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The Significance of Privacy and Trust in Providing Health-Related Services to Behaviorally Bisexual Men in the United States

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Abstract

Previous research suggests that bisexual men face unique health concerns in comparison to their exclusively homosexual and heterosexual counterparts. However, little is known about behaviorally bisexual men's experiences with health services, including ways of providing services that would be most appropriate to meet the health needs of this population. This study sought to understand preferences for health-related services among behaviorally bisexual men in the Midwestern United States. Using a community-based research approach, a diverse sample of 75 behaviorally bisexual men was recruited for in-depth interviews. Qualitative data were analyzed utilizing inductive coding through established team-based protocols to ensure reliability. Themes emerged involving the importance of privacy and trust when reaching, recruiting, and engaging behaviorally bisexual men in health services. Findings suggest that multifaceted approaches are needed, including those that provide relevant and confidential services while allowing for the development and ongoing maintenance of trust.

Keywords

Bisexuality; Men who Have Sex with Both Men and Women (MSMW); Health-Related Services; Sexual Health; Bisexual Men

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INTRODUCTION

A wide range of unique health concerns have emerged among behaviorally and self-identified bisexual men in previous research. In comparison to their exclusively homosexual and heterosexual counterparts, bisexual men have display higher levels of anxiety, depression, suicidal ideation, substance abuse, as well as other adverse mental health outcomes (Davis & Wright, 2001; Dobinson et al., 2005; Dodge & Sandfort, 2007; Jorm et al., 2002; Remafedi, Farrow, & Deischer, 1991; Paul et al., 2002). Researchers have also found that these men report specific HIV/STI prevention issues, including gender-specific barriers to inconsistent condom use with both female and male partners (Dodge, Jeffries, & Sandfort, 2008; Munoz-Laboy & Dodge, 2007). Overall, bisexual men face a combination of health concerns relative to both heterosexual and homosexual men, as well as some that are specific to being bisexual. Understanding health concerns among bisexual men is important for determining how health services may be designed and targeted toward them.

Research related to bisexual men's specific health service preferences and needs is limited. Studies have indicated that bisexual men often report negative experiences when accessing health services. A Canadian assessment found that bisexual men did not receive appropriate information about safer sex with male and female partners while accessing health services (Ontario Public Health Association, 2003). Providers often assumed these men engaged in risky behaviors with multiple partners; furthermore, participants reported inappropriate jokes implying that they were "either gay or straight" and that their bisexuality was "the problem." Page (2004) reported similar findings regarding bisexual men's negative experiences with engaging in mental health services, in particular. Not only did participants describe difficult interactions with service providers relating to their sexuality, they also reported not disclosing their bisexuality to health providers due to fear of judgment or receiving sub-standard services.

In one of the only existing studies focusing on health interventions for bisexual men, Ross, Dobinson, & Eady (2010) proposed a basic theoretical model with three components contributing to the health of bisexual men. The first component involves issues relates to the *institutional level*, including institutionalized "biphobia" (i.e., stigma and discrimination toward bisexual individuals from both homosexual and heterosexuals), heterosexist depictions of bisexuality in mainstream media, and negative attitudes and beliefs about bisexuality, in general. The second component, or the *interpersonal level*, encompasses supportive or unsupportive relationships with family members, partners, friends, and others in the proximal social network. The final component, the *intrapersonal level*, includes internalized biphobia, or the difficulty bisexual individuals may find in terms of accepting themselves and their own bisexuality. Although relatively generic in terms of levels of social organization and influence, this model provides a preliminary framework for understanding comprehensive health issues among bisexual men, including factors that contribute to their use (or non-use) of health services.

Sexual health research that does differentiate between bisexual men and gay men often characterize bisexual men as vectors of disease transmission from their male ("homosexual") partners to their female ("heterosexual") partners (Knight et al., 2007; Mercer, Hart, Johnson, & Cassell, 2009). However, epidemiological literature has yet to establish conclusive evidence for such a "bisexual bridge" (Malebranche et al., 2010). This stereotype may also incidentally create further stigma toward bisexual men (Dodge & Sandfort, 2007; Sandfort & Dodge, 2009). Bisexuality is also seen by many as a "temporary" sexual orientation for men who are "on their way" to exclusive homosexuality or heterosexuality (Stokes, Damon, & McKirnan, 1997). Further, the content of many current gay/MSM-targeted health services does not focus on issues specific to bisexual men,

most notably sexual health prevention and negotiation skills with their female partners (Dodge et al., in press 1). Prevention information and care services delivered in typical gay/MSM-targeted efforts are often geared toward gay-identified audiences and delivered in gay-identified settings, in which bisexual men may not be comfortable in participating (Dodge et al., in press 2). Researchers have not yet given bisexual men the opportunity to describe their own preferences and needs in terms of how they prefer to be reached and which health services they prefer.

This paper presents findings on venues for reaching behaviorally bisexual men, appropriate types of health services and delivery methods, and recommendations for recruitment for health services described by a group of bisexual men living in the Midwestern United States. To ensure relevance in terms of bisexual behaviors and risk, we focused on men who have engaged in oral, vaginal, and/or anal sex with at least one male and at least one female partner during the past six months, regardless of sexual identity. We provide evidence to support previous theoretical efforts to identify and address the specific health service-related needs of this population and provide data that illuminate behaviorally bisexual men's preferences for a variety of health-related services. As behaviorally bisexual men are often characterized as being "hard to reach," this information will be of great utility to researchers and health care providers who work with bisexual men in a variety of settings.

METHODS

PARTICIPANTS

A total of 75 men participated in the study. The average age was 33.3 years (SD = 11.5), with a range from 19 to 70 years old. Equal numbers of non-Latino White, (n = 25), non-Latino Black (n = 25), and Latino (n = 25) men took part in the study. Table 1 summarizes the demographic characteristics of the sample. This research project involved an interdisciplinary collaboration among researchers at two large academic institutions, the local health department, as well as stakeholders from the broader community. Community-based research approaches have been instrumental when exploring sexual and other health concerns affecting diverse communities, particularly those of a hidden nature (Israel et al., 2010; Reece & Dodge, 2004). A community advisory committee (CAC), consisting of behaviorally bisexual men as well as partners from community-based organizations and the health department, provided guidance throughout the study, including elaborating research questions, determining recruitment venues, designing recruitment materials, and reviewing results for meaning and local relevance.

Our sample was composed of biological males who engaged in recent bisexual behavior. Research studies have varied greatly in the time period for which sexual behavior may be classified as "bisexual," but we chose six months as the duration defining bisexual behavior to obtain a more accurate account of participants who are currently behaviorally bisexual, and therefore distinct from currently behaviorally homosexual or heterosexual (Malebranche, 2008; Muñoz-Laboy & Dodge, 2007). Based on the previous studies, more data are currently needed from bisexual men of diverse ethnic groups (Dodge, Jeffries, & Sandfort, 2008; Muñoz-Laboy & Dodge, 2007). Previous work suggests that race/ethnicity, perhaps as a surrogate of socio-cultural setting, is intricately linked with sexuality (Lewis & Kertzner, 2003). Thus, we recruited a diverse sample in terms of race/ethnicity. For the purposes of this study, the term "Non-Latino White" included individuals of European-American ancestry. The term "Non-Latino Black" included African-American men, Afro-Caribbean men, and other men of African descent. The term "Latino" referred to an individual of Latin American ancestry, regardless of racial background. All categorizations of race/ethnicity were based on self-identification.

In an effort to recruit a diverse sample of participants, with guidance from our CAC, we used a combination of clinic-based recruitment, Internet-based recruitment using general social websites (e.g., Craigslist – Men for Men and Women), and participant referral. A detailed description of the recruitment process, including issues related specifically to Latino participants, may be found in previous papers (Martinez, et al., 2011; Dodge, et al., in press 1). In short, our community partners discouraged us from relying on traditionally utilized "gay-identified" spaces (bars, clubs, bathhouses, etc.), and instead recommended general community locations including community-based organizations, shopping areas, restaurants, newspapers, etc. Recruitment flyers and cards were posted within the selected venues. All recruitment materials targeted men, in general, and did not contain the word "bisexual." Instead potential participants were invited to take part in a study on "men's sexual health." Potential participants were pre-screened during a telephone interview and, if they were eligible, were invited to participate in the study. While this process involved pre-screening dozens of potentially ineligible participants, they enabled our research team to reach a diverse sample of participants that could not have been reached otherwise. When asked about how they came to participate in the study, the vast majority of men (n = 65, 87.7%) indicated that they would not have taken recruitment materials that contained the words "bisexual" or "gay."

PROCEDURES

Data were collected during a face-to-face in-depth interview. All participants were required to give written informed consent to the study procedures, including digital audio-recording, before the interviews take place. No identifying information, with the exception of broad demographic characteristics, was collected. Potential participants were informed of all study procedures prior to data collection. Upon completion of the interview and STI specimen collection, participants received $50. This amount is in line with similar studies that have been recently conducted in this study setting. All protocols for the study, including procedures for collaborating with non-academic organization, were approved by the institutional review boards of the researchers' academic institutions.

The interviews lasted approximately 90 minutes and were conducted by a bilingual interviewer in a private location of participant's choosing. The interview guide was developed in English and Spanish. The majority of the interviews with Latino men (n=15, 60%) were conducted in Spanish since many of the Latino participants were not proficient in English. All audio recorded interviews were recorded and transcribed verbatim. Those interviews conducted in Spanish were translated into English by a certified bilingual translator. Based on previous research 1with other groups of men, and seeking to increase testing availability and services in non-clinical settings, participants were also offered the opportunity to participate in self-administered testing for urine- and rectal-based sexually transmitted infections (STI) (Dodge, et al. 2010). Results from participants' STI testing, including experiences of self-sampling, have been published elsewhere (Dodge, et al., in press 2).

DATA ANALYSIS

Processing the qualitative interview data occurred in several established stages of organization, analysis, and reflection (Creswell, 2003). Text data served as the basis for analysis. The texts of all interviews were reviewed and coded systematically by three members of the study team. All text data were coded and analyzed using NVivo. The thematic analysis involved careful fragmentation and coding of the qualitative data, and organizing the data into "chunks" before bringing meaning to these (Rossman & Rallis, 1998). During the coding process, an analytical codebook was constructed that consisted of a theoretically-informed manual of codes and sub-codes. By coding textual data using a

codebook that defined all codes of interest using a hierarchical structure similar to a conceptual outline, large volumes of data were summarized using a manageable number of central "themes." Using the codebook, emergent themes and patterns in the data related to the study aims were identified and documented by the individual investigators.

After mapping the initial themes, the researchers began the process of collaborative interpretation of the coded themes. Emergent ideas were compiled and compared among investigators to ensure consensus (Creswell, 2000). The list of topics was collaboratively organized into a matrix of themes and sub-themes. By structuring the themes in this way, the team was able to develop a scheme that was used for analyzing all the narrative data in a systematic way. The coding team met on a regular basis to review the development and interpretation of the thematic matrix. During the manuscript production process, the authors quantified select themes in order to show the distribution of responses across participants.

RESULTS

Several domains regarding health service preferences were explored during the course of the interviews including determining which ways would be best for reaching other bisexual men, assessing ways of recruitment that are most effective, and prioritizing which types of health services would be most appropriate for bisexual men.

REACHING BEHAVIORALLY BISEXUAL MEN WITH HEALTH SERVICES

Participants were asked to discuss the best ways to reach other bisexual men in terms of recruitment for or engagement in health services (including education, testing, treatment, care, and support). Additionally, they were asked the best channels for reaching bisexual men with health-related messages. The most consistent finding that emerged while discussing reaching bisexual men with health services was the recommendation to respect privacy. Participants sought to limit concerns of disclosure of sexuality, whether overtly or inadvertently, regardless of where they were recruited. They described issues related to privacy concerning the environment and physical context of the spaces in which services or related materials were made available.

In terms of specific places to reach other bisexual men, about a third (n = 26, 34.7%) of the participants indicated that non-gay identified bars, clubs or similar social spaces would be ideal locales. Just under a quarter (n = 17, 21.3%) stated using the internet would be the most effective means of reaching out to bisexual men, followed by 13.3% (n = 10) specifically indicating "gay-identified" bars or spaces. Additionally, 10.7% (n = 8) suggested general advertising via local media would be the best way to recruit participants. The radio was particularly popular among Latino participants. It is important to note that a substantial number of participants (n = 10, 13.3%) indicated that they were unaware of how to reach other bisexual men. These participants also reported feelings of "social isolation, "being the only one," and not knowing any other individuals like themselves.

In regards to reaching bisexual men using bars or clubs, participants reinforced the notion that these spaces could be useful regardless of the perceived clientele that the venue served. Several participants suggested that using bars or clubs not identified as "gay" would work best because they often serve a more diverse group of individuals.

> I think the pub is a really good place to go because it has gay people. It has straight people … they can come and they actually have fun and you'll meet a lot of people that are willing to be talkative. (Participant 49, 26, Black)

Overall, many more participants reported that using non-gay identified bars (n = 26, 34.7%) was a more effective approach to finding bisexual men than using "gay bars" (n = 10,

13.3%) in reaching bisexual men. Furthermore, as described by Participant 52, using these types of venues allowed everyone to hear a general message, but also gave them the opportunity to ask questions about specific services when they were alone or had more privacy.

> The DJs can make an announcement about the services. I would bet that Latinos will call when they are in a private location. (24, Latino)

Some participants suggested that the privacy of the internet, in particular, would make it a useful tool for reaching out to bisexual men to offer services. It is noteworthy that White participants were the most likely to suggest using the internet and Latino participants were the least.

> Yeah, because there is a sense of … or there's an anonymous aspect to it where someone can go online and actually read that stuff and nobody else has to know about it. (Participant 44, 59, White)

Additionally, some participants suggested that general advertising efforts would be useful for reaching bisexual men (i.e., advertising services for "men" and screening out bisexual men in later stages). A number of participants described the need to relay information to bisexual men without necessarily singling them out, again emphasizing the importance of maintaining their privacy.

> So you can't aim something directly at them. You have to kind of glance it off of them. Say, hey, if you're bisexual, if this, this is available. If you want it, we're here for it but you can't say, hey, bisexual men come here because a lot of people I know especially if you're going through high school being my age, they're not open to everyone. I mean I'm not so to try and direct an absolute advertising approach wouldn't work. (Participant 62, 24, White)

Participants' reports differed somewhat by race/ethnicity, with over a third of White participants suggesting that the internet (n = 9, 36.0%) or broad media campaigns (n = 5, 20.0%) would be best and almost half of Latino (n = 12, 48.0%) and more than a third of Black participants (n = 9, 36%) suggesting non-gay related bars or clubs to be the best way to reach bisexual men. This suggests that a variety of channels, including the Internet, need to be used in delivering diverse messages.

Table 3 provides an overview of participants' recommendations for reaching bisexual men in terms of specifically providing HIV/STI testing, providing mental health services, and providing sexual health education and materials. General community spaces were preferred over traditional health services delivery settings. When asked specifically about providing HIV/STI testing services, participants indicated doing so in general public areas that could maintain privacy (i.e., community-based organizations) would be best (n = 16, 21.3%), followed by 18.7% (n = 14) suggesting non-gay identified bars and clubs, and 16.0% (n = 12) specifically stating "gay bars." Similarly, when asked about where to provide support or mental health services over a quarter (n = 19, 25.3%) indicated that general community-based organizations would be best for this type of activity followed by 17.3% (n = 13) being unsure of where to provide these services. Fewer participants reported using other venues such as local clinics or hospitals (n = 10, 13.3%) or the internet (n = 8, 10.7%). In terms of providing sexual health education, just over a quarter (n = 20, 26.7%) suggested the best way to do this was online and 18.7% (n = 14) were unsure. In addition, 13.3% (n = 10) suggested non-gay identified bars and clubs and 13.3% (n = 10) specifically indicated gay bars or gay-identified spaces.

RECRUITING BISEXUAL MEN TO PARTICIPATE IN HEALTH SERVICES

When asked if specific words on recruitment materials advertising health-related services would influence their decision to read materials or participate in services, 77.3% (n = 58) responded they would not read materials with the word “bisexual” written on it. Decisions to read material, or not read material, centered on two themes: what others would think and whether or not participants felt these labels adequately described them. When deciding whether or not to read materials, specifically using the word “gay,” some participants had reservations based on fear of what others would think.

> INT: If it had the word gay?
>
> Participant 59: I think I would “watch myself” more.
>
> INT: Why?
>
> Participant 59: Because of what my friends would say, only that (38, Latino)

Participant 53 expressed concern about using the word “bisexual”

> I don’t think so. I think they’ll be actually more – they’ll look away faster, because they don’t even want to see people seeing them looking at something like that, and wondering if they are bisexual or not. (21, Latino)

The concept of “looking away faster” was also suggested by Participant 20.

> Maybe if I was just curious about it. Maybe that would draw a little curiosity but I mean I wouldn’t grab it if nobody else was around or maybe if I was by myself somewhere just walking past, I would probably look at it real quick and then put it back but as far as if anybody around me had a chance to see me grab it, no. (41, Black)

He later goes on to contrast picking up literature with “heterosexual” on it, with the latter being “okay to grab.”

> Yes, because it’s okay to grab that. Nobody would have any questions if they see you grab that. If they see you grab the other one, it would be like with that situation at work, if somebody jumps in my car and they see it and what’s this pamphlet for gay and then … (41, Black)

This indicates that, based on the context and others within that context, participants may feel able to select materials with the words “gay” or “bisexual” on them, but typically in the presence of others these materials would not be “okay to grab.”

Other participants indicated that if they believed the word represented them, as a person, they would read material. Participant 23 expressed willingness to read health service materials with any of the three words (homosexual, bisexual, or heterosexual), more specifically that he would “select all three.”

> Not really. I’d probably grab all three. I’d probably want to know just as much about one as the other. (41, White)

These participants indicated they would read materials addressing men, in general, or material addressing all sexual orientations (bisexual, heterosexual, homosexual). However, most participants made it apparent they would not select health related material they did not feel addressed them or their needs.

> Because I’m in that category, I guess, but also it’s not pigeonholing you into the gay community or the straight community. It’s kind of like both, so to speak. (Participant 46, 41, White)

Some participants suggested they would be most likely to read materials addressing "men," in general. This idea that broad, non-targeted materials would be best was conveyed by Participant 62.

> Yeah, I mean it's not a label that I use in day-to-day life. It's not a label that I generally affiliate with so if I see it, it's just there. I think it would be easier or better to aim it at everyone as opposed to turn to lump sum, some group together. (24, White)

This suggests that using a broad approach to reaching this population may be beneficial. Using phrases that decrease "pigeonholing" participants into any sexual identity category may make them more inclined to select and read information regardless of the context in which they found themselves.

PROVIDING APPROPRIATE HEALTH SERVICES FOR BISEXUAL MEN

Participants were asked which types of health services would be most beneficial to offer to bisexual men. In terms of different types of services, participants were provided with standard definitions of each type of health-related service as well as several examples of what was entailed in specific services. The vast majority of participants (n = 62, 82.7%) suggested that individual services, particularly applying a case management model, would be most beneficial. This was followed by outreach (n = 43, 57.3%) and group services (n = 19, 25.3%). In terms of individual services, participants reported that these provide privacy, trust, confidentiality and comfort. In fact, most participants suggested one-on-one services, even when conducting outreach, was optimal based on these concerns.

> Because it's more confidential and intimate. It's between two people and it makes it a little bit more comfortable (Participant 67, 37, Black)

Participant 44 further expressed his view that outreach is needed because, like one-on-one, it is possible to maintain confidentiality.

> It would, probably, be because of being anonymous. I would have to remain anonymous. There are a lot of people out there that I feel that are like me, probably in the closet about most things. And allowing that to come out, although the neighborhood I'm in, people, there are gay people in the community. There are, probably, a lot of bi people in the community if we all knew but it's a pretty private thing. (59, White)

Similarly, many participants also indicated they would be reluctant to use group services because of trust and privacy issues. For example Participant 16 expressed reservations concerning privacy in group services.

> I think in a group, especially talking about stuff like that there's going to be a lot of misrepresentation, and also a lot of people not saying what they really want to say, just because there's other people in the room. (22, White)

This idea of individuals "not being themselves" in a group setting was a common theme involving group services. Participants expressed concerns about the men within the group and also feared others from outside the group violating privacy. This relates to lack of trust of others in a group setting telling others outside the group, or more generally about others finding out that such a group exists.

The theme of building trust was also overarching and many participants felt this was actually difficult to do within a group setting. They often suggested one-on-one counseling, or other individual services, would be best because they allowed for a development of a deeper level of trust and comfort:

> Yeah, because you can't feel it's lucky, just face to face with someone that's maybe professional. I think maybe because we don't never know who's in front of you like I told you. There is a lot of fake psychologists around too. A lot of fake doctors around too. You don't never know who is who and but while you are looking, you have someone very professional in front of you, I like to talk face to face with someone that I know. (Participant 15, 34, Latino)

Not only does this participant indicate that making connections and building trust is something he would rather do one-on-one, but paradoxically he also suggests this may be difficult to do because there are "fake" service providers. Thus, one-on-one services allow an individual to know, more easily, if the provider, or those he is interacting with while receiving services, is "legitimate."

Not all participants were apprehensive about group services. While participants agreed that issues related to privacy and disclosure are important in the lives of bisexual men, utilization of group services could possibly assist them in making connections to similar others.

> I think group services. That's the thing with people if they're like me, they need to interact with other people that not only are on the same page, they are on the same culture, not necessarily the same culture, but going through the same thing. (Participant 39, 45, Black)

The development of a means for providing services that maintain individual privacy, but allow users to make connections with others who share similar concerns and experiences, was seen as important for many participants. These two apparently divergent needs, to remain anonymous and connect to other individuals like themselves, could be addressed by providing services through establishment of general men's health clinics addressing the health service needs of all men, with private support and social group options for bisexual men.

Furthermore, when asked about specific methods that would be useful for delivering services targeting bisexual men's health, again the vast majority, just under three quarters (n = 54, 72.0%) responded that one-on-one counseling was most appropriate. Again, participants strongly endorsed themes of maintaining confidentiality and privacy, as well as the need for development of trust and comfort with providers and in the spaces where services are provided. Additionally, participants suggested public information and education efforts (n = 54, 72.0%) were important while fewer reported that referrals to specialized services (n = 27, 36.0%) and partner counseling (n = 22, 29.3%) were needed.

DISCUSSION

Our findings highlight several significant and innovative themes regarding behaviorally bisexual men's preferences for appropriate health services. The most prominent theme that crossed all domains of the interview was the need to respect privacy and build trust. A variety of venues were recommended for reaching out to bisexual men, and these varied further in regards to specific health services. Multiple channels should be used in order to reach a large proportion of these men. Participants suggested that messages targeting men, in general, would be appropriate in bars, clubs, and social spaces while information directly targeting bisexual men could be used online because of the amount of privacy this setting allows. Some participants suggested that solely relying on the internet would not reach all bisexual men because not everyone has access or uses the internet.

In terms of the language used to recruit this population, participants most often suggested that using a broad approach was more appropriate than specifically targeting a group using "bisexual" or any other terms. More often than not, participants were concerned with how

others would perceive their sexuality based on selecting health-related materials. In other words, participants were often concerned they would be perceived as "gay" if someone saw them selecting materials using this word. It may be beneficial to use broad terms like "men's health," or list all three sexual orientation categories (bisexual, heterosexual, and homosexual) on health service materials, since this diminish concerns related to others' perceptions of their sexuality.

Overall, the types of health services participants described as most relevant for bisexual men were also influenced by issues of privacy and trust. Individual and one-on-one services were considered to be the most private and easiest ways to establish trust. Group services, while important to some participants, were the least favored because of potential threats to privacy and trust. Those providing services at the individual level may consider further developing relationships among health care providers and patients by setting up systems that facilitate an individual being seen by the same provider over time, versus one of many providers at a clinic. The consistency of relationships was also central to the participants' discussion of trust.

It is noteworthy that participants pointed to issues of privacy as being of utmost importance in relation to engaging bisexual men in health services. Participants relayed an underlying sentiment of concern for being stigmatized or discriminated against for being bisexual. The fear of inadvertent disclosure appeared throughout the narratives and across participants. Our data establish that the influence of others' perceptions of their sexuality have an impact on their likelihood of engaging in health services. This suggests, as had a number of participants throughout the study, that a generalized (non-specific) approach to reaching bisexual men may be most appropriate for at least initially engaging them health services. Rather than marketing health messages directly towards bisexual men, although they certainly have their own health needs, using terminology such as "men's health" or "men's sexual health" for advertisement of services or on health education materials may be more effective compared to specifically targeting this population with materials branded as "bisexual." This broad approach toward "marketing" may be useful in reaching men for various efforts. Additionally, providing information that is pertinent to men of all behavioral repertoires (i.e., use condoms with all sexual partners whose status is unknown, male or female) would allow men the option to read about issues facing men of all sexual orientations without the fear of inadvertent disclosure.

Not only would a general messaging approach be useful, a multifaceted delivery system may be relevant for addressing their complex needs. We discovered a lack of venues that are specifically designated for bisexual men in the community in which our study took place (Martinez, et al., 2011). The fear of disclosure, desire for privacy, and anticipation of stigma from gay men for being "bisexual" often limited participants' interactions in venues that were gay-identified. It is important to note that in health-related research and practice efforts, using gay-identified venues to reach out to and recruit bisexual men may actually only engage a small number of bisexual men who are comfortable and present in such spaces and, importantly, may miss crucial contingencies of bisexual men who do not congregate in such spaces.

LIMITATIONS

While the study used established qualitative methods, there are some limitations to our research study. As probability samples of behaviorally bisexual men are difficult to obtain (Jeffries & Dodge, 2007), we relied on purposeful convenience sampling techniques in order to acquire study participants. Additionally, although the focus of our study was on behaviorally bisexual men, we do not know how well our approach sampled the wide array

of existing sub-populations of bisexual men. For example, even though the majority of our participants also self-identified as bisexual, it is possible that self-identified bisexual men who are not behaviorally bisexual may have different health service preferences and needs. Additionally, the sample may not be representative in regards to associated demographics (e.g., income). Therefore, the findings are not generalizable. While we recognize the important differences among the types of health services used by participants in our study, we sought to gain a basic understanding of men's experiences with a wide range of different services in order to determine how specific types of services could be explored in detail in a subsequent study. Therefore, the data presented do not take into account important considerations including how specific types of health services (e.g., sexual health, mental health, etc.) are accessed differently, particularly by ethnic minority populations.

CONCLUSION

The findings of this study suggest that issues of privacy, trust and comfort lead back to how behaviorally bisexual men believe others will label them and whether they will be treated differently. This is not surprising considering that most participants reported lifetime experiences of shame and stigma from both homosexual and heterosexual individuals based on their existence as bisexual men. Ultimately, the challenge involves ensuring that bisexual men feel comfortable when accessing and engaging in appropriate health services. Thus, it will be necessary not only to maintain privacy but also to begin to normalize bisexuality on a structural level, so that other individuals' potentially negative feelings about bisexual men do not interfere with decisions about health services. Additionally, health service providers' encouragement of self-acceptance, self-love, and pride in being a bisexual man, in affirmative ongoing health care interactions (as suggested as standard of care by the American Psychological Association and similar organizations) would be beneficial when engaging these men in services. As has been demonstrated in the recent past with gay men, this may also help to decrease stigma and facilitate more openness surrounding bisexuality, in general.

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Table 1

Participant Characteristics (N = 75)

	n	%
Race/Ethnicity		
Black	25	33.3
Latino	25	33.3
White	25	33.3
Living Situation		
Living Alone	18	24.0
Living with Someone	57	76.0
Marital Status		
Single	55	73.3
Married	13	17.3
Separated	3	4.0
Divorced	4	5.3
Children		
None	41	54.7
One	15	20.0
Two	10	13.3
Three	8	10.7
Four	1	1.3
Highest Level of Education		
No School	1	1.3
Less than High School	15	20.0
High School/GED	22	16.0
Some College/Associate Degree	16	21.3
Bachelor Degree	14	18.7
Graduate School/Master's Degree	5	6.7
Professional Degree	2	2.7
Employment		
Yes	56	74.7
No	19	25.3

	mean	SD	min.	max.
Age	33.27	11.46	19.00	70.00
Monthly Net Income	1565.87	1582.92	0.00	8500.00

Table 2

Reaching and Providing Health Services for Bisexual Men

	n	%
Best places to reach bisexual men		
Gay bars or clubs	10	13.3
Non-gay identified bars or clubs	26	34.7
Online	17	21.3
Broad marketing campaigns	8	10.7
Local clinics/hospitals	2	2.7
Research studies	2	2.7
Unsure	10	13.3
Best places to provide HIV/STI testing		
Gay bars or clubs	12	16
Non-gay identified bars or clubs	14	18.7
Online	3	4
College campuses	8	10.7
Local clinics/hospitals	10	13.3
Gay friendly spaces	1	1.3
Community-based organization	16	21.3
Research studies	1	1.3
Unsure	10	13.3
Best places provide mental health services		
Gay bars or clubs	7	9.3
Non-gay identified bars or clubs	5	6.7
Online	8	10.7
College campus	12	16
Local clinics/hospitals	10	13.3
Community-based organization	19	25.3
Research studies	1	1.3
Unsure	13	17.3
Best places to provide sexual health education		
Gay bars or clubs	10	13.3
Non-gay identified bars or clubs	10	13.3
Online	20	26.7
College campus	3	4
Broad marketing campaigns	9	12
Local clinics/hospitals	8	10.6
Gay friendly space	1	1.3
Unsure	14	18.7

Table 3

Types of Services and Delivery Methods for Bisexual Men

Case management		
Yes	62	82.7
No	11	14.7
Unsure	2	2.6
Group services		
Yes	19	25.3
No	51	68
Unsure	5	6.6
Outreach		
Yes	43	57.3
No	29	38.7
Unsure	3	4
One-on-one counseling		
Yes	54	72
No	19	25.3
Unsure	2	2.6
Partner counseling		
Yes	22	29.3
No	42	56
Unsure	11	14.6
Public information and education		
Yes	54	72
No	20	26.7
Unsure	1	1.3
Referrals		
Yes	27	36
No	40	53.3
Unsure	8	10.7