unbearable.***

We are who We are because we've been where we've been

- Signmund Freud

Dig Deeper the context

9. Surveillance: “Don't Let Them See You”

HISTORICAL CONTEXT: Lavender Scare, police surveillance, entrapment, criminalization, hidden queer spaces.

RIGIDITY

- Hide
- Pass
- Straight-acting
- Monitor gender expression
- Compartmentalize
- Separate erotic self from public self

CHAOS

- Desire exists only underground
- Sexual opportunity becomes intense
- Anonymous or highly compartmentalized encounters
- “Anything can happen as long as nobody knows”



Cruising and anonymous sex are not themselves pathology. Historically, secrecy was often required for access to queer connection.

10. Pathology: “There Is Something Wrong With You”

HISTORICAL CONTEXT: Homosexuality was classified as psychiatric pathology; the APA removed it from DSM-II in 1973.

RIGIDITY

- Sexual suppression
- Straight-acting & Respectability
- Perfectionism & Desexualization
- Sexual anorexia

“Be the good gay person”

CHAOS

- Dissociation from sexuality
- Compulsion & disconnected identity
- Behavior happening *to* me rather than authored *by* me

“If I'm already bad, why does it matter?”



KEY TAKEAWAY & CITATION

Internalized pathology forces a split between rigid perfectionism and chaotic self-disavowal. ***Slide citation: (Drescher, 2015)***

11. HIV/AIDS: “Your Desire Can Harm You”

HISTORICAL CONTEXT: 1980s HIV/AIDS epidemic, systemic trauma, profound loss, and deep societal moralization.

RIGIDITY

- Hypervigilance
- Restriction
- Sexual self-surveillance
- Shame
- “Good” versus “bad” gay men
- Self-judgment

CHAOS

- Dissociative sex
- Compulsion
- Drug-facilitated sex
- Fatalism
- “Anything goes”
- Escape from constant monitoring



This is about more than infection:
It is about death, stigma, abandonment, moralization, survivor grief, and bodies becoming understood as dangerous.

12. Violence & Rejection: “Hide—or Fight”

HISTORICAL CONTEXT & THEORY: Hate violence, family rejection, bullying, culture wars. Minority-stress theory explains chronic stress from stigma.

RIGIDITY

- Hide
- Appease
- Overfunction
- Rescue
- Don't upset anyone
- “Prove that we're respectable”
- Self-abandonment

CHAOS

- Rage
- Attack
- Escape
- Relational volatility
- Self-destructive behavior
- Persecutor/victim enactments

13. Queer Diaspora: “Freedom Doesn't Automatically Create Integration”

CONTEXT: Spent years hiding, splitting identities, negotiating family obligations & surviving hostile environments—and suddenly there is access.

RIGIDITY

- Concealment
- Double lives
- Duty
- Silence

CHAOS

- Sudden sexual access
- Intensity
- Searching for belonging
- Freedom without a developed erotic self



KEY TAKEAWAY

Freedom without an opportunity to develop identity does not automatically create integration.

The Context and Generational Messages

Bringing it all together: The spectrum between Rigidity and Chaos across core themes

RIGIDITY	GENERATIONAL THEMES	CHAOS
Hide	Surveillance	Underground
Suppress	Pathology	Dissociate
Control	HIV/AIDS	Escape
Appease	Violence / Rejection	Fight
Conceal	Diaspora	Rush toward belonging

Integration
This is where all of our work lives

Moving beyond binary survival responses toward wholeness, self-authorship, and healthy connection

So, what does integrated healthy sex look like?

Beyond risk reduction and the simple absence of symptoms

RIGIDITY --- **← INTEGRATION →** --- **CHAOS**

INTEGRATIVE & EROTIC DEFINITION (KATEHAKIS & NELSON)

“A mutual, embodied, and erotic connection—the ability to experience desire, pleasure, boundaries, intensity, and identity without abandoning parts of ourselves.” *(Katehakis, 2010; Nelson, 2020)*

- Embodied & erotic mutual connection
- Experiencing authentic desire, pleasure & boundaries
- Sustaining identity & wholeness without self-abandonment
- Restorative to identity
- In alignment with personal integrity



HOW DO WE GET THERE?

Moving beyond binary survival responses toward wholeness, self-authorship, and healthy connection. The integrative Tool Kit

eas

t

Tool 1 — Erotic / Sexual Literacy

Can we name it?

EXPRESSION & PRACTICES

Casual sex. • Anonymous sex. • Kink.

ROLES & POSITIONING

Top. Bottom. Verse. • Receiving. Giving. Side

INNER LANDSCAPE

Desire. • Fantasy. • Avoidance.

INTEGRATION & AUTONOMY

Pleasure. • Boundaries.



Tool 2 — Erotic Fluency

Can I understand what my desire is communicating?

REFLECTION QUESTIONS

- **Who do you desire?**
- **How do you want to be desired by those you desire?**
- **What kinds of erotic connection actually feel good and why?**

AND THE SIMPLEST QUESTION:

Is it still fun?



Intensity ≠ Intimacy

Erotic Fluency: Distinguishing Urgency from Authentic Connection

INTENSITY

- Novelty
- Urgency
- Risk
- Arousal
- Validation
- Escape

INTIMACY

- Recognition
- Vulnerability
- Presence
- Being known
- Knowing
- Staying



CLINICIAN NOTE — EROTIC FLUENCY

Neither is bad. Sex can be beautifully intense.

The core question: *"Can I distinguish them—and can I choose?"* Sexual fluency develops when patients move from compulsion to conscious relational choice.

Tool 3 — Erotic Expression / True North

Now move from understanding sexuality to authoring it.

REFLECTION QUESTIONS

- What values feel important towards your erotic connections?
- What are the proudest sexual experiences you've had? why?
- How do you want to feel afterward?

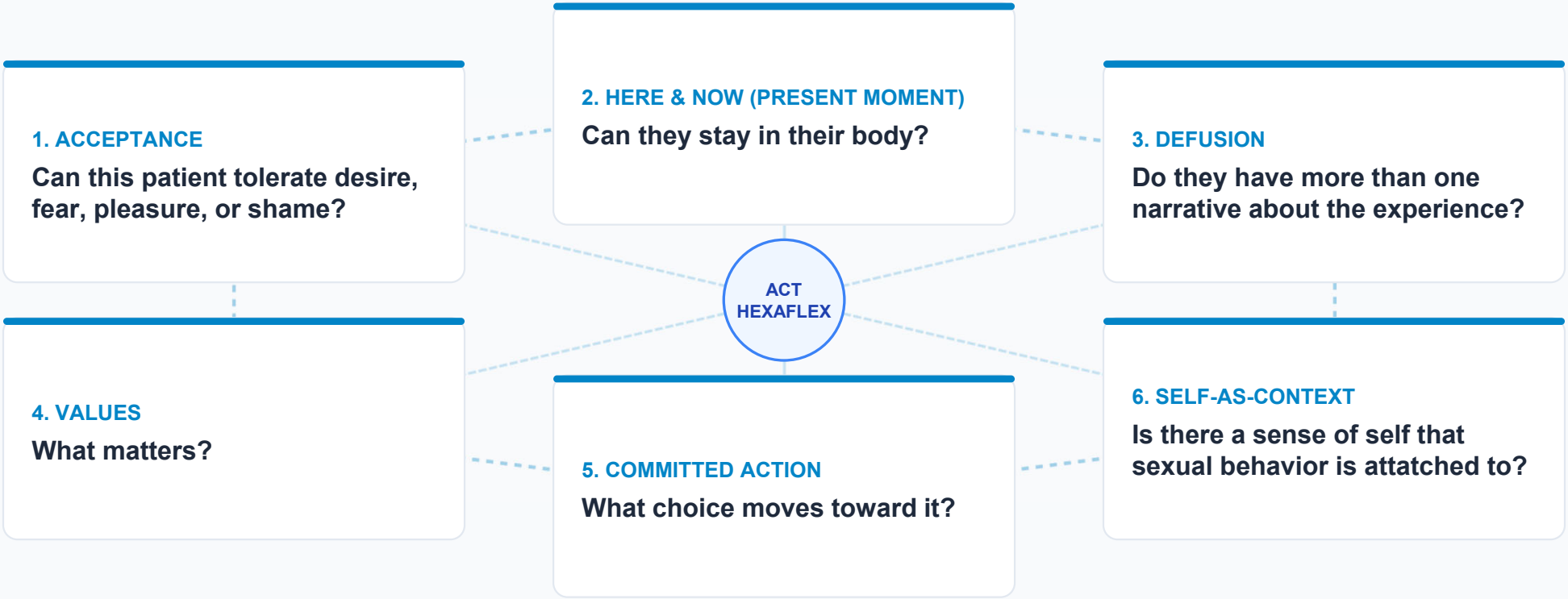
EROTIC TRUE NORTH

What is your Erotic True North?

Define it: Not the sex you're supposed to have—the direction you want your erotic life to move.



Tool 4 — Psychological Flexibility



Psychological flexibility is integration in motion.

ACT TriFlex — Psychological Flexibility

A simplified clinical framework: **Open, Aware, and Engaged.**

OPEN

1. Acceptance
Making room for painful feelings, urges, and sensations without fighting them.

2. Cognitive Defusion
Stepping back and observing thoughts without getting caught up in them.

AWARE

3. Present-Moment Awareness
Paying attention to here-and-now experience with openness and curiosity.

4. Self-as-Context
Connecting with the observing self beyond internal stories and roles who you are and who you've always been.

ENGAGED

5. Values
Clarifying what matters most to guide meaningful life choices.

6. Committed Action
Taking effective, intentional action aligned with core values.

CORE DEFINITION

Psychological Flexibility & Integration = OPEN • AWARE • ENGAGED

Being present, opening up, and doing what matters in alignment with your values.

Turn the Mirror Toward the Provider

Before We Ask Patients to Integrate... Now ask clinicians to examine themselves.

SELF-EXAMINATION QUESTIONS

- **Do I have sexual literacy & erotic fluency?**
- Do I understand what sexuality activates in me?
- Where do I become rigid? Where do I want to rescue?
- Where do I crave chaos…and why?
- Where do I judge? Where do I avoid?
- **What helps me stay present?**



CLINICAL INTENT

The point is clinical self-awareness.

You don't need providers to publicly reveal their sex lives—only to develop internal presence and self-reflection.

Psychological Flexibility for Providers

Applying the TriFlex model to clinical self-reflection

lock_openOPEN

1. Acceptance

Can I tolerate what this patient is telling me?

2. Defusion

Can I notice my judgment without treating it as truth?

psychologyAWARE

3. Present Moment

Can I stay with this person?

4. Self-as-Context

Can I remember who I am beyond my discomfort? And the spirit of my work vs the content of what is out there?

touch_appENGAGED

5. Values

What kind of provider do I want to be?

6. Committed Action

What does that require of me right now?



auto_awesomeCLINICAL APPLICATION

Turn the Mirror Toward the Clinician

Pause in tough encounters to ask: Am I open, aware, and engaged right now?

Who do you want to be?

Clinical Case Reflection & Real Integration in the Exam Room

CARLOS

Who do we want to be?

DIGGING DEEPER EXAM ROOM INTEGRATION

1. Relational Attunement

Did the clinician offer genuine curiosity and safety, or routine procedural distance?

2. Psychological Flexibility

How did the provider manage their own internal reactivity and stay present?

3. The Provider's Stance

Who do you choose to be when a patient shares their vulnerability with you?

THE EXAM ROOM OPPORTUNITY

Finishing the story requires bringing our clinical gifts into action.

The most consequential thing we offer in an exam room is an experience of being fully seen—discovering that nothing about you requires the clinician to look away.