The syndemic of AIDS and STDS among MSM

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The spread of HIV and other STDs among men who have sex with men (MSM) has been labeled a syndemic because in this population a number of different and interrelated health problems have come together and interact with one another. The various elements of the syndemic have an additive effect, each one intensifying the others. These factors include the number of infectious diseases endemic in this population, the high rate of substance abuse problems and psychological disorders, and the significant percentage of MSM who have experienced childhood sexual abuse and other adverse events. While MSM are disproportionately affected by HIV, syphilis, and other STDs, health activists from the gay community have systematically resisted the application of the full range of public health strategies traditionally used to prevent their spread. In the more than three decades since the beginning of the HIV/AIDS epidemic, there have been substantial advances in testing and treatment, yet the infection rate among MSM, and particularly young MSM, remains high, even as it has been dropping among other risk groups. This paper deals with the history of the syndemic, the failure of various risk reduction strategies, and treatment as prevention.

Keywords: HIV, AIDS, MSM, STDS, Syndemic

PART I—THE EPIDEMIC

The first report of what would become the HIV epidemic appeared in *MMWR Weekly* in June of 1981.

In the period October 1980–May 1981, 5 young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different hospitals in Los Angeles, California. Two of the patients died. (CDC 1981)

Since then over 302,143 men who have sex with men (MSM) with AIDS have died. In 2009 the last year for which figures are available, the CDC estimated that 8361 MSM with AIDS died. This includes the transmission category MSM and use injection drugs. It includes some

MSM with AIDS who died of other causes (Cranor 2013). According to the CDC:

In 2010, the estimated number of new HIV infections among MSM was 29,800, a significant 12% increase from the 26,700 new infections among MSM in 2008. Although MSM represent about 4% of the male population in the United States, in 2010, MSM accounted for 78% of new HIV infections among males and 63% of all new infections. MSM accounted for 52% of all people living with HIV infection in 2009, the most recent year these data are available. (CDC 2013a)

According to the CDC, one in five sexually active gays and bisexuals is

carrying the AIDS virus and nearly half of those infected don't know it (CDC 2013b). MSM are 44 to 86 times more likely to be diagnosed HIV positive than men who don't (Purcell et al. 2010; CDC 2013c).

The STD Epidemic before AIDS

It was not an accident that the AIDS epidemic first struck MSM. Even before the first MSM was infected with the virus, MSM were already in the midst of an epidemic of STDs.

In the 1970s, physicians were treating the large number of conditions affecting the lower intestinal tract of MSM under the classification "gay bowel syndrome." These included viral infections, infectious diarrheal diseases caused by bacteria and parasites, and injuries caused by anal sexual activity. Infectious agents included *Shigella sonnei*, *Shigella flexneri*, *Campylobacter* spp., or *Salmonella enterica*; intestinal parasites such as *Giardia* and *Entamoeba* spp.; herpes simplex virus (HSV); and *Chlamydia trachomatis*.

According to Randy Shilts, who before his death from AIDS covered the epidemic:

In San Francisco, incidence of the "Gay Bowel Syndrome," as it was called in medical journals, had increased by 8,000 percent after 1973. Infection with these parasites was a likely effect of anal intercourse, which was apt to put a man in contact with his partner's fecal matter, and was virtually a certainty through the then-popular practice of rimming, which medical journals politely called oral-anal intercourse. (Shilts 1987, 18)

In addition, MSM were at risk for syphilis, gonorrhea, hepatitis A, B, and C, cytomegalovirus, Epstein-Barr virus,

human papillomavirus, chancroid, lymphogranuloma venereum, granuloma inguinale, pubic lice, pinworms, scabies, and flea bites. Many MSM had multiple recurrences of the same disease. A survey of 4212 MSM found that "the number of different lifetime sexual partners best predicted the number of venereal infections" (Darrow et al. 1981). During the pre-AIDS period, infection with a STD carried no stigma within the gay community. The ritual of repeated infection and treatment had become part of the gay lifestyle (Shilts 1987). Doctors were pessimistic:

Education of gay men to limit the nature and numbers of their sexual partners is unlikely to be productive on a large scale ... traditional contact tracing is not productive in populations with large numbers of anonymous sexual contacts. (Handsfield 1981)

According to Shilts, "Promiscuity ... was central to the raucous gay movement of the 1970s." In the fall of 1980, Dr. Selma Dritz, the infectious disease specialist for the San Francisco Department of Public Health, warned:

Too much is being transmitted ... We've got all these diseases going unchecked. There are so many opportunities for transmission that, if something new gets loose here, we're going to have hell to pay. (Shilts 1987, 40)

Even as she spoke, the infectious agent Dr. Dritz feared was spreading through the gay community.

HIV/AIDS

Human immunodeficiency virus (HIV) is not easily transmitted. It requires

percutaneous or mucosal contact with blood or other body fluids. HIV has a long latency period before the infected person's health deteriorates and during which he is capable of infecting others. Thus, the virus had spread throughout the gay community for several years before physicians realized they were dealing with a new disease.

In 1981 and 1982 CDC researchers conducted in-depth interviews with the first AIDS patients. They were shocked by the sheer number of sexual partners reported, typically over 1000 (Shilts 1987, 132). The virus spread quickly. For example, in 1983, the HIV seroprevalence among MSM tested in a Baltimore STD clinic was 14 percent. One year later, it was 58 percent (Rompalo 1990).

During the first decade of the epidemic, HIV infection was the equivalent of a death sentence. HIV infection usually doesn't kill outright, but destroys the immune system, making its victims prone to a range of other diseases. The first victims died of *Pneumocystis* pneumonia which under other conditions would have been treatable. The failure of their immune systems left victims vulnerable to a host of diseases, including toxoplasmosis (a cat disease), cryptococcal meningitis, candidiasis, severe herpes, *Cryptosporidium* (an animal parasite), encephalitis, and a fulminant form of Kaposi's sarcoma (a skin cancer previously found mainly in older men of Mediterranean origin).

AIDS Exceptionalism

By late February of 1982, 251 Americans had been diagnosed with AIDS and 99 had died. (The disease at that time was labeled GRID gay related immune deficiency.) Although the pathogen

responsible had not been identified, experts were convinced that they were dealing with a disease caused by a virus and transmitted by semen and blood, and that the gay bathhouses were a likely venue for transmission, since many of the first victims could be linked to these establishments.

When Dr. Dan Williams, a prominent gay NY physician, suggested that bathhouses catering to gay men be required to post signs warning patrons about the danger of infection, the gay community reacted angrily, refusing to consider anything that would turn back the sexual liberation the bathhouses represented. Williams was castigated as a "monogamist" and accused of stirring up unnecessary panic and fear (Shilts 1987, 186).

By 1985, the pathogen that causes AIDS had been identified, the modes of transmission known, and a test developed to identify those infected. The standard public health procedures used for other STDs—"routine testing for infection often undertaken without explicit patient consent; reporting to local health authorities of the names of those who test positive for infection; contact tracing, or identification of any people who may have been exposed to infection; and notification of possibly infected persons" (Burr 1997) should have been immediately instituted. Instead, spokesmen for the gay community objected to any form of mandatory or routine testing. They insisted that all that was necessary was for everyone to use a condom every time. No one should be tested unless they wanted to be. All testing information should be absolutely confidential to avoid outing gay men. The names of the infected should not be reported. There should be no routine testing, no contact tracing, and no

notification of possibly infected persons. No one had a moral responsibility to tell their sexual partners they were HIV positive. According to a pamphlet from the Gay Men's Health Crisis, "Safer Sex for HIV Positives":

If you follow [the guidelines on the use of condoms], you don't need to worry about whether your partners know that you're positive. You've already protected them from infection and yourself from reinfection. Just use your judgment about whom to tell—there's still discrimination out there. (Rotello 1997, 109)

In spite of the known failure rate of condoms even of the best of conditions (Kelly and St. Lawrence 1987), MSM were encouraged to believe that using a condom was "safer sex" and they could go on engaging in anal sex with multiple or anonymous partners. This was not a prevention program, but a risk "reduction" program. In an opinion piece in the *New England Journal of Medicine*, Ronald Bayer expressed concern that:

many of the traditional practices of public health that might have been brought to bear were dismissed as inappropriate. (Bayer 1991)

Initially, some MSM changed their behavior. New infections declined. The "condom code" was deemed a success. However, research into the behavior of MSM found that many were not following the code. A 1985 survey of gay men in San Francisco found that (Research 1986):

only 30% of our respondents reported having maintained completely or probably safe sexual practices during both reporting periods, which means that 70% of the men we surveyed had regularly engaged in sexual practices capable of exposing

them to HIV infection. (Siegel et al. 1988)

A 1986 study of MSM in New York City found that 49.6 percent had not changed their behavior (Feldman 1986). A 1987 study found that 67 percent of MSM admitted engaging in anal intercourse without condoms during the previous year. Many of those who initially adopted safer sex practices failed to persist:

It appears, then that some of the factors associated with continued participation in high-risk sexual behavior are resistant to current educative intervention. Educational campaigns, however well executed and well intentioned, have been insufficient to stem the spread of HIV infections. (Jones et al. 1987)

The problem was not ignorance:

Most of the men in our sample were highly educated, mature adults. All were well informed about the transmissibility of AIDS through sexual activity and could describe the specific measures necessary to protect against infection. Yet even under these relatively ideal conditions, the large majority of these informed men did not adopt and maintain behavior to the extent necessary to prevent HIV infection in themselves or others. (Jones et al. 1987)

Gay AIDS activists insisted that AIDS education must be sex positive, avoid moralizing, and not distinguish between those who were HIV positive and those who were HIV negative (Odets 2004). The gay AIDS establishment defended the right of infected persons to remain ignorant of their condition and the right of infected persons to conceal their contagious condition from others, including sexual partners and healthcare personnel. They wanted gay bathhouses kept open, arguing that they could be places to impart

prevention education, and distribute condoms (Nieves 1999).

Prevention efforts were focused on self-protection rather than the duty to protect others:

It was considered crucial to articulate an ideology of solidarity, one that rejected as divisive all efforts to distinguish the infected from the uninfected. Such distinctions, it was feared, would lead to "viral apartheid." Solidarity was endangered to the extent that the infected were held to have special duties ... Cohesiveness could best be grounded in the concepts of universal vulnerability to HIV and the universal importance of safe sexual practices. (Nieves 1999)

For gay activists, the proper goal of AIDS prevention was defense of the gay sexual revolution, and since gay liberation was founded on a "sexual brotherhood of promiscuity ... any abandonment of that promiscuity would amount to a communal betrayal of gargantuan proportions" (Rotello 1997, 109). AIDS educators were:

to encourage condom use rather than attempt to persuade them to abandon anal intercourse ... AIDS educators have a responsibility to aim only for the minimum necessary changes in individuals' lives which are needed to reduce the risk of getting AIDS. (Rotello 1997, 109)

Suggestions that the infected might have a duty toward others were often greeted with scorn. For example:

To mark the occasion of the city's [N.Y.] 50,000th AIDS case, efforts were made to launch a prevention campaign that would focus on protecting others as well as oneself. Those efforts were aborted when AIDS specialists inside the health department denounced the proposal as "victim blaming." (Bayer 1996)

It was assumed by those outside the gay community that fear of contracting an incurable, debilitating disease would motivate gay men to refrain from risky sexual activity, but the gay community reacted to the crisis by romanticizing HIV infection:

A stranger to gay culture, unaware of the reality of AIDS, might believe from much of the gay press that HIV infection was a sort of elixir that produced high self-esteem, solved long-standing psychological and substance abuse problems, and enhanced physical appearance ... creating the subconscious impression that infection—the "penalty" of unsafe sex—is really not so bad after all. (Rotello 1997, 241)

HIV-positive status was portrayed in some homosexual publications as more fun. An editorial in *Steam*, a magazine aimed at gay men, quotes a man who has been positive since the early years of the epidemic:

I'm so sick and tired of these Negatives whining about how difficult it is to stay safe. Why don't they just get over it and get Positive. (Rotello 1997)

According to Scott O'Hara, *Steam's* HIV-positive editor who died of AIDS in 1998:

One of my primary goals is the Maximization of Pleasure, and just as I believe that Gay Men Have More Fun, so too do I believe that Positives have learned to have much more fun than Negatives. I'm delighted to be Positive ... The Negative world is defined by fear, ours by pleasure. (Rotello 1997)

Those who died of AIDS were memorialized as martyrs. Rather than calling for changes in the behaviors, which led to these deaths, the AIDS establishment

blamed the government, religion, and the straight world for not finding a cure, for not funding education, for its homophobia, for causing homosexuals' low self-esteem, and for denying their "right" to marry (Kramer 2005).

Because the thought of using condoms for the rest of their lives was unacceptable to many MSM, in 1992 the AIDS activists came up with the slogan "Be Here for the Cure" (Califia 2002, 287). They demanded that government-funded scientists immediately find a cure for HIV/AIDS, one which would allow MSM to return to their previous behavior without the risk of dying.

For some, even the risk reduction compromise of "condom code" was too sex negative. Walt Odets, a gay psychologist—writing when the AIDS diagnosis was still a death sentence—argued that if it was a choice between anal intercourse (AI) and other high risk practices and life, homosexual men should feel free to choose AI and take their chances. Reduction of HIV transmission should "only be the secondary task because it must be built on the foundation of lives experienced as worth the trouble." Odets argued that the condom code made MSM feel guilty about unprotected sex and having just escaped what they regarded as a shaming culture, they were very reluctant to establish another one (Odets 1994). Odets felt that those who designed the condom code ignore the realities of gay life:

The idea that gay men would readily adapt to condoms, ignore or fail to recognize their limitations, and, according to many educators, have fun with them is rooted in homophobia. Also homophobic is the expectation that gay men ought to feel shame and guilt for not liking them and, often, not using them.

Odets condemned the social marketing model embodied in the condom code, and did not believe that this approach had ever really been successful. In this Odets was correct, a careful study of the epidemic revealed that the dramatic drop in new infections in the late 1980s was in large part due to epidemic saturation (Rotello 1997, 127–130).

Epidemic saturation occurs when a significant portion of an at-risk population is infected, usually those most vulnerable—in this case promiscuous gay men with multiple concurrent partners. Since, as the number of the infected increased, the number of uninfected decreased and since those uninfected at that stage of the epidemic were less likely to be engaged in multiple high-risk acts, the epidemic has fewer and fewer potential victims. It was burning itself out. However, as soon as more young men entered the gay community, the rate of new infections began to rise and continues to rise (Morris and Dean 1994; Hoover et al. 1991).

The process of epidemic saturation was recorded in blood samples taken from MSM from 1978 to 1988, as part of a longitudinal hepatitis B vaccine trial. Testing revealed that by 1985, 73.1 percent of the original sample was HIV positive (Hessol et al. 1989).

A study of young HIV-negative gay men revealed the problem with prevention campaigns:

The data suggests that lack of knowledge about HIV transmission is insufficient in explaining risk-taking. Rather, rationalization processes may be a factor in the sexual risk-taking behaviors of young HIV-negative men, and moreover, deep intrapsychic processes (often heightened by concurrent substance use), and the desire to please sexual partners may drive

the decision-making of these men. (Halkitis et al. 2008)

The motivations for high-risk behavior included:

more intense physical pleasure during sex, the need to feel a physical and emotional connection with partners, and eroticization of behavior that is considered taboo. (Halkitis et al. 2008)

In the 1990s the revolt against safe-sex education took the form of open advocacy for “barebacking”—unprotected AI. At a round table discussion on barebacking, Michael Scarce, a San Francisco writer and activist, defended gay culture against the “condom police and safer sex Nazis”:

I think that it's very dangerous for AIDS organizations or public health in general to tread that far into moralizing and prescribing particular sets of morals upon any give population, because you're going to have that segment of that population who feels differently, and who holds different shared values, who will organize in resistance and in rebellion and in retaliation to that, and I do see barebacking, in some small ways, as a manifestation of that. (Scarce 1999)

If barebacking takes place between two men who are both positive, there is still the risk of contracting another STD or a different strain of HIV. Men who have tested HIV negative and are in a relationship, could engage in the behavior without risk, assuming that both are faithful. Unfortunately, monogamy among gay men is rare. A study done in the Netherlands concluded that gay men in relationships were actually at higher risk of infection (Xirdou et al. 2003). But the greatest risk involves HIV-negative gay men who engage in unprotected AI with

partners who are HIV positive or whose status is unknown (Wolitski 2005).

The development of highly active antiretroviral therapy (ART) transformed HIV infection from a death sentence to a chronic disease. However, optimism about treatment caused many MSM to become even more careless about prevention. A study tracking changes in behavior among MSM in San Francisco found that:

Estimated HIV prevalence increased from 19.6% in 1997 to 26.8% in 2002. Unprotected anal intercourse with a partner of different or unknown HIV serostatus increased from 9.3% to 14.6%. Mean number of male partners increased from 10.7 to 13.8. (Osmond et al. 2007)

A study published in 2003 found that 42 percent of HIV-positive MSM reported sex without disclosing their infection, predominantly in nonexclusive relationships (Ciccarone et al. 2003). In 2003, in an editorial in the *American Journal of Public Health*, titled “When Plagues Don’t End,” recognized the failure of prevention strategies (Gross 2003). A 2008 editorial in the prestigious British journal *The Lancet* was blunt, “US efforts to prevent HIV have failed dismally.” (*Lancet* 2008)

Gay AIDS activists refuse to admit their strategy has failed and continue to push for more money for education, particularly in schools. There is, however, no evidence that the thousands of MSM, who become HIV positive each year, have not heard of AIDS, do not know how it is spread, and do not know how to prevent infection.

Between 1999 and 2002, 28,530 MSM who attended STD clinics in England for treatment of other STDs were anonymously tested for HIV. Of these 3,593 (12.9%) were HIV positive, and 2,520 of

these had been previously diagnosed (Brown et al. 2009). This is reason for concern since infection with another STD is a sign that these HIV-positive men or their partners were having sex with other partners. Of the remaining 25,910, 11,655 (45%) refused HIV testing even though they were at high risk for HIV infection. Of the 11,655 who refused testing, the anonymous testing revealed that 737 were HIV positive. These HIV-positive men went back into the community, untreated, and purposefully ignorant of the threat they posed to others. This includes the 4 percent of MSM who are also intravenous drug users.

According to Dr. Philip Alcabes, an epidemiologist at Hunter College:

it looks like prevention campaigns make even less difference than anyone thought ... HIV incidence did not decline as much from the 1980s to the 1990s as we believed despite the dramatic increase in condom promotion and so-called prevention education. (Altman 2008)

Education not only failed to achieve significant results, in some cases it proved counter productive. A study reported in the *British Medical Journal* compared gay men who received “behavioral intervention to reduce sexually transmitted infections” with a control group who didn’t receive any special education. The researchers found that “the intervention was more likely to be harmful.” There was a “higher risk of acquiring a sexually transmitted infection among the participants in the intervention.” This was “unexpected.... And clearly a cause for concern.” The authors theorized that “the intervention engendered in the participants a misplaced sense of confidence in their ability to negotiate high risk sexual situation.” (Imrie et al. 2001)

In 2010, the Obama administration announced a new strategy designed to cut the number of new HIV infections in the US by 25 percent over the next five years (National 2010). While recognizing the failure of previous educational efforts, the report suggested that:

A new framework for HIV prevention must give voice to gay men; must consider the totality of their lives; must delineate the underlying logic, which directs their relation to sex and HIV; and must concurrently respect their diverse life experiences. (Halkitis 2010)

In 2011, a media campaign designed to combat the growing perception that advances in drug therapy have made HIV infections “no big deal” was announced, gay AIDS activists objected because the commercial showed a “melancholy-looking man standing against a shadowy black-and-white backdrop of menacing New York City streets. ‘When you get HIV,’ the narrator intones, ‘it’s never just HIV.’ The ad focused on the other diseases that those on drug therapy may suffer from. Marjorie Hill of the Gay Men’s Health Crisis complained:

We know from our longstanding H.I.V. prevention work that portraying gay and bisexual men as dispensing diseases is counter productive. (Hartocollis 2011)

A letter to the mayor from a coalition of activist groups suggested that, rather than using scare tactics, communication strategies to gay men should focus on:

acknowledging their resilience in the face of this epidemic, will be far more successful than perpetuating outdated images of sickness, dying, and death. (Hartocollis 2011)

The images of “sickness, dying, and death” may be old, but they are not

outdated. Each year over 16,000 Americans die of AIDS and more than half of them are MSM (CDC 2013d).

PART II. THE SYNDOMIC

Recognizing educational programs to prevent new infections had only limited success, experts now see the problem of HIV among MSM is not a simple epidemic, but a *syndemic*. According to an article by Dr. Ron Stall and associates, an analysis of the data from a large number of studies reveals that:

additive psychosocial health problems—otherwise known collectively as a syndemic—exist among urban MSM and that the interconnection of these problems functions to magnify the effects of the HIV/AIDS epidemic in this population. A variation of this question has been empirically tested since the very earliest days of the HIV/AIDS epidemic, in that substantial literature now exists on the relationship between substance use and HIV/AIDS (Cochran et al. 2000; McKirnan and Peterson 1989; Stall et al. 2001; Stall and Purcell 2000), depression and HIV/AIDS (Sandfort et al. 2001; Ciesla and Roberts 2001; Frost, Parsons, and Nanin 2007), childhood sexual abuse and HIV/AIDS (Dilorio, Hartwell and Hansen 2002), and violence and HIV/AIDS (Greenwood et al. 2002). Our analysis extends this literature to show that the connection among these epidemic health problems and HIV/AIDS is far more complex than a 1-to-1 relationship; rather it is the *additive interplay* of these health problems that magnifies the vulnerability of a population to serious health conditions such as HIV/AIDS. (Stall et al. 2003)

In addition to depression, drug use, and a history of childhood abuse and/or

violence, MSM are more likely to suffer from other psychological disorders, paraphilias (Buhrich 1983), and sexual addiction and compulsion (Downtown 1995; Elder 2007; Froese et al. 1990; Goode and Troiden 1980; Socarides 2000).

Psychological Disorders and Suicidal Ideation

In the 1950s a poorly designed study by Evelyn Hooker, which compared 30 carefully selected gay men to 30 randomly selected heterosexual men, claimed that there were no differences in psychological health (Hooker 1957). However, since then a number of well-designed studies with large samples done in the US, New Zealand, UK, and the Netherlands have found that MSM were far more likely to have a history of psychological disorders, suicidal ideation, and substance abuse problems (Fergusson, Horwood, and Beautrais 1999; Herrell et al. 1999; Cochran Mays, and Sullivan 2003; Gilman et al. 2001; Sandfort et al. 2001, 2006; Warner et al. 2004). A meta-analysis of articles on the mental health of lesbian, gay, and bisexual people concluded that:

LGB people are at higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self harm than heterosexual people. (King et al. 2008)

Given the overwhelming evidence, gay advocates admit:

that LGBT people suffer higher rates of anxiety, depression and depression-related illnesses and behaviors like alcohol and drug abuse than the general population. (Southern Poverty 2010)

These disparities are, however, blamed on homophobia (negative societal attitudes

toward homosexuality), heterosexism (the belief that heterosexuality is better than homosexuality), and internalized homophobia (the belief of a person with same-sex attraction [SSA] that his own homosexuality is inferior) (Fleming and Wasserheit 1999). Rather than consider the possibility that there might be something intrinsically disordered about SSA, they argue that it is the:

stress of being a member of a minority group in an often-hostile society—and not LGBT identity itself—that accounts for the higher levels of mental illness and drug use. (Fleming and Wasserheit 1999)

If that were true, one would expect that more tolerant locations would have lower rates of psychological disorders among SSA. However, the authors of a study done in the Netherlands, a country known for its acceptance of SSA, admitted that:

This study suggests that even in a country with a comparatively tolerant climate regarding homosexuality, homosexual men were at much higher risk for suicidality than heterosexual men. (de Graaf, Sandfort and ten Have 2006)

Drugs

The sexual excesses of the gay community, including the weekend-long circuit parties (See Part III) are only possible through the use of various drugs (Wainberg, Kolodny, and Drescher 2006). Besides the more traditional substances—alcohol, marijuana, and cocaine—gay men used a number of substances which are taken singly or in combination to enhance the Circuit party, club, or sexual experience.

Ecstasy or MDMA (crystal meth) acts as a stimulant and a hallucinogen, gives users a sense of well-being and sensory

distortion. It appears to be the new drug of choice because it is cheap and can keep a user high for 48–72 hours at a time (Moore 2005). For MSM, addiction to crystal meth is difficult to overcome because:

methamphetamine usage and sex have become fused; these men believe they will be unable to achieve a satisfying sexual life if they abstain from methamphetamine. (Larkins, Reback, and Shoptaw 2006)

The book *Crystal Meth and Men Who Have Sex with Men: What Mental Health-care Professionals Need to Know* lays out in graphic detail the physical and psychological risks of crystal meth use (Urbina 2006).

Ketamine or Special K, is an animal tranquilizer, which can disrupt attentional function, explicit memory, and verbal fluency. It is associated with increases in unprotected AI (Rusch et al. 2004).

Poppers, a slang term for nitrites (amyl nitrite, butyl nitrite, isopropyl nitrite, and isobutyl nitrite), are inhaled in order to enhance sexual pleasure. Use of poppers “more than double[s] the receptive partner’s risk of HIV infection during unprotected anal intercourse” (NAM AIDSmag 2013a).

GHB (gamma hydroxyl butyrate), a nervous system depressant, relaxes and sedates the body. When used with alcohol it can result in respiratory depression.

Viagra or other drugs prescribed for erectile dysfunction are used to facilitate multiple sexual encounters.

“Trail Mix” is the slang for a mixture of various drugs, often crushed together.

Multidrug use has been positively linked to sexually transmitted infections (Sack 1999). Drugs lead to disinhibition, feelings of invincibility, and unsafe sex.

Bruce Kellerhouse, speaking at a public forum, explained the problem:

crystal meth use is one of many shards that form this mosaic that might explain why more men are becoming infected with HIV. Other pieces include the perception that HIV is a manageable disease and that it is no big deal to live with it. Or the widespread use of the Internet as a private means of finding sex partners and the unexamined practice of bareback sex to avoid plastic sex, either on crystal or off. (Wainberg, Kolodny, and Drescher 2006)

According to one physician, 75 percent of his gay male patients have experimented with illegal substances (Meeks 1998). Odets argues that gay men are not having unprotected sex because they are using mind-altering drugs, but using drugs in order to have sex:

Our current [safe-sex] education's homophobia, moralism, directiveness, erotophobia and penchant for "erring on the safe side" are important contributions to many men's need to use substances to engage in sex of any sort. (Odets 1994, 14)

Childhood Sexual Abuse and Other Adverse Events

MSM are more likely to have been victims of childhood sexual abuse. Stall and associates note that a history of childhood sexual abuse has been linked to increased risk of HIV infection:

mounting research evidence suggests that men with a history of unwanted sexual activity during childhood are more likely than those without such a history to engage in sexual practices that place them at risk for contracting HIV. (Dilorio, Hartwell, and Hansen 2002)

This was confirmed by other studies, including one by Zierler and associates which found that men reporting childhood sexual abuse were 8 times more likely than unabused men to be involved in prostitution, 2.4 times more likely to have multiple partners, and 1.2 times more likely to have anonymous partners (Zierler et al. 1991). Such behaviors would increase the risk of contracting HIV.

A study by Bartholow and associates found that gay men who had been victims of forced sexual contact as children were more likely to engage in unprotected sex, to exchange sex for money or drugs, and to be HIV or syphilis positive (Bartholow et al. 1994).

A study of homosexual and bisexual men found that:

Childhood sexual abuse was reported by 15.5% of the survey respondents ... Those who reported experiencing abuse regularly were more likely to (1) be HIV positive, (2) have exchanged sex for payment, and (3) be a current user of sex-related drugs. (Brennan et al. 2007)

A study from New Zealand found that people who experience trauma or disruption in their childhoods were more likely to have engaged in homosexual behavior or self-identify as gay:

People brought up with a step-parent or two non-biological parents were less likely to be exclusively heterosexual. Adverse events in childhood, particularly sexual assault and rape, were associated with increased likelihood of belonging to all of the non-exclusively heterosexual groups. (Wells, McGee, and Beautrais 2010)

A study by Jorm and associates found more childhood adversity among those with same-sex partners than those without

(Jorm et al. 2002). Still another study found that:

Lesbians and gay men, bisexuals, and heterosexuals who reported any same-sex sexual partners over their lifetime had greater risk of childhood maltreatment, interpersonal violence, trauma to a close friend or relative, and unexpected death of someone close than did heterosexuals with no same-sex attractions or partners. (Roberts et al. 2010)

Sexual coercion and outright rape is not uncommon among MSM. One study of MSM found that:

29% of the participants ... reported being coerced into unwanted sexual contact and 92% of the time the coercion involved unprotected anal intercourse. (Kalichman and Rompa 1995)

Another study found that 12 percent of gay men reported being victims of forced sex by their current or most recent partners, while 5.9 percent reported being perpetrators of forced sex (Waterman et al. 1989). A study of university students found that "sexual victimization experienced by gay/bisexual students is greater than experienced by heterosexual students" (Baier et al. 1991). In another study of 2881 MSM, 34 percent reported psychological battering, 22 percent physical battering, and 5 percent sexual battering. This rate is higher than that for heterosexual men and women (Greenwood et al. 2002).

Other STDs

MSM are far more likely to be diagnosed with other STDs, some of which have become resistant to commonly used antibiotics (Maugh 1998), and some of which can make them more vulnerable to infection with HIV (Fleming and Wasserheit

1999). They are more likely than other men to engage in a wide variety of sexual practices which have the potential to spread STDs, to do so with a larger number of partners in venues which cater to multiple and anonymous sexual encounters. Given the proliferation of sexual networks and international travel, new diseases and mutated forms of old diseases present a constant challenge to the medical profession (Burr 1997). In 2004, there was an outbreak of lymphogranuloma venereum (LGV), a previously rare sexually transmitted disease among MSM engaging in "leather parties" in the Netherlands (Nieuwenhuis et al. 2004). Outbreaks of LGV were reported in England and the US (Bernard 2002). Hepatitis C, which can lead to liver cancer, can be sexually transmitted and is spreading not only among HIV-positive gay men, but also among HIV-negative MSM (Highleyman 2007; Fisher et al. 2007; Danta et al. 2007). Human papillomavirus is epidemic and has led to a dramatic increase in anal cancer among MSM, especially those who are HIV positive (Wilkins 2010).

PART III. GAY CULTURE

Multiple Concurrent Partners

Many MSM are a part of a distinct culture, centered in major urban areas. They are more likely to have multiple, concurrent sexual partners. Gay bars, gay bookstores, theaters, certain resort communities, and circuit parties have traditionally provided venues where MSM could engage in various forms of sexual activity with numerous partners.

In the 1970s bathhouses catering to gay men "became virtual convenience stores

for quick cavorting” (Shilts 1987, 89), offering private rooms and other spaces where AI could be engaged in with a number of partners during a single visit. The result was that diseases contracted mainly by AI spread quickly through the gay community. Even those who did not frequent a bathhouse were at risk of encountering a partner who had been infected in one.

The experts who tracked the HIV/AIDS epidemic immediately recognized the part that bathhouses played in spreading the disease. The gay community resisted efforts to close these facilities. However, as the death toll climbed in the late 1980s the clients stopped coming and the bathhouses shut their doors. The closure of the bathhouses did not stop gay men from seeking multiple, anonymous partners. The 1990s saw the rise of the “Circuit,” originally organized to raise funds for AIDS and other causes:

Circuit parties are typically lavish affairs with elaborate lighting, music, and decor and are held in venues that can accommodate large crowds. Some of the larger circuit parties are the White Party in Palm Springs, the Black and Blue Party in Montreal, and the Winter Party in Miami, each of which attracts attendees in the thousands to tens of thousands. (Ghaziani and Cook 2004)

According to an article on HIV and circuit parties:

circuit parties may lead to unsafe sex through beliefs about the need for authentic social connection at parties and also through beliefs that authenticity is linked to having sex without condoms, especially given persistent stigmas surrounding condom use. (Wikipedia 2013)

Circuit parties are venues for drug abuse and unsafe sex, which is particularly ironic

since many of these events are fund raisers for AIDS research, care, and education. In spite of the risks, gay activists defended the activity:

Circuit parties are community-building and profit-generating events, and short of legally closing them, they are not likely to go away... Circuit parties are an important venue on multiple levels for one subpopulation of the gay community, and it is unfortunate and ironic that building up this community via parties should increase the likelihood of HIV transmittable sexual practices. (Ghaziani and Cook 2004)

Men looking for partners could also reach them through telephone and Internet chat rooms. In the twenty-first century the most popular resource for meeting willing partners is Manhunt.net. Billed as “The world’s fastest—growing gay website,” it is “quietly abetting a revolution in social and sexual mores, under the slogan ‘get on, get off’” (Gross 2008). Michael J. Gross, in an article titled “Has Manhunt Destroyed Gay Culture?” published in *Out*, a magazine for gay men, expressed his concerns:

When we started cruising online, neither I nor any of many friends would have dreamed we’d post naked pictures of ourselves for strangers to see. Now almost all of us have done it... But it got us laid... When we questioned our choices, we reminded ourselves, “We’re gay, this is our culture.” Manhunt is the 21st-century gay bar.

... settling for Mr. Right Now becomes a failure of hope. When you came out, you did it because you wanted something. Part of what you wanted was sex, but part of what you hoped for the possibility of being loved as your true self. And when, as often happens while cruising online, we diminish the hopes that drew us out

of the closet, we reduce sex to a purely physical act.

Gay urban life has always been a meat market, and cruising, you could argue, has always been a form of consumption. For gay men seeking sex, as for all kinds of shoppers, the Internet removed constraints of space and time on access to the market—and at the same time offered an unprecedented range of products to choose from.

Gross found Manhunt to be unapologetic:

Manhunt's employees can brag about the site's addictive quality because they're not doing anything illegal and because they can count on no one making a moral argument against their business, because no gay man wants to risk sounding anti-sex. (Gross 2008)

The gay community's defense of promiscuity as central to their identity leads to a defense of venues that make the acquisition of multiple, anonymous parties possible, which in turn leads to a need for drugs to sustain their sexual availability, and overcome concerns about the risks, all of which leads to exposure to STDs including HIV and puts in jeopardy those already HIV positive.

Steroids and the Cult of Masculinity

Steroids and sharing of needles used for steroid injection also pose a threat to the health of gay men. Since many gay men grew up without a close relationship with their father or male peers, they long for the acceptance they did not achieve as children (Fitzgibbons 1996). Gay men are attracted to men, and the more masculine a man is, the more attractive he is to other gay men. Therefore, in order to attract

other gay men, a gay man must present himself as masculine. In order to achieve the perfect body, gay men are more likely to work out to build up their bodies and to take steroids. Typical of those caught up in the cult of masculinity is Mark who takes steroids to attract "muscle gods":

It's not like you really want to hang out with them—you just don't like them excluding you. It pushes all those buttons from when you're a kid. At least for me it does. And that was one of the biggest reasons why I started doing steroids. (Signorile 1997, 168)

Another steroids user explained his reasons:

To suddenly have everyone wanting you in bed and including you in everything, in parties and social gatherings, after years of being the shy awkward type who wasn't looked at—that is a major ego boost. (Signorile 1997, 169)

Excessive doses of steroids can damage the liver and kidneys and lead to breast and prostate cancer. Stopping steroid use can cause the enlarged muscles to shrink. Steroids cause irrational aggression, mood swings, hypomania, and depression (Signorile 1997, 163–165).

Relationships

Many experts believe that HIV was around for years, perhaps decades, but because those infected had a very limited number of sexual partners, there was no epidemic. It was only when it invaded a population where multiple, concurrent sexual partners were the norm, that it spread rapidly. If, on observing the obvious consequences of HIV infection and watching scores of friends sicken and die, gay men had decided to enter into

monogamous relationships, or even practice serial monogamy, the epidemic would have been brought under control, but this did not happen.

Although the push for “gay marriage” might lead the general public to believe that gay men want their monogamous faithful relationships recognized by law, in fact fidelity for same-sex male couples is not defined by sexual monogamy, but honesty about outside sexual relationships (Kort 2008). A recent article in *The New York Times* confirmed what has long been known, namely that many same-sex relationships, whether formalized by marriage ceremonies, civil partnerships, or commitment ceremonies, are “open” (James 2010). According to the Gay Couples Study conducted in San Francisco, which followed 556 male couples for three years, 50 percent had sex outside their relationship, with the knowledge and approval of their partners. As time passed the number of faithful couples declined. A study of 156 male couples found that after 5 years all of the couples “had incorporated some provision for outside sexual activity in their relationship” (McWhirter and Mattison 1984, 252).

A recently published report *Beyond Monogamy: Lessons from Long-Term Male Couples in Non-Monogamous Relationships* (Spears and Lowen 2010), was based on interviews of male couples, who admitted not just occasional affairs, but a consistent pattern of sex outside the relationship, some anonymous in clubs, some with acquaintances, and some threesomes. The couples generally had rules about what was acceptable, but these appeared to be fairly flexible. One of the participants explained, “I’m gay; you’re gay; you’ll play; I’ll play. Let’s be realistic and open about it.” Almost half of the participants in the study were HIV-positive.

Behavior Change

It is difficult for many to understand why in the face of the epidemic so many MSM continued to engage in high-risk behavior. Odets links the pursuit of sex to adolescent experiences:

As adolescents caught in confusing webs of sexual drive, hopelessness and societal prohibition, many men found sex itself the only completely convincing, natural, and conflict-free aspect of being gay. (Odets 1995, 198)

Gross links it to the process of coming out:

We are defined by our sex drive—and our political goals amount, essentially to ensuring that we are in no way penalized for it. In our personal lives ... coming out requires a painful exertion of energy to rout the puritan fear that gay sex is bad. To vanquish this fear, especially when first coming out, many of us become preoccupied with the pursuit of sex. (Gross 2008)

A paper published on AIDSmap.com admits that “behaviour-change programmes to reduce sexual risk and encourage the use of condoms ... have all had limited and unpredictable success” (NAM AIDSmap 2013b). Gay men do not contract STDs because they are uneducated about the risks or the ways to prevent infection, but because they use sex to meet psychological needs:

Jeremy ... There’s nothing that can make me feel better if I’m feeling down than getting laid ... Nothing at all. But I should stress that is not the actual sex that does it as much as feeling completely and utterly validated by someone. (Signorile 1997, 20)

Alex ... I wasn't horny and that's not why I ended up in the sex club. I ended up there because I needed attention, validation, and remember, I had been spiraling downward all night. I need to be worshipped because I felt I was being ignored. And if someone would worship my body, I'd realize and I'm not unattractive. (Signorile 1997, 21)

They may also need to increase the stimulus to achieve the same degree of arousal, as one gay man explains:

As one gains experience, vanilla sex with one partner becomes familiar, tame, and boring, and loses its capacity to arouse. At first, the increasingly jaded gay man seeks novelty in partners ... Risk is one way to increase the excitement and overcome boredom. (Kirk and Madsen 1990)

PART IV. TREATMENT AS PREVENTION

Not all self-identified gay men defend the behaviors driving the syndemic. In 1981 when gay men started dying from strange diseases, author Larry Kramer organized fund raisers, and demanded action. He was able to draw attention to the need for research, but his pleas for changes in behavior were rejected (Kramer 1989).

In 2004, Kramer gave a speech at Cooper Union in which he railed against all those he blamed for not acting effectively enough to stop the AIDS epidemic. But under the rage, there was guilt, because Kramer remembered those whom he might have infected:

The sweet young boy who didn't know anything and was in awe of me. I was the first man who f—d him. I think I murdered him. The old boyfriend who did not want to go to bed with me and I made him. The man I let f—me because I was trying to make my then boyfriend,

now lover, jealous ... Has it never, ever occurred to you that not using a condom is tantamount to murder? I cannot believe you have never considered this. It is such a simple and intelligent thought to have. And we all should have had it from Day One. Why didn't we? That has been haunting me for a long time, that question. Why didn't we? It is incredibly selfish not to have at least thought that question. (Kramer 2005, 57)

Other gay men sounded warnings. Randy Shilts covered the epidemic as a reporter for the *San Francisco Chronicle*. In his book *As the Band Played on*, he revealed how the gay community fought sensible public health initiatives (Shilts 1987). Gabrielle Rotello, in *Sexual Ecology: AIDS and the Destiny of Gay Men*, wondered about the future:

Each new homosexual generation is replenished by heterosexuals, whose production of gay sons is entirely unrelated to the dynamics of the epidemic. AIDS can therefore keep mowing down gay men, and rather than dying out, phalanx after phalanx will emerge from the trenches, ready to be mowed down anew ... There won't be a small number of people who survived whether through genetic mutation or behavioral and cultural adaptation, and who then produce healthy and immune future generation, the epidemic could literally go on forever. (Rotello 1997, 208)

Michelangelo Signorile, author of *Life Outside: The Signorile Report on Gay Men: Sex, Drugs, Muscles, and the Passages of Life*, worried that "a legacy of narcissistic attention to physical ideals, excessive drug use, and unsafe sex continue to bring on new waves of anxiety, emotional insecurity, and HIV transmission" (Signorile 1997).

Simon Fanshawe, British writer and broadcaster, created the documentary

“The Trouble With Gay Men” to focus on the problems:

When I was a student in the 1970s, what we were fighting for was visibility. ... But the fight just to be seen and heard ended up with us defending all of our behaviour. Because the lid had been on the pressure cooker for so long, and we were defined by sex, then in order to be truly, madly, deeply gay, we had to celebrate everything homosexual. We made no judgments about our behaviour, our morality or the morals of the culture in which we swam and into which we introduced successive generations of gay men. (Fanshawe 2006)

These concerns have been ignored. The gay community continues to defend its behavior. Although the syndemic grinds on, the media focus shifted away from AIDS to the marriage debate and the public has been led to believe that the epidemic is, if not over, at least under control.

Aggressive Medication

While a medication that would “cure” (meaning kill every trace of the virus in a person’s body) or a vaccine that would prevent infection both appear out of reach given the current technology, immediate ART offers the best option. According to the website AIDSmap.com:

Until now, the epidemic has therefore lacked a generally applicable biomedical prevention method which is less dependent of the vagaries of human sexual behaviour than barrier. (NAM AIDSmap 2013b)

A recent study from the HIV Prevention Trials Network (HPTN) found that if, rather than waiting until a person showed signs of lowered CD4 count, those who test positive for HIV were immediately placed on ART, new

infections among their partners dropped by 96 percent (Cohen et al. 2011). A study in the *Journal of Infectious Diseases*, found that “intensive antiretroviral regimen achieves rapid suppression of HIV in semen” (Carter 2013). This means that a regime of universal testing of those in high-risk groups—MSM, intravenous drug users, and those with other STDS—and intensive, immediate treatment of those found infected, combined with aggressive contact tracing and partner notification could dramatically reduce new infections.

A study done in England found that a massive increase in testing and treatment for those with a low CD4 count was not enough to decrease new infections. The authors blamed this on a “resurgence in unsafe sexual behaviour (largely because of treatment optimism).” Their study found that the average time between infection and diagnosis was 3.2 years. Since HIV-positive persons are highly contagious early in the course of the disease, this means that the majority of those infected present a danger to others for years. According to a study:

Early infection accounts for approximately half of onward transmissions in this urban North American study. Therapy at early stages of disease may prevent onward HIV transmission. (Brenner et al. 2007)

The goal of mandatory testing, contact tracing, partner notification, and universal treatment would be to identify and treat all those infected and shrink the time between infection and treatment—the time when the HIV-positive person is highly infectious. While some AIDS activists still argue that universal testing and treatment would violate civil rights, such arguments should not guide public health

policy. HIV/AIDS should be treated like any other serious contagious disease. No one has a civil right to spread disease. The sooner an infection is identified and the infected person placed on ART, the less likely that person is to spread the virus to others. Under such a strategy, initially there would be a dramatic increase in the number of MSM diagnosed HIV positive, as those who didn't know they were infected are discovered, but as the infected—and particularly the newly infected—receive ART, the number of new infections should decrease. Treatment as prevention, plus contact tracing and partner notification offers real hope that the HIV/AIDS epidemic can finally be brought under control, but only if public health community are willing to stand up to the gay AIDS activists.

It has been over 30 years since the beginning of the epidemic. It is now recognized as a syndemic, in which substance abuse, psychological disorders, a previous history of trauma, and other STDs combine and magnify one another. Optimism about improvements in treatment appears to be increasing risk taking. A study done in Quebec found that:

23% of newly diagnosed men who have sex with men had engaged in high risk sexual behavior with ≥ 5 partners before becoming infected, and such behaviors did not significantly change subsequent to infection. These observations are consistent with those recently reported in regard to increased coincidence of HIV with sexually transmitted diseases and high risk sexual behavior. (Brenner et al. 2007)

However, even if the incidence of new HIV infections decreases, given the other factors driving the syndemic, there is every

reason to fear that MSM will continue or even increase their high-risk behavior (NAM AIDSmap 2013b). Because HIV is not the only disease spread by these behaviors, MSM already have higher rates of cancer due to HPV and hepatitis. While there are vaccines for HPV and hepatitis B—vaccines which every MSM should receive—the current HPV vaccine covers only 4 of the approximately 100 strains of HPV and currently there is no vaccine for hepatitis C, a leading cause of cancer and liver failure. There is already concern that the pattern of infection, treatment, and reinfection can produce strains of pathogens which are resistant to standard treatment (Workowski, Berman, and Douglas 2008). Resistant strains have shown up first in men who have sex with men (Alexander 2010). In addition to all the known diseases that can be spread by high-risk behavior among MSM, there may be diseases, which are currently unknown or not currently transmitted by sexual contact that will take advantage of the route provided by the behavior of MSM (Chamberland 2002).

The latest data from the CDC show that the US is in the midst of an epidemic of STDs, treatment of which costs almost \$16 billion a year in healthcare costs (CDC 2012). While MSM make up for only a tiny percentage of the population, they account for 72 percent of primary and secondary syphilis cases, plus 79 percent of HIV diagnoses among men, and a significant percentage of other STDs.

Gay AIDS activists have put protection of MSM's sexual freedom above disease prevention. AIDS exceptionalism has failed. Unfortunately, there is no evidence that the mainstream media will expose this failure or that MSM will change their behavior.

Another Approach

While immediately beginning ART for those who are discovered to be HIV positive could reduce HIV infections, unless strict, mandatory contact tracing, and partner notification are implemented, it will come too late to significantly reduce infections among MSM with multiple concurrent partners. This is further complicated by the fact that many MSM engage in AI with partners met in bathhouses or surfing the web, men whose names and addresses they do not know. However, it should be noted that with other communicable diseases public health officials do overcome such obstacles. In addition, medical treatment of the other diseases spread by MSM will continue to be a massive drain on the healthcare system. There is another way to approach the problem—the prevention and treatment of same sex attraction (SSA).

Contrary to public perception, there is no evidence that SSA is genetically predetermined and unchangeable (De Cecco and Parker 1995). While gay activists have labored to promote the belief that changes in sexual orientation are impossible, various forms of therapy have been found to be effective for some men (Nicolosi 1991, 2009; Bieber et al. 1962). In addition, a number of men with SSA have experienced spontaneous change, belying the claim that change is impossible (Golwyn and Sevlie 1993; Fluker 1976). While there is no reason to believe there is a single cause for all SSA, there is substantial evidence that for many early childhood experiences play a significant role in its development (O’Leary 2007). Recognizing at-risk boys and modifying their environment can not only alleviate childhood distress, but may prevent the development

of SSA in adolescence (Zucker and Bradley 1995).

Gay rights activists are fighting to make such therapy illegal (Slosson 2012; Shapiro 2013), not because it is never effective, but because the existence of people who believe that SSA can be changed or at least can be resisted causes emotional distress for gay men who have struggled with negative feelings about their SSA (internalized homophobia) (Dresher and Zucker 2006). Those providing such treatment currently face obstacles. Dr. Miriam Grossman, author of the book *Unprotected*, writes of how she knew she was risking her professional standing by simply giving a client, who didn’t want SSA, the choice between gay affirming therapy and therapy that would support his struggle against SSA (Grossman 2013).

While not all those who desire freedom from SSA are able to develop healthy other sex attraction, according to the *Catechism of the Catholic Church*, “Homosexual persons are called to chastity” (CCC, n. 2359). Therapy or membership in a support group, such as Courage, can help persons experiencing same-sex temptations to “gradually and resolutely approach Christian perfection” (CCC, n. 2357). The teachings of Scripture and the constant witness of the Church restricting sexual relations to marriage between one man and one woman are unchangeable. It is not enough to disapprove of homosexual acts, or, as this article does, point out the very real consequences of this behavior: believers must offer their prayers, their loving concern, and real help to those who struggle with these temptations, even if it means being labeled a “homophobe” or “bigot.”

Persons with SSA should have the right to be informed that therapy, counseling, and support groups are available for those who want to be free from these attractions,

whether for religious reasons, or because they want to avoid the STDs syndemic, or simply because they don't want to be "gay."

Physicians need to work with groups dedicated to protecting their legal right to offer a full range of advice to patients and the freedom of religion of physicians, mental health professionals, and their clients. Physicians should have the right to tell patients with STDs or who report homosexual activity, particularly those who hold religious beliefs that conflict with their behavior, that therapy to deal with the underlying problems may help them resist temptation in this area. Parents should be allowed to seek therapy for boys with gender identity disorder, which is often the precursor of SSA. Clergy and Catholic educators should be educated on the issue and able to recommend therapists and support groups. Making such treatment illegal, labeling those who recommend or provide it as "homophobes, bigots, or hateful" or, worse, instituting sanctions against them through professional organizations, contravenes good medical practice and must be resisted. At stake is nothing less than the fundamental human right of each man to seek help to achieve his personal psychological, physical, and spiritual well-being.

The *Catechism of the Catholic Church* teaches that "homosexual acts are intrinsically disordered" and the "inclination ... is objectively disordered" (CCC, n. 2357). The evidence presented above sadly demonstrates how that disorder when embraced leads to further disorder, to disease, and to death.

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BIOGRAPHICAL NOTE

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