Research Update

There are a variety of labels to describe a person’s sexuality based on the sex of his or her partners, but there is sometimes a discrepancy between people’s sexual identities and their actual sexual behaviors. For example, some people who identify as heterosexual also engage in homosexual sex, and some people who identify as homosexual also engage in heterosexual sex. Discrepancies between sexual identity and sexual behavior are often related to the different but interrelated components of sexuality as well as societal perceptions, expectations, and stigma, such as homophobia and heterosexism.

Components of Sexuality

“Sexuality” is an umbrella term that encompasses a variety of individual components related to the ways humans experience and think about their sexual knowledge, attractions, beliefs, attitudes, values, and behaviors. These components of sexuality include sexual orientation, sexual identity, sexual preference, sexual behavior, and gender role.

Sexual Orientation. The term “sexual orientation” describes a person’s inherent sexual attraction to particular or multiple genders. Although experts have argued over the exact meaning of sexual orientation and the methods of determining it,1 there is a general consensus that people have no choice about their sexual orientation; it is something they are born with.2

Historically, the language used by researchers and experts to describe and understand variations and differences in sexual orientation has undergone significant change. In the late 19th century, sexologists developed what became the dominant belief that each person fits into one of three categories: heterosexual, homosexual, or bisexual. Another common belief during this time was that homosexuality and bisexuality were not “natural” but rather the result of some form of psychological maladjustment.3

In two influential reports released in 19484 and 1953,5 Alfred Kinsey and colleagues developed a model of sexuality that largely changed the conception of sexual orientation. Kinsey argued that sexual orientation should be considered in terms of a continuum spanning two poles. At one end of the continuum, known as the “Kinsey scale,” is the pure heterosexual who is attracted only to members of the opposite sex, while at the other end of the scale is the pure homosexual who is attracted only to members of the
same sex. In between these two poles is a spectrum consisting of people who experience some combination of desires for members of both sexes. In developing this model and applying it to his research on the sexual behaviors of individual men and women, Kinsey found that most people fall somewhere in the middle of the spectrum, meaning that they experience some combination of sexual attraction towards both men and women. Kinsey’s model challenged the earlier assumption that people fit into one of three discrete categories of sexual orientation and that homosexuality and bisexuality are not natural. The model also changed the ways in which researchers and the public consider sexuality in general and sexual orientation in particular.

**Sexual Identity.** Closely linked to sexual orientation is the concept of “sexual identity.” Whereas sexual orientation refers to a person’s inherent sexual desires in relation to a particular gender or genders, sexual identity refers to the ways in which people incorporate those desires into their sense of self as sexual beings. Sexual identity is the result of a process through which people come to terms with their sexual desires.

Disclosing sexual identity to other people serves as a tool to facilitate communication and interaction between people. Identifying one’s sexuality also allows a person to associate more easily with other people who share their sexual interests, and increases his or her chances of finding potential sex partners.

A common assumption is that a person’s sexual identity corresponds with his or her sexual orientation, but this is not always the case. For example, a man who is sexually attracted primarily to other men may consider himself to be heterosexual in identity and present himself as such to other people. Similarly, some people who are bisexual present themselves as either heterosexual or homosexual to other people. In addition, many men of color who have sex with men consider the word “gay” to refer specifically to White homosexual men. In some cultures, including Spanish-speaking ones, men who engage in insertive anal sex often do not consider this behavior to be homosexual in nature.

Men who have sex with men but do not identify as gay may be at higher risk for HIV infection than gay men because they are less likely to be exposed to HIV prevention campaigns, which are usually designed to target risk groups such as gay men.

**Sexual Preference.** Some experts include the concept of “sexual preference” in their overall picture of sexuality. There has been much debate over the validity of the concept of sexual preference in relation to sexual orientation. Many argue that sexual orientation is not a choice, and that the continued use of the term sexual preference wrongly implies that people have the ability to choose whether they are attracted to men or women. Others suggest that the concept of sexual preference is still an important facet of the overall picture of sexuality because it helps to clarify that people are still free to choose the types of sex in which they might want to engage.

**Sexual Behavior.** “Sexual behavior” refers to the types of sexual activities in which a person engages and the gender with whom one chooses to have sex. A sexual encounter between two men, for example, is a sexual behavior that is homosexual in nature regardless of either of the participants’ sexual identity. In addition, people may have a certain sexual identity without ever having engaged in any of the corresponding sexual behaviors. This is particularly true of young people who, despite never having had sex, still have a sexual identity.

In some cases, people express discrepancies between their sexual identity and their sexual behavior. A study of 6,935 self-identified lesbians found that 77.3 percent of participants reported having had one or more male sex partners in their lifetimes, and 5.7 percent reported having had a male sex partner during the prior year. In a 1994 study of lesbians and bisexual women, 85 percent identified as lesbians, 7 percent identified as bisexual, and 9 percent did not label their sexuality but acknowledged that they had sex with women. Of the self-identified lesbians, 53 percent reported having had sex with at least one man since 1978, and 13 percent reported having had sex with a known or presumed gay or bisexual man since 1978. Of the self-defined bisexual women, 90 percent reported having had sex with a man since 1978, and 42 percent reported having had sex with a known or presumed gay or bisexual man since 1978. Of the women who had sex with a gay or bisexual man, 75 percent engaged in unprotected vaginal sex, 15 percent engaged in unprotected anal sex, and 50 percent engaged in unprotected oral sex.

**Gender Role and Gender Identity.** Gender role and gender identity both play an important role in the development of sexuality. The term “gender identity” refers to a person’s identification with a particular gender, while the term “gender role” refers to the societal assumptions and expectations based upon a person’s

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**The way people express their sexuality may vary at different times in their lives.**
gender. Unlike the term “sex,” which refers to biological categories based on a person’s reproductive organs and functions, “gender” refers to social or cultural categories that reflect the meanings and assumptions related to being male or female.

Societal gender roles tend to dictate that men are expected to be sexually attracted to women and to act out these sexual attractions in their sexual behavior. Similarly, women are expected to be sexually attracted to men. People who contradict these expectations by expressing a desire to have sex with other people of the same sex are sometimes considered to be deviating from their gender roles. For this reason, gay men are sometimes labeled by other people as “feminine,” and lesbians are sometimes labeled as “masculine.”

**Homophobia and Heterosexism**

Prevailing cultural attitudes towards sexuality often affect the ways in which people express, explore, or develop their sexuality. The term “homophobia” refers to the fear and enmity directed towards people who maintain homosexual identities or engage in homosexual behaviors. Researchers and theorists have more recently begun to use the term “heterosexism.” Whereas homophobia describes the ways in which gay men and lesbians experience stigma as a result of their natural sexual desires, heterosexism refers to the societal belief that heterosexuality is a norm from which homosexual behavior deviates. One theory states that heterosexism manifests on both cultural and individual levels. On a cultural level, heterosexuality is presented as the norm by powerful social factors, including governmental policy, the popular media, and the church. The individual members of society who hear these messages may then internalize the belief that homosexuality is abnormal.

Until 1973, the American Psychiatric Association considered homosexuality to be a mental disease. As a result of this and other societal attitudes, many people perceive their homosexual desires to be the result of a psychiatric disorder rather than of their natural disposition. This phenomenon, known as “internalized homophobia,” often causes people who identify as homosexual or bisexual to experience a degree of negative feeling towards themselves. This hinders their ability to come to terms with their sexual orientation and to develop a healthy sexual identity.

Because homophobia and heterosexism are prevalent societal influences, they also affect the development of sexuality during childhood and adolescence. Even before reaching puberty, most children are exposed to homophobic and heterosexist messages. As a result, children may have certain expectations about their future sexualities, and adolescents may feel pressure to be heterosexual regard-

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**The Kinsey Scale of Sexuality**

The Kinsey scale depicts the spectrum of human sexuality as a continuum. According to Kinsey's research, very few people are “exclusively heterosexual” or “exclusively homosexual.” Most people's sexuality falls somewhere between the two extremes, meaning that they experience some level of attraction towards both men and women. The Kinsey scale changed the perception that the only distinct categories of sexuality are heterosexual, bisexual, and homosexual.

Sexual development is a particularly complex process for most adolescents. Perhaps at no point in human development is sexual identity as unrelated to sexual behavior as in adolescence. For those who discover that they are sexually attracted to members of the same sex, the developmental path is even more complicated. Some people “come out,” either during adolescence or in later years, personally acknowledging a gay or bisexual orientation, and publicly sharing a homosexual or bisexual identity. Others engage in homosexual activity as part of a general experimentation process integral to adolescence, but this behavior may be unrelated to how they perceive their sexual orientation and identity in later years.

For those adolescents who ultimately come out, researchers have attempted to construct models to explain the developmental progression toward a homosexual identity. According to these models, the beginning of homosexual identity development occurs when a child first recognizes a same-sex attraction. As the child moves into adolescence, there is a period of experimentation with same-sex contact, later leading to self-labeling as gay or lesbian and disclosure of sexual identity. While helpful in describing the developmental process, models are necessarily broad, and each person develops in a unique way.

The difference in individual developmental paths is influenced by gender, race, socioeconomic status, and other factors, with many adolescents attempting to manage multiple minority group identities.

Some of the most profound differences in the development of sexual identity and sexual behavior seem to be related to gender. Some studies indicate that adolescent boys are more likely to engage in sex with male partners before labeling themselves as gay, while adolescent girls are more likely to label themselves as lesbian before having sex with female partners. Choice of sex partner also appears to differ by gender. In one study, 20 percent of gay men reported that their first homosexual encounter was with a stranger, while no lesbians reported strangers as their first homosexual partners.

For adolescents who make the connection between their same-sex attraction and a homosexual or bisexual identity, there are risks in both disclosing and denying of their sexuality. Young people who are homosexual often feel the need to conceal their sexual behavior, often because of the negative consequences they fear from family, peers, and society. The social stigma associated with homosexuality contributes to some adolescents “compartmentalizing” their sexual behavior, creating a discrepancy between their sexual identity and their sexual behavior. Teens who are attracted to members of the same sex are often heterosexually active, perhaps because they are bisexual, because they are experimenting, or because of societal expectations to be heterosexual. Some may be “overcompensating,” that is, engaging in heterosexual sex in an attempt to deny to themselves or to others that they are gay or lesbian.
Implications for Counseling

When working with clients who engage in sexual risk behaviors that do not correspond to their sexual identity, HIV test counselors may find it challenging to perform accurate risk assessments and provide useful risk reduction counseling. Clients whose sexual behaviors are different from their sexual identities often are reluctant to discuss these behaviors. Some clients may never admit these behaviors to other people, including HIV test counselors. Other clients who are reluctant may discuss their behaviors not only because of HIV risk, but also because of the safety of the counseling session, particularly if the counselor has established rapport and trust with the client.

In addition to fulfilling its goals of assessing HIV risk and disclosing HIV test results, the HIV test counseling session provides clients with an opportunity to talk about sex in a neutral and client-centered setting. Because such discussions are uncommon for many clients, they may feel awkward or embarrassed, but at some level, clients may want to discuss behaviors they have kept secret. The counseling session often marks the first time clients have had such a discussion, and they may feel relieved to finally admit these behaviors to another person.

It is essential for counselors to express empathy with supportive comments, encouraging clients to talk further. For example, a counselor might say, “I can tell that these things are difficult for you to discuss, and I’m glad you feel comfortable enough with me to discuss them. I’d like us to look at your risks and what you can do to lower them. I may also have some referrals for you so that you can talk about this further and get a better understanding for yourself.”

Assessing Risks

Client-centered counseling teaches counselors to accept clients’ definitions of their sexual identities and to treat each client as an individual with unique circumstances. Therefore, when performing a risk assessment, it is important to ask clients if they engage in risk behaviors inconsistent with their sexual identity. Some counselors may be reluctant to ask about these behaviors out of fear that the client may think that the counselor does not accept the client’s self-identification.

Counselors should never argue with clients about how they choose to identify their sexuality, but asking about risk behaviors that do not correspond to clients’ sexual identity is appropriately client-centered because it facilitates a discussion about the client’s unique circumstances and helps counselors make more thorough risk assessments. The standard question, “Do you have sex with men, women, or both?” is a good way to assess for risk behavior with all clients.

An integral element of an adequate risk assessment is discussing relevant details about a client’s sexual behavior. For example, with a heterosexual-identified male client who reports having anal sex with other men, ask if he is the insertive partner, the receptive partner, or both. Then ask if he uses condoms during these encounters. After assessing the client’s risks for HIV and other sexually transmitted diseases (STDs), explore what he is willing to do to reduce his risks. Remember that when counseling a heterosexual-identified man who has sex with men, it is important not to overlook possible risk behaviors related to sex with women. Similarly, when counseling lesbian-identified clients who have sex with men, explore if the sex in which they engage is oral, anal, vaginal, or a combination of these, and if they practice safer sex.

An important concern for a client who engages in sex that does not correlate with his or her sexual identity is that partners may not be aware of the client’s risks, as in the case of a female partner of a lesbian client who does not disclose that she has sex with men. The same is true for female partners of heterosexual men who have sex with other men. It is important to explore these matters in a way that does not threaten or alienate clients but inspires them to think about the possible risks associated with their behaviors. For example, a counselor might say, “I’m concerned that your female partner doesn’t realize the risk of having sex with you because she doesn’t know you have sex with men. What would it be like if you told her?” If clients are unwilling to disclose this information to female partners, explore what they are willing to do to minimize their partners’ risks.

After assessing risk, it is also important to ask how clients have tried to reduce their risks. When counseling a heterosexual man who has oral sex with men, for example, ask if his partners ejaculate in his mouth.

A Counselor’s Perspective

“It is difficult to listen to young clients bash themselves because they have same-sex feelings.”

A Counselor’s Perspective

“I can’t imagine the issues middle-aged people face when changing their sexual identity. But the vitality I see in some of them as they finally come to accept who they really are is amazing.”
Substance Use

Clients who are uncomfortable with inconsistencies between their sexual behaviors and sexual identities may use alcohol or other drugs to ease this discomfort and facilitate those behaviors. Substance use lowers inhibitions, enabling people to engage in behaviors in which they may not usually partake. Counselors need to be aware of this possibility and assess for substance use as a possible co-factor for HIV risk. Assessing for alcohol use, in particular, is important because it is common for people who are exploring their homosexual desires to meet sex partners in bars.

Help clients see the possible connections between risk behaviors and substance use. Wondering aloud in the third-person voice is a good way to invite conversation, for example, “Many people place themselves at risk while they are under the influence of alcohol or other drugs. I’m wondering if this is true for you.”

If substance use is a risk factor, explore what clients can feasibly do to reduce their risks. For example, if a self-identified homosexual man says he will never drink and have anal sex with men again, a counselor might say, “It’s great that you are connecting the alcohol use with your HIV risk. But is it realistic for you to never drink again? I’m wondering how you might manage that since alcohol has played a big role in your enjoyment of sex.”

Missed Prevention Messages

HIV prevention messages are often more effective when they target specific at-risk populations by using the vernacular of the targeted group and images that are most likely to elicit a response from that group. For example, prevention posters targeting gay men may use words like “gay” and “queer” with an image of two men hugging or kissing. Although such a poster may reach many gay men, men who identify as heterosexual and have sex with other men probably will not pay attention to the poster; these men are unlikely to think it is intended for them or to respond to affectionate images of men. Therefore, it is a mistake for counselors to assume that clients are knowledgeable about HIV, especially if clients do not identify with populations that have been traditionally targeted for prevention messages.

A good way to assess a client’s knowledge of HIV is to use open-ended questions or statements such as, “Tell me what you know about how HIV is transmitted,” or, “Which behaviors that you engage in may put you at risk for HIV infection?” Counselors can then add or correct information, as necessary.

Questioning Sexuality

When working with adolescents or clients who are unsure about their sexuality, it is essential to remain neutral to prevent influencing the way clients develop their sexual identity. It is common for young people to experiment sexually to discover their sexual preferences. It is just as harmful for a gay or lesbian counselor to steer a questioning client toward homosexuality as it is for a heterosexual counselor to steer a questioning client towards heterosexuality.

If a young client is concerned about being sexually attracted to members of the same sex, be supportive while maintaining the focus of the session on HIV risk, for example, by saying, “It’s very common for young people to have all kinds of feelings and confusion about their sexuality, but it doesn’t necessarily mean the person is gay, lesbian, bisexual, or straight. One of these days, you’ll come to know what’s right for you, but the most

References

Case Study

Joe is a 19-year-old male client who has never before tested for HIV antibodies. He is concerned because he has had unprotected vaginal sex with female partners and has been the insertive partner during oral sex with male partners. Joe is also anxious because he is attracted to men and is unsure about his sexual identity. He also states that he is more concerned about receiving oral sex from male partners than having unprotected vaginal sex with female partners.

Counseling Intervention

After establishing rapport with Joe and giving him positive reinforcement for testing, assess his knowledge of HIV by asking what he knows about how the virus is transmitted. Support what he knows and correct any misinformation. Because Joe is more concerned about receiving oral sex from men—a relatively low-risk activity for HIV infection—than about his potentially more significant risk of unprotected vaginal sex, discuss the hierarchy of risk to help him understand the different levels of HIV risk associated with different behaviors.

If Joe continues to place emphasis on his risk for receiving oral sex with male partners, ask him what may be contributing to this concern, for example, by saying, “You seem to understand that being the insertive partner in oral sex is an extremely low risk for HIV, although there is some risk for STD infection, and that having unprotected vaginal sex is a higher risk than oral sex. I’m wondering what you may be thinking about. You seem very anxious about this.”

After this intervention, Joe may say that his concern is a result of his belief that it is wrong to have sex with male partners and his fear that he may be gay. He may also express desire to have oral sex with his male friends. Let Joe know that his HIV risk via oral sex is slightly higher if he is the receptive partner than if he is the insertive partner, and educate him about risk reduction.

Acknowledge the concerns and fears he has about his sexual orientation, and try to normalize them, for example, by saying, “Many young people have big and often frightening questions about their sexual orientation. If you choose to experiment, we’ve talked about what you can do to keep your risks low. I also want to give you a phone number of a place you can go to talk about these feelings.” Then provide Joe with referrals for supportive counseling.

One of the difficulties in making complete risk assessments is taking into account possible future behaviors. Because of time constraints, counselors often focus on clients’ risk behaviors without exploring the possibility that preferences for behaviors may change and lead to entirely new risks in the future. Trying to assess the risks of potential new behaviors may be especially difficult if clients do not express their desires. In these instances, use open-ended statements or questions that invite clients to talk about these possibilities, for example, by saying, “I’m wondering if there is any new behavior you are thinking about trying that we haven’t covered.”

Referrals

To be prepared to provide clients with appropriate referrals, research and maintain current information on local resources. Find out where young people can go to talk about these feelings.” Then provide Joe with referrals for supportive counseling.

Because these types of changes often affect spouses or family members, also explore counseling and other supportive resources for couples and families. For adults who are agonizing over their confusion about their sexuality, provide referrals for therapy to help them resolve and cope with these issues.

It is important for counselors to have some knowledge of the referrals they provide to ensure that the resources reflect client-centered principles as much as possible. For example, avoid referring clients to organizations that discourage clients from changing their sexual identity. If a limited base of resources is available, remember to alert clients whenever there may be uncertainty about a referral’s appropriateness. In areas where there are no appropriate local referrals available, telephone resources such as hotlines based in other areas are often useful.
Test Yourself

Review Questions

1. True or False: Men who have sex with men but do not identify as gay may be at higher risk for HIV infection than gay men because they are not frequently exposed to HIV prevention campaigns, which usually target risk groups such as gay men.

2. True or False: Most researchers agree that a person’s sexual orientation is a matter of personal choice.

3. According to the Kinsey model of sexuality, which of the following statements are true? a) sexual orientation occurs on a continuum, also known as the Kinsey scale; b) most people fall somewhere in the middle of the Kinsey scale, meaning that they experience some combination of sexual attraction towards both men and women; c) homosexuality and bisexuality are natural and not the result of psychological maladjustment; d) all of the above.

4. True or False: The term “heterosexism” refers to the societal belief that heterosexuality is “normal,” and homosexuality is a deviation.

5. True or False: Once formed, a person’s sexuality remains consistent.

6. True or False: A person’s sexual identity is not necessarily the same as his or her sexual orientation.

7. According to models developed by researchers to describe the developmental progression toward a homosexual identity, adolescents who ultimately adopt a homosexual identity tend to experience which of the following? a) first recognizing same-sex attraction as a child; b) a period of experimentation with same-sex contact during adolescence; c) self-labeling as gay or lesbian and disclosure of sexual identity; d) all of the above.

8. True or False: After reaching adulthood, people no longer question their sexuality.

Discussion Questions

1. What are some ways in which a client’s sexual identity may differ from his or her sexual behavior?

2. What are some of the issues counselors may face when they have young clients who are questioning their sexual identities?

3. How can counselors address their own reluctance to assess the risks of their clients whose behaviors and identities are inconsistent?

4. How can counselors assess the risks of clients whose sexual behaviors are not congruent with their sexual identities?

5. Why would clients be reluctant to discuss behaviors that are inconsistent with their sexual identity?

6. How can counselors maintain current local referrals for clients who are questioning their sexuality?

Answers

1. True.

2. False. The term “sexual orientation” describes a person’s inherent sexual attraction to particular or multiple genders. Most researchers agree that sexual orientation is something people are born with rather than something people choose.

3. d.

4. True.

5. False. Sexuality is a continuously developing process. The way people express their sexuality may differ at different times in their lives.

6. True.

7. d.

8. False. People can question their sexuality at any age. Many people who question their sexuality are challenging the assumption of heterosexuality imposed upon them by the hetero-sexist society in which they live. In other instances, they may be coming into conflict with the social expectations to define their sexuality within a limited range.
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