Throughout the AIDS epidemic, some researchers have been concerned that the sexual activity of men who have sex with both men and women might form a sexual transmission bridge from gay male communities, in which HIV prevalence rates have historically been high, to heterosexual communities.¹⁻³ This concern has focused, in particular, on behaviorally bisexual men who identify publicly as heterosexual, that is, those who do not disclose their same-sex behavior to others, including their female partners.

Current research on this topic is beginning to define the frequency and characteristics of behavioral bisexuality among heterosexual men and some of the risk factors related to their behavior. But findings are inconsistent and do not offer comprehensive or definitive data on these topics.³⁻⁶ For example, while there are a number of studies of “bisexual” men, different researchers have used different definitions of “bisexual” and “behaviorally bisexual.”⁴⁻⁵ Further, some studies have asked subjects about both their behavior and their identity, while others have asked only about one of these. In addition, it is not always clear from the studies whether men who identify as “heterosexual” and admit to having sex with men actually have had sex with women.

In its recent coverage of behavioral bisexuality, the mass media have focused on heterosexually identified African American men who have sex with men and women, concentrating especially on African American men. This issue of PERSPECTIVES reviews the limited research on this topic, emphasizing less the demographic profile of this population than the various ways HIV-related risk might enter the lives of all heterosexually identified men who have sex with men. The Implications for Counseling section underscores the fact that discussion with clients remains the most accurate source of information about their behaviors and concerns.

Research Update

Recently, the media have focused attention on the HIV-related risks of heterosexually identified men who have sex with men and women, concentrating especially on African American men. This issue of PERSPECTIVES reviews the limited research on this topic, emphasizing less the demographic profile of this population than the various ways HIV-related risk might enter the lives of all heterosexually identified men who have sex with men. The Implications for Counseling section underscores the fact that discussion with clients remains the most accurate source of information about their behaviors and concerns.

Ambiguities in the Research

Keeping these messages in mind, it is useful to outline the ambiguities in the research. Studies of bisexual behavior among heterosexual men are few, scattered, and inconsistent in definitions and methods, making their findings difficult to interpret and generalize.⁵⁻⁶ For example, while there are a number of studies of “bisexual” men, different researchers have used different definitions of “bisexual” and “behaviorally bisexual.” Further, some studies have asked subjects about both their behavior and their identity, while others have asked only about one of these. In addition, it is not always clear from the studies whether men who identify as “heterosexual” and admit to having sex with men actually have had sex with women.
same-sex activities, and there is not enough research to fully understand the relationship between race and the prevalence of this behavior or related activities that increase the risk of HIV transmission. In addition, different subcultures, such as Latinos, view “bisexuality,” in different ways, and some cultures have more fluid conceptions of sexual behavior that make labels difficult to apply.

Finally, HIV prevalence among Black women may be related to the activities of “men on the down low,” but research has not clearly documented the connection between these two phenomena. Likewise, although nondisclosure of same-sex behavior by men may increase HIV risk for their female partners, the complex dynamic between these two factors is not well understood.

**Numbers, Labels, and Definitions**

It is difficult to say how commonly heterosexually identified men have sex with men because, by definition, heterosexually identified men often hide their same-sex behavior. A study of male substance users offers an analysis of this identity-behavior split. The five-city study proposed three categories: the way a person described his behavior to the researcher, the way he identifies to himself, and the way he identifies to the world. The identity choices were: “heterosexual,” “bisexual,” “homosexual,” “gay,” and “other.” Of the study’s 144 subjects, 31 percent described their sexual activity as “bisexual,” but only 17 percent used this term to describe their public identity.

Three studies offer some sense of the proportion of men with HIV or at risk for HIV who may be behaviorally bisexual. None of these studies distinguishes between a man who has sex with men many times and a man who experiments once.

The Supplement to HIV/AIDS Surveillance (SHAS) study surveyed 5,156 HIV-positive men from Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, New Jersey, New Mexico, South Carolina, Washington, and Los Angeles. It found that of the 1,114 men who said they had had sex with both men and women in the prior five years, 11 percent identified as heterosexual. Similarly, a four-city study—in Dallas, Denver, Seattle, and Long Beach, California—found that among 1,396 men recruited at public sex sites where men have sex with men, 10 percent characterized themselves as “straight.”

Unpublished data from a large UCSF AIDS Health Project sample of San Francisco men coming in for anonymous HIV testing examined this issue from another angle. Instead of asking how many men who have sex with men and women identify as heterosexual, it asked how many men who identify as heterosexual have sex with men and women. It found that among 3,984 men who identified as heterosexual, 216 (5.4 percent) reported a sexual risk behavior with at least one man in their lifetime.

**Co-Factors of Behavioral Bisexuality**

The few studies on behavioral bisexuality among men who identify as heterosexual suggest two factors that may correlate with undisclosed same-sex behavior: age, and race and ethnicity. Regarding age, one study found that straight-identified men who have sex with men tend to be older than gay-identified or bisexual-identified men, although this difference was not significant. Consistent with this, another study found that younger men are more likely than older men to disclose their sexual activity with men to their steady female partners.

While some studies have found that African American and Latino or Hispanic men tend to have higher rates than White men of behavioral bisexuality, the data are limited. In one unpublished study of almost 9,000 HIV-positive men who have sex with men, nearly 25 percent of African American men, 15 percent of Hispanic men, 7 percent of Asian-Pacific Islander men, and 6 percent of White men considered themselves heterosexual, although the source that cited this study did not specify whether these men actually had sex with women.

The AIDS Health Project study of HIV test-takers also found that people of color were statistically overrepresented: of the study population of 12,836 sexually active men, 11 percent were African American men and 6 percent were Latino; of the heterosexually identified men who have sex with men, 13 percent were African American and 8 percent were Latino. At the same time, although the SHAS study of 5,156 HIV-positive men found that men of color were more likely than White men to have sex with both men and women, this disparity became statistically insignificant among the 1,114 heterosexually identified men who have sex with men and women. Other studies have found that African American men tend to avoid self-identification as gay or bisexual, even when engaging in homosexual behavior, and that they disclose their sexual activity with men to their female partners less often than White men, although high rates of non-disclosure occurred in both groups. For example, a study of 350 bisexual men found that African Americans (61 percent) were more likely than Whites (46 percent) to have told no female partner about their homosexual behavior.

Anecdotal evidence suggests that heterosexually identified Latino men are more likely than White men to have sex with men, but there is scant data other than this study about whether and how much Latino men engage in and disclose same-sex behavior. There is also little data on straight-
identified Asian-Pacific Islander American men who have sex with men.

Future research may find that region, age, subculture, and substance use may amplify or diminish racial or ethnic differences. It is important to add that it is unwise for counselors to make generalizations across cultures based on the research on race and ethnicity—even if this research were more comprehensive—because issues such as sexuality and disclosure are so strongly tied to culture.18

**Homophobia and Racism**

Sexual activity and HIV-related risk are motivated by a range of internal factors, such as psychology and biology, and external factors, such as family and social group. Among the most pervasive of external factors are the values, including racism and homophobia, of the society or community in which a person lives and a person’s economic status. Homophobia, both external and internalized, forms a basis for stigma and discrimination against those who engage in same-sex behavior, whether their race or ethnicity. In addition, some religious and cultural forces idealize heterosexuality. These forces can make acknowledging homosexual behavior emotionally and physically dangerous.

Reprisals for acknowledging sex with other men may range from emotional and physical abuse to the loss of intimate relationships. Men who wish to disclose their same-sex activity to steady female partners may be inhibited by the fact that, in doing so, they must disclose not only taboo homosexual activity but also sexual activity outside the steady relationship.12 Each of these disclosures, in itself, can cause a rift in a relationship; the two together may make disclosure seem especially dangerous. Further, the man who does disclose no longer has control over the information; his female partner may disclose to other, possibly less sympathetic people. Finally, regardless of what his partner or outsiders think, the man may feel guilt and shame about his own homosexual desires and actions.19

Some researchers have noted that behaviorally bisexual men of color, especially, face cultural norms about masculinity that make it particularly difficult to identify outwardly as gay or bisexual.16,17 For example, one study found that Black bisexual men, more than White men, see their communities as less accepting of homosexual behavior.12,15 Other evidence, however, contradicts this perception: several studies have found that African Americans are no more disapproving of homosexual behavior than Whites.5,16 According to some scholars, cultural stigma may also lead to increased HIV-related risk, because of reduced self-esteem and more severe internalized homophobia.19

Men of color face a particularly difficult time “coming out” as gay or bisexual, not only because of homophobia in their own communities, but also because organized and established gay communities tend to be mostly White, confronting a man of color with many of the same issues of racism he encounters in the broader society.16,19 Those men who do choose to come out risk identifying themselves as a “double minority.”15,19,20 Some men of color may choose to avoid the double-minority status by identifying as heterosexual.19

Other cultural constructs of sexuality may influence the way in which homophobia expresses itself and the way a person perceives his sexual identity. For example, a number of authors have suggested that Latino populations have traditionally identified men who are insertive partners during sex (activo) not as “gay” but as heterosexual.16,19,21 However, there is evidence that in some places in the United States (and in many places in Latin America), the strict distinction between activo and pasivo may be shifting.22 and there may be ways for men to play the pasivo (receptive) role from time to time without compromising their heterosexual image.23

It is difficult to generalize from the slim literature that exists on Latinos living in the United States, both because there are so many different Latino and Hispanic communities and because most of the information about Latino bisexual behavior comes from international research. Values, norms, and practices among Latinos in the United States are influenced both by mainstream U.S. culture and by migration, globalization, and cultural ties to Latin American societies.24

Finally, the data on bisexual behavior in Latino communities may be sparse, because the concept of bisexual identity may not be relevant. Unlike mainstream U.S. culture, Latino culture may not force sexual identity into rigid categories. Instead, in various Latino cultures, same-sex behavior may be invisibly situated in the context of masculine and feminine sex roles and sexual behavior.21,25

**Circumstantial Bisexual Behavior**

Many people who engage in sexual activity that is not related to their desire or orientation do so in response to external circumstances such as economic conditions. For example, a person may trade homosexual sex, even if he identifies as heterosexual, for money or drugs. Because of the stigma related to sex work, substance use, and same-sex behavior, men who sell sex may be reluctant to disclose this activity to non-paying sexual partners. The power imbalances inherent in sex-for-trade relationships may also make it difficult for sex workers to negotiate condom use with paying customers, increasing their HIV risk.16

**Men of color face a difficult time “coming out” not only because of homophobia in their own communities, but also because of racism in gay communities.**
The four-city study of public sex venues found, across all races, that straight-identified men who have sex with men were more likely than gay-identified or bisexual-identified men to report selling sex for drugs or money. The study suggests that “straight men who exchange sex for drugs or money may be less discriminating in their choice of partners, more willing to have unprotected sex, and thus more vulnerable to...HIV.”

Likewise, in the AIDS Health Project study of HIV test-takers, receiving money or drugs in exchange for sex was more common for heterosexually identified men who have sex with men than either men who identify as having sex with men or as heterosexual.

Finally, the existence of environments where women are not present for long periods of time—for instance, prisons—may motivate same-sex activity among heterosexually identified men. Another example of this is migrant labor camps among Latino men who report having sex with men in the absence of women.

The Manifestation of HIV-Related Risk

The result of all these conditions may be increased HIV-related risk, although the data on the prevalence and nature of HIV-related risk that may derive from behavioral bisexuality is as sparse and inconsistent as the data on the behavior itself. The four-city study of public sex venues found that 46 percent of heterosexually identified men who have sex with men had engaged in anal sex with a man at least once. The study of HIV test-takers, a survey of a much broader population of men, found that 19 percent of the 216 heterosexually identified men who had sex with men reported unprotected anal intercourse with a male partner who was either HIV-positive or of unknown serostatus. Men who are not open about same-sex behavior (to themselves or to others) encounter risk in at least three areas: perception of HIV-related messages; specific sexual behaviors in which they engage; and lack of disclosure and negotiation in sexual relationships.

Behaviorally bisexual men may not understand that they are at risk for HIV, because they may not perceive the HIV prevention messages targeted at gay men as being meant for them. In fact, they may not even be exposed to these messages because their social and sexual activity may take place outside of the gay community centers in which these messages are most prominent. Even if they recognize HIV prevention messages as applicable to them, societal and psychological forces—in particular, homophobia and discrimination—may lead these men to reject these messages or may inhibit disclosure of same-sex activity to female partners, which limits the ability of partners to make informed sexual decisions.

Some studies have found that heterosexually identified men who have sex with men were significantly less likely than gay-identified or bisexual-identified men to have anal sex with men. Another found that compared to men who did publicly identify as bisexual, men who did not tended to have lower rates of unprotected insertive and receptive oral and anal sex with male partners. However, a study of HIV-positive bisexual men found that among those who engaged in unprotected anal sex with men, heterosexually identified men were least likely to use condoms with male partners.

Many sources have noted that hidden same-sex activity is correlated with sex at public sex environments, including bathhouses and sex parties, and sex with anonymous partners. These activities may in addition correlate with increased alcohol use and increased HIV-related risk. Several studies have found that behaviorally bisexual men, whatever their identity, have less unprotected penetrative sex with their male partners than with their female partners. This may diminish the “bridging” concern mentioned earlier: if heterosexually identified bisexual men are less likely to engage in unprotected sex with male partners, then they would be less likely to contract HIV and transmit it to their female partners. However, if these men lapse in their use of protection or other risk reduction with male partners, then their female partners may be at risk, particularly since a female partner, unaware that her male partner is having sex outside the relationship, may not seek to protect herself. Some researchers assert that women should not assume that their male partners are unwaveringly heterosexual or monogamous, and that these women should use protection or negotiate safety accordingly.

Conclusion

Several researchers have called for changes in intervention strategies for reaching heterosexually identified men who have sex with men and women. Many assert that greater tolerance of homosexuality and bisexuality would reduce stigma and increase disclosure. Others suggest that prevention messages—both in the media and in counseling venues—be detached from identification with the gay community and instead address risk reduction for the range of sexual practices rather than for practices associated with specific sexual identities.

Effective counseling interventions, in particular, begin “where the client is,” for example, avoiding assumptions about behaviors or cultural norms and asking questions to uncover a client’s individual reality. It is wise for counselors to be cautious about encouraging closeted men to come out as gay or bisexual, and to avoid communicating blame towards those men who engage in secretive behavior. Telephone counseling may increase anonymity and comfort.

The state of the research makes it very difficult to know how common behavioral bisexuality is and the degree of HIV risk it incurs. Future studies, which specifically recruit heterosexually identified men who have sex with men as well as men of all ages, races, and ethnicities, are needed to shed light on these questions.
Implications for Counseling

Counseling men who identify as heterosexual but who have sex with both men and women is complicated by factors such as secrecy, stigma, and denial. In response, counselors working with these clients need to be skilled in distinguishing between behavior and identity, managing countertransference, and remaining client centered.

Beyond “Denial”

There is sometimes a temptation to dismiss the complex motivations and experiences of heterosexually identified men who have sex with men as “denial.” For some clients, this may be partially true, but it is an oversimplification to assume that all heterosexually identified clients who have sex with men are closeted gay or bisexual men unable to admit their real feelings to themselves. For example, many have families and primary relationships with wives or girlfriends that they wish to preserve. Acknowledgment of any “infidelity” or non-monogamy in some of these relationships could lead to rejection, and this may be particularly true when sex outside the relationship is with men.

For many people, secrecy about same-sex behavior is motivated by societal and community values that punish homosexuality. All men who have sex with men face homophobia and discrimination, and this can lead to a sense of disconnection from familial and community support and is a disincentive to identify as “gay” or “bisexual” or to admit to same-sex activity.

Despite recent media attention on men of color, particularly African American men, counselors must be aware that the phenomenon of men identifying as heterosexual and having sex with men is neither new nor confined to communities of color. However, men of color who have sex with men face additional challenges, experiencing racism both in the larger society and within the White gay and bisexual community.

Behavior versus Identity

Because hiding same-sex behavior may be related to stigma, fear, or ambivalence, it is essential for counselors to develop rapport with clients in order to conduct an accurate risk assessment. HIV test counseling offers an opportunity to talk about sex in a neutral, supportive, confidential setting.

Client-centered counseling teaches counselors to accept clients’ definitions of their sexual identities. When performing risk assessments, counselors ask about a variety of sexual partners and behaviors, including some that may seem to contradict the client’s stated heterosexual identity. A client who has identified himself as “straight” may react negatively to the question, “Do you have sex with men, women, or both?” A counselor might respond, “Some of these behaviors may not apply to you, but it’s not uncommon for some straight men to sometimes have sex with men.” At the same time, it is important to remember that behaviors such as having sex with men may be objective, but sexual identity is subjective, defined by each individual.

When counselors impose labels, clients are robbed of the right to describe and define their experience. By seeking to understand an individual client’s motivations for not identifying as gay or bisexual or not disclosing same-sex behavior, counselors can build rapport with the client and protect themselves against making generalizations. Negotiating safer sex under any circumstance is challenging and is perhaps especially difficult for people who are hiding parts of themselves. Do not minimize the implications of disclosure for a client or the discovery of his same-sex behavior—in his family, with his partner, among friends, at his work or place of worship. Also, be aware that disclosure in one area could lead to exposure in others. Finally, remember that disclosure is not the only, or even the best, way for a client to protect female and male partners from HIV-related risk.

Do not assume that a client never discloses or does not want to be more open about his sexuality. Ask, “In what situations do you feel comfortable talking about having sex with men?” In addition, do not assume that heterosexually identified men who have sex with men are not protecting themselves and their partners from HIV transmission. Express empathy by using supportive comments as appropriate.

Discuss the level of communication, disclosure, and sexual negotiation in each type of sexual relationship the client has. Does he have a primary partner or partners? Are they men, women, or both? Are they friends, casual acquaintances, sex workers, or anonymous partners? This discussion can lead the counselor toward an understanding of the client’s life beyond labels.

Explore the role drugs and alcohol play in his sexual encounters, and if the client believes they affect his ability to engage in safer sex. Some men feel uncomfortable having sex with other men only when they are drunk or high. Clients may also use alcohol or other drugs to manage the stress of keeping secrets. In addition, some clients may exchange sex with other men for money or drugs.

Reducing Risk

Counseling is most effective when it refrains from attempting to radically change the client’s world view. For example, heterosexually identified men who have sex with men may not believe they face HIV-related risks, because they may associate risk with “gay” or “bisexual” identity, not with same-sex behavior. Rather than “work-

When counselors impose labels, clients are robbed of the right to describe and define their experience.
ing uphill”—attempting to get a heterosexual identified man to identify as gay or bisexual and thereby recognize his risks—counselors can “work downhill.”3 They can help him understand his own risks, as a straight-identified man having sex with men and women, and his reasons and options for protecting himself and his partners.

While disclosure and consistent condom use with all partners are ideal, clients who test HIV-negative might consider other risk reduction options such as consistent condom use with non-primary sexual partners, sexually transmitted disease screening and treatment, or alternatives to anal sex such as mutual masturbation or oral sex for sex outside their primary relationships. Gently asking, “How might your life change if you tested HIV-positive?” may help make one of these options seem more attractive. For clients who test HIV-positive, risk reduction in all relationships is the only way to protect both female and male partners.

Many heterosexual couples do not consider risk reduction necessary within the primary relationship, making it difficult to explain the need to reduce risk, for example, by using condoms in what is presumably a monogamous relationship. In response to this, a client may be struggling with whether to disclose his same-sex encounters to his female sexual partners. While it may be ideal for a client to engage his female partner as an ally in risk reduction, it may be dangerous for a client to disclose if he believes that his partner might reject him or expose him to others. Be particularly careful about counseling disclosure if a client believes he is at risk for violent retribution. Remember also that disclosure by itself does not reduce risk, nor is it the only way to reduce risk.

If a client is considering disclosing to female partners, it may be helpful to role play a disclosure focusing on the aspects of disclosure about which the client says he is most uncomfortable. If, after the role play, the client is feeling more comfortable about disclosure, discuss risk reduction approaches that might work for him and his partner. Count health department “partner counseling and referral services” can either help clients who test HIV-positive inform their partners of this fact or

References
Case Study

Marcus is a 35-year-old African American man who has never tested for HIV. He identifies as “straight” and his doctor recommended that he have an HIV test as part of his overall checkup because he has had a few sexually transmitted diseases over the last five years, including rectal gonorrhea. In answer to the question “Do you have sex with men, women, or both?” he says “Women.” Then he asks “What do you mean by ‘sex?’”

Counseling Intervention

Knowing that behavior and identity are separate issues, Marcus’s counselor, Adam, responds, “That’s a really good question: ‘sex’ means different things to folks. Since our focus here is on any behavior that might cause a risk for HIV, ‘sex’ includes a lot of activities.” Adam then uses the “third-personing” technique, saying, “Some of my straight clients tell me that they get together with other guys. Any activity that might expose them to blood or semen could give them an STD like HIV.”

Marcus says that sometimes he “kicks it” with his pals. Most of the time, he has insertive oral sex and insertive anal sex, but occasionally he has receptive anal sex.

Adam also asks Marcus about the sexual activities he has with women. Adam says, “This gives us a better picture of how to protect your health,” and then asks Marcus what he knows about HIV transmission. It is important for Adam to support what Marcus knows, correct any misinformation, and ensure that Marcus understands the different levels of risk associated with the sexual behaviors he engages in with both his male and female partners.

Marcus says that he sometimes uses condoms, “unless I know the guy.” Adam follows up by asking whether or not Marcus and his partners discuss HIV or know their status. He also asks what makes it possible for Marcus to use condoms “sometimes,” and what might make it possible to use them even more often. Marcus reports no recreational drug use, and only limited alcohol use, which he describes as unrelated to his sex life.

Since Marcus has disclosed a recent history of STDs, Adam might bring up the relationship between HIV and STDs and note the role of condoms in helping to prevent both. Adam might also explore how Marcus would feel disclosing his sex with men to his female sex partners, emphasizing that there are ways Marcus can protect himself and others even if he does not choose to disclose. Adam closes the session by affirming Marcus’s decision to take control of his health, by reiterating that the session, the test results, and Marcus’s identity will be kept private, and by offering Marcus additional referrals to help him stay healthy.

inform the partners a client identifies—without identifying the client, himself—that they may have been exposed to HIV. It is also useful to identify local resources—whether supportive counseling, substance abuse treatment, or ongoing health care—that can provide ongoing support to clients.

Managing Countertransference

Counseling heterosexually identified men who have sex with men can arouse feelings of judgment, helplessness, and anger in counselors and such “countertransference,” while a normal part of the counseling experience, can be particularly difficult to resolve. While a counselor’s personal ethics may be very different from a client’s, a counselor’s feelings are secondary to the goal of being client centered, understanding the client’s own life story, increasing a client’s awareness of risk, and reducing harm to the client and his partners. As always, supervision can provide counselors an opportunity for airing feelings and obtaining support, feedback, and guidance.

Awareness of the types of issues that arouse discomfort is the counselor’s first step to minimizing countertransference. For example, a gay-identified counselor might disapprove of a client’s not “coming out,” believing this is the client’s way of avoiding social stigma, or may dismiss behavioral bisexuality as “just a phase” before coming out. Conversely, a counselor who is uncomfortable with secretive same-sex activity may ignore a client’s sexual risk with men, focusing on risk with women or on substance use. A female counselor might find herself focused solely on the risk to a client’s female partners. Acknowledging these feelings can help counselors release their judgments, avoid projecting their own experiences, and focus on the client. Any discomfort may become apparent to clients, who may feel uncomfortable in response.

Non-disclosure of same-sex activity to female sexual partners may be the most uncomfortable issue for counselors. Many women believe they are in monogamous relationships and so do not perceive themselves to be at risk for HIV. Placing blame on heterosexually identified men who have sex with men or viewing them solely as “vectors of disease,” however, can undermine counseling.

At the same time, counselors should neither downplay risks to the client or his sexual partners, nor overlook societal conditions such as homophobia and racism. The focus should always be on the areas of greatest HIV risk and the realistic changes the client can make to reduce risk.
Test Yourself

Review Questions

1. True or False: Heterosexually identified men who have sex with men are only found within the African American community.

2. Which has not been found by studies to be a reason why behaviorally bisexual men might maintain a publicly heterosexual identity? a) adherence to their community’s expectations of “masculinity”; b) the fear of fracturing a primary heterosexual relationship; c) worries about losing control over their own power to disclose or not disclose their activities; d) the belief that others would encourage their same-sex over their heterosexual activities.

3. True or False: Denial is the main reason heterosexually identified men who have sex with men and women do not come out.

4. Which of the following is most effective at educating heterosexually identified men who have sex with men and women about their potential risk for HIV infection? a) developing ad campaigns targeting the gay population; b) motivating these men to identify as either gay or bisexual; c) counseling these men about reasons and options for protecting themselves and their sexual partners; d) disclosing the risk behaviors of these men to their sexual partners.

5. True or False: Because the research on behavioral bisexuality is scant, it’s best not to attempt to discuss this subject within the confines of the limited HIV counseling session.

6. True or False: Hidden same-sex activity is often correlated with sex in public sex environments and with anonymous sex partners.

Discussion Questions

1. How might labels that are applied to sexual behavior increase or reduce the risk behavior of heterosexually identified men who have sex with men and women?

2. What are your expectations about disclosure of sexual activities? How would you help a behaviorally bisexual, heterosexually identified client think about disclosure of his same-sex activity to his female partner(s)?

3. How might a counselor resolve judgmental feelings about a client’s sexual identity? How might you help your colleagues resolve such feelings?

4. Do you think the media attention on the “down low” issue with African American men is affecting any of your clients and the way they seek testing and information?

5. What approaches might help a client cope with cultural stigmas and the effect they have on a person’s willingness to disclose (or not disclose) his same-sex behaviors?

Answers to Review Questions

1. False. While media has focused on minority instances of behavioral bisexuality among men who identify as heterosexual, there is evidence that this occurs among men of all ethnicities.

2. d.

3. False. While denial may be a factor for some clients to hide same-sex behavior, the motivations and experiences of these clients are very complex and cannot be oversimplified.

4. c.

5. False. By being client centered, distinguishing between behavior and identity, and managing countertransference, a counselor can effectively address this issue with clients.

6. True.
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