SP021

Gender dysphoria and neurodiversity: understanding the intersections

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Abstract: Treatment units for gender dysphoria show an increased number of people with neurodiversity compared to the general population. Similarly, outpatient units for autism show a high percentage of people who also suffer from gender dysphoria. The causes for this clustering are unknown, altohugh it has now been etablished as a fact in research. Studies show that people with both conditions experience particularly high levels of psychological stress and concomitant psychiatric disorders. Treating people with neurodiversity and gender dysphoria requires special expertise in both areas. Surveys of experts using the Delphi method resulted in guidelines about how specific features need to be taken into account, and how both condition sshould be addressed at the same tine. it is ethically unacceptable to deny people with neurodiversity access to gender reassignment mesures. However, they often need more support during the assassement and transition process,

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SP022

Understanding chemsex: clinical features, risk constellations and implications for mental health services

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Abstract: Chemsex describes the intentional use of psychoactive substances to facilitate or enhance sexual experiences, most commonly reported among men who have sex with men (MSM) in urban settings. Substances frequently involved include methamphetamine, γ-hydroxybutyrate/γ-butyrolactone (GHB/GBL), mephedrone and other synthetic cathinones, often used in combination and in prolonged sexual sessions. Digital platforms have facilitated network formation and access to drugs, contributing to the expansion and normalization of the phenomenon in certain subcultures. While chemsex may be perceived by participants as enhancing intimacy, pleasure and connectedness, it is increasingly recognized as a complex biopsychosocial issue with significant psychiatric and somatic implications.

From a clinical perspective, chemsex is associated with elevated rates of substance use disorders, mood and anxiety disorders, trauma-related symptoms and personality vulnerabilities. Acute psychiatric presentations may include intoxication syndromes, agitation, psychosis, suicidal ideation and impaired judgment. Repeated use, particularly of stimulants and GHB/GBL, carries risks of dependence, withdrawal syndromes, cognitive impairment and persistent affective instability. Polysubstance use and sexualized drug injection ("slamming") further increase the likelihood of overdose, blood-borne infections and other medical complications. High-risk sexual behaviors contribute to increased transmission of HIV and other sexually transmitted infections, despite advances in preventive strategies such as PrEP.

Clinicians face specific challenges, including stigma, underreporting, fragmented care between addiction, sexual health and mental health services, and the need for culturally competent, non-judgmental approaches. Routine assessment should integrate sexual health, substance use patterns, psychiatric comorbidity and psychosocial stressors. Emerging perspectives emphasize harm reduction, community-based interventions, trauma-informed care and integrated service models that bridge psychiatry, addiction medicine and infectious disease care.

Chemsex represents a paradigmatic interface between sexuality, substance use and mental health. A nuanced understanding of its motivations, risks and clinical trajectories is essential for developing tailored prevention and treatment strategies within contemporary European psychiatric practice.

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SP023

Assisting the individuals with the burden of concealment

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Abstract: Sexual and gender minorities often face stigma and discrimination from the time they start exploring their identities, even if they don't choose to diclose this to others. They may experience negative attitudes in almost all social contexts, starting from the closest one including the family, if they don't conform with the expected gender roles. Finallly, even if they work hard not to reveal their identity in their appearance, behavior or attire, in addition to the mental effort load related to this nonstop effort, they have to carry the burden of the expected stigmatization and discrimination. In many contexts, nondiclosure may appear protective mentally; it has been shown to be so especially in societies with higher levels of stigmatization. But in all social contexts, concealment of an identity comes with a burden, especially when its control is not on the individual but it is forced on the individual by the social environment. Mental health professionals should be famiiar with the threats existing in the society for the individual, but also should have the capacity to work on the individual's use of concealment as a defense strategy. Since when it is used excessively and rigidly, this defense can itself be a source of stress. Furthermore, it may lead to missing the authentic potential of the individuals in their personal, interpersonal, and professional domains. In addition to increasing the capacity to use disclosure and concealment interchangeably and to the benefit of the individual, the professional should work on possible resources of psychological resilience for the individual. These efforts often involve the improved relationships with peers from the same or similar minorirty groups, peers from the general population, and family members.

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