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Inter-Group and Intraminority-Group Discrimination Experiences and the Coping Responses of Latino Sexual Minority Men Living With HIV

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Abstract

Discrimination negatively impacts the health of HIV-positive Latino sexual minority men (LSMM+). A growing literature on LSMM+ chronicles associations based on multiple devalued identities and mental health symptoms, HIV medication nonadherence, and sexual behaviors with the potential to transmit HIV. To gain additional insights on identity-based discrimination—as well as the associated coping responses—we conducted 30 qualitative interviews with LSMM+.Participantswereprobedregardingrecentdiscriminationevents(context,details,perpetrator, type) based on their intersecting identities (Latinx ethnicity, residency status, sexual minority orientation, HIV-positive serostatus) and their coping responses. We transcribed and translated the interviews and conducted a content analysis. Participants reported inter-group (i.e., between majority and minority group members) and intraminority-group (i.e., within minority group members) experiences as common. Participants described their intraminority-group experiences with discrimination based on being a Latinx sexual minority person in their families and home communities. Participants reported a range of coping responses to discrimination experiences. However, participants reported only functional (and no dysfunctional) coping strategies, and they endorsed using similar strategies in response to inter-group and intraminority-group discrimination. Coping strategies included strategic avoidance, social support, self-advocacy, and external attribution. Additional coping strategies (spirituality and positive reframing) emerged more strongly in response to inter-group experiences with discrimination. Our results underscore the need to address both inter-group and intraminority-group discrimination experiences. Future interventions can focus on strengthening the effective coping skills that LSMM+ currently employ as potential levers to address LSMM+ health disparities.

Keywords

discrimination/stigma; discrimination/stigma; HIV/AIDS; intersectionality; Latino/Latino; men who have sex with men; coping

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In the United States, sexual minority men (SMM) are affected disproportionately by HIV and other health conditions. Especially in urban settings, HIV prevalence among SMM is as high as that found in some parts of sub-Saharan Africa.[1] Among Latino SMM living in Los Angeles County (LAC), home to the nation's second largest HIV epidemic,[2] the estimated HIV prevalence is 40%.[3] Moreover, compared to their heterosexual peers, SMM are more likely to experience multiple mental health challenges, including depression[4] and anxiety,[5] as well as substance abuse.[6,7] SMM also have high rates of chronic illness such as diabetes,[8] asthma,[9] and anal and other cancers.[10] Such health disparities disproportionately affect Latino SMM, especially those living with HIV (HIV-positive Latino sexual minority men [LSMM+]).[11]

Experiencing discrimination based on different minority identities (e.g., including undocumented legal status, minority ethnicity, sexual minority orientation, and HIV-positive serostatus) has been linked to a range of poor health outcomes and sexual behaviors with the potential to transmit HIV.[12] Discrimination is common among LSMM+.[13,14] Several studies document how experiences with different types of discrimination are associated with increased sexual risk behaviors (e.g., engaging in unprotected sex, incorrect, and/or inconsistent condom use)[15–20] and HIV-related health problems, such as nonadherence to antiretroviral therapy (ART), medication side effects, and AIDS symptoms across racial and ethnic minority samples, including LSMM+.[21–25]

Research examining associations between discrimination and health has largely focused on how discrimination perpetrated by dominant, majority group members affects minority group members, which is known as "inter-group discrimination." However, there is growing literature to suggest that discrimination perpetrated within minority groups, termed "intraminority-group stress," can negatively impact a range of health outcomes.[26] (Note that, in the present research, we recognize discrimination to be a major source of stress and therefore consider the term "intraminority-group stress" to be inclusive of discrimination experiences.) Research has found that gay men who self-reported exposure to intraminority stress also reported more behaviors known to increase the likelihood of transmitting HIV, even when adjusting for general perceived stress and other indicators of minority stress.[27] To date, intraminority stress may be a unique contributor to SMM's HIV risk behavior. However, studies on intraminority stress have largely focused on sexual orientation-related discrimination within gay communities,[27,28] with little attention to diversity based on other core identities (e.g., race/ethnicity).

An intersectional approach suggests that having multiple, devalued identities can manifest in a variety of ways for LSMM+. For example, LSMM+ could experience discrimination from being at the intersection of both HIV-positive and gay when trying to disclose their serostatus to sexual partners. LSMM+ may also experience discrimination from the intersectional identity of being both undocumented and Latino when engaging with law enforcement. Prior research has not sufficiently explored the range of these potential inter-group and intraminority-group discrimination experiences from LMSMM+'s devalued identities and consequent coping responses.

Research has documented how coping responses may moderate the associations between discrimination and health.[29,30] Social stress theory[31,32] posits that stress from devalued identities (such as undocumented legal status, minority ethnicity, sexual minority orientation, and HIV-positive serostatus), including discrimination experiences, can cause disease, and that coping strategies can attenuate the impact of stress on disease processes (Figure A).

Promising data have emerged from several recent pilot tests of interventions to address discrimination-related coping among HIV-positive Black[33,34] and Latino[35,36] SMM. These trials have shown preliminary intervention effects for increased effective coping responses, and decreased ineffective coping responses, to discrimination—as well as improved ART adherence.[33,34,35,36] Thus, there may be a causal pathway between enhanced coping and improved health behaviors, suggesting a need for research to more fully understand coping responses to discrimination as potential levers for clinical practice and public health programs to use in efforts to minimize health disparities.

An intersectional approach is needed to develop anti-stigma interventions that include appropriate, holistic sources of support for LSMM+. For example, LSMM+ may be able to find ways to access support for some of their core identities (e.g., support for being a Latino man through faith-based organizations), but may have difficulties accessing support for all of their intersectional core identities simultaneously (e.g., support for being a gay Latino man). Similarly, people in LSMM+'s social networks may be supportive of one of their identities (e.g., support for their sexual minority identity from gay friends), but not other identities (e.g., stigma from being undocumented by the same gay friends.)

In the present study, we used qualitative methods to explore how both inter-group and intraminority-group stress may be generated from devalued intersectional identities related to undocumented legal status, minority ethnicity, sexual minority orientation, and HIV-positive serostatus among LSMM+ living in LAC, California. We also compared and contrasted the extent to which coping responses to inter-group and intraminority-group experiences with discrimination differ. Thus, the present study extends prior research by examining intersectional discrimination and exploring if and how coping responses vary based on experiencing inter-versus intraminority-group discrimination.

METHODS

Here we report qualitative study details informed by the Consolidated Criteria for Reporting Qualitative Studies.[37]

Participants

Participants were recruited through flyers posted at a Latinx-serving community-based organization Bienestar Human Services, Inc. based in LAC, California. Bienestar Human Services, Inc. offers culturally and linguistically tailored programs to predominately Latinx populations across LAC. Bienestar Human Services, Inc. serves people living with and at risk for HIV, sexual, and gender minority adults and youth, and people who use substances.

Men were eligible to participate if they reported that they were 18 years old or older; identified as Latino/Latinx/Hispanic; reported being HIV-positive; and reported being a man who had sex with men. Being transgender was an exclusion criterion because the interview (and subsequent intervention informed by the interview data) did not address discrimination regarding gender identity, which would necessitate a differently tailored intervention with additional content and components.

Of the 30 participants recruited, 29 identified as gay or bisexual, or reported having had sex with men during the study interview; one participant did not explicitly disclose his sexual orientation but implied a sexual history with men during the interview. Note that we did not explicitly target SMM in our recruitment materials and self-identifying as a sexual minority was not an eligibility criterion. In our previous experience with this population, having recruitment materials that were strongly focused on SMM could result inadvertently in men who have sex with both men and women feeling unwelcome. Also, based on our prior experiences, we felt assured that using the planned recruitment methods at Bienestar Human Services, Inc. would yield a large number of SMM.

The research received continuous approval from the institutional review board of the Los Angeles County Department of Public Health.

Data Collection

Study procedures followed APA guidance regarding standards for qualitative methods.[38] Data were collected from February to September 2013. After providing written informed consent, participants completed an in-person, 1- to 2-hour, semi-structured interview at Bienestar Human Services, Inc. Participants were given a choice of completing an English or Spanish interview; all participants requested to complete the interviews in Spanish. Interviews were conducted by a native Spanish-speaking research assistant. The interviewer did not have a prior relationship with the participants (i.e., they had not previously interacted), a strategy that we used to help limit social desirability bias.

We developed the interview guide based on the existing literature and iteratively revised it in collaboration with study investigators and Bienestar Human Services, Inc staff. In the structured elements of the interview, participants were asked to describe recent experiences with discrimination (context, details, perpetrator, type) based on their identities (Latinx ethnicity, residency status, sexual minority orientation, HIV-positive serostatus). Individualized follow-up probes focused on how participants coped with the different discrimination experiences. Interviews were audio-recorded, transcribed, and professionally translated. The investigators and coding team members were diverse with respect to race/ethnicity (one Latinx, two White,Pdf_Folio:4 four African American/Black, one Indian American), sexual orientation (four sexual minority-identified), and gender identity (four cisgender men, four cisgender women).

Measures

Table 1 provides example questions from the interview script. Interviews began with a brief survey of previously validated measures of sociodemographic characteristics administered verbally by the interviewer.

Qualitative Analysis

We followed the theory and methods of directed content analysis. The analysis began with our relevant research as guidance for developing initial codes (e.g., attention to inter-group discrimination based on minority ethnicity, residency status, sexual minority orientation, and HIV-positive status) and provided flexibility for additional codes to emerge inductively (e.g., intraminority-group discrimination based on those characteristics).[39] Data were managed within *Dedoose*, a web-based qualitative data management program.[40]

Two investigators independently reviewed transcripts to create an initial coding scheme and created a codebook that listed each type of discrimination and included descriptions, inclusion/exclusion criteria, and example quotes. Two coders double-coded six interviews to ensure that coders could consistently identify each theme. Any emergent inconsistencies were discussed and the codebook was revised iteratively to increase precision. After Cohen's kappa of ≥.70 was achieved across codes, indicating high concordance, the two coders independently coded the remaining interviews. We then organized relevant quotes into categories based on Latinx ethnicity, residency status, sexual minority orientation, and HIV-positive serostatus.

To understand the types of coping strategies employed for inter-group and intraminority-group discrimination experiences, we reviewed all the discrimination experiences and compared and contrasted their associated coping responses. We used prior empirically derived typologies of coping responses as a guide for coding potential coping strategies.[41] We added additional categories to the coding scheme based on the coping responses that emerged inductively from these data as well as our other similar datasets.[36] The final list of coping strategies that emerged appears in Table 2.

RESULTS

Table 3 provides descriptive statistics of the sample (n = 30). Data analysis identified two major themes regarding inter-group and intraminority-group discrimination. Similar, functional coping strategies were employed in response to both types of discrimination experienced by LSMM+. Dysfunctional coping strategies were rarely reported.

Theme 1: Inter-Group Discrimination Continues to be Widespread

Most participants identified experiences with inter-group discrimination based on their Latinx ethnicity—which was often conflated with their residency status by perpetrators—as well as on their sexual minority orientation or HIV-positive serostatus. Participants generally reflected on these experiences of discrimination based on singular identities (e.g., being gay or being HIV-positive) and not on their intersection (e.g., being a gay man living with HIV).

Discrimination Based on the Combination of Minority Ethnicity and Residency-Status.—Ethnic discrimination was often conflated with discrimination based on residency status. One respondent (permanent resident, gay-identified, age 50) noted, "*Discrimination against immigrants [happens because] most see you as Latino, and they assume that we are all illegal, and that you are worthless.*" Respondents also expressed frustration that others assumed they were not from the U.S. One participant (permanent

resident, gay-identified, age 47) recalled being told, "*Go back to Mexico*!" to which he replied, "*But I'm not even Mexican!*" Further, respondents also reported experiencing ethnic discrimination as a result of their real or perceived inability to speak English. For example, respondents reflected on the discomfort displayed by native English speakers when Spanish was spoken. A respondent (undocumented status, gay-identified, age 49) shared, "*It is enough (for them) to say, 'I'm sorry; I don't like Spanish,' or, 'I prefer to speak in English'; there is a difference. Not so much yelling, 'No Spanish*!"' Often stories relayed by participants were experiences with discriminatory comments from other racial/ethnic minority people. One participant said, "*Well, when I am on the bus, believe it or not, especially the Asians [discriminate against me]* …" (U.S. citizen, gay-identified, age 62).

Discrimination Related to Perceived Sexual Minority Orientation.—Participants often relayed situations in which strangers used expletives to denigrate them in public, often either while they were walking down the street or using public transportation. Illustrating this point, one participant recounted: "*Perhaps we are on the bus or the train, walking on the street … but there are people that just because you turn around, they begin to yell, 'f*cking f*ggot' and I don't know how many other words … [Two days ago] I was on the metro and I was holding onto the rail in the metro and a black guy and lady were sitting by there, and I grabbed the pole and accidentally touched the guy's hand and he started to yell at me, 'You f*cking f*ggot!*"' (undocumented status, gay-identified, age 41). Another participant relayed a similar experience he faced while riding a bus: *"I was staring at that guy a lot. So, he said to me, 'What are you looking at, f*ggot?"'* (U.S. citizen, gay-identified, age 62). In reflecting on the experience, the participant relayed that he felt that the discrimination experience was ultimately his fault as a result of trying to initiate the flirtation. One participant said that walking down the street with his brother, "*Men pass by in their cars and shout things at us … Rude words … [they call us] f*ggots, rude words … at any time, they pass by in their cars and shout things at us*" (undocumented status, gay-identified, age 35).

Discrimination Related to HIV-Positive Serostatus.—Participants primarily reported discrimination related to their HIV-positive serostatus that occurred in the context of their healthcare engagement. This category included interactions with receptionists and subsequent exchanges with medical professionals. For example, a respondent (undocumented status, gay-identified, age 58) recalled, "*The [receptionist] couldn't figure out how to take my card; she would grab it with the corner of her nails, as if she was saying, 'how gross,' … As if it was disgusting, something dirty … she didn't want to touch it*." Some participants mentioned additional contexts in which they experienced HIV-related discrimination, for example, once they disclosed their HIV status to potential dating partners who they met through dating apps, they were then blocked from interacting further. One respondent said: "*Yes, supposedly I met someone who had interest in me, but since I saw he was interested in me I said I was going to tell him I was positive to see if he wanted to move forward with things. I confessed to him that I was positive. He told me that it wasn't a problem and I never saw him again*" (temporary protected status for residency, gay-identified, age 48).

Theme 2: Intraminority-Group Discrimination Was a Critical Concern

Participants described their intraminority-group experiences with discrimination based on being a Latinx sexual minority person in their families and home communities. The emergence of this theme is notable for its truly inductive nature, that is, none of the standardized questions inquired about intraminority-group discrimination. The anecdotes provided by the participants on this topic were all fully spontaneous.

General Impressions of Intraminority-Group Discrimination.—Respondents described how Latinx individuals discriminated against each other. One respondent (undocumented status, gay-identified, age 49) remembered a Latino walking by him saying, "*F*cking Mexicans*," and he wondered, "*For someone to go against their own people, I just don't get that.*" Remembering a time when police were needed to break up a dispute, another respondent (permanent resident, gay-identified, age 34) said, "*To make matters worse, he was Hispanic, a Hispanic policeman*." Later, the respondent explained that the Hispanic police officer claimed he could not speak Spanish. Testing the assertion, the respondent made a derogatory remark in Spanish and, when the officer responded negatively, the respondent said, "*I thought you didn't speak Spanish."* The participant reported that the officer then said, "*You live in California; you have to speak English.*" Later in the interview, the respondent summarized how he interpreted discrimination within Latinx communities: " *… a Hispanic is someone born in American territory but with Latino blood. They are the most discriminatory, in many aspects. White and African American folks almost don't discriminate [against] you, but … always Hispanics for me are very discriminatory."*

Being a Latino Immigrant.—Respondents experienced discrimination from other Latinx people, especially based on the intersection between their ethnicity and residency status. Respondents noted how being undocumented often made individuals feel as though they were "illegitimate." One respondent (undocumented status, gay-identified, age 36) summarized a negative interaction with a Latino police officer following his effort to secure a U visa (i.e., visa for victims of crimes such as domestic violence and trafficking, who have suffered mental or physical abuse). Specifically, his lawyer told him to request the police report of a prior domestic violence incident. At the station, a Latino police officer said that he would likely not get the visa and said he should not try to get the report. The participant reported feeling upset and explained, "*[Latinos] are people who are not used to having power … all of a sudden, they see themselves in a different position; they feel of higher status than the rest*." Another respondent (undocumented status, gay-identified, age 41) said that his partner, who was Latino and born in the United States, often referred to the participant's undocumented status as a way to assert power. The respondent reflected, "*I felt useless … in the sense that the same Latino race discriminates against you for being illegal. Instead of supporting each other, we discriminate against one another*."

Being a Latino Sexual Minority Man.—Participants described the intersectional experiences of being a sexual minority and Latino in their communities and in their families. One respondent (undocumented status, bisexual-identified, age 30) mentioned how Latino coworkers, who themselves were discriminated against by other employees, would discriminate against him and call him a "*f*cking f*ggot*." Many respondents also noted that

their family played a major role in perpetrating sexual orientation-related discrimination. One respondent (undocumented status, gay-identified, age 35) recalled, "*Sometimes parents know, and the dad feels ashamed, 'Uh, my son is a fag,' and the mom, instead of helping the son, ignores it."* This respondent reported that, although his family relationships were strained, he still felt close to his family. However, he did not disclose explicitly that he was gay because he did not want to "*hear comments that [he was] not going to like*." Another participant (permanent resident, bisexual, 53) reflected: "*I would like to change, I didn't plan it to be this way. It makes me feel bad … No father accepts you this way; no father wants to accept; if you're homosexual, everyone points at you*." This respondent reported being married to a woman and having grown children. Although he disclosed his HIV-positive status to them, he had not disclosed his sexual orientation. He hoped to talk with them more openly in the future; however, he remained reluctant to do so.

Men Endorsed Similar Functional Coping Responses to Inter-Group and Intraminority-Group Discrimination

Table 4 provides quotes from the most common types of coping strategies discussed by LSMM+. All coping strategies reported by participants would be considered *functional* coping strategies (sometimes called adaptive, effective, positive, etc.). Of note, dysfunctional coping strategies were rarely reported by participants. The strategies mentioned most often by participants included strategic avoidance, social support seeking, self-advocacy, and external attribution.

Strategic Avoidance.—Participants employed strategic avoidance in different ways. Often participants who experienced discrimination perpetrated by coworkers in workplace settings would remain silent out of a fear of jeopardizing their employment status. For example, one participant relayed how he reacted to his boss asking for documentation: *"[My boss said], 'I'm just calling you because I need you to bring your legal papers' and he repeated again 'legal papers.' [He continued], 'Otherwise, if you do not bring them, I'll have to let you go' … it was like a discrimination that I had never experienced … it makes you feel at that moment your true situation of being here in this country illegally, that difference between a legal person and an illegal person. At that moment I [should] have said, 'What do you mean with legal papers?' But I kept quiet … so I just replied 'Ok*."' (undocumented, gay-identitied, age 35). Experiencing discriminatory comments outside of work often resulted in the participants simply avoiding the perpetrator or venues in which they were likely to see each other. Illustrating this coping response, one participant relayed how he responded when another gay male got upset that he didn't disclose his HIV status when they started dancing together at a club, " … *I told him, 'But I just invited you to dance, I just danced. Like I'm not sleeping with you, nothing. We just danced and nothing more, like you don't get HIV that way.' He said, 'No, but you have to say it,' and this and that … I felt very bad, like discriminated … The truth is that I panicked, I felt bad, I don't go dancing there anymore."* (U.S. citizen, gay-identitied, age 58).

Social Support.—In seeking social support, participants reported preferring to connect with people who shared similar core identities. Most often, they referenced enjoying the opportunity to attend support groups that included other Latino gay men living with HIV.

Reflecting this sentiment, one participant said, "*Yes, the support groups have helped me out a lot. I have learned about others experiences there and things that have happened to them*" (undocumented, gay-identitied, age 36). Of note, participants did not explicitly state the need to attend support groups including others who had an undocumented legal status.

Self-Advocacy.—Participants reported advocating for themselves in meaningful ways. One participant was a healthcare worker and explained to his colleagues how the organization could be sued if they continued to discriminate against patients based on their sexual minority orientation or HIV-positive serostatus. His colleagues responded positively and remarked that they were impressed at his framing being focused on how to improve the organization. Another participant relayed a situation when he was discriminated against for being Latino and the person assumed he was undocumented. In response he said, "*'You know what? I'm American, same you. I'm an American citizen … I speak many languages: I speak Italian, I speak Spanish. How many languages do you speak?' He stayed quiet*" (U.S. citizen, gay-identitied, age 58).

External Attribution.—Finally, although there are different variants of external attribution, participants most often took the approach that placed blame on the perpetrator, noting that the shortcoming was a result of their ignorance ("it's not me, it's them"). Oftentimes participants thought up possible reasons to justify why the person had discriminated against them. For example, one participant said the following, "*There came a point where I wanted to take classes to eliminate my accent but I said, 'Why? This is how I am and people like me like this so I am not going to change how I am for an incident that happened with someone who probably didn't intentionally mean to do it because he was stressed'*" (undocumented, gay-identitied, age 36). Another participant said the following after describing an experience whereby he was discriminated against for his sexual orientation, "*I just thought about what she needed … she was an older lady already and I just think she needed to be more educated …*" (undocumented, gay-identitied, age 32).

Additional Functional Coping Strategies Emerged More Strongly in Response to Inter-Group Experiences With Discrimination

Sprituality and Positive Reframing.—Two additional coping strategies, spirituality and positive reframing, did appear to emerge more frequently in response to inter-group discrimination. Turning to God, faith, and their church community presented a complicated source of support for many of the men. Despite some participants reporting experiences with discrimination at church for having sex with men, or feeling internalized homophobia due to the heteronormative teachings of the church, many men still turned to their belief in a higher power to cope. Reflecting this point one participant said, "*Well with Christians you are discriminated because they don't want you to be gay and what you to be a person in the right to them like the words of God say, between a man and a woman … Between the churches I have gone to I like to go to the churches that are open to accepting gays, lesbians, bisexuals that there isn't that judgment by heterosexual people*" (permanent resident, gay-identitied, age 37). The positive reframing highlighted resilience developed by participants in response to discriminatory experiences more often associated with being Latino or HIV-positive. One participant, "*Something good came out of that … I know what my legal rights are, I know*

what's bad for me and what isn't bad for me, what I should do if I'm attacked or discriminated against" (undocumented, gay-identitied, age 41).

DISCUSSION

Our findings complement and extend the literature documenting inter-group discrimination.[42] Historically, work in this area have focused on the impact of discrimination based on actual or perceived Latinx ethnicity, residency status, sexual minority orientation, or HIV-positive serostatus, or combinations of those identities.[43–45] However, increasingly, research is exploring how intersecting identities may change the experience of discrimination.[46] Specifically, quantitative studies have shown how experiencing discrimination based on multiple stigmatized identities can exacerbate certain HIV outcomes (e.g., higher viral load).[25] In the present study, participants most often spoke about their experience with inter-group discrimination based on singular identities. It possible that it is more common to talk about inter-group discrimination where the majority (e.g., HIV-negative person) is a clear and common aggressor against the minority (e.g., HIV-positive person). Further, participants may have experienced less discrimination based on certain characteristics that may be more concealable and that may require disclosure, such as serostatus or sexual orientation.

In the present study, given the ongoing presence of HIV as well as sexual orientation-based stigmas in their communities, it is possible that many participants did not experience discrimination based on their serostatus or sexual orientation simply because they did not publicly disclose these aspects of their identities. Participants may have more commonly reported experiencing discrimination due to their Latinx ethnicity, because ethnicity can be more challenging or impossible to conceal.[47] This disclosure paradox is one that mental health clinicians struggle to address with clients. That is, some identities can remain concealed but individuals may still suffer from concealment stress.[47] Specifically, despite the common assumption that certain identities can remain hidden and allowing one to escape the associated stigma and discrimination, research suggest there are multiple psychological consequences of this process.[47] It will be important to continue to empirically investigate discrimination and concealment for individuals with multiple stigmatized identities—regardless of their level of apparent visibility.

Our analysis of intraminority-group discrimination identified two key themes. First, discrimination based on residency status was perpetrated by majority group members (i.e., White individuals) and was reinforced further by other Latinx individuals. National surveys document substantial discrimination against Latinx individuals. In a recent Pew Research Center survey on race in America, more than half (52%) of Latinx people said they experienced discrimination, or were treated unfairly because of their ethnicity.[48] More research is needed on discrimination based on residency status within Latinx communities.

Participants raised significant concerns regarding their residency status, relationships with the police, and subsequent experiences with discrimination. Since 2013, conservative immigration policies have been implemented, especially with respect to Mexican immigration into the United States—and concerns have heightened in light of several highly publicized local[49] and national[50,51] instances of police misconduct and federal Immigration

and Customs Enforcement aggression toward undocumented individuals. Further, studies have increasingly shown the negative impact of such punitive immigration policies on health of Latinx communities.[52–54] A recent report by the Federal Bureau of Investigation further echoes this troubling trend: The total number of hate crimes targeting Latinos increased by 41% since 2016.[55]

A second theme emerged related to the intersectional identity of being Latino and a sexual minority man. Prior studies have explored the health implications of certain constructs in Latinx cultures. For example, respondents discussed the experience of being a sexual minority man in the context of their Latinx families. The term they used, *familialismo,* is a cultural construct that stresses the importance of familial obligations, relying on family for support, and using family members as referents for decisions. In one study of bisexual Latino men, respondents who lived closer to their families, or reported having interacted with their families more, had a higher likelihood of maintaining a heterosexual and masculine image.[56] In another study, investigators found that younger individuals (age 25 or below) reported having disclosed their sexual orientation and having support from parents or siblings; however, individuals age 26 and older (similar to the age range of participants in the present study) reported more internal conflict over their sexual orientation and were less likely to have disclosed same-sex behavior to anyone in their family.[57] Findings from yet another study suggest that some Latino gay men accepted an imposed “code of silence” due to their fear of being shamed or humiliated by their families.[58] Our respondents noted, similarly, that the central role of family increased the difficulty of disclosing their sexual orientation when they wanted to, expressing concern about how their sexual minority orientation would be perceived and about the interpersonal consequences for them of such a disclosure. Participants consistently underscored a desire to disclose their sexual orientation, and also concealed their sexual minority identity to avoid rejection, discrimination, and ostracism from family members.

Common coping strategies (strategic avoidance, social support, self-advocacy, and external attribution) were employed for inter-group and intraminority-group experiences with discrimination. Often described as “functional,” these coping strategies are effective in that they help an individual achieve a desired goal and their enactment were consistent with their values. In contrast, “dysfunctional” coping strategies are viewed as less useful to achieving one’s goals.[59] Of note, none of the latter were reported by participants. This suggests that efforts to strengthen coping responses to discrimination experiences may not need to introduce new coping skills, but instead strengthen the innate coping responses of LSMM+. Doing so embraces the inherent knowledge and skills within an individual and suggests that these traditionally marginalized communities have, in spite of facing multiple adversities, developed resilient responses to these experiences.[60]

Our results also showed two coping strategies (i.e., spirituality and positive reframing) seemed to emerge more strongly in response to inter-group discrimination experiences. Of note, these strategies aim to change one’s own outlook or interpretation rather than to bring about a change in the external circumstances of the situation. It is plausible that such coping strategies are employed in response to inter-group discrimination when individuals feel less in control of the situation, or when they objectively do have less ability to influence the other

person/people due to a power differential. For example, the power differential in inter-group discrimination may also appear more explicit due to long histories of discrimination against people with sexual or racial/ethnic minority identities and people living with HIV. Across these core identities, the more powerful person has been established as the norm and may therefore appear harder to confront. Importantly, our finding that similar coping strategies were employed across discrimination experiences provides a focal point for future clinical interventions and public health programs. For example, teaching the difference between these effective coping strategies and other less effective strategies (e.g., substance use) may empower individuals to better identify if and when to employ different coping strategies strategically in order to better navigate discrimination experiences in the future.

The results presented here further contribute to critical theories relevant to multiple devalued intersectional identities.[61–64] Intersectionality theory highlights the complex interactions between race, gender, class, sexuality, and power, all of which are grounded in structural and social contexts. These interactions can produce or heighten inter-group and Intraminority-group differences in health outcomes.[61] Intersectionality theory posits that individuals experience the world as simultaneously cross-cutting identities, rather than as singular isolated identities.[65,66] Our results highlights the ways in which identities (e.g., being Latino and being gay) overlapped in different contexts (e.g., being a gay Latino man) and further emphasizes how public health programs and policies should take an intersectional approach to understanding and addressing health disparities experienced by LSMM+. Further, our study is unique in its exploration of multiple devalued identities with respect to inter-group discrimination. It also extends existing literature by discussing intraminority-group experiences with discrimination and explores the associated coping responses.

Study limitations should be considered in interpreting our findings. Our qualitative exploration of experiences with discrimination did not focus explicitly on the health consequences of discrimination events, or probe specifically the mechanisms through which the experiences impacted participants' health or health behaviors. Further, although we explored how being Latino affected participants' experiences with discrimination, we acknowledge the significant heterogeneity among Latinx communities, as they represent diverse experiences, national origins, histories, cultures, and racial identities. Moreover, although we carefully adhered to guidance about overcoming the additive (vs. multiplicative) nature of our data in terms of participants' intersecting identities, it is plausible that participants were biased by the question structure that asked about each type of discrimination experience separately—for example, they were asked about their experiences as an immigrant and as a gay man in separate questions. We encourage future researchers to frame questions that are intersectional by their design (e.g., lead with asking participants about their experiences with discrimination as a Latino gay man living with HIV, rather than first asking about their experiences with discrimination based on being Latino, being gay, or being HIV-positive).

CONCLUSIONS

In addition to addressing the ways that inter-group discrimination negatively impacts health, our study underscores the need to recognize and address intraminority-group discrimination.

Research is needed to develop policies and programs that address the multifaceted and intersectional discrimination experiences faced by LSMM+. Acknowledging heterogeneity within men's communities, alongside their shared experiences, creates an opportunity to build more effective clinical interventions, programs, and policies. Further, identifying and strengthening commonly used effective coping responses, which appeared inherent to many of our participants, may provide an important lever to address a range of health behaviors that disproportionately contribute to the pervasive disparities experienced by LSMM+.

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Statement of Public Health Significance:

Our research extends prior literature to consider how LSMM+ experience both inter-group and intraminority-group discrimination based on multiple de-valued identities, including ethnicity, sexual orientation, and HIV-positive status. We identified common, effective coping strategies that could potentially be leveraged to address negative health consequences resulting from widespread discrimination experiences.

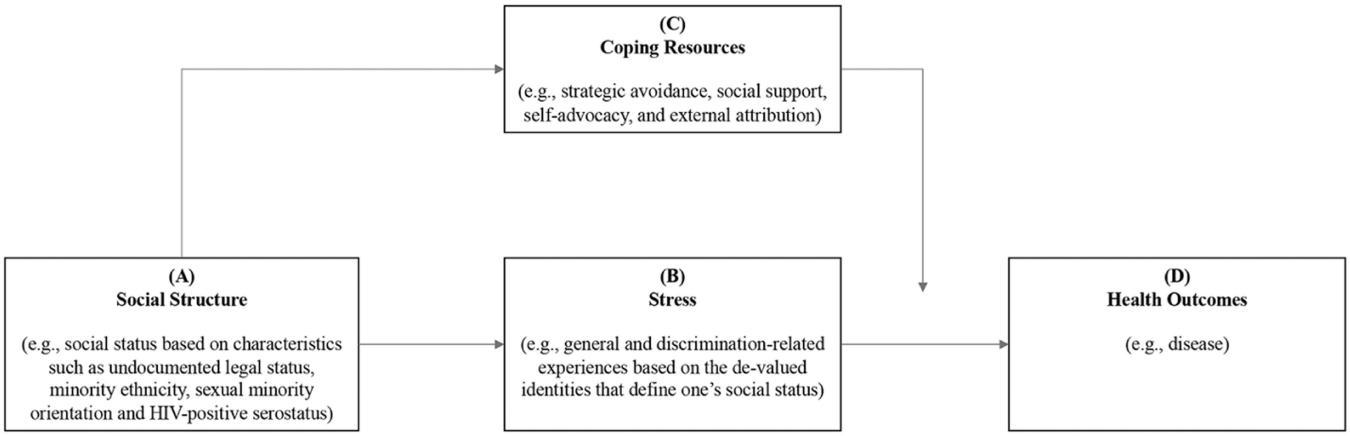

Figure A.

TABLE 1.

Semi-Structured Interview Guide on Discrimination Experiences and Coping with Discrimination among HIV-Positive Latino Sexual Minority Male Participants in Los Angeles County, CA (n = 30)

	Discrimination Experience	Coping With Discrimination
Interpersonal discrimination (e.g., another person was not nice to you, was disrespectful or mistreated you)	Can you describe a time in the past 12 months when another person was not nice to you, was disrespectful, or mistreated you because you are Latino/an immigrant/HIV-positive/ because of your sexual orientation? What happened? Who did it, and where and when did it happen? What was the reason for or cause of the event?	What did you do immediately after the event? Did you confront anyone about the event? Did you talk with anyone? Who did you tell, and what did they say? How did you feel after it happened? Did you feel angry? Sad? Depressed? Did you try not to feel anything or ignore your feelings about it? Did you try to get your mind off of it? If so, how? What kinds of emotions do you feel when you think about it now? Did you think about the event right after it happened? Do you sometimes still think about it? [IF YES] How much do you think about it now? Do you try not to think about it? Have you discussed this experience with other people? With whom? What did you tell them and what did they say? Do you think it was up to other people, God, or fate, and out of your control, or that it was up to you and under your control? To what extent do you think you could have prevented the event from happening? Do you try to avoid similar situations now? If so, how?
Trauma/threat (e.g., an act of violence or the threat of harm from another)	Can you describe a time in the past 12 months when another person did something to threaten, insult, or physically harm you because you are Latino/an immigrant/HIV-positive/ because of your sexual orientation? What happened? Who did it, and where and when did it happen? What was the reason for or cause of the event?	(Same as above)
Institutional discrimination (e.g., discrimination you encountered when dealing with health care, law enforcement, housing)	Can you describe a time in the past 12 months when you felt discriminated against by institutions or systems in society because you are Latino/an immigrant/HIV-positive/ because of your sexual orientation? What happened? Who did it, and where and when did it happen? What was the reason for or cause of the event?	(Same as above)

TABLE 2.

Definitions for the Coping Strategies Employed by HIV-positive Latino Sexual Minority Male Participants in Los Angeles County, CA ($n = 30$)

Type of Coping Strategy	Definition
Engagement in activities	Utilizing activities to distract him from the discrimination event (e.g., playing or listening to music, exercising)
External attribution— acceptance and awareness	Accepting reality as it is
External attribution—it's not me, it's them	Blaming others for their ignorance, not himself
Humor	Trying to see the humor in a difficult situation
Official reporting	Asking for the manager, reporting a violation, planful problemsolving
Positive reframing	Creating positive meaning by focusing on the good things and personal growth instead of the bad and embracing self-acceptance
Putting up their guard	Assessing one's safety and putting up their guard
Selective disclosure	Planning to whom you disclose information
Self-advocacy	Directly confronting the perpetrator, standing up for himself
Self-presentation and role shifting	Planning about how to behave when anticipating discrimination and changing identity expression
Self-segregation or self-selection of environments	Planning to go certain places and be around certain people
Social support	Reaching out to someone formally or informally; therapy, support groups, friends, family, providers
Spirituality	Utilizing faith and God as a way to respond to discrimination
Strategic avoidance	Walking away from, choosing not to engage in, or refusing to get emotionally involved in a dysfunctional situation

TABLE 3.

Sociodemographic Characteristics of HIV-positive Latino Sexual Minority Male Semi-Structured Interview Participants in Los Angeles County, CA (n = 30)

Characteristic	Percentage (n)
Age, years[a]	
30–39	26.7 (8)
40–49	36.7 (11)
50 and older	36.7 (11)
National background	
Mexican	76.7 (23)
Salvadorian	6.7 (2)
Argentine	6.7 (2)
Other	10.0 (3)
Residency	
U.S. citizen	10.0 (3)
Permanent resident	23.3 (7)
Undocumented	53.3 (16)
Other	13.3 (4)
Years living in the United States	
6–10 years	16.7 (5)
11–15 years	20.0 (6)
16–20 years	20.0 (6)
More than 20 years	43.3 (13)
Level of education	
1st to 6th grade	13.3 (4)
7th to 11 grade	23.3 (7)
High school diploma or GED	43.3 (13)
At least some college	20.0 (6)
Housing	
Renting or publicly subsidized housing	76.9 (23)
Unstably housed	23.3 (7)
Employment	
Employed (full or part time)	33.3 (10)
Unemployed	66.7 (20)
Total household income	
Less than $5,000	60.0 (18)
$5,000 through $11,999	13.3 (4)
$16,000 or more	26.7 (8)

[a]The mean age was 47 years, with a standard deviation of 9.42.

TABLE 4.

Illustrative Quotes for the Main Coping Strategies Used by HIV-positive Latino Sexual Minority Male Participants in Los Angeles County, CA (n = 30)

Type of Coping Strategy	Quote
Strategic Avoidance	
Inter-group discrimination: HIV-positive serostatus and sexual minority orientation	"They make comments like saying, 'F*cking infected f*gs or f*cking f*g, he must have HIV, he must have AIDS.' These are comments that in many aspects bother me and they also hurt. I have been wanting to tell them, 'I am HIV positive. I am like you say, 'a f*cking f*g' … But you know this is work and so I rather stay quiet." (undocumented status, gay-identified, age 30)
Intraminority-group discrimination: HIV-positive serostatus within the family	"[My brother] was talking [to] me about (HIV)-positive people and that positive people get a lot of help from the government. We grab all this and we use it for drugs and alcohol… I don't like the way he is and the way he says things… I don't like to spend time with him to avoid it." (undocumented status, gay-identified, age 35)
Social Support	
Inter-group discrimination: sexual minority orientation	"I have strength because I am not alone. I am not the only gay because I have a lot of gay friends because the community is big and we are a big community that always supports each other when there are needs and to defend social justice and demonstrate our values about how we are equal to the rest of the people … we are also human and we are there to erase that image that people sometimes create about us that we are also people worthy of respect and dignity. What is strengthening me is attempting to attend social groups …" (permanent resident, gay-identified, age 37)
Intraminority-group discrimination: minority ethnicity	(In response to a Latino cop discriminating against him): "I try to get involved in groups like the ones [the organization] offers. (permanent resident, gay-identified, age 34)
Self-Advocacy	
Inter-group discrimination: HIV-positive serostatus and sexual minority orientation	"I said, 'Go to school and get educated, inform yourself on what HIV really is and what are the steps to take when treating someone who has HIV.' They said, 'You only say that because you are gay.' [I said], 'What does that have to do with it? I am doing a job for which they are paying me for. They are not paying me to figure out if this patient is HIV-positive or not or gay, lesbian whatever you want to call them. In other words, act professional because if this patient finds out that you are discriminating, with solely knowing you are discriminating they will report you and the company and you will come out 'losing."' (undocumented status, gay-identified, 41)
Intraminority-group discrimination: HIV-positive serostatus and residency status	"[My partner is] (HIV)-negative… I tell him, 'You know what, that's so rude… that's the way he sees things. It's not just like you're the f*cking Mexican illegal. It's the f*cking Mexican HIV-positive illegal" (undocumented status, bisexual-identified, age 30)
External Attribution —"It's not me, it's them."	
Inter-group discrimination: sexual minority orientation	"… sometimes at work I interact with people in construction and I frequently hear them talk about homosexuals in a demeaning way. In construction they use the lowest level of vocabulary, of education. There they refer to the worst nicknames for homosexuals, that they should be burned, that if they had a gay son, they would kick them out or make a man out of them… I find it stupid their way of thinking about these people they don't know, without thinking that they could have children come out like that and then have to struggle to accept them and support them." (undocumented status, gay-identified, age 47)
Intraminority-group discrimination—sexual minority orientation and HIV-positive serostatus	"I became disappointed not in me but of the people. I said, 'How can it be that we are in the 21st century and that ignorance still exists?' That is what disappointed me the most. I said that person needs to learn more about this. That is all." (permanent resident, gay-identified, age 47)
Spirituality	
Inter-group discrimination	"I draw strength from God almighty, the one I call onto him, "God give me patience to tolerate all this ignorance…" (undocumented status, gay-identified, age 41)
Positive Reframing	
Inter-group discrimination	"I do want to be successful. And though they continue to discriminate me and everything, I know that I still have many more challenges left in my life, many things, but I am willing to overcome them" (permanent resident, gay-identified, age 34)