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Coping with discrimination among HIV-positive Black men who have sex with men

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Abstract

In the USA, HIV-positive Black men who have sex with men show large disparities in disease outcomes compared to other racial/ethnic and risk groups. This study examined the strategies that HIV-positive Black men who have sex with men use to cope with different types of discrimination. Twenty-seven HIV-positive Black men who have sex with men participated in semi-structured interviews. Interviews were transcribed verbatim and coded using thematic analysis by multiple raters. Major coping themes included reactive avoidance (using behaviours, cognitions, and emotions to escape from discrimination), a common reaction to racism; proactive avoidance (avoiding situations in which discrimination is anticipated), manifested as selective disclosure of HIV-serostatus; external attribution for discrimination (versus self-blame), used more for sexual orientation and HIV discrimination; and social support-seeking, which most often emerged in response to racism. Active coping strategies, such as self-advocacy (countering discrimination directly or indirectly), were infrequently reported. Findings suggest a need for structural anti-discrimination interventions, in tandem with culturally congruent individual- or group-level interventions that aim to enhance men's existing adaptive coping strategies.

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Keywords

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In the USA, among Black men who have sex with men, stigma and discrimination from intersecting identities related to HIV-positive serostatus, minority race, and marginalised sexuality contribute to HIV-related disparities (Earnshaw et al. 2013). HIV-positive Black men who have sex with men are stigmatised in non-Black communities because of their race (Hirschfield and Piquero 2010), in US society because of their sexual orientation, and in Black and gay communities because of their serostatus (Radcliffe et al. 2010; Arnold, Rebchook, and Kegeles 2014).

The goal of this study was to explore how HIV-positive Black men who have sex with men cope with discrimination stemming from their intersectional, marginalised identities. We take an intersectionality perspective, recognising that multiple externally devalued social categories, including race, HIV-serostatus, and sexuality, need to be simultaneously considered when examining inequalities; that multiple social identities are interdependent and mutually constitutive; and that the whole identity is more than the sum of its parts (Cole 2009; Crenshaw 1989). We define stigma as an attribute or behaviour that is socially discrediting and focus our research on one type of stigma, perceived discrimination (i.e. actual discrimination experiences (Earnshaw and Chaudoir 2009; Goffman 2009).

Discrimination may affect health through coping in the form of responses to the stress of feeling stigmatised (Carver, Scheier, and Weintraub 1989). Coping responses may be emotion-focused (regulation of distress) or problem-focused (engaging in behaviours to directly change the situation) (Lazarus and Folkman 1984), and stigma-related characteristics (along the dimensions of visibility and perceived controllability) may influence the coping strategy used (Berjot and Gillet 2011). Race is an example of a visible stigma, potentially leading to greater discrimination, whereas HIV-serostatus and sexual orientation may be less visible but perceived to be controllable (which may be related to victim blame and discrimination). Because discrimination may be seen as a threat to core identity, individuals are highly motivated to engage in self-protective coping strategies.

The prior literature has identified several self-protective strategies that are used to cope with discrimination from HIV, sexual minority identity, and race/ethnicity. A common, proactive problem-focused coping strategy among people living with HIV and sexual minorities is nondisclosure of serostatus or sexual orientation (Asakura and Craig 2014; McDavitt et al. 2008). Concealment of sexual orientation can lead to internal distress (Pachankis 2007), but can help to protect the self by avoiding discrimination (Choi et al. 2011). Black men who have sex with men may practise a race-based form of concealment known as role flexing (Balaji et al. 2012), conforming to situational norms to blend in (e.g. acting masculine when interacting with heterosexual men).

Another proactive self-protective coping strategy is avoidance of places and people perceived as stigmatising, which can lead to worse health through diminished social support

(Moskowitz et al. 2009; Crocker, Major, and Steele 1998). HIV-positive Black men who have sex with men may avoid places and people associated with being HIV-positive and gay/bisexual (McDavitt et al. 2008; Choi et al. 2011; Jeffries et al. 2015). In qualitative research, young Black men who have sex with men have described how experiences with sexual minority discrimination precipitated decisions to selectively disclose, isolate themselves from LGBT communities, and not engage with healthcare (Jeffries et al. 2015).

Another emotion-focused coping strategy identified among men who have sex with men of colour, used when discrimination cannot be avoided proactively, is disengagement—which can take the form of denial, escape through substance use, or physical avoidance (David and Knight 2008). Individuals may regulate emotions and thoughts when being discriminated against by avoiding or leaving the situation (McDavitt et al. 2008; Asakura and Craig 2014). Although such avoidance may serve a self-protective function initially, denial or suppression of emotions can have negative health effects (Quartana and Burns 2007).

Selective affiliation (restricting social interactions to members of one's in-group, such as individuals with similar intersecting identities), is a self-protective, problem-focused coping strategy that may be used to cope with discrimination. People living with HIV may seek similar others to cope, for example, in support groups (Makoe et al. 2008; Siegel, Lune, and Meyer 1998). Creating a community of similar individuals helps to protect the self from discrimination by restricting the circle of people to those who are also marginalised.

Social support and spirituality have been shown to be adaptive coping strategies in the face of HIV, racial, and sexual orientation stigma (Chaudoir et al. 2012; Hickman et al. 2013; Jeffries, Dodge, and Sandfort 2008; Teti et al. 2012; Brondolo et al. 2009; Tate et al. 2006; Graham 2012). Different spirituality dimensions can protect individuals from HIV stigma, including spiritual peace, the degree to which spiritual beliefs provide peace, meaning, and comfort (Chaudoir et al. 2012). However, Black men who have sex with men may simultaneously feel empowered through spirituality and stigmatised by traditional religious teachings (Foster et al. 2011).

In sum, limited work exists on strategies used to cope with discrimination from intersecting identities, specifically among Black men who have sex with men living with HIV. With few exceptions (Graham et al. 2011; Peterson, Folkman, and Bakeman 1996), almost no published research on coping among Black men who have sex with men takes an intersectionality perspective. Therefore, we conducted qualitative research to explore strategies that Black men who have sex with men living with HIV use to cope with discrimination related to being Black, HIV-positive, and perceived as gay, comparing and contrasting ways of coping with discrimination from each type of identity. An intersectionality perspective would suggest that men respond to discrimination through the lens of the whole of their identity (as an HIV-positive Black sexual minority), rather than compartmentalising responses to discrimination by identity.

Methods

Setting

The present study was conducted as an academic-community partnership that included a medical school; a research institute attached to a community health centre focused on lesbian, gay, bisexual and transgender health; and a racial minority-serving AIDS service organisation in the Northeastern USA. The team obtained ongoing input from two community advisory boards (at the medical school and community health centre). Following data collection, participants were invited to a 'member check' forum in which to discuss preliminary results for respondent validation (Krefting 1991).

Participants

Men were eligible if they were at least 18 years-old, self-identified as Black or African American, reported being HIV-positive, and were biologically male at birth. Mixed-race individuals were eligible if they primarily identified as Black or African American.

Forty Black men living with HIV participated in semi-structured interviews, of whom 27 reported having sex with men in their lifetime and, thus, were included in the present analysis. Participants were passively recruited via flyers at community organisations focused on people of colour, persons living with HIV, and LGBTQ clients, as well as through word-of-mouth from staff and community advisory board members. All interviews took place in private rooms at the community health centre or AIDS service organisation from January–April, 2013. Participants received a \$50 incentive.

Procedure—In 1–2 hour semi-structured interviews, participants were asked to describe discrimination events in the past 12-months due to race, HIV-serostatus and sexual orientation. They were probed about institutional (e.g. criminal justice), interpersonal (e.g. family), and traumatic (e.g. assault) discrimination events. Participants were asked their immediate emotional (e.g. 'How did you feel after it happened?'), cognitive (e.g. 'Did you think about the event right after it happened?'), and behavioural (e.g. 'What did you do immediately after the event?') responses. Participants were probed specifically about coping related to social support ('With whom have you discussed this experience?') and avoidance ('Do you try to avoid similar situations now, and if so, how?'), as well general reflections ('To what extent do you think that this event affected your life?'). Finally, participants were asked about psychosocial resources ('What helps you to cope with situations like that?'), with probes for social support and spirituality. Interviews were audio-recorded and transcribed verbatim. Table 1 shows sample characteristics (collected in a brief survey). Procedures were approved by the Fenway Institute Institutional Review Board.

Analysis

Data were organised with qualitative analysis software (Dedoose; www.dedoose.com). Using thematic analysis (Joffe and Yardley 2004), narratives were coded for discrimination experiences and coping responses. The investigators and coding team members were diverse with respect to race/ethnicity (2 White, 4 Black/African American, 1 Indian American), sexual orientation (3 gay-identified, 4 heterosexually identified), and gender (3 cisgender

men, 4 cisgender women), and the interviewers included 2 Black/African American women and 2 Black gay men. Two investigators independently reviewed all transcripts to develop the coding scheme, by creating an initial listing of types of discrimination and coping strategies. The team then developed a codebook listing each type of discrimination and coping strategy accompanied by a detailed description, inclusion/exclusion criteria, and typical examples (Ryan and Bernard 2011). Two coders marked areas of text pertaining to each type of discrimination and coping strategy, practising with a random sample of 20% of transcript sections, coding independently, and then reviewing codes together. When coder disagreement revealed ambiguity in the codebook, the team added examples and combined similar categories of codes. After each coder consistently identified each theme, both coders worked on 20% of interviews independently, after which we assessed coder consistency, evidenced by Cohen's kappas of .70 (Cohen 1960). The kappa for discrimination target (HIV, race, sexual orientation) was 0.93 and for discrimination type (interpersonal, institutional, traumatic) was 0.94. See table 2 for kappas for and definitions of each coping theme.

Following coding completion, we examined the distribution of themes to understand how participants coped with discrimination. We examined repetitions across interviews and examples of psychosocial processes, behaviours, and cultural assumptions (Ryan and Bernard 2011; Ryan and Bernard 2003). We compared and contrasted coping strategies from discrimination related to different identities.

Findings

Discrimination events

Interpersonal discrimination—Participants spoke frequently about HIV- and gay-related interpersonal discrimination. Unprompted, public and overt racist incidents from strangers were commonly shared (e.g. being called racial epithets on the street). When discrimination involved multiple identities, often participants reported that their race was central to the event. For example, a 47-year-old gay man was verbally harassed by another Black man when walking with his boyfriend, highlighting the combined stigmas of being a Black gay man in the eyes of other members of the Black community: 'We were walking in Times Square and some young Black dude in the crowd yells, "Hey, you big Black dude! Why are you holding that dude's hand?"'

Several instances of HIV-related interpersonal discrimination involved involuntary serostatus disclosure. For example, as recounted by this 21-year-old man: 'I told him it was highly confidential that you do not tell your family... the first time we went to their house for Thanksgiving, I wasn't allowed to cook or use sharp objects to cook [because his family knew my status]'.

Institutional discrimination—Black-related institutional discrimination was commonly discussed. Several striking law enforcement examples were elicited, all of which started as a racial event, and some of which involved discrimination from other identities. For example, a 42-year-old bisexual man was made to wear a mask while he was incarcerated because of fear that he would transmit HIV: 'When I was incarcerated... I had a cold, and I was told

that I had to wear a mask, and I couldn't really breathe... It made me feel like an animal, like I was less than a human being.'

In an example of racism and sexual minority discrimination by the police, a 23-year-old college student discussed an incident in which he was leaving a liquor store with his fraternity brother. Eight police officers surrounded their van, demanded to see their licenses, and threatened to call their university to jeopardise their financial aid (they were assumed to be on financial aid based on their skin colour): 'One of the female officers was making all of the homophobic jokes... "We're going to take you in and you're going to be in a cell with a lot of guys but... you might like that... you guys might like guys, don't you?"'

Other institutional discrimination events involved housing, healthcare, and the church, and tended to be exhibited as microaggressions (subtle and/or ambiguous verbal, behavioural, and environmental indignities) (Sue et al. 2007). In a narrative about racial discrimination, a 39-year-old bisexual man described how he was told that no rental units were available for several months, despite the recent posting of a newspaper advertisement for the housing complex. Several participants experienced discrimination at the dentist's office based on their serostatus (e.g., by receptionists who did not keep their medical information confidential). Others experienced insults for being gay at church; a 52-year-old gay man reported, 'My reverend... explained to me—gay... is an abomination to God.'

Traumatic discrimination—Traumatic discrimination in the form of physical assault was less common and usually involved race, either alone or as a backdrop to the event; many such instances could also be considered institutional discrimination. For example, a 42-year old bisexual man was severely beaten up by multiple prison guards and called a racial epithet because he refused to lie on the floor when asked ('When they were attacking me, they were calling me a n——').

Coping

Avoidance—Across narratives, the main reported coping strategy was *avoidance*, which included using behaviours, cognitions, and emotions to escape from thinking about the discrimination-related stressor itself, or from the effects of it. Avoidance was most commonly used to counter racial discrimination, and the ways in which avoidance manifested as a coping strategy differed by identity. Avoidance could be both reactive (responses in the immediate aftermath of a discrimination event) as well as proactive (behaviourally avoiding situations in which discrimination was anticipated/had been experienced previously). Proactive avoidance specific to HIV involved selective disclosure to those who were felt to be tolerant and trustworthy.

Reactive avoidance: Participants described affective and cognitive avoidance in response to discrimination, in which they carefully controlled external reactions to the perpetrator, trying to remain calm and disengage from the situation, trying not to let the situation affect them, and generally suppressing overt emotional responses. Participants also described behavioural reactions (walking away from the perpetrator; physically disengaging).

Many participants faced with racism echoed the sentiments of this 67-year-old gay man, walking away, letting go emotionally, and remaining stoic in the face of discrimination: 'In the moment, my response would be to disengage, to be very polite, to be very quiet, and try not to be or seem aggressive or angry or upset... to check my own emotions and feelings... It took all of my power to not let them know, in any way, that I heard them'.

Although some participants were able to disengage fully, others described the need to suppress internal negative emotions, including concealed anger and anxiety. Although a less common reaction to sexual minority and HIV discrimination, participants had similar responses to these stressors as they did to racism, and tended to discuss more cognitive and emotional disengagement than behavioural: '... take my mind someplace else, so that I'm not wallowing in that. Just move onto the next thing' (59-year-old gay man, in response to sexual orientation discrimination).

Proactive avoidance: Some forms of behavioural avoidance were physical, characterised by choosing not to be in certain situations, or segregating oneself from certain people. This coping strategy was used as a protection from future mistreatment. Participants would choose not to be in places in which discrimination had occurred (e.g. neighbourhoods, clinics, stores) or not to associate with people who had mistreated them in the past. After experiencing racism, participants spoke of trying to avoid White people and the police, and trying to staying within Black neighbourhoods whenever possible. For example, a 52-year-old gay man was not willing to call the police when he was the victim of a sexual orientation-related hate crime, based on fears of facing racial discrimination: 'I don't want to call the cops—when you're Black, you don't like to deal with the police too much.' Although physical avoidance was frequently mentioned across discrimination types, it was more commonly discussed in response to sexual minority and HIV-related discrimination compared to racism, perhaps because people considered racism to be ubiquitous and hard to avoid.

In contrast to proactive avoidance of racism, which tended to be discussed in the context of strangers or institutions, for heteronegativity or HIV discrimination, physical avoidance was most often discussed in the context of interpersonal relationships. A 23-year-old gay man expressed his need for physical isolation to protect himself from sexual minority discrimination and to create safe spaces:

'For physical survival, I try to curtail the ways in which I have to interact with these people... the path of least resistance, to be away from them, to try and isolate myself... I try to imagine a space or a place where these types of things don't exist, or at least aren't as pervasive, and then I try to—with my studies, research, and school, and careers I want to have—create that space'.

For HIV-related discrimination in particular, participants tended to use a specific type of proactive avoidance, selective disclosure (planning whom to tell and not to tell). To avoid discrimination, participants withheld information about their serostatus from others and, in some cases, used deception. For example, a 59-year-old gay man told others that his medications were for a mental illness:

‘To avoid HIV stigma... I feel more comfortable telling someone that I’m bipolar than I feel telling them that I’m HIV. Because, at least with bipolar, you didn’t do anything to get to be bipolar. Whereas, if you tell someone [you] have HIV, people assume that there’s something that *you did* that resulted in your being HIV-positive’.

Another 21-year-old gay man discussed hiding his serostatus because of not wanting to add another stigmatised identity to others’ perceptions of him:

‘I’ve been wanting to step up and talk to somebody about my HIV-status, but I’ve also been hiding from it because I just don’t want to deal with the fact that I have it. It’s really hard especially if I’m gay, Black, *and* HIV positive... people discriminate [against] me because I’m that kind of person.’

External attribution—Another major coping strategy was *external attribution*, which manifested in two ways: placing responsibility on the perpetrator, or making an attribution to wider societal attitudes, rather than internalising the discrimination and blaming the self. Although this strategy was used across identities, participants tended to be more optimistic that HIV- and sexual minority-related discrimination would decrease in society in the future, as compared to racism—which they felt was more entrenched, leading them to be more resigned.

External attribution was intertwined with avoidance. Participants tended to avoid, or want to avoid, people who or places that they felt were innately discriminatory, especially those that they did not believe could be changed. Participants realised that they themselves did not do anything wrong and did not need to change, protecting their own sense of self-worth by attributing responsibility to the perpetrator or society.

Similar external attributions to perpetrators emerged across identities. This strategy was most commonly exhibited as a belief that others were ignorant, needed to be educated (especially about sexual minorities and HIV), had ‘their own issues,’ or were ‘having a bad day’. Speaking about sexual minority discrimination, this 29-year-old bisexual man said, ‘There’s a big demographic of Black men who think like this, who are very ignorant... that’s who we got to change, because they’re going to pass it along to their kin.’

In response to racism in White communities, and heteronegativity or HIV discrimination in Black communities, participants sometimes noted that perpetrators were from an older generation that needed to be educated, or that Black communities tended to harbor such attitudes about sexual orientation. A 42-year-old bisexual man discussed a racist comment from his wife’s White stepmother: ‘When she was a kid, even when I was a kid, racism was really, really, really, really big.’

External attribution also manifested more generally, about society as a whole—as an awareness of discrimination as an unfortunate, uncontrollable reality in everyday life. People were aware that discrimination, especially racism, was pervasive, and felt that they did not have the agency to change societal norms. Most instances categorised under this theme focused on dismissing a particular perpetrator; however, in some cases, there was an

understanding that discrimination was systemic, institutionalised in society, and larger than one person. Participants seemed particularly resigned to thinking that racism, especially institutional racism, was embedded in US culture and could not be changed (e.g. ‘that’s how police are’). Men spoke of racism as being entrenched, permeating their daily lives:

‘It’s not like I wake up thinking, “I’m a Black man!” I wake up thinking, “I’m a human being on this earth and an American.” And then I go out into society and something happens that reminds me, don’t forget who you are.’—47-year-old bisexual man’

In contrast, participants believed that attitudes about sexual minorities and HIV were evolving over time and improving among younger generations. A 29-year-old bisexual man noted the intersectionality between sexual minority and HIV stigma, with attitudes toward both becoming more positive: ‘What HIV was is not now. We are an evolved people, and things are going to continue to change. We can’t stay being ignorant with the old ways of the eighties.’

Similarly, a 42-year-old bisexual man reflected that he, too, used to have misconceptions about HIV, but that he grew more enlightened:

‘Some people are very ignorant... I used to be one of them people, where I thought that if you breathe the same air, it was catchy... I just got educated.’

Social support—The third major coping strategy to emerge was social support-seeking from friends and family, as well as the church. Social support allowed for strength in the face of future anticipated discrimination. Social support was most often used to deal with experienced and anticipated racial discrimination.

Social support-seeking most often emerged in response to racial discrimination. Participants seemed to have a larger circle of support to deal with racism, because they perceived greater social acceptability to discuss racism with family and friends in their mostly Black social networks. In contrast, heteronegativity or HIV discrimination could only be shared with those to whom they had disclosed their sexual orientation and/or HIV-serostatus. The circle of confidants who could be told about discrimination from all three types identities was small and, therefore, this strategy was reported less often for those types of discrimination experiences.

Participants related several ways in which they leveraged support—to gain information and advice, get reassurance, and help them take action. For all types of discrimination discussed, most participants noted that they could rely on at least a subset of family members and friends to provide counsel. Particularly in response to racism, participants sought strength from the church. Some participants, like the following 45-year-old gay man, got advice about, for example, ways to avoid racism:

‘A lot of my friends said, “Don’t go shopping, don’t go to [the mall in the city]. Go to the [malls in the suburbs],” because they’re not gonna follow you here.’

Some participants found that family members gave more support than anticipated when learning of their sexual orientation or HIV-serostatus:

‘When my parents found out [about my serostatus], it wasn’t the big deal that I thought it was gonna be... Nobody treated me any different. In fact, they said, “we love you, we will always love—cause you’re such a nice person and don’t change. We’re just happy that you’re here.” ’ –67-year-old gay man

Participants expressed the challenge of finding people to support the whole of their identities. For example, this 42-year-old heterosexual man heard positive and negative messages from fellow church-goers, and non-acceptance in church teachings, about sexual orientation: ‘I also have a home myself in church... my support is there and, at the same time, there’s people who try to limit me from getting those blessings’. Some participants found that people who shared some but not all of their identities gave imperfect support, and that individuals most similar to them were best able to support their integrated identity as a Black gay/bisexual man:

‘When I talk to Black men about race, there’s not a lot of decoding. But when I talk to Black queer men... I don’t have to talk to you like code, or ease you in to the sexuality part of it, or your own kind of masculine privilege or assumptions.’ (23-year-old gay man)

Self-advocacy—Active problem-focused coping strategies (intended to change the nature of the stressor) were reported infrequently. A handful of participants discussed self-advocacy (actively countering discrimination by confronting perpetrators or reporting discrimination to authorities). For example, some participants spoke up when someone made an insensitive remark or acted in a discriminatory way. Such participants educated the perpetrator (e.g. about the reality of how HIV is transmitted: ‘I educated her. I go over there and we eat off of the same plates.’ –52-year-old gay man). Only a few participants reported resorting to violence (e.g. physically assaulting the person who insulted them). A small number of participants reached out for help to friends or acquaintances who were in power positions (e.g. lawyers, law enforcement officers), or to formal organisations that handle anti-discrimination legal cases such as the American Civil Liberties Union, Gay and Lesbian Advocates and Defenders (a Massachusetts-based legal action organisation), the National Association for the Advancement of Coloured People, and the Better Business Bureau. In most of these cases, however, participants recounted that the perpetrator was not penalised or did not suffer negative consequences that they knew about.

Whether participants responded to discrimination actively or passively seemed to depend on their assessment of the situation’s risk. When they feared for their safety, or were unsure of the risks (e.g. of confronting a stranger in public), men reported using avoidance instead of direct confrontation.

‘Sometimes, you need to shut your mouth, just sit there... If you got a thug and, you know... he’s bigger than you, he can beat you up, get you involved, you know, gay bashing... sometimes, you don’t need to say those things. By your reactions and by... ignoring them, that’s the best thing you can do... Sometimes, you need to say things and sometimes you don’t need to say things.’ (52-year-old gay man)

Discussion

In this study, Black men who have sex with men living with HIV described experiencing ongoing discrimination across all of their identities, with frequent narratives about institutional racial discrimination, by law enforcement, as well as interpersonal discrimination prompted by HIV-serostatus and sexual minority identity. The theme of intersectionality ran through the narratives, with discrimination experienced through the lens of being a Black HIV-positive man who has sex with men. Discrimination that targeted one aspect of participants' identity (e.g. race) was experienced (and managed) from the standpoint of their full array of identities. For example, participants told stories of being insulted by other Black individuals for being gay, potentially because they did not conform to a Black masculinity ideal (Fields et al. 2015); their sexual orientation was viewed by others in their community, and themselves, through the lens of being Black. Consistent with some participants' narratives in prior research (Bowleg et al. 2003), Black identity emerged as a salient identity, in terms of others' perceptions (and mistreatment), and their own self-perceptions.

Participants developed diverse coping strategies for survival in the face of discrimination. They seemed to have a more well-established, broader repertoire for responding to racism than to other discrimination types. Because race is an ascribed characteristic, visible from birth, participants would have had the opportunity to practice a variety of different strategies over time, and to determine which worked best for them in different contexts through trial-and-error. Additionally, participants may have developed their racial identities in the context of socialisation within Black families, peers, and communities, who likely transmitted stories of racism and guidance about how to respond, for example, when one is detained by the police (Sanders-Phillips 2009; Hughes 2003; Thompson 1994). Such identity socialisation was likely less available for their sexual orientation and HIV-related identities, especially for those who rarely disclosed these identities to others.

Participants seemed to use similar coping strategies across all identities. However, consistent with prior research, participants discussed avoidance and support-seeking most commonly in response to racism (Brondolo et al. 2009). Support seeking did not work as well for sexual minority and HIV-related discrimination, because many chose not to disclose these identities to others whom they feared might be intolerant. Although participants tried to find ways to share their sexual orientation and HIV-related discrimination experiences with similar others, this was challenging. For example, consistent with prior work, they encountered stigma within the church related to HIV and sexual orientation, but also drew strength from the church when they experienced racism (Foster et al. 2011; Quinn, Dickson-Gomez, and Kelly 2016).

Well-honed passive strategies, such as ignoring or avoiding the perpetrator, and attributing mistreatment to the perpetrator or societal norms, were helpful as a survival mechanism—to protect individuals from potential escalation of the situation. Prior research has indicated similar identity protection strategies, including attributing poor outcomes to the prejudice of others, rather than to one's own personal shortcomings (Crocker and Major 1989). Moreover, when some participants were insulted by strangers in public, many refused to

show outward signs of emotion, suppressing their reactions. However, a pattern of suppressing negative feelings can erode health (Gentry 1985; Quartana and Burns 2007; Koh et al. 2005).

Although participants expressed a desire to act against discrimination, few did, because of a fear that social action would lead to greater personal harm, or a pessimism and resignation that action would be fruitless. Most determined that active coping in the form of social advocacy and legal action was not worth the personal costs, given limited probability of success (Bell 1973). Of the few participants who confronted perpetrators, either directly or working through advocacy organisations or the legal system, most were unsuccessful, potentially contributing to the despair and hopelessness observed about racism in particular.

Despite the barriers that participants encountered in overcoming discrimination, our research suggests that the men maintained a will for social action, and that they had a set of well-developed coping skills, especially for racism. Given the isolation reported by participants, and the helplessness they expressed in the face of chronic and unavoidable discrimination, interventions could be developed to guide men on further developing their innate coping skills. For example, cognitive-behavioural therapy, which is well-positioned to improve mental health among minorities (Pantalone, Iwamasa, and Martell 2009), could be used to track responses to discrimination experiences, and to guide individuals to consider their responses in relation to life goals and values. Importantly, however, to narrow disparities, societal efforts to reduce discrimination need to be implemented in tandem with individual-level interventions, as the burden of societal change should not be placed on the targets of discrimination.

Our results contrast with some prior published research. Two quantitative studies did not find significant associations between coping and mental health among Black sexual minority men (Graham et al. 2011; Peterson, Folkman, and Bakeman 1996). However, these studies used quantitative coping measures that were developed with largely non-minority samples (Folkman and Lazarus 1980; Carver, Scheier, and Weintraub 1989). Additional qualitative research is needed to tailor coping measures for individuals with multiple marginalised identities, in order to further advance the field.

As with any individual study, there are limitations. Qualitative explorations are not meant to extract representative data and, thus, our data should not be used to make conclusions about population levels of discrimination and coping. Men's experiences may have been influenced by the study's unique urban context. Many participants came from largely racially segregated neighbourhoods, where they could draw on social support from similar others, and where they may not have been frequently exposed to people of other racial groups. In addition, the average age of the sample was 46. The discrimination experiences and coping strategies among younger men merit further exploration.

Our qualitative investigation uncovered a range of discrimination experiences and coping mechanisms among Black men who have sex with men living with HIV, from which we were able to present a picture of how men at the intersection of multiple identities interact with their environment when experiencing mistreatment. These data are intended to provide

a springboard for discussion about structural-level interventions that ultimately could provide a pathway to reduced societal discrimination, and ultimately, health equity.

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Table 1

Characteristics of 27 HIV-Positive Black Men Who Have Sex with Men interviewed

Socio-Demographic Characteristics	Mean (SD) or n (%)
Age [M (SD); range]	46.5 (11.6); 21–67
Education [n (%)]	
Less than high school diploma	1 (4%)
Completed high school	8 (30%)
Some college	8 (30%)
College degree	6 (22%)
Some graduate	1 (4%)
Graduate degree	3 (11%)
Income [n (%)]	
Below \$10,000	7 (26%)
\$10,000–\$20,000	10 (37%)
\$20,001–\$30,000	5 (19%)
\$30,001 or over	2 (7%)
Don't know	3 (11%)
Employment status [n (%)]	
Full-time	1 (4%)
Part-time	10 (37%)
Unemployed	10 (37%)
Retired	1 (4%)
Refused to answer	1 (4%)
Other	4 (15%)
Housing status [n (%)]	
Own or rent home or apartment	18 (67%)
Subsidised housing	3 (11%)
Residential treatment facility	2 (7%)
Living with a friend/relative	3 (11%)
Temporary/transitional housing	1 (4%)
Sexual orientation [n (%)]	
Heterosexual	1 (4%)
Gay/same-gender loving	17 (63%)
Bisexual	9 (33%)
Medical Characteristics	
CD4+ count [M(SD)]	1230.1 (2354.7)
Viral load [n (%)]	
Undetectable	14 (52%)
Detectable	10 (37%)

Socio-Demographic Characteristics	Mean (<i>SD</i>) or n (%)
Don't know	2 (7%)
Refuse to answer	1 (4%)
Taking antiretroviral medications [n (%)]	23 (85%)

Note: Percentages do not equal 100% due to rounding.

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Table 2

Discrimination-Related Coping Strategies (Kappas and Definitions)

Coping Strategy	Kappa	Definition
Reactive Avoidance	0.74	Choosing not to engage (cognitively, emotionally, or behaviourally) with perpetrator after discrimination event
Proactive Avoidance: General	0.70	Choosing to avoid certain situations or people
Proactive Avoidance: Selective Disclosure of Serostatus	0.84	Choosing to hide or not disclose serostatus
External Attribution: Individual Perpetrator	0.77 ^a	Placing responsibility on perpetrator
External Attribution: Societal Norms/Attitudes	0.77 ^a	Accepting reality of societal discrimination being beyond one's control
Social Support	0.88	Reaching out to someone formally or informally (e.g. friends, family, support groups)
Self-Advocacy	0.83	Taking steps against discrimination (e.g. directly confronting perpetrator, reporting discrimination)

^aNote: Kappa calculated for external attribution theme as a whole