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"So Much Is at Stake": Professional Views on Engaging Heterosexually Identified Men who Have Sex with Men with Sexual Health Care in Australia

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Abstract Australian HIV prevention, testing, and treatment services are well-established for men who have sex with men (MSM) who identify as gay or bisexual. However, the sexual health needs of heterosexually identified MSM (hereafter called "straight MSM" as a shorthand) and opportunities to engage this sub-group with services and information are less clear. Semi-structured interviews were conducted in 2015–2016 with 30 professionals working in the sexual health sector in the state of New South Wales, Australia. Participants viewed straight MSM as comprising multiple, intersecting sub-groups, but sharing a common preference for services which promise "discretion" and "confidentiality", and information which does not presume an alignment between gay identity and sex between men. Participants described these men as typically very concerned about keeping this aspect of their sexual lives secret and separate from their family, work, and community lives. Participants were keenly aware of both the benefits and the challenges of providing respectful and non-judgmental care. This exploratory study provides initial evidence of the complexities of engaging straight MSM with sexual health care and suggests a range of strategies for increasing cultural understanding of the diverse sexual practices that can be present in the lives of some heterosexually identified men.

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Introduction

While sexuality is organized quite differently in different cultural contexts, the design and delivery of the Australian health system largely depend on a fixed number of stable social and identity categories (Australian Institute of Health and Welfare 2014). However, human experience and behavior inevitably exceed and complicate these categories (Parker, Aggleton, and Perez-Brumer 2016). This can prove confounding for those involved in health service delivery and policy and frustrating for service users (Khan, Plummer, Hussain, and Minichiello 2007). A sense of disconnection from the health system may be amplified for those whose practices do not fit easily with a single identity category (Albury 2015): heterosexually identified men who also have sex with men are a good example.

Despite the concept of sexual fluidity now being well-established in sexuality studies (e.g., Diamond 2009) and mainstream society becoming familiarized with the existence of a range of sexual identities (e.g., de Visser et al. 2014; Twenge, Sherman, and Wells 2016), social institutions still do not find it easy to recognize that many people do not fit easily into one of the primary sexual identity categories of "heterosexual" or "homosexual." Men who primarily identify as heterosexual in both their public and private lives, but also have sex with men often or on occasion, may not wish to be categorized as "bisexual" in terms of identity because they do not feel a "fit" with that category, for various reasons. Yet, they also cannot be categorized as either homosexual or heterosexual in terms of their behavior. A common view is that they are really "just" gay men who society has locked into a normative heterosexual role (e.g., Glenn and Spieldenner 2013). Yet, evidence suggests this inadequately explains their own views and experiences and perpetuates the belief that sexual identity is stable and dichotomous (Savin-Williams 2016).

While there is little doubt that it is both possible and unremarkable that there are men whose sexual lives do not predictably align with their everyday identities, some countries, such as Australia, despite claims to progressive social attitudes towards sexual diversity (e.g., Richters et al. 2014), have not yet achieved broad cultural understanding and support of sexualities which exceed standard categories (Persson et al. forthcoming). In addition, given these societies are also culturally and religiously diverse, there is no shared agreement regarding how sexual diversity should be recognized. While there is some recognition that health services should accommodate non-heterosexual identities, this has mostly resulted in the creation of "gay-friendly" spaces and practices, such as using LGBT-signifying posters and images in waiting rooms and using gay-specific terminology in sexual health consultations with men assumed to be gay (McNair 2012; NSW STIPU 2017). These accommodations have not generally extended beyond a perceived stable binary between gay and straight, with unintended consequences for those who may not identify with those representations of gay identity in the way health services may be anticipating (Newman, Persson, Paquette, and Kidd 2013).

Unfortunately, despite recognition among individual clinicians and policy makers working in the sexual health sector that many people do not fit stable identity categories, hardly any research has been conducted or published on the experiences and needs of "straight"-identified MSM in Australia. Exceptions to this include projects which have focused on men attending sex-on-premises-venues (Santella et al. 2015), the experiences of female partners of MSM (particularly men who identify as bisexual) (Pallotta-Chiarolli 2016), and research conducted over 20 years ago (Joseph 1997; Prestage and Drielsma 1996). The international literature is also scant and context-specific: mainly published in the USA and tends to frame the behavior of straight MSM in terms of perceived risk to their own health and the health of sexual partners, both male and female (e.g., Benoit, Pass, Randolph, Murray, and Downing 2012; Pettaway, Bryant, Keane, and Craig 2014; Reback and Larkins 2010; Schrimshaw, Downing, and Siegel 2013). While a small but growing arm of queer studies has begun investigating different sub-cultures of heterosexual men who have sex with men in the US (Carrillo and Hoffman 2016, 2017; Reynolds 2015; Ward 2015), there is a pressing need for research on this topic in other contexts. This paper responds to this gap in the literature by reporting the perspectives of professionals working in the New South Wales (NSW) sexual health sector on the following: (1) conceptualizing the sexual lives and cultures of heterosexually identified men who have sex with men and (2) the complexities of engaging these men with sexual health information and care.

Methods

Setting

The Centre for Social Research in Health, in collaboration with Pozhet (the NSW Heterosexual HIV Service), and representatives of the NSW Ministry of Health and publically funded sexual health services, conducted exploratory research (Newman et al. 2016) to scope existing professional understandings of and experiences with men who identify as straight and also have sex with men. Australian HIV prevention, testing, and treatment services are well-established for men who have sex with men (MSM) who identify as gay or bisexual (Kippax and Race 2003). While approximately 80% of HIV notifications reported in New South Wales are attributed to sex between men, this is not differentiated by sexual identity (NSW Health 2016b). Therefore, the proportion of heterosexually identified men who acquire HIV through sex with men (and report this either as sex with a man or "risk not further specified") is unknown (NSW Health 2016a). In addition, while there has been no research conducted directly with this group, there is a belief among those working in the sexual health sector that men identifying as heterosexual are likely to be able to meet men for sex more easily through the use of hookup apps, thus potentially increasing the risk of sexually transmissible infections, including HIV. However, there are no specific policies, strategies, or guidelines which can support clinicians and other sexual health workers with tailoring health promotion and care to this hard to define and reach population. Thus, this research represents one of the first attempts to provide insights into the specific needs and experiences of these men (Newman et al. 2016).

Data Collection

Ethical approval was granted by the Sydney Local Health District (Royal Prince Alfred Zone) [X15-0275 & HREC/15/RPAH/376]. Key informants were purposively selected and recruited on the basis of their recognized expertise regarding this group or their role in services or organizations who engage with this group. Participants were mostly interviewed one-on-one; in three cases, a group interview was requested by small teams of clinicians who were keen to provide their views as a group. Thirty participants were interviewed across 21 interviews conducted between November 2015 and February 2016, in person or by phone. Interviews followed a semi-structured interview guide, lasted up to 1 h, and explored expert views on how to define and reach straight MSM, and their observations of these men's sexual lives and practices, contact mechanisms, strategies, and spaces for engaging with other MSM, HIV/STI knowledge, engagement with and expectations regarding health services, health promotion and prevention strategies for this group, and intersections with diversity in cultural backgrounds. Audio recordings of interviews were transcribed verbatim and deidentified to protect participant confidentiality.

Data Analysis

Our approach to analysis was informed by a poststructural approach in moving from observing "what is said" to recognizing the discursive practices which shape how we know and understand what is said, including the production of particular subject positions through this process (Bacchi and Bonham 2016). To this end, interview transcripts were first coded independently by CN and AP, following a constant comparison approach in which data were read line by line and then sections of text were allocated to one or more broad themes, with the coding framework refined during the course of analysis and discussion (Braun and Clarke 2006). Brief summaries of the dominant themes were reported in a research summary which was distributed online to relevant sector organizations and emailed to participants in fulfillment of our commitment to provide them with an overview of results in a timely manner (Newman et al. 2016). More in-depth analyses of the interview data were then prepared by CN and AP, this time taking a more inductive, open-ended approach to analysis, focusing on data pertaining to the conceptualization and definition of straight MSM (Persson et al. forthcoming), and to the engagement of straight MSM with sexual health services and information. The benefit of taking a two-stage approach to analysis is that we were able to first describe results of particular relevance to sector organizations, which permitted a range of policy and practice recommendations to be articulated and advocated by the study team, and to then take the additional time required to conduct in-depth, scholarly appraisals of particular issues of broader relevance across the sexualities, health, and social policy literatures. All authors were consulted closely during the course of analysis and writing. The analysis of interview data relating to the question of how to "engage" or "reach" these men for the purposes of promoting sexual health resulted in three overarching themes, which are described and discussed here in detail.

Results

The participant sample comprised an even gender balance. Slightly more than half (n = 17) identified as practicing clinicians with frontline knowledge of straight MSM, including sexual health physicians, nurses, social workers, and counselors. The remainder identified as primarily engaged with health promotion, advocacy, policy or community development, and/or academic work. More than half (n = 18) were employed by publically funded health services, and the remainder by policy or health promotion units of local health districts, non-government organizations, in private general practice, and/or higher education institutions. Although there is no publically available profile of the sexual health workforce in Australia, this diverse range of employers and roles aligns with the membership of the ASHM, the peak organization of health professionals in Australia and New Zealand who work in HIV, viral hepatitis, and sexually transmissible infections (ASHM 2016).

"It's Like There's Two Lives": Comprehending the Complexities of Managing Hidden Sexual Practices

Participants argued that the general public have little or no understanding these men exist, in part because of an almost complete cultural silence regarding sexual practices which do not align with sexual identities. As one health promotion worker suggested: "I think people would see it as a major transgression". In contrast, those working in and around the sexual health sector were represented as viewing these men as a perplexing but largely unsurprising fact of sexual life. As a social worker put it: "I suspect that we just underestimate the diversity of sexual activity, in general" (KI 11).

Their appreciation of the cultural disconnect between lived realities and social understandings of sexual fluidity also framed how our participants made sense of the lives of straight MSM. Men who fit this description were seen to comprise multiple, intersecting sub-groups, including those who could be described as "culturally straight" due to community, family, or religious beliefs, and may well take up the option to identify as gay if they viewed it as safe or available to them, alongside those who are "hetero-flexible" (Carrillo and Hoffman 2016), identifying strongly as heterosexual but occasionally having sex with men for fun or a desire for

particular practices (Persson et al. forthcoming). However, across this diversity, straight MSM were described as almost always having one characteristic in common: a desire to keep this aspect of their sexual lives a "secret" from their family, workplace, and community.

While a minority of men in heterosexual relationships were reported to be open with their wives or girlfriends about having sex with men on occasion, a more common view was that straight MSM invested considerable work in achieving "discretion" regarding their sexual lives because they believed too much was at stake to risk exposure. As one health promotion worker emphasizes, representing what many others also observed: "I think that any one of those men would rather have cut their arm off than have their family and community know what they were doing" (KI 7). Participants described finding it hard to comprehend the emotional and practical "work" that likely goes into managing the secret of their hidden sexual lives. While men were believed to make use of many of the "usual" ways that gay-identified men meet other men for sex, they placed additional emphasis on careful planning regarding the physical location and strategies to secure anonymity or at least "discretion" in their sexual partners. As one participant, who worked with women who had discovered their male partners had a history of sex with men, explained:

> Some men tended to be model husbands and this is often what struck women really amazingly. Like these guys were charming and loving, and romantic, and they did everything perfectly in order to not raise any suspicion … You know, you learn to be really attentive. You learn to be really organized. You make sure you never miss any private event or social event that your wife's organized … So so careful. And then … if you can find the gaps say in your work day or when you know that she's definitely somewhere … So these guys are often organizing things at lunch or straight after work. Never to miss things like picking up the kids … And this was a sad thing because a lot of these guys really love their wives, are sexually happy with their wives. They [love] the life they have with their kids and their family and all that is exactly what they want. There's this need or this desire that's either about love or sex, or both with a man that they don't know how to introduce that, how to discuss that in, within that context. So they've gotta really keep these worlds apart. (KI 21)

Overall, participants believed that the considerable effort involved in demarcating sexual and everyday lives revealed how fearful men were of losing social relationships and roles if their sexual practices became more generally known. But the personal consequences of the work involved in managing "two lives" (KI 17: service manager) were also represented as complex and multifaceted. While a few men were seen to be "so relaxed" (KI 2: health promotion worker) about moving between their everyday heterosexual lives and sexual encounters with men, particularly those who had "been doing it for a long time" (KI 28: doctor), others were seen to be living in "a perpetual state of cognitive dissonance" (KI 6: social worker). Those men were often described as being overwhelmed by feelings of guilt about not being fully honest with their female partners or the stress of "compartmentalizing" (KI 5: advocacy/support worker) and maintaining "cover stories" (KI 11: social worker).

Participants believed—although we recognize that this is a considerable assumption to make—that men who were not open about their sexual practices were less likely to access sexual health information and services and to potentially avoid using condoms or other safer sex strategies. This was either because they saw them as something only gay men would use or as increasing the risk that others might discover they were having sex with men. There was considerable concern expressed about a small number of men who did present to sexual health services "at those crisis points" (KI 28: doctor). Some participants feared that this represented only a small proportion of the men who may actually be engaging in high-risk practices who are not connecting to clinic- or community-based testing and care services. However, in general, the health risks of engaging in sex with men were not emphasized by participants as much as the mental and emotional challenges of "living a secret life" (KI 6: social worker) and feeling intensely worried about "other people finding out" (KI 13: nurse). As this exchange between two advocacy/support workers in a group interview revealed:

> KI 19: So much is at stake. Your whole identity as a family man …
> K18: And their identity amongst their mates.
> KI 19: … and as a provider and a father and a, you know, family figure and good citizen, is at stake.

"Safe with Us": Establishing the Conditions for Honest Conversations in Sexual Health Settings

While the phenomenon of straight-identified men having sex with men may be well-accepted by our participants, the challenges of engaging them with sexual health promotion and care were described as confounding and complex. A key challenge in health promotion was reported to be reaching a disparate group who may actively not view messaging, images, and language they associate with "gay" men as being relevant or applicable to their own lives. As a sexual health nurse recalled: "I remember sitting down with [an older man] and [going through] some [health promotion] resources … He's like, "Oh, I'm not a poofta, you know?" … [because] the language is very gay [but] they don't speak like that and they

don't see it like that" [KI 25]. Similar challenges are faced by those working in sexual health services, who recognize that seeking out testing and care can be incredibly confronting for men who, as one sexual health physician put it, can have "a massive fear of being found out" (KI 12). A participant working in an advocacy/support role suggested this meant the proportion actually engaging with services was far less than ideal: "I am not sure that they generally do look into their sexual health. Because that means also going into a sexual health clinic and disclosing they've had sex with another man" (KI 5: advocacy/support worker). Participants explained that these men were often "very invested with the heterosexual identity, so we don't wanna ever take that away from them" [KI 18: advocacy/support worker] but also recognized that men may have to be pushed out of their comfort zones in disclosing fully. As a general practice doctor put it: "even when they're presenting to services and asking for a sexual health check-up, sometimes you feel that there are things that people are not telling you." [KI 30]

A major theme in the interviews, therefore, examined the conditions participants believed were most helpful in encouraging men to firstly access sexual health services and to then, when they do, feel able to speak openly and honestly about their sexual histories in order to receive appropriate care. Some of these conditions related to the structural and contextual factors which influence service provision, such as the perceived "anonymity" of larger, public sexual health clinics, and outreach services, where full names and addresses are not required, compared with private family doctors, who may be viewed as more likely to be biased or judgmental, or to risk a breach of confidentiality. The model of care in Australia may differ from other contexts, with sexual health clinics funded only to focus on sexual health issues and general practitioners providing sexual health screening and care to a much broader population (Newman et al. 2012). However, the issues of trust and confidentiality reported here are likely to apply across settings. As a counselor put it, "I think a lot of the men don't wanna see their GP though because it's the family GP. It's a bit too close to home" [KI 23]. Or as a sexual health doctor explained:

> "They come to us rather than tell their GP about their full life … They're very, very reluctant to give any details … don't want Band-Aids left on their arm to show that they've had a blood test … they're gonna ring for a result rather than us ringing them … There's a lot of effort that some of the straight guys with male partners will go to." (KI 28)

A wide range of suggestions were proposed for innovative models of service delivery which might be more effective in encouraging men to attend for screening and information. For example, making services as accessible and discrete as possible was described as highly valued by men who are managing complex, and largely secret, sexual lives: "something that's time-efficient and time-effective" [KI 30: general practice doctor]. But the most consistent advice across all of the interviews was that clinics and clinicians needed to establish a sense of "safety" for men who do attend, so they could discover through experience that disclosing secrets does not lead to "judgment" [KI 28: sexual health doctor] and "that their information is safe with us" [KI 16: social worker].

There were consistencies across the interviews regarding the intersecting components of establishing confidence in sexual health services among straight MSM: increasing awareness of and willingness to attend health services, building familiarity and trust through repeat visits, demonstrating confidentiality and lack of judgment, providing reassurance the men's practices are normal, explaining benefits for self and partners of sexual health screenings, and providing an opportunity to share their story in a safe environment. However, there was also some discussion about the complexities of establishing these enabling conditions in reality. Some participants felt strongly that standardized screening processes helped encourage more comprehensive discussions of sexual practices, since all questions were asked of everyone, so there was a reduced risk of perceived stigma. Others felt equally strongly that many men were so resistant to talking about these practices that even a carefully worded sexual history tool risked shutting them down. As a social worker put it: "I reflect the language the person is using [and] go at their pace, in terms of what they're ready to reveal … sexual history-taking [is] too direct and it's too confronting … I think a conversation is a better way to get that information" [KI 11]. Adding to this complexity was the recognition that trust is established in a clinical consultation through instinct and adaptability, making it hard to systematize what is an intensely relational, embodied, and affective process: "I know if I'm going into [visit] a practitioner you make a judgement in the first couple of minutes about whether it's a safe space or not … it happens very quickly and the cues are non-verbal" [KI 28: sexual health doctor].

A few participants questioned whether those working in the sexual health field were able to achieve this idealized state of "non-judgment" as often as they hoped. Some participants felt that those working in the sexual health sector were remarkably effective at this: "Most of the clinics I've worked in, I've actually been pretty impressed with how non-judgmental the staff are, actually. From all different walks of life, how they actually do manage to provide a really good service that's quite safe" [KI 28: sexual health doctor]. In contrast, we also heard participants express the recognition that even this more open-minded workforce forms "part of a community and they have their backgrounds, so they have their own prejudices and, you know, their own experiences as well" [KI 8: social worker]. One health promotion worker suggested that "I think

services have to be utterly respectful and utterly maintaining of the dignity of the people who are accessing them [but] I actually have a bit of a theory that often sexual health services are a bit judgy, underneath. And they haven't really examined that" [KI 22: health promotion worker].

Finally, one key issue was identified by a number of participants as provoking the most difficult reactions in service providers: heterosexual men having sex with men who had female partners or wives who were unaware of the full extent of their sexual lives.

> Even though people, professionals are non-judgmental to the person in front of them, I think that sometimes that's a very hard thing to be in terms of communicating that risk to the other person and feeling that you're looking after *everybody* in that relationship, if you know what I mean. So … I think that there is an element of personal judgement sometimes. Hopefully, that doesn't [get communicated] to the patient. But I think that a lot of people feel that they wish that [straight MSM] could address the issue, maybe, in a different way [KI 30: general practice doctor].

"Let People Tell Their Own Stories": Envisioning Strategies for Increasing Cultural Understanding

This leads us to the final theme, which captures a broad range of ideas expressed in the interviews about how to encourage a greater openness and understanding of sexual diversity in our communities, including among those men who present and identify as heterosexual in their everyday lives. Some of the strategies for achieving a greater cultural understanding and acceptance of this diversity focused on building awareness among the broader clinical workforce, particularly those with less familiarity and engagement with the sexual health field. The main message underpinning these suggestions was that clinicians needed to be open minded and curious about every person sitting in front of them: "Don't assume anything! [Or] assume that straight men *can* have sex with men sometimes" [KI 18: advocacy/support worker]. And when presented with information about sexual practices: "Keep an open mind about the special behavior of this person" [KI 6: social worker]. An advocacy/support worker captured this advice beautifully in describing the disempowering consequences of making an assumption about the sexuality of a man on the basis of his practices:

> Let people tell their own stories and, and elicit that information rather than assuming … That's not happening because the [HIV] context in New South Wales is so strongly [oriented] towards gay men, even doctors forget that they might be sitting in front of someone who's not. And they just start to tell their story for them. [KI 19]

Several participants also stressed the importance of investing in community education strategies which seek to broaden cultural understanding and openness regarding sexual practices that challenge the assumed binary between homosexuality and heterosexuality. This included suggestions that: "community campaigns [should] speak to everyone, [and seek to be] inclusive of all of the sexual behaviors that people might practice" [KI 22: health promotion worker], rather than targeting specific populations. The shared principle underpinning these suggestions, however, is that encouraging more open cultural communication about sexual practices benefits everyone.

Sexuality education in school and other educational settings emerged as another area of interest for many participants. For some, the benefit of increasing sexual health literacy among young people was that it worked towards ensuring that as wide a cross-section of the community would eventually achieve an improved understanding of how to promote sexual health, regardless of their own identity or practice: "We need an educated, younger population coming through schools that know … the risks for sexually-transmitted infections, the importance of having a sexual check-up every three months … irrespective of who you're having sex with" [KI 5: advocacy/support worker]. But for others, sexuality education was also seen to support generational changes in understanding and acceptance of difference and diversity, extending beyond just the provision of information, and beyond just the school setting:

> It's not just sex education, it's about an environment in schools and, obviously, the home that doesn't tolerate a non-acceptance of difference … you need to be able to create spaces … where people can come together in ways that feel comfortable for them [KI 3: academic].

There was a belief expressed by a few participants that generational shifts were already apparent in the way that people relate to categories of sexual identity—"like with a lot of young people, they are a lot more fluid" [KI 8: social worker], but there was a shared recognition that for now, those changes had not impacted broader society.

With that in mind, strategies to support men to tell their stories were discussed, but the complexities of achieving this in a safe, confidential way were readily acknowledged. Many participants believed, as previously noted, that supporting men to talk about the more secretive aspects of their sexual lives was more important in terms of their emotional wellbeing than in terms of their sexual health:

> When I talk to these guys, they seem to know [about sexual health and HIV prevention]. So … I think they need to be targeted with something else to say, "Hey,

> you're struggling with this. Living a secret life. Hey, come and talk to us!" … And that's a much bigger battle, that one [KI 6: social worker].

Our own research was described by the participants as an example of a welcome first step in exploring these men's experiences in a way that does not "stigmatize, pathologies or problematize these relationships" [KI 21: academic]. Several participants suggested that if men were made aware of the research outputs, it would potentially help them to understand their own experiences as not only more common than they might believe, but also as important contributions to a broader cultural discussion about sexuality: "I think this research will serve to normalize for these guys that they are not alone … [that] they are one of many that do do this, who want to remain in their jobs and their families" [KI 19: advocacy/support worker].

Discussion

Our aim in this initial research was to gather information from professionals working in the sexual health sector about what they perceived were the most pressing sexual health needs and issues affecting Australian heterosexually identified MSM. The major limitation in this approach was that we were unable to ask men themselves to provide their own views and accounts of these matters. Instead, we were limited to making sense of these issues through accessing expert views and conceptualizations, which are mediated via the multiple, intersecting lenses of professional training, organizational context, and personal understandings and beliefs. Our study was also limited to the specific cultural, political, and economic context of urban Australia. Nonetheless, we believe that participant views were based on a careful and considered appreciation of the complexities of men's lives, as far as participants were themselves able to form an impression through personal and professional observations. Certainly, the interview data we collected revealed a deliberateness and concern regarding how to understand and respond to the complexities of designing and delivering sexual health promotion and care to better engage this and other marginalized populations.

This paper was organized around a central theme of "secrecy": comprehending hidden lives, encouraging honest conversations, and increasing cultural understanding. This particular group of professionals held progressive views about sexual diversity and challenged their own and others' assumptions about the alignment between identity and practice in order to provide a safe environment for men to open up about their sexual lives. They felt strongly that this required an emphasis on confidentiality, non-judgment, and open-mindedness in all encounters, but also readily acknowledged how challenging this could be to achieve in practice, no doubt contributed to by a lack of either a policy framework or a cultural narrative to support their work. The range of strategies proposed to challenge the broad cultural silence about diversity in sexual practice, including in the context of professional development for clinicians, sexuality education in schools, and opportunities to support men to tell their own stories, can be seen as attempts to expand the cultural repertoire regarding sexual practice and identity, and thus to bring together what they see as "reality" in their professional work with what is "recognized" in the broader community.

As Kenneth Plummer established in his seminal book, "Telling Sexual Stories", over 20 years ago, we "live in a world of sexual stories" (1995: 5). So, how is it that we are still faced with this clear example of a sexual story which remains hidden from view and hard to tell, both at the interpersonal level of the clinic consultation and at the social and cultural level of representations and norms? Perhaps, as Plummer himself argued, accounts of sexual practices which do not align with one of the three dominant sexual identity categories—heterosexual, homosexual, bisexual—are still largely hidden:

> For stories to flourish, there must be social worlds waiting to hear … The gay movement, the women's movement and the therapy movement have provided such social worlds whilst other stories … may be waiting in the wings for their time, their voice, their audience (1995: 121, 16).

While there has been considerable public health research interest in straight MSM for some time now, particularly in the US, it is notable that a small but growing number of researchers are now beginning to investigate these experiences from the perspective of queer and cultural studies (Reynolds 2015; Ward 2015), aiming to support men to tell their own stories outside of a preoccupation with sexual health and risk.

Closer to home, Michael Flood has argued that "there are multiple heterosexual sexual cultures" (2008: 225), which may be challenging traditional understandings of the limits of heterosexuality and leading to, in particular, "a blurring of the boundaries between gay and straight" (2008: 238). However, we cannot conclude from our study of professionals in the sexual health sector that more "mainstream" communities are similarly accepting of non-normative sexual behaviors. While the gay and lesbian "coming out" narrative is now widely recognized as a cultural trope, and there is an increasing emphasis on training health professionals to not presume heterosexuality in their patients (Cant 2008; McNair and Hegarty 2010), what is perhaps less familiar is the notion that their patients may identify as heterosexual but still require support in disclosing sexual practices that do not conform to this identity. Complicating this further, we also cannot assume that "telling the truth" about sexual practices is always a safe and feasible option. As Hardon and Posel have convincingly

argued: "advocates of disclosure and sexual rights need to think more contextually and tactically in promoting truth-telling. In certain settings, the adverse effects of openness and premature disclosure may necessitate a more cautious and subtle approach" (2012: S2–S4). Those working to promote sexual health and wellbeing are therefore faced with a difficult dilemma. Achieving a degree of openness in "truth-telling" is undoubtedly essential to providing the appropriate health information and care. Yet, the right to be careful about the timing and contexts for disclosing "secrets" must also be fully respected, particularly when we have continuing evidence that the health care workforce is sometimes complicit in the reproduction of stigmatized attitudes towards difference (ASHM and NCHSR 2011). This is further complicated by the technical dimensions of health care systems, which rely on standardized tools for client intake, history-taking, follow-up procedures, and so on. How should those who are managing hidden sexual lives be engaged with care in a way that feels safe and meaningful to them, when the categories available to record their identity and practice information are restrictive?

Albury (2015) has proposed the concept of "identity plus" to capture this idea of sexualities which exceed standard categories, arguing that her research on sexual practices in Australia has found repeatedly that multiple sexual orientations can coexist with and within heterosexuality. For example, both "strongly heterosexual" and "strongly bi-curious" are sometimes selected as options for identifying the self in sexuality and sexual health surveys. This observation aligns well with the argument proposed recently by Carrillo and Hoffman (2017), building on the work of Ward (2015), that heterosexuality itself needs to be thought about as more "elastic" in how it is conceived and practiced in everyday life than has been previously conceptualized. Albury also argues that people who identify with more than one of the standard identity categories which typically structure health administration and research systems are disadvantaged when services make decisions about admission and prioritization on the basis of those categories, as can happen if a man identifies as "heterosexual" when seeking admission to a sexual health clinic and potentially missing linkage to services better suited to his sexual history, rather than his identity. Similar observations have been made in other settings, such as in the US: "When you first meet somebody [in a health clinic], no, you're not gonna say well, I had sex with a male. Because firstly I figure out how they're gonna judge me" (Martinez and Hosek 2005: 1111).

This also has implications for health promotion messaging, which is largely predicated on target audiences holding a sexual identity which aligns with their sexual practices. Straight men, may, for example, "be unwilling to obtain HIV testing, safer-sex education or other programmes in gay-identified locations … be unresponsive to materials (e.g., pamphlets, websites) that explicitly state that they are designed for gay and bisexual men" (Schrimshaw, Downing, Cohn, and Siegel 2014: 361) and because they "consider themselves heterosexual, they often ignore safe-sex warnings targeting bisexual and gay men" (Icard 2008: 440). Thus, although the contexts may have many differences, we can see that these issues are believed—at least in the views of the professionals we interviewed—to play out in quite similar ways to those observed in North American settings. We can therefore argue that despite our many cultural differences, activities which seek to engage straight MSM with sexual health information and services will be more likely to succeed if they follow the key principles documented in US-based intervention research, so that they: "address social contextual determinants of risk, reinforce men's public identifications as straight/heterosexual, and maintain men's need for privacy about same-sex behaviors" (Operario, Smith, and Kegeles 2008: 347). Making testing more accessible outside of mainstream clinics, at, for example, sex-on-premises-venues (Santella et al. 2015) or through self-testing (Krause, Subklew-Sehume, Kenyon, and Colebunders 2013), may appeal to populations such as straight MSM, who may have a greater preference for privacy and accessibility.

Our analysis extends this work with additional insights into the complex and emotional work that professionals are immersed in when trying to understand and respond to the right for their clients or constituents to tell their own stories in their way, and in their own time. Thus, we can see that indeed, "so much is at stake," both for men who are managing secrets in their own lives, for their own reasons, and for those who seek to engage them.

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