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Authors

del Pino, Homero E

Dacus, Jagadisa-devasri

Harawa, Nina T

et al.

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"Being downcast by society… adds to the stress levels and would explain why [we] smoke more.": Smoking among HIV-Positive Black Men Who Have Sex with Men

Homero E. del Pino, PhD, MS[*],

Psychiatry and Human Behaviors, Charles R. Drew University of Medicine and Science, 1731 E. 120th St., Building N, Los Angeles, CA 90059

Department of Medicine— Division of Geriatrics, David Geffen School of Medicine at UCLA, Los Angeles, CA 90095-1687

Jagadisa-devasri Dacus, PhD, LMSW,

HIV Center for Clinical and Behavioral Studies, Columbia University and New York State Psychiatric Institute, 1051 Riverside Drive, Room 6602, New York, NY 10032

Nina T. Harawa, MPH, PhD,

Department of Medicine—Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at UCLA, 1100 Glendon Ave Suite 850, Los Angeles, CA 90024

Psychiatry and Human Behaviors, Charles R. Drew University of Medicine and Science, 1731 E. 120th St., Building N, Los Angeles, CA 90059

Charles McWells, BA

Los Angeles Centers for Alcohol and Substance Abuse (L.A. CADA), 11015 Bloomfield Ave., Santa Fe Springs, CA 90670

Division of Community Engagement, Charles R. Drew University of Medicine and Science, Los Angeles, CA 90059

Abstract

Smoking causes more deaths among people living with HIV than HIV infection itself. Few smoking cessation interventions and studies of sexual minority communities have considered the lived experiences of Black men who have sex with men (BMSM) living with HIV. Before developing interventions for these men, we need to answer: How do experiences of discrimination and stigma influence their perceptions of smoking? This phenomenological study was led by a community-based organization. We conducted six focus groups with 53 BMSM living with HIV in Los Angeles. We used minority stress theory in the analysis and interpretation of the data. We identified two themes: (1) co-occurrence of race and sexual orientation stressors and smoking (e.g., "I feel like I'd be discriminated against sometimes because I'm gay and because I'm Black.") and (2) smoking as a reaction to HIV-positive status (e.g., "I know more people that started smoking after they found out they [had] HIV."). Participants smoked to cope with stressors around race, sexual orientation, and living with HIV. These findings challenge us to ensure that

[*]Corresponding author: Phone: (323) 357-3434, homerodelpino@cdrewu.edu.

smoking cessation interventions address the personal and social concerns of BMSM living with HIV and help them identify healthier ways to cope with stressors.

Keywords

smoking; African American; minority stress; MSM; HIV

Introduction

People living with HIV smoke cigarettes at up to twice the rate of the general population (Mdodo et al., 2015; Mdodo et al., 2016; Niaura et al., 2000; O'Cleirigh et al., 2015). People living with HIV who smoke are also less likely than the general population to quit smoking (Frazier et al. 2018). The negative consequences cannot be overstated: 60% of the deaths among HIV-positive people in the United States are attributable to smoking; the life expectancy of people living with HIV who smoke is 63 years, compared to 78 years for those who do not smoke; and the mortality rate among smokers living with HIV is three times that of HIV-negative smokers (Helleberg et al., 2013). Smokers living with HIV also experience an increased risk for other diseases such as chronic obstructive pulmonary disease and non-AIDS-defining cancers (O'Cleirigh, et al., 2015).

Lesbian, gay, and bisexual persons have a higher prevalence of smoking cigarettes than do their heterosexual counterparts (Centers for Disease Control and Prevention [CDC], 2018a; Lee, Griffin, & Melvin, 2009). Among gay and bisexual men in California, for example, smoking is expected to surpass HIV/AIDS as a cause of death within a few decades (Max et al., 2019). Smoking among men who have sex with men (MSM) is associated with the internalization of negative messages about their sexual identity (Pachankis, Hatzenbuehler, & Starks, 2014). Among people living with HIV, smoking prevalence seems to be higher among non-Hispanic Blacks and Whites than Hispanics and among persons who have experienced incarceration, homelessness, or poverty (Frazier et al., 2018; Mdodo, et al., 2015). Studies have shown that smoking cessation programs increase the life expectancy of people living with HIV (Reddy et al. 2016, 2017; Wiebe, 2018). Yet, there is a dearth of smoking cessation interventions that address the challenges specific to people living HIV (Dickson-Spillmann, Sullivan, Zahno, & Schaub, 2014; Harding, Bensley, & Corrigan, 2004). Extant smoking cessation interventions and studies in sexual minority communities have focused primarily on young adults, such as how youth use smoking as a coping strategy for sexual identity-related stress and the association between early sexual debut, homophobia, and tobacco use among MSM (Lombardi, Silvestre, Janosky, Fisher, & Rinaldo, 2008; Newcomb, Heinz, Birkett, & Mustanski, 2014; Rosario, Schrimshaw, & Hunter, 2011). Black MSM (BMSM) living with HIV have been under-researched in this area because studies have focused on groups defined by a single axis, either by race, sexual identity, or HIV risk/status. The experiences of Black MSM who are living with HIV lay at this intersection (Wyatt et al., 2013). It is critical to recognize and acknowledge how, from an intersectional perspective, their social identities and locations factor into their multilevel experiences of discrimination and marginalization (Collins & Bilge, 2016; Crenshaw, 1990; McCall, 2008; Syed, 2010). By taking an intersectional perspective, we consciously make

efforts to include their exact, concise narrative experiences as a population that is particularly vulnerable to HIV infection. This subpopulation represents the highest proportion of new HIV infections among all Black men (80%) and among all MSM (38%) (CDC, 2018b, 2018c). Hence, we need to understand how the intersectional identities of BMSM living with HIV may create unique stressors that may either lead to smoking as a coping strategy or make smoking cessation challenging.

Before developing smoking cessation programs for BMSM living with HIV, we first need to answer: How do experiences of discrimination and stigma influence HIV-positive BMSM's perceptions of smoking? We need to describe aspects of BMSM's smoking behaviors that have been poorly understood. This study aimed to explore the association between intersectional experiences of perceived discrimination and stigma and attitudes and beliefs about smoking. We sought to understand *how* BMSM living with HIV experience discrimination and *how* they perceive smoking in relation to potential stressors stemming from society's treatment of their race, gender, sexuality, and HIV status.

Method

We used a phenomenological approach as our method of inquiry. We facilitated focus group discussions to explore how participants interpreted their motivation for smoking and how they perceived smoking vis-à-vis their social environment (Bloor, Frankland, Thomas, & Robson, 2001). Focus groups can yield insight not only into the individual experiences of participants, but also their collective beliefs about those experiences, as well as the emotional and symbolic meanings of those experiences (Morgan, 1998). Most importantly, focus groups generate data that reflect a socially-influenced, collective experience in ways that individual interviews cannot. We obtained approval to conduct this study from the Institutional Review Board of Charles R. Drew University of Medicine and Science.

Theoretical Framework

Phenomenology—The phenomenological approach to inquiry facilitates a means to describe and explain individuals' lived experience of the phenomenon of interest (Giorgi & Giorgi, 2003; Giorgi, 2010; van Manen, 2017). With this approach, we gather individuals' descriptions of their experiences and discover how they make meaning of and interpret their lived phenomenon. Because of our interest in the experiences of discrimination and stigma among BMSM living with HIV and the influence of these experiences on their perception of smoking, this theoretical approach seemed fitting. Phenomenology has been applied in research with BMSM for devoloping HIV prevention intervention and studying their effectiveness, for understanding BMSM's ability to maintain seronegativity, and for understanding their experiences of HIV-related stigma and spirituality/religion (Dacus et al., 2018; Miller, 2019; Wilson et al., 2016). By employing phenomenological methods, such as narrative data collection, we were better able to comprehend their impressions, renderings, and experiential accounts.

Minority Stress Theory—*Minority stress* refers to the excess stress individuals from stigmatized social categories experience (Meyer, 2003). Populations with stigmatized identities experience stressors that are unique (in addition to the usual stressors experienced

by everyone), chronic (related to relatively stable social and cultural structures), and socially based (stemming from social or institutional processes beyond the individual's experience or life events) (Meyer, 2003). Stigma, prejudice, and discrimination create a hostile and stressful social environment that can cause mental health problems for people with a minority status (Meyer, 2003). Minority stress theory suggests that people exposed to this type of stress would be at greater health risks because they face greater social stressors due to stigma and prejudice (Frost, Lehavot, & Meyer, 2013). We used this theory because BMSM living with HIV have *co-occurring* identities— as Black men, sexual minorities (either gay-, bisexual-, or nonheterosexual- identified MSM), and people living with HIV— that result in stress associated with social experiences of stigma and prejudice.

Minority stress is associated with health outcomes. For example, one study found that sexual minorities who reported experiences of minority stress (measured as stressful life events and externally rated by independent judges for prejudice) at baseline were more likely to report the onset of an externally rated physical health problem at 1-year follow-up (OR = 3.47, $p < .01$) (Frost et al., 2013) than those who did not. Minority stress also predicts mental health outcomes: Black sexual minority women who experience marginalized identities on account of their race, gender, and sexuality, reported worse psychological and social wellbeing scores than did White sexual minority women (on account of race) and worse depressive symptoms and psychological and social wellbeing scores than did Black sexual minority men (on account of gender) (Toomey, Ryan, Diaz, & Russell, 2018). Finally, one study found evidence of both a direct pathway between perceived discrimination and physical health, as well as an indirect pathway—through internalized homophobia— through which perceived discrimination negatively impacts mental health among sexual minorities (Walch, Ngamake, Bovornusvakool, & Walker, 2016). Our application of this theory is in line with prior studies of sexual minorities.

Study Design

Recruitment—We employed a purposeful sampling strategy to recruit a diverse cohort of BMSM with a history of tobacco use. We wanted to access study participants that could articulate their intertwined experiences of tobacco use, cessation, and recovery and of HIV diagnosis, care and treatment. We recruited participants via flyers posted at the CBO and direct outreach to its clients. Participants had to meet the following inclusion criteria:

1. be between ages 18–65;
2. self-identify as Black/African American;
3. self-identify as a man who has sex with men (MSM);
4. self-report an HIV-positive status;
5. self-report a history of tobacco use; and
6. receive HIV-related medical or social services from a local provider.

Data Collection—We conducted focus groups between January and March 2013 to explore BMSM's perceptions of intersectional discrimination, stigma, and smoking behaviors. The principal investigator (PI), C. McWells, who has extensive experience

working with BMSM and is a member of the study population, facilitated the groups. The focus groups took place in the CBO's offices. Participants gave verbal and written consent to be audio recorded and received a $35 gift card as an incentive. Focus groups lasted approximately 60 minutes and were conducted in English. The focus group interview guide contained questions specific to social experiences associated with initiating or maintaining smoking and was reflective of our phenomenological approach. Sample questions include, "What are some of the reasons you started smoking," "How did testing positive for HIV impact your decision to quit or keep smoking," and "What sorts of things make it harder for Black HIV-positive MSM to quit smoking?"

Data Analysis—The analysis was led by the PI. He works in community-based organization (CBO) that provides substance use treatment and HIV education and prevention services to MSM and to the general public in Los Angeles. He also has an appointment as Community Faculty at an academic institution. "Community Faculty" is unique model in which community leaders are recognized for their expertise in working with their respective communities and invited to become faculty, with full rights and privileges (del Pino et al., 2016). The recordings of the focus groups were transcribed verbatim and the transcripts entered into Atlas.ti, a qualitative data management and analysis software (Muhr, 1991). We used phrases uttered by participants in the focus groups as our *in vivo* codes instead of using *a priori* codes. The PI (who identifies as a Black gay man) coded transcripts through repeated examinations of select transcripts with the lead author (who identifies as a gay Latino) and achieved intercoder reliability of 93%. Any differences regarding coding were reconciled through team consensus. We then sorted the coded data by the emerging themes (e.g., smoking as a means of coping with stress). Through our coding process, we organized clusters of text into broader categories at consecutively higher levels of abstraction. Finally, we "identified" the themes by reading each manuscript and exploring the variable and personal nature of social constructs, such as race and sexual orientation, that were developed from the participants' descriptions of their experiences (Guba and Licoln, 1994). Using minority stress theory enabled us to increase the abstraction level of emerging themes, for example, whether a reported experience was unique, chronic, and socially based.

Results

Fifty-three BMSM living with HIV, both current and former smokers, participated in 6 focus groups. The average participant was 41 years old, had been living with HIV for eight years, and had been smoking for 17 years. Everyone reported an income of less than $15,000, with just 13 (25%) of them being currently employed. Eleven (21%) participants had less than a high school education, 24 (45%) completed high school, 12 (23%) had some college education, and six (11%) had college degrees. Our analyses of participants' experiences identified two major themes: (1) co-occurrence of racial and sexual minority stressors and smoking and (2) smoking as a reaction to HIV-positive status.

Theme 1: Co-occurrence of Race and Sexual Orientation Stressors and Smoking

Participants reported smoking cigarettes to deal with the stress of being Black and/or gay. A participant from focus group (FG) 4 shared, "[Y]ou're always under a microscope. You're

always under scrutiny…if [people you work with] think you're gay, you can get all this pressure and prejudice." He shared, "I feel like I'd be discriminated against sometimes because I'm gay and because I'm Black." He remembered, "[I smoked a] pack of cigarettes [before a job interview] and I always found it just… stressing, stressing, stressing [because I'm gay]." Similarly, someone from FG 2 said, "Being downcast by society… adds to the stress levels and that would explain why [we] smoke more." The stress of these co-occuring identities was succinctly stated thus, "I feel being black or being gay man, the two aren't supposed to go together…" (FG 6).

Many of the participants' stressors and fears stemmed from the violence that they had either experienced, feared, or anticipated in their social environment. A participant from FG 5 talked about smoking to calm himself after getting into fights in high school.

> Once I finished that fight…I had [to smoke] a cigarette to keep me calm from the shaking. I was fighting because… they called me 'sissy,' 'faggot' or whatever…so I started buying a pack of cigarettes because I'm like, 'Damn, I got to fight every day.'

Other participants talked about different types of violence in their environments, such as "the inner city…where there's lots of crime," [FG 3], or about the "trauma" associated with a "heterosexual environment" [FG 3]. A participant from FG3 said, "[Y]ou use cigarettes to focus and to calm us down, get control… That's one way to deal with the problems… drinking, smoking, dope, drugs, whatever else." Repeatedly, BMSM living with HIV described how smoking helped them attain a measure of control and composure in the midst of chronic stress. As this participant succinctly expressed, "It's self-medicating when you're smoking…. It's a way of relaxing yourself even though you've got all these stressors pushing on you" [FG 2].

Theme 2: Smoking as a Reaction to HIV-positive Status

Perception of higher stress due to HIV status—An HIV-positive status introduced new stress and fear into the lives of participants. They talked about HIV as "an additional stress added…to the other things [i.e., race and sexual orientation] you already had to deal with before you found out [your status]." [FG 2]. Participants from FG 6 reported that they previously had quit smoking, but when asked what made them start smoking again, they typically responded, "[HIV] status and [lack of] acceptance" from other men. This "additional stress" included increased vigilance that others might find out about their status. "You're thinking about you got [HIV]. You're thinking about people judging you… you're having fear… because you're thinking what they're thinking about and them thinking about you and what they think of you" [FG 3].

HIV-positive diagnosis influenced attitudes toward smoking—More importantly, the "additional stress" of the participants' HIV status also made some of them feel fatalistic and altered their calculus about the risks of smoking. For example, a participant in FG 5 shared that, "I know more people that started smoking after they found out they [had] HIV." Someone in FG 6 echoed that sentiment:

> I have a friend…who just found out he's HIV positive, and he's never smoked a cigarette in his life. [Now he smokes] like three packs a day. He's stressed. [He says] 'I can't get it off my mind,' and all that.

Fatalism is the belief that a person's life is subject to external forces such as luck, fate, or a god, and often leads to a passive attitude toward the events in one's life (Hess and McKinney, 2007). Even those who had lived with HIV for several years expressed a sense of fatalism when they agreed with a participant from FG2 who expressed that, "[W]hen you have been diagnosed positive, and you have lost friends who were also positive, you have a different take on your own mortality because… you don't know how much time you have."

Discussion

We aimed to explore the intersectional experiences of perceived discrimination and stigma, and attitudes and beliefs about smoking. These narratives indicate how BMSM living with HIV might experience stress incrementally over the life course, both prior to any risk for HIV and following an HIV diagnosis. Our findings augment our understanding of how HIV-positive BMSM participants handled social stressors around race, sexual orientation, and HIV status: They smoked to cope. In short, the minority stress that BMSM living with HIV experienced on account of their concurrent stigmatized identities motivated them to turn to or to maintain smoking as a coping strategy. These findings align with studies showing the positive relationship between experiences of discrimination and tobacco use among people living with HIV (Crockett, Rice, & Turan, 2018), and also reveal additional dimensions related to sexual orientation and race.

Stigmatized Identities and Stress

The stress these men experienced fit the criteria of minority stress: unique, chronic, and socially based. These experiences of stress were *unique* to them given their intersecting status as racial and sexual minorities living with HIV. As indicated by other studies, we found that BMSM living with HIV will experience social stressors that their heterosexual counterparts will never experience (Conron, Mimiaga, & Landers, 2010; Mays and Cochran, 2001; Meyer, 2003). Experiences of multiple and concurrent stressors can have lasting psychological consequences (Feinstein, Goldfried, & Davila, 2012; Herek and Garnets, 2007; Institute of Medicine [IOM], 2011). They worried about how others might perceive them because of their HIV status. Their worry exemplified another aspect of minority stress: Being vigilant for negative experiences on account of their stigmatized identities (Meyer, 2003; Meyer, Schwartz, & Frost, 2008). Their stress is *chronic*, because it is ongoing. Their stress is *socially based*, because it is not merely a reaction to their perception of circumstances, but rather a reaction to lived experiences of violence, threats of violence, rejection, and socioeconomic marginalization. Their experiences align with a study by the Institute of Medicine (2011) that found that gay men continue to face stigma, discrimination, and violence. Finally, as minority stress theory suggests, their stress put them at greater health risks— in this case, smoking-related health risks— because of the greater social stress due to stigma and prejudice (Frost, Lehavot, & Meyer, 2013).

Smoking to Cope with the Social Stressors

All of the participants reported smoking to cope with racism, homophobia, and HIV stigma. Their coping choices took place in a social environment with a legacy and history of racial discrimination, crime, violence against gay men, stigmatization of people living with HIV, and the "trauma" of the "heterosexual environment." This is consistent with studies showing that people smoke to cope with minority status-related stressors and that Black people who report more experiences of racial discrimination have higher odds of smoking (Borrell et al., 2010; Reynolds, et al., 2004; Siqueira, Diab, Bodian, & Rolnitzky, 2000). Furthermore, due both to their low SES and their frequent residence in poor, high-crime communities, participants had scant access to healthy strategies for coping with stress, such as seeing a therapist, going for a jog, or walking on the beach.

Smoking by racial and sexual minorities living with HIV continues to be a response to the social nature of stressors around race, gender, sexual orientation, and HIV status. Understanding how social factors interact with BMSM's lived experiences can also help us understand what barriers they face due to smoking cessation. If some BMSM living with HIV smoke to cope with their social stressors, then changing this environment seems part-and-parcel of any work to support efforts of BMSM living with HIV to quit smoking.

Our finding of fatalism and smoking as a direct response to an HIV diagnosis do not readily align with results of a cohort study that found a positive association between cigarette smoking and being Black, lower education, alcohol and marijuana use, but not with HIV status (Akhtar-Khaleel, Cook, Shoptaw, et al., 2016). Still, our finding aligns with results of a qualitative study of men living with HIV who believed that HIV would impact their mortality long before smoking would (Reynolds, Neidig, & Wewers, 2004). Juxtaposed with these quantitative findings, our research makes salient how, for some people, living with HIV colors their perceptions of the overall harm posed by smoking.

Recommendations for Addressing Smoking in BMSM Living with HIV

Our findings point to the limitations of approaches to addiction treatment that view smoking as a biological problem divorced from the social context of the smoker. They can also inform the content and implementation of smoking cessation strategies for Black MSM living with HIV. Service providers, for example, can help their BMSM clients understand the connection between their day-to-day contexts, their beliefs, and their smoking behaviors then work with them to identify alternative coping strategies. This is especially important for their BMSM clients who hold fatalistic beliefs about their HIV infection because these fatalistic beliefs may also impact other health behaviors. Traditional cognitive behavior therapy can be supplemented with a multifactorial approach. For instance, any acknowledgement of unhealthy behaviors and steps to modify these behaviors have to be contextualized. Contextualization allows service providers to address the cumulative stresses their clients experience as Black men, as MSM, and as persons living with HIV. Any behavior change approach would need to be comprehensive and culturally congruent.

These findings challenge us to ensure that health messages regarding the treatment and suppression of HIV, as is the case for the *U=U* campaign (an undetectable HIV viral load

equals untransmittable HIV), are crafted in such a way that they reach, resonate with, and address the concerns of BMSM. This would be one way to intervene in the environment that gives rise to and sustains HIV-related fatalism among BMSM living with HIV. Given the high HIV incidence and prevalence in BMSM, it behooves public health agencies to customize otherwise generic health messages to center on their needs. Doing so might mitigate the stress associated with living with HIV and thereby lower BMSM's motivation to smoke as a coping mechanism.

Limitations

Our study has several limitations. We did not conduct a focus group with BMSM living with HIV who have never smoked. Because study participants all shared stigmatized statuses and knew the study aims, they may have been inadvertently primed to talk about experiences related to these factors and to ignore other types of motivations for smoking. We also acknowledge the limitations of using the term MSM for this group of men, and how this term may render invisible the political contexts and cultural and regional differences that inform the lives of Black MSM who may or may not identify as gay, bisexual, or same-gender loving (Truong, Perez-Brumer, Burton, Gipson, & Hickson, 2016). Nevertheless, this study is a step in the right direction of understanding smoking among BMSM living with HIV. Additional research is needed to understand the different types and levels of stress that BMSM living with HIV seek to relieve by smoking and successful approaches that individuals have used to replace smoking as a coping strategy. This would include longitudinal and mixed-methods studies exploring how BMSM living with or without HIV and how Black men's experiences of other types of stressors initiate smoking, are motivated to quit smoking, and experience/approach efforts to quit smoking.

Conclusion

Discrimination and other social stressors facilitate one of the most negative health behaviors – smoking– in this highly vulnerable population. Smoking cessation efforts that ignore the social nature of the stressors faced by BMSM may yield minimal success or lead individuals to compensate with potentially unhealthy coping strategies after quitting. BMSM deserve our best efforts and support to support their journey to achieve positive health outcomes.

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Table 1.

Additional Quotes Supporting the Themes

Theme 1: Co-occurrence of Race and Sexual Orientation Stressors and Smoking	
1	I think if you're not comfortable with yourself [liking men], then you're going to do it [smoke]. I think that there's more possibility that you're going to smoke because of the tension. I'm just saying if you're not comfortable with the things that you're doing. In other words, if I can't [it] keep real with you that I want to sleep with you, you know what I'm saying? (FG 1)
2	So until I got to know me, and I got to understand what I was dealing with, then once I got to know me and find out who I was and what I was dealing with, then it was a lot easier for me to start backing away from different things. It was a process. The cigarettes were the last thing, but it was all a process. (FG 1)
3	Black folks go through a lot of stress.… You gotta deal with that and you gotta deal with these fools on the street, then you gotta deal with these bills, you gotta – I mean, it's just, it's just pressure! (FG 2)
4	I think any group that has to deal with being downcast by society and how to deal with not being accepted and, and having to deal with all the other stresses that come along with the choices that they make, I think that address to the stress levels and that would explain why they smoke more. I, I just think they, that they [stress and smoking] would go hand in hand. (FG2)
5	I went to a job interview Monday, and I had my little Ralph Lauren suit on, my little Kenneth Cole shoes, and just beat the phase, and make sure you step on your back, because I was looking good that day! And they told me the interview was on Melrose, and I'm thinking this section of Melrose here: like beside Highland, down here. I'm thinking, 'Oh, those are some cool white people. I can work in there.' But when the guy gave me the address, it was past the Beverly Center, just before you go into Beverly Hills. I'm like, 'What the fuck! Ain't no Black people working up in those boutiques over there.' …They didn't hire me. And I was gonna tell the guy who sent me there, 'If you want that contract, don't send a Black person.' Because they – nothing I [could do]– and I sat correct with my back straight and interview position, and smiled, but they was, 'You a nigger.' (FG 5)
6	I hear that ['You're different from the other Black people I see.'] all the time. (FG 5)
7	[Society accepts] two women faster than they would accept two men. That's stressed out because like for me, sometimes I wish I had somebody I could've gone down the street and hold my hand if I wanna kiss in public. You see women kissing all the time. It's nothing big about it but when you see two men kiss, it's just taboo. It's like you know, you ain't a man…(FG 6)
Theme 2: Smoking as a Reaction to HIV-positive Status	
1	But if you do choose to smoke, certainly the amount that you smoke, added with the stressors that you have of being Black and then being positive, would certainly spike it and make it [smoking] be higher. (FG 2)
2	When you find out you have HIV, you've got more to deal with, you got more on your plate. You've got your own personal health issues to deal with in addition to the shunning and the oppressiveness of the society.… I understand completely why that would be a real spike in [smoking] and why I would be more – you know, smoking more. [I understand] why positive gay men would smoke more. I can clearly see why. (FG 2)
3	More smoking [from] HIV-positive than negative [MSM]. That stands to Reason. (FG 3)
4	You're thinking about you got [HIV]. You're thinking about people judging you. Maybe you're having fear of being around people because you're thinking what they're thinking about and them thinking about you and what they think of you… and before you know it, you're smoking a cigarette, trying to calm down. You're just nervous from being around people. (FG 3)
5	What could happen is once you found out you're positive you go, 'Well, hell, I'm already positive now so what the hell… I wanna smoke so this is helping me deal with it.…' You create a reason to do it [smoke], 'Well, I'm positive now so I'm stressed, I'm nerved up, I gotta take all these medications,' and then you just smoke more and more. (FG 4)
6	You don't know the day that viral load's gonna shoot up, where it's gonna shoot; you don't know if your immune system's gonna shut down. It can be fearful. (FG 5)
7	I had a friend, he found out he was HIV positive, and he like died overnight. But fear killed him. It was like, dude! Calm down! You're gonna kill yourself from this fear of the disease. (FG 5)