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# Identity management strategies among HIV-positive Colombian gay men in London

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## ABSTRACT

This study set out to explore the social-psychological aspects of living with HIV among a group of HIV-positive Colombian gay men in London, and the strategies that they deployed to manage ensuing threats to their identities. Focus group and individual interview data were collected from 14 Colombian gay men living with HIV, and were analysed using qualitative thematic analysis and identity process theory. The following themes are discussed: (1) identity struggles and conflicts in Colombia, (2), managing multiple layers of social stigma in England, and (3) changing interpersonal and intergroup dynamics, which highlight the inter-connections between sexual prejudice, sexual risk-taking and HIV stigma. Identity may be chronically threatened due to the multiple layers of stigma, which can limit the coping strategies available to individuals. Findings strongly support the need for action and programmes to highlight and tackle both racism and HIV stigma on the gay scene and to fund more specific resources for sub-communities of gay, bisexual and other men who have sex with men, which employ appropriately trained and culturally competent staff.

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## Introduction

The incidence of HIV among gay, bisexual and other men who have sex with men in the UK continues to rise each year. 69% of those infected in 2011 were born outside the UK (PHE 2013). Latin American gay and bisexual men are deemed to constitute a high-risk group (Granada and Paccoud 2014). A diagnosis of HIV can constitute a particularly traumatic experience, especially for those from already marginalised groups, such as Latin American gay and bisexual men who may lack the social support key to coping with HIV-related stressors (Weaver et al. 2005). These stressors can challenge wellbeing (Lee, Kochman, and Sikkema 2002).

There is much empirical work on experiences of living with HIV among various sociodemographic groups (e.g. Alexias, Savvakis, and Stratopoulou 2016; Flowers et al. 2011; Varas-Díaz, Serrano-García, and Toro-Alfonso 2005). These studies demonstrate the impact of HIV diagnosis on identity construction/management. Despite the growing Latin American

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presence in the UK, estimated at approximately 186,500 people (Milmo 2013), there has been no research into the experience of living with HIV among Latin American gay men living in England. To begin to address this lacuna, this study examined the social-psychological aspects of living with HIV among a group of HIV-positive Colombian men who have sex with men in London and the strategies for coping with identity threat.

### **Threats to identity**

This study draws on identity process theory (Jaspal and Breakwell 2014), which provides an integrative model of identity construction, threat and coping. The theory postulates that individuals construct their identity through two processes:

- (1) *Assimilation-accommodation*, which refers to the process of absorbing and creating space for new information in identity.
- (2) *Evaluation*, which refers to the process of attributing meaning/value to identity components.

These processes are in turn guided by various motivational principles that specify the desirable end-states for identity: self-esteem, self-efficacy, distinctiveness, continuity and coherence. Authenticity has been defined as ‘the sense that one’s life, both public and private, reflects one’s real self’ (George 1998, 134). It could be considered an additional principle of identity as it constitutes a guiding goal. We construct our identities in ways that provide us with appropriate levels of these principles. If these principles are somehow jeopardised, for instance by changes in the social context, identity is threatened. When identity is threatened, the individual engages in strategies for coping. Existing research demonstrates the potential threats to identity among HIV-positive gay men, such as the imposition of change in identity due to HIV diagnosis (Flowers et al. 2011) and the loss of self-esteem as a result of HIV stigma (Lee, Kochman, and Sikkema 2002). Contrariwise, some of these strategies could also be interpreted as adaptive strategies for managing or resisting societal stigmatisation (Parker and Aggleton 2003).

### **Gay men’s experiences of living with HIV**

Given advances in HIV treatment, HIV-positive individuals in most industrialised countries now have a near normal life expectancy. Yet, HIV diagnosis can still have a profoundly negative impact for identity. Flowers et al. (2011) note that a positive diagnosis can lead to unwelcome changes in self-construal as individuals must assimilate/accommodate a stigmatised identity element, namely their new serostatus. The assimilation/accommodation of this new identity element can include a range of deflective strategies for coping, including denial, anxiety, depression and suicide ideation (Ciesla and Roberts 2001).

One of the chronic complex problems associated with living with HIV is social stigma, which can introduce setbacks both for individual health (Pence 2009) and for HIV prevention (Glick and Golden 2010). HIV stigma is described by UNAIDS (2003, 1) as ‘a process of devaluation of people either living with, or associated with, HIV and AIDS’ and HIV discrimination as the ‘unfair and unjust treatment of an individual based on his or her perceived HIV status’. HIV stigma is widespread, even in contexts in which HIV prevalence, advocacy and awareness are high (Stutterheim, Bos, and Schaalma 2008).

Some research has explored the qualitative nature of HIV stigma and its social-psychological impact. One survey of HIV-negative Latino gay and bisexual men in the USA found that over 50% of respondents believed that HIV-positive people were more promiscuous than HIV-negative people and thus responsible for their serostatus (Courtenay-Quirk et al. 2006). These negative representations of seropositive individuals can jeopardise their social-psychological wellbeing.

HIV stigma may in turn lead to problematic behavioural outcomes, possibly as individuals attempt to cope with the ensuing threats to identity. For instance, low self-esteem (itself associated with the experience of HIV stigma) can lead individuals to engage in: high-risk sexual behaviours (Thomas et al. 2014), potentially exposing others to HIV and themselves to co-infections; and drug use in sexualised settings (Bourne et al. 2015), which can lead to sexual risk-taking behaviours. Moreover, stigma may induce a reluctance to disclose one's HIV status to sexual partners as a means of avoiding rejection (Smith, Rossetto, and Peterson 2008), which can potentially lead to onward HIV transmission. HIV-positive individuals who report social stigma are over twice as likely to manifest poor adherence to their HIV medication regimen and five times more likely to experience poor access to HIV-related medical care (Sayles et al. 2009).

Cultural heritage is likely to play an important role in the ways in which individuals respond to HIV diagnosis, as individuals rely at least partly on social representations of HIV that are prevalent in their respective cultural and community contexts. For instance, a dominant social representation in religious discourses surrounding HIV and AIDS is that of divine retribution for non-adherence to religious norms, which may plausibly shape meaning-making among Christians diagnosed with HIV (van Dijk et al. 2014).

### ***HIV among Latin American gay and bisexual men***

In 2008 186,500 Latin Americans were estimated to be living in the UK (61% of them in London) (McIlwaine, Cock, and Linneker 2011). Latin American gay and bisexual men in the UK face significant sexual health inequalities, including an increased HIV burden, which can be attributed partly to socioeconomic inequalities, including low levels of education, poverty and poor access to healthcare. Of men who have sex with men who were diagnosed with an STI in 2013, 8% were born in Latin America (PHE 2014). Moreover, it is estimated that in 2011, 1-in-8 men who have sex with men diagnosed with HIV in the UK was born in Latin America (PHE 2013). There is also a sizeable Colombian population in the UK – according to the 2011 UK Census, 25,182 UK residents were born in Colombia.<sup>1</sup>

Colombia has the second highest HIV prevalence in Latin America – estimated to be between 0.7 and 1.1% of the general population (UNAIDS 2010). HIV prevalence may be as much as 23.7% among men who have sex with men in Cali, 15.3% in Barranquilla and 16.3% in Bogota (Rubio Mendoza et al. 2015). Many men who have sex with men in Bogota are living with HIV for extended periods of time without diagnosis or treatment, which jeopardises disease prognosis and heightens the risk of onward transmission (Zea et al. 2016). Given the current healthcare system in Colombia, many HIV-positive individuals end up incurring considerable out-of-pocket expenses and some decide to emigrate for better health prospects (Hart et al. 2015).

Research with Colombian men has found high rates of condomless anal intercourse (Miguez-Burbano et al. 2001), which puts this group at high risk of HIV infection. HIV

awareness and knowledge are generally low among Colombian young adults, and there is a perception of low risk of infection particularly among men, which can contribute to growing HIV incidence (Djellouli and Quevedo-Gómez 2015). In a cultural context of *machismo*, some men may find it difficult to negotiate condom use. Some men who do have sex with other men but who identify as heterosexual may perceive themselves to be at low risk of HIV acquisition and, thus, refuse to use condoms (Quevedo-Gómez et al. 2012).

The influence of the Church over sociopolitical affairs also constitutes a barrier to distributing condoms and sex education, both at school and in the home environment (Djellouli and Quevedo-Gómez 2015). These effects are compounded by anti-lesbian, gay, bisexual and transgender discourses and HIV-related prejudice prevalent across various Christian dominations in Latin America (Djellouli and Quevedo-Gómez 2015; Chaux and León 2016). HIV stigma is a barrier to HIV testing. It can seriously compromise self-esteem (Lee, Kochman, and Sikkema 2002) and, thus, some individuals simply prefer not to know their HIV status. Given that HIV infection is often anchored to sin and promiscuity, many feel ashamed of testing for HIV. Furthermore, there is a general distrust of healthcare professionals, some of whom may have violated confidentiality and disclosed their clients' HIV status to others (Djellouli and Quevedo-Gómez 2015). This can lead to infrequent testing behaviours, greater cases of undiagnosed HIV and increased onward transmission. Indeed, in a study of men who have sex with men and transgender women in Bogota, Zea et al. (2015) found that over 60% of their HIV-positive respondents were unaware of their infection before the study.

HIV patients in Colombia have a greater probability of mental health problems and an increased risk of progression to AIDS than other groups, which has been attributed partly to the association of psychological disturbances with low drug adherence, fewer medical visits, increased illicit drug use and continued sexual risk-taking (Castillo et al. 2008). Social support has emerged as a key variable predicting positive health and wellbeing outcomes among HIV-positive Latin Americans (Rodríguez et al. 2007). However, given the prevalence of social stigma and the misinformation about HIV and AIDS, social support may be difficult to obtain.

In a study of Colombian men who have sex with men living in New York (Zea et al. 2009), it was found that 32% of respondents were living with HIV and that an additional 12.4% were unaware of their serostatus. In the UK, there has recently been greater recognition of the need to respond to the sexual health inequalities faced by Colombian and other Latin American men who have sex with men (PHE 2016). This paper therefore addresses a lacuna in existing research, namely the social-psychological implications of living with HIV among Colombian gay men living in the UK. Drawing upon identity process theory, the study explores the ways in which identity may be challenged and indeed defended in the face of HIV diagnosis.

## Methods

Data for this study were collected as part of a project funded by Public Health England/MAC AIDS that set out to evaluate a series of sexual health interventions aimed at Black and minority ethnic men who have sex with men (Jaspal, Fish et al. 2016). In this paper, we focus only on the HIV-positive Colombian cohort.

### **Participant selection and data generation**

Data collection consisted of a focus group, in which four individuals participated (age range: 28–42) and 10 individual interviews (age range: 25–45). All interviewees were recruited at a sexual health charity in London. All participants self-identified as gay. Participants had been living in the UK for 1–25 years. Nine of the interviewees indicated ‘cleaning assistant’ as their occupation, three were studying in college and one was a hairdresser. Twelve of the interviewees had completed high school and two had finished university education in Colombia. All of the interviewees had family ties with Colombia and travelled back to the country periodically. Only one interviewee had close family members in London. Eight individuals were diagnosed with HIV in Colombia and six in the UK. All interviewees were currently on antiretroviral therapy and virally suppressed (HIV viral load < 50 copies/ml).

Both the focus group and individual interviews were guided by a semi-structured interview schedule that tapped into self-description, self-categorisation, identity, sexual health perceptions and experiences of living with HIV. While the focus group yielded rich insights into the more socially shared experiences of Colombian gay-identified men living with HIV, the interviews captured individual affective and psychological processes. The focus group lasted for 70 minutes and individual interviews between 60 and 90 minutes. All interviews were conducted in Spanish by the bilingual first author and digitally recorded and transcribed verbatim. Data were collected in a community centre, where several of the participants attended lesbian, gay, bisexual and transgender social/support groups.

### **Analytic approach and procedure**

The data were analysed using an inductive, interpretative variant of thematic analysis, which has been described as ‘a method which works both to reflect reality, and to unpick or unravel the surface of “reality”’ (Braun and Clarke 2006, 78). This approach allowed the authors theoretical and epistemological flexibility to consider both experiential and more discursive elements of the accounts and aspects of their intersection, which is useful in the context of identities which are complex, dynamic and both internally represented and externally performed.

Initial analysis was carried out by the first author. During each reading of the transcripts, preliminary impressions and interpretations were noted in the left-hand margin. These initial codes included *inter alia* participants’ meaning-making, particular forms of language and apparent contradictions and patterns within the data. Subsequently, the right margin was used to collate these initial codes into potential themes with subsequent higher-level interpretative work. Specific data extracts, which were considered vivid, compelling and representative of the themes, were selected for presentation below. Each quote indicates the participant’s pseudonym, their age and number of years living in London.

### **Findings**

In this section, the following three themes are discussed: (1) identity struggles and conflicts in Colombia, (2), managing multiple layers of social stigma in England and (3) changing interpersonal and intergroup dynamics. In keeping with the aims of the paper, the analysis is informed, but not driven, by tenets of identity process theory.

## ***Sexual identity struggles and conflicts***

Several participants described the challenges that they experienced in relation to their sexual identity development in Colombia, which they felt had led them to conceal their gay identity from significant others:

There was a lot of homophobia in Colombia, you know. It wasn't talked about at all and you, deep down, knew it was wrong ... I couldn't tell anyone I was gay. I had to lie. (Pablo, age 30, 2 years)

My childhood was the worst time in my life because I was abused you know and I always wonder if this was the reason I turned out gay .... When I felt sexual attraction, it felt dirty. (Fernando, age 36, 4 years)

Individuals reported giving negative valence to their developing sexual identity and, thus, self-categorisation as gay could challenge their self-esteem. Some interviewees anchored their sexual identity to traumatic past experiences, such as sexual abuse or homophobic bullying. Individuals were socialised in a social context that provided only negative explanations for the 'causality' of gay sexuality. This social context included, among other things, their religious group identity, which overtly condemned homosexuality, and the *machista* Colombian culture that prioritises traditional masculinity (Quevedo-Gómez et al. 2012). This attribution tendency exhibited a discernible sense of internalised homophobia in some participants.

The negative value appended to their sexual identity had implications for sexual behaviour. Many felt immersed in a world of secrecy in which any public recognition of their sexual behaviour was unthinkable. In addition to undermining identity authenticity, this often led to a lack of emotional connection with partners and, in some cases, to sexual risk-taking:

I didn't want to be seen at all so I just had sex, anonymous sex, in fields, cruising places. It was just with strangers. There was no 'what's your messenger or phone number?' it was just sex and then goodbye. (David, age 29, 1 year)

No, I never used condoms. I didn't even think about this at all. It was just about getting sex. Quick and discreet sex. (Miguel, age 32, 1 year)

The secrecy that enveloped individuals' sexual lives led them to seek sexual encounters in clandestine ways. Miguel, David and other respondents reported having sought sexual encounters in public spaces at night. This enabled them to derive sexual pleasure with strangers without the need to share contact details or to maintain any sort of relationship following the sexual encounter. In these contexts, sex was reportedly often unprotected. Individuals' appreciation of sexual risk was low and, in many cases, they simply did not think about the potential health risks of sex without condoms. The priority was to have sex, which needed to be 'discreet', and, thus, the need for condoms was often of secondary importance.

In addition to the stigmatised gay identity, which individuals concealed, their HIV diagnosis came to constitute a source of identity threat:

When I tested positive for gonorrhoea the nurse in Colombia told me I deserved this and that this is what happens to gay people, and then when I tested positive for HIV, I felt like an outcast from society. (Pedro, age 45, 25 years)

HIV for me, it confirmed that this is what you get for all of the bad things that you've done. It was like a payback. I felt very bad about myself. (Alvaro, age 27, 3 years)



Interviewees were exposed to negative social representations concerning both their sexual identity and their HIV status, which led to internalised homophobia and HIV-related self-stigma. Individuals' interactions with sexual health professionals and other medical professionals in Colombia were generally negative and judgmental, which severely impeded individuals' willingness to engage with sexual health services in the UK (see also Varas-Díaz, Serrano-García, and Toro-Alfonso 2005). Furthermore, perceived judgment from health professionals and concerns surrounding confidentiality in Colombia can inhibit HIV testing behaviours (Reisen et al. 2014). HIV diagnosis was construed as a consequence of their own perceived misconduct, which could undermine self-esteem. This is consistent with research that demonstrates the negative impact of HIV diagnosis for psychological wellbeing (Flowers et al. 2011).

Despite the potential social-psychological benefits of disclosure in the process of coping with HIV diagnosis (Smith, Rossetto, and Peterson 2008), several interviewees had not disclosed their positive serostatus to family members because of the stigma appended to the condition and its association with gay sexuality. This could challenge identity authenticity. Interviewees believed that HIV was still considered a 'gay disease' and some manifested this view themselves. One of the focus group participants indicated that he had found it much easier to disclose his HIV status to his family than his sexual identity:

My family knows I'm positive, yes, that's fine. They didn't ask how but they can think of many things you see but if I tell them I'm gay, that's a big problem for them, for me. (Pablo, age 30, 2 years)

The analysis demonstrated the severe social-psychological challenges experienced in Colombia and subsequently in England, which continued to shape participants' engagement with both their sexual identity and their HIV status. An overarching challenge was the experience of multifaceted social stigma.

### ***Multiple levels of social stigma in England***

Interviewees generally believed that migration would enhance their social-psychological wellbeing due to their image of England as a tolerant society. However, they discussed the multiple layers of stigma stemming from their identities as immigrants, gay and HIV-positive, which they encountered in England:

It's really difficult for me as a Colombian in the UK because I don't have a good level of English so relating to other guys is difficult ... and sometimes I feel rejected by them, but also I'm gay and then I feel rejected by my colleagues so I try to hide it ... Being positive has been the biggest struggle because there you feel, other people make you feel like you're a monster, you're going to infect other people, you did something so wrong in your life. (José, age 36, 7 months)

In the gay community and especially in the Latino gay community we have many barriers and divisions. I chose not to tell anyone, except my mother, that I'm positive .... Yes, I am playing a role and have to be careful and that can be difficult for me. (Angel, age 30, 1 year)

Participants highlighted the challenges associated with their immigrant status, such as their inability to speak English well, which impeded a sense of acceptance and inclusion in the broader gay community. Some also found it difficult to negotiate safer sex practices due to their inability to communicate in English and, thus, sometimes found themselves engaging in sexual practices with which they felt uncomfortable. Indeed, as Fernández-Dávila (2014) found in his research with Latin American men who have sex with men living in Spain, some



individuals agreed to engage in particular sexual practices, such as condomless anal intercourse, in order to acquire feelings of belonging and acceptance in the gay community. Migrants may long for a sense of belonging in the aftermath of migration, which can be a lonely experience. Furthermore, in their study of Brazilian, Colombian and Dominican men who have sex with men in New York, Bianchi et al. (2007) found that their respondents resorted to anonymous sex as this obviated the need to communicate in English, which many of them did not speak fluently.

The negative social-psychological consequences of these multiple layers of stigma were evident in participants' accounts – many felt under-informed medically and unsupported psychologically:

I go to my doctor and because of the language issue I don't always understand everything as he speaks so fast. Sometimes I left just thinking I will die as I have nobody really .... Nobody seems to understand my language, my feelings, what it's like, you see .... I am feeling very vulnerable and alone. (Alejandro, age 30, 1 year)

Most participants had not disclosed their HIV status to their family and friends, due to fear of stigma and rejection. In most cases, their medical professional was their key contact as regards to their HIV infection. However, some respondents believed that they were not respected by health professionals or that insufficient effort was made to explain their condition to them. The inability to communicate effectively in English induced feelings of vulnerability and depression while also impeding access to information that might enable them to cope more effectively with HIV. Perceived disempowerment due to their lack of English-language proficiency could undermine self-efficacy.

Some men knew little about HIV and were exposed to social stigma upon disclosure of their HIV status:

When I discovered I was positive and then went through all the difficult times ... I was being rejected, isolated ... I had no friends for support. I couldn't face saying the words 'I am positive' to anyone else. I was almost suicidal. Thankfully I had my mother by my side to help me. (Pedro, age 45, 25 years)

The social stigma described by Pedro reduced his ability to discuss this with other people. The lack of social support from friends and family to whom he had disclosed his status but from whom he subsequently faced rejection led him to experience suicide ideation. A few participants reported receiving social support from family members in the face of rejection from others. Yet, as highlighted previously, family members may not be supportive of one's gay sexual identity, which can in turn render disclosure of HIV status difficult. Jorge experienced threats to continuity, coherence and self-efficacy, as he believed that he would return to Colombia with neither social status nor economic resources but a stigmatising serostatus:

I came to England to work and I will go back to Colombia with HIV. I don't know how this all fits together – gay, Colombian, now positive .... My family know nothing. (Jorge, age 28, 9 months)

Participants' experiences of enacted stigma did not correspond to the image of an accepting Britain that had partly underpinned their decision to migrate:

I do not feel totally 100% safe in England .... Here, we have lots of medical assistance, yes, but the social level is not so good. Sometimes it feels like being in Colombia. (Cesar, age 36, 3 years)

People here are so close-minded about HIV and I have often been told on Grindr that I'm bringing disease from my country, which hurts me very much and that I'm here for treatment ... It is part of the stereotype. (Juan, age 27, 1 year)

Although individuals generally praised the quality of HIV care in England, particularly in comparison to health services in Colombia, the societal responses they encountered in response to their HIV status did provoke threats to identity. Their experiences of social stigma evoked negative memories of enacted stigma in Colombia, which individuals sought to evade upon migration to England. While prejudice in Colombia was often based on two components of identity – sexuality and HIV status – in England, individuals also felt devalued as immigrants. For instance, Juan recounted his negative experiences of disclosing his HIV status on a gay/bisexual mobile application, which led to derogatory and xenophobic remarks from other users.

Experiences like these reinforced HIV stigma and, thus, the threats to self-esteem and belonging that individuals experienced as a result of popular misinformation concerning HIV. Individuals' experiences further compounded the experiences of shame and stigma that they had hoped to escape through migration.

### ***Changing interpersonal and intergroup dynamics***

In response to multi-faceted threats to identity, individuals deployed deflection strategies for coping:

I started by telling people I'm [HIV]-positive, then I was rejected. Now I just tell someone if it is getting serious or if a relationship could happen .... For casual sex I don't say anything about my status at all. (José, age 36, 7 months)

I have a group of gay friends and I have not told any of them that I'm positive ... I don't want to be rejected .... They could spread the information to everyone .... Being with them [HIV-negative friends] I can forget my status and just not think of it, as I always have. I can forget. (Pablo, age 30, 2 years)

Given the general lack of social support, individuals were selective about HIV-disclosure. As documented in previous research (e.g. Derlega et al. 2002), disclosure could result in negative social-psychological outcomes for HIV-positive individuals, such as rejection and decreased self-esteem. Pablo and others, therefore, decided not to disclose their status to their friends, which enabled them to shield themselves from social stigma and rejection. The interpersonal strategy of passing, that is, feigning membership in another group (in this case, the HIV-negative group), enabled individuals to engage in a form of denial at a psychological level. By representing himself as HIV-negative, Pablo was himself able to 'forget' about his positive serostatus given that nobody in his social circle could flag this up. Moreover, this enabled individuals to suppress knowledge of their HIV status transiently when engaging in condomless sex with casual partners. Yet, this strategy was not conducive to identity authenticity.

Similarly, some interviewees engaged in an intergroup strategy for minimising threats to identity, that is, they came to delineate themselves, as HIV-positive gay men, from HIV-negative gay men:

When I was diagnosed and then felt the pain of stigma, I put up a barrier, I suppose. I mainly just have sex with other positive guys .... I use a site for this and I go to places where I know there are positive guys. (Alvaro, age 27, 3 years)

The stage I'm at in my life, after one year with HIV, I can't ever imagine being in a relationship with a negative guy. They don't understand, do they? (Ricardo, age 30, 2 years)

In order to avoid the social stigma and rejection that they anticipated from HIV-negative individuals, some participants decided to limit their sexual and, in some cases, social contact to other HIV-positive men. Alvaro and Ricardo made use of social and technological spaces that allowed them to meet other HIV-positive individuals. However, in reflecting upon their decisions to have sex with other HIV-positive men, these participants appeared to have formed a negative stereotype of HIV-negative men as exclusionary and ignorant about HIV.

Fear of HIV-disclosure impeded serodiscordant interpersonal relations. For some individuals, this did protect their sense of self-esteem from threat but did little to protect their sense of belonging:

I can't lie [about my HIV status], so I just deleted my [Grindr] account and that was it. I haven't heard any comments about my status ... but I do feel lonely. I don't really have anyone. (Cesar, age 36, 3 years)

The interpersonal strategy of isolating oneself from potential threats to identity served only to protect self-esteem, because individuals no longer faced disparaging remarks on the basis of their HIV status. Yet, this also engendered and, in some cases, accentuated threats to their sense of belonging. Interviewees who engaged in this strategy reported feelings of solitude despite the clear need for social support among individuals living with HIV.

## Discussion

In our analysis, we outline and discuss the multiple intrapsychic and interpersonal challenges experienced by a diverse sample of Colombian HIV-positive gay men. Many had migrated to the UK with a legacy of shame, abuse and internalised homophobia seeking acceptance of their sexual identity and/or better HIV care. However, challenges arose. Medical appointments were often sub-optimal because of language difficulties. Moreover, participants had to navigate complex patterns of (non-)disclosure with significant others. Experiences of stigma around a 'triple jeopardy' of sexuality, ethnicity, HIV status and immigration status represented a significant social-psychological burden. It is noteworthy that, despite the diversity of the sample (in terms of age and time in England), there were no discernible differences in levels of perceived stigma, shame and internalised homophobia. Here, we reconsider these findings drawing on identity process theory and discuss possible implications for public health interventions.

For most participants, identity congruence and self-acceptance were difficult to achieve, due to their past history; the negative explanations they themselves ascribed to being gay; the legacy of negative discourse about homosexuality within the Church; and experiences of rejection. There was a widespread sense of fragmentation in how identities were disclosed and performed in different domains of their lives. Participants also experienced several schisms or major 'biographical disruptions', most notably from Colombia to the UK and from being HIV-negative to becoming HIV-positive (Alexias, Savvakis, and Stratopoulou 2016). This challenged their sense of continuity, especially in view of the self-blame participants often ascribed to their seroconversion. Whilst certain individuals were regarded as pivotal sources of support, very few salutogenic resources were identified within either the London Colombian diasporic community or the wider London gay community (Brooks and Kendall 2013). Individuals' sense of continuity may have been challenged given the discrepancy between their expectation to encounter a more accepting environment in London and their lived experience of rejection.

The isolation and sense of disconnection experienced by interviewees were further compounded by their experiences of sex. Sexual activity was rarely discussed in a context of emotional intimacy. Rather, sexual episodes were typically represented as physical gratification being met through casual partners with resultant challenges in HIV status disclosure and safer sex negotiation. This finding has been validated in quantitative survey research that suggests that Latin American men who have sex with men are more likely to use mobile applications for sex than other Black and minority ethnic groups (Jaspal, Jamal et al. 2016). Many interviewees sought committed and reciprocal long-term relationships, which were difficult to develop and maintain in a context of shame, stigma and secrecy. This clearly had a negative impact for self-esteem as some individuals felt unable to derive a positive self-conception in such a social context. Indeed, negative views of sexuality and poor self-image are associated with sexual risk-taking (Thomas et al. 2014; Bourne et al. 2015), as well as with difficulties in sustaining satisfying intimate relations (Doyle and Molix 2014). This too represented a schism in expectations and lived reality, presenting potential challenges to continuity.

Study participants were recruited from a British charity that provides advocacy and support for Latin American men who have sex with men. Most attended psycho-educational, counselling or social groups at the group. They may arguably have been more troubled by identity threats than men who do not seek out support. Additionally, all our participants identified themselves as gay and therefore represent only a sub-section of the Colombian gay population in London. Whilst this has advantages for researching the intersection of identities in textured and theoretically informed social-psychological research, it poses significant problems for transferability as it may be that our participants' sexual health, HIV literacy and psychological wellbeing were better or worse than similar men who were unable or unwilling to access these resources for support or information (Cohen and Crabtree 2008). Participants' accounts of a sense of belonging were in marked contrast to the sense of alienation that many expressed about the wider London gay scene – although it was accompanied by a sense of wariness about their sexuality or HIV status becoming more widely known within Colombian communities. The findings strongly support the need for more interventions to highlight and tackle both racism and HIV stigma on the gay scene (Caluya 2006) and to fund more specific resources for sub-communities of gay, bisexual and other men who have sex with men that employ appropriately trained and culturally competent staff (Fish et al. 2016). In the UK, there are currently very limited resources outside of London for Latin American gay men, and differing views over whether interventions should build on shared or unique aspects of cultural heritage (Fish et al. 2016).

Our findings echo those of other researchers who have demonstrated the potency of being 'triple cursed' as gay, from an ethnic minority community and HIV-positive (Arnold, Rebchook, and Kegeles 2014). On the commercial gay scene in London other inequalities, such as disability, poor body image and mental health difficulties, may further compound alienation (Wood 2004). There is a need for further research and theorising around the intersections of ethnicity and sexuality both in the context of HIV and more broadly (Kennedy and Dalla 2014), especially in the context of xenophobic media and political representations around migrant groups seeking healthcare in the UK, which is particularly powerful in the context of ethnic minorities and HIV treatment (Dodds 2006).

Researchers and policy makers alike need to look beyond sexual health concerns and understand the health and wellbeing of gay men from specific communities in more integrated ways through assessing and addressing the intersection of sexual risk with mental health and the misuse of drugs and alcohol. Our knowledge of which approaches are efficacious for Black and minority ethnic gay men generally, and for gay men from particular ethno-cultural groups, is only in its infancy – especially in relation to mental health and psychological wellbeing. Researchers and advocates from voluntary and statutory agencies need to be wary of the potentially disempowering elements of paternalistic models of support and individualistic models of both identity (i.e. as largely being seen as a ‘property’ of the individual) and behaviour change (McPhail-Bell et al. 2016). Although it has as yet been little researched in relation to Latin American men living with HIV, a greater understanding of project and resistance identities through which members of marginalised communities collectively take action to counter stigma and discrimination, and facilitating the creation and maintenance of socio-political resources that foster such identities is key to tackling compound manifestations of prejudice (Aggleton, Parker, and Maluwa 2003). A key component of this is an understanding not only of how identities intersect for individuals and communities but also the relationships between imposed identities (such as migrant) and chosen identities and nomenclature.

It is necessary to develop more sophisticated ways of understanding the relationships individuals have with chronic conditions, and to acknowledge that illness self-concepts are diverse and dynamic and that even serious conditions may not be as ‘engulfing’ of identity as presumed by researchers or healthcare professionals (Rapport and Wainwright 2006). Notably, the success of antiretroviral medication raises complex questions for gay men to understand and identify with being HIV-positive and to disclose their status to both sexual partners and to significant others (Murphy et al. 2016).

This study makes an important contribution to understanding the social-psychological challenges faced by HIV-positive gay men in an important and growing Black and minority ethnic group in London. There has been no other research with this community in a British context and further research to confirm, challenge and advance these findings is important. In addition to focusing on HIV prevention, investment in the physical, psychological and sexual health of people living with HIV is vital. We must address the psychosocial challenges associated with HIV infection, as well as those that may be specific to non-UK born gay men. Addressing these issues in collaboration with gay men from Latin American backgrounds living with HIV should lead to both improved visibility and wellbeing for those communities and potentially positive public health outcomes.

## Note

1. <http://www.ons.gov.uk/ons/rel/census/2011-census/quick-statistics-for-england-and-wales-on-national-identity--passports-held-and-country-of-birth/rft-qs213ew.xls>

## Disclosure statement

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