Published in final edited form as:

Qual Res Psychol. 2011 ; 8(1): 26–39. doi:10.1080/14780880903061812.

Felt Stigma in Injection Drug Users and Sex Workers: Focus Group Research with HIV-Risk Populations in Puerto Rico

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Abstract

Though many studies have conclusively linked felt stigma and HIV, few have focused on the experiences of rejection felt by members of such socially marginalized groups as intravenous drug users (IDU) and sex workers (SW). Using focus groups, our study explored these experiences in 34 individuals (17 male UDUs and 17 female SWs) at risk of becoming infected with HIV, the objective being to discover why they engaged in maladaptive behaviors as a way of coping with felt stigma. We used deductive and inductive analysis to codify the resulting data. Concepts associated with the word stigma, emotional reactions to felt stigma, and the impact of felt stigma on self-schema helped elucidate how the internalization of felt stigma can lead to negative affective states and self-destructive behaviors (e.g., drug use and syringe exchange). Results underline the importance of developing intervention models that reduce stigma as a means of HIV prevention in vulnerable populations.

Keywords

drug users; felt stigma; focus groups; HIV at-risk populations; self-schema; sex workers

Background

The topic of stigma has been addressed from diverse standpoints and in many contexts where human nature is present. Stigma and its collective repercussions (as well as its individual impact upon those stigmatized) has been reported in multiple studies for decades (Goffman 1963; Stafford & Scott 1986). However, following the appearance of HIV/AIDS, a significant group of studies published on the subject of stigma revolve around its relationship to HIV (Alonzo & Reynolds 1995; Crawford 1996; Herek, Capitano & Widaman 2002; Pryor, Reeder & Landau 1999). Many of these studies focused on the social exclusion felt by and the discrimination directed toward people living with HIV (Herek & Capitano 1999), particularly when those individuals belonged to groups associated with virus transmission and traditionally marginalized by society (e.g., men who have sex with men [MSM], injection drug users [IDU], sex workers [SW]).

The likelihood of any member of one of these groups being the victim of stigmatizing acts or behaviors may be related to the idea that stigmatization is profoundly linked to prejudices against conduct considered deviant or deserving of social condemnation (Crandall 1991;

Goffman 1963). Such acts seem justified by the need to uphold social order (Kurzban & Leary 2001), but, in fact, stigma breeds profound social division as seen, for example, in reports from injection drug users, sex workers, and people living with HIV/AIDS (Crandall 1991; Juliano 2005; Parker & Aggleton 2003; WHO 2005).

An important aspect of the study of stigma is recognizing its impact (resulting from the process of internalization) on the person stigmatized (Crocker 1999). People who are stigmatized often experience the effects of what is known as *felt stigma*. Felt stigma refers to real or imagined fear of both societal attitudes and potential discrimination arising from a specific undesirable attribute, disease, or association with a particular group (Jacoby 1994; Malcolm et al. 1998; Scrambler 1998; Scrambler & Hopkins 1986).

IDUs are socially labeled as “drug addicts” while SWs are subjected to the epithets “promiscuous,” “prostitute,” and “whore,” all terms associated with criminal and/or immoral acts. These groups are subsequently treated as if they were carriers of a highly contagious disease (Kallen 1989; Stafford & Scott 1986). Diverse authors have pointed out that those who are stigmatized frequently exhibit long-lasting behaviors that are deemed socially unacceptable (and should therefore, according to societal norms, be concealed) and perhaps even condemned. Likewise, behaviors that are considered controllable—those that are the responsibility of the individual—as well as those that may produce changes in a person's physical appearance are often stigmatized (Crandall 1994; Goffman 1963; Jones et al. 1984). Consequently, it is society's disapproving look that can contribute to all or many of these behaviors becoming typical or habitual in IDUs and SWs.

As described by Link and Phelan (2001), stigma exists when elements such as labeling, stereotyping, separation, status loss, and discrimination present themselves in a power situation that allows these processes to be revealed. These elements are typically attached to illegal drug use and sex work (Agustin 2001; Alexander 1998).

The internalization of stigmatizing behaviors and/or attitudes penetrates and erodes the internal world of the individual, attacking concepts linked to his/her personal appraisal and self-concept, with the consequent interference of the individual's ability to function on a social and/or occupational level (Fick 2005). Such internalization of stigma by the person marginalized may produce feelings of loneliness (Deacon 2006) or increase high-risk behaviors that may lead to HIV infection as one possible outcome (Preston et al. 2004).

In Puerto Rico, statistics reported by the Department of Health (2008) demonstrate that injection drug use and heterosexual contact are among the top modes of HIV transmission on the island (IDU, 38%; heterosexual contact, 32%). Of those infected through heterosexual contact, 63% are women. This illustrates the need to know more about the presence of felt stigma in groups that are socially vulnerable as well as its potential effect on behavior, emotions, and quality of life in general.

At the time of this study, researchers had not identified any local investigations that looked at felt stigma in this population. Our objective is to understand felt stigma as it is experienced by groups at risk of becoming infected with HIV (particularly IDUs and SWs in

Puerto Rico), focusing on why these groups engage in maladaptive behaviors as a way of dealing with felt stigma.

Methods

Design

The objective of this qualitative focus group study was to explore felt stigma (specifically in the lives of persons at risk of becoming infected with HIV) and its impact on risk behaviors. Four focus groups of 8-10 participants, all of whom practiced behaviors that placed them at risk of becoming infected with HIV, were conducted in March 2005. The discussions were held at the Research Community Initiative Center located in San Juan, Puerto Rico. Focus groups were used to obtain information concerning the participants' feelings, opinions, and perceptions regarding felt stigma.

Participant Recruitment and Screening

The screening and recruitment of PBRH (34) was accomplished in collaboration with case managers from "*Iniciativa Comunitaria*," following the protocol accepted by the Institutional Review Board (IRB) of the Ponce School of Medicine. The case managers described the nature of the study to possible participants and informed them that those selected to participate in a focus group would receive a stipend for their participation in the study. In order to be considered for participation in the focus groups, individuals had to meet the following criteria: able to consent; 21 years of age or older (which corresponds to the legal majority requirement in Puerto Rico); have been tested and found negative for HIV; sex workers or injection drug users; persons who did not present any psychotic symptoms; and persons willing to participate in focus-group activities.

Description of the Participants

Thirty-four (34) persons identified as practicing behaviors that placed them at risk of becoming infected with HIV participated in the study. Participants consisted of 17 male IDUs and 17 female street SWs (who were also drug users). Most male participants were between 30 and 49 years old, single (47%), and had at least a high school education (76%). Women who reported personal information were single and had at least a high school education. Most participants lived in urban areas.

The participants' sociodemographic characteristics are shown in Table 1.

Training of Focus Group Facilitators

Five advanced graduate students from the Ponce School of Medicine Clinical Psychology Doctoral Program were selected as group facilitators based on their experiences with running groups. The facilitators attended two training sessions in which the project's main objectives and research design procedures were presented. They also participated in training sessions provided by one of the project's consultants, a specialist in focus group research; the sessions addressed methodology in group facilitation, collection and analysis of data, and report writing.

Procedures

A team consisting of experts in focus groups, a bioethicist, psychologists, a psychiatrist with expertise working with at-risk populations, and doctoral students with experience in conducting group sessions convened for three meetings and developed the following question guide for the focus group interviews:

1. When you hear the word *stigma*, what is the first thing that comes to your mind?
2. Do you remember having any experiences in which you felt “rejected”?
3. How did you feel during those experiences of rejection?
4. Have you told others of your occupation or drug habit?
5. If you have not done so, why not?
6. How did those whom you told react when informed of your occupation or drug habit?
7. How have you dealt with those reactions?
8. Before becoming an IDU, SW, or both, what did you think of drug users/sex workers?
9. What other things about rejection would you add to the discussion?

The focus group meetings were conducted in Spanish, the participants' native language; each group was guided by a trained facilitator/lead interviewer and an assistant. The sessions took place in private rooms with seating arrangements that allowed the participants to maintain eye contact with the facilitators. Meetings lasted from 90 to 100 minutes.

At the beginning of each session, the lead interviewer/facilitator described the purpose of the study and detailed the activities in which the participants would be expected to take part. The participants' rights were explained. The informed consent form was read aloud, and participants' comments and questions were addressed. The informed consent established that participants who felt uncomfortable at any time could leave the discussion and would be referred to a mental health provider if needed. Afterwards, the lead interviewer asked participants to sign the consent forms. To maintain anonymity, participants chose names by which they wished to be identified throughout the discussion. Participants were assured of the confidential nature of the process, and facilitators directed the discussion according to the previously elaborated question guide. Finally, participants were invited to talk about any unexplored topics they considered pertinent. Participants received a \$25.00 stipend for their attendance.

To facilitate the analysis of the participants' conversation, the focus group sessions were audio recorded. In addition, during the meetings a research assistant wrote down what participants said and made annotations concerning participants' comments, nonverbal expressions, emotional reactions (e.g., crying, laughing), silences, facial expressions, and actions (e.g., hitting the table).

Content Analysis of Focus Group Transcripts

To fulfill the main objective of this study, exploring perceptions related to felt stigma, as well as emotions and beliefs of people at risk of becoming infected with HIV/AIDS, content analysis of focus group transcripts was used. Content analysis is a detailed and systemic interpretation of material which aims at identifying patterns, themes and meanings within material analyzed (Berg 2006). A thematic framework was used to classify and organize data according to key themes, concepts, and categories (Ritchie & O'Connor 2003).

Main themes and subtopics were selected from the entire transcription based on our study objectives, guide questions, and existing literature on felt stigma. The thematic framework established helped develop a codification system for researchers to follow.

The audio recordings of the focus groups were transcribed into written text and minutely analyzed and coded according to the established thematic framework. For example, “definition of stigma” was coded as a main theme, and subtopics that appeared throughout the text were given a second code (e.g., 3.1 - Definition of Stigma, 3.1.1 - Rejection, 3.1.2 - Devaluation, 3.1.3 - Prejudice & Disdain). This process was followed in analyzing the entire transcription leading emergent categories which were not originally established within our framework. For example, “3.3 - Impact on the Self-Schema” and “3.4 - Consequences of Felt Stigma” were not originally included within the framework, but researchers agreed they contributed valuable information related to the phenomena of felt stigma.

To maintain qualitative reliability, an investigator independently coded and analyzed the material using the established thematic framework. These findings were compared and integrated with previous findings. Disagreements were discussed and resolved. Another investigator, this one experienced in conducting content analysis, reviewed the analysis process.

Findings

Most focus group members actively participated in group discussions, expressing a desire to collaborate with moderators and share experiences related to their habits and/or behaviors. The topics that emerged from the participants' discourse provided valuable information about their experiences and emotions related to felt stigma resulting from their interactions with family members, friends, and different members of the community. Topics discussed can be grouped into four categories: concepts related to the word *stigma*, emotional reactions to felt-stigma, impact on self-schema, and consequences of felt-stigma.

Concepts Related to the Word Stigma

The data from both focus groups highlighted stigma as being related to rejection for being linked to a particular group (e.g., IDUs or SWs). When the meaning of the word *stigma* was explored, various concepts emerged in all four focus groups: rejection, devaluation, prejudice, and disdain.

Rejection—The majority of the participants coincided in defining stigma as rejection. A female sex worker, for example, defined stigma using experiences in which she was rejected

by others: “They look at us like we were addicts and don't even want to be near us, as if we have leprosy.” Similarly, another sex worker described her sense of stigma as experiences in which others avoid proximity: “Well, nobody wants us next to them.”

Stigma, when defined as rejection, was also frequently described with images and metaphors. Female sex workers commented: “They put a label on you,” and “Well, the only thing missing is a sign that says ‘you stink.’” Various IDUs agreed, suggesting, “It's like a label that they put on you; that's when you feel rejected” and “... as if you were some sort of leper.”

Devaluation—Participants from both SWs and IDUs also included devaluation as part of the definition of stigma. A female sex worker mentioned that “for many people we are a public nuisance.” Another sex worker echoed this view, adding the following explanation:

I mean, you're not an addict. I'm an addict; you're afraid that when I'm next to your house, or that when I'm near you, I might steal something from you to get my fix - “no, I don't want that woman here because she's a thief, she's filthy, she's this, she's that.” Understand? They categorize us in the worst way.

Similarly, a man from the IDU sample indicated a sense of devaluation, suggesting others scorn and reject them:

Rejecting a person who's not on a good path, that is doing things that will make everybody look at him/her over their shoulders; people won't look at you as they should. Looking down on the person, the human being.

When defining stigma and its relation to devaluation, participants, particularly female sex workers, also described it with images and metaphors. “The scum of the earth”; “a public nuisance”; “they look at you as if you were an animal”; “the scum of the earth; that's the word ... the scum that everybody kicks.”

Prejudice and Disdain—Participants related stigma to prejudice and disdain. A female sex worker, for instance, described how others expressed fear when looking at her: “He saw you and got scared.” While an IDU shared experiences of unequal treatment: “Policemen, also, they don't treat you with the same rights as a normal citizen.” Similarly, another IDU expressed being mistreated by an employer because of his addiction problem:

When we have a job, since we are addicts, they pay less. I got beat up once because he paid me very little and I told him; since we are addicts, they are abusive. He beat me with a stick [that was] on the floor.

Emotional Reactions to Felt Stigma

Emotional reactions to stigma ranged from shame, sadness, and defeat to anger and hostility. Various sex workers, for instance, reported feeling “embarrassed”; “sad”; “like crying”; “bad”; “defeated”; and “as if an avalanche had fallen on me.” Participants from the IDU sample, on the other hand, reported more intense emotions, such as feeling “fed up” and asserting that “rejection hurts.”

Men from the IDU sample reported instances in which rejection instilled anger to the point of tears as well as aggressiveness and rage. Notice how the last quote suggests the feelings of rejection prompted emotional alteration, which itself provoked the desire to hurt others, thereby implying the possibility of engaging in high-risk behaviors.

It feels bad. At times, I've been so angry I've cried. Because this awakes some feelings, that, like, lead to anger for the same reasons.

Me, I get pissed and curse at them. Aggressive, verbally ... physically. I curse at people.

The feeling is of rage, remorse, emotionally altered—you are emotionally altered, altered to such an extent that you want to hurt the person.

Feelings of Loneliness—Primarily in the IDU sample, there were various men who also reported that rejection led to feelings of loneliness, which they implied produced self-destructive impulses. One participant, for example, declared, “Loneliness is self-destructive.” Other members of the group agreed that loneliness could be more self-destructive than living on the streets or having a severe medical diagnosis.

Loneliness plays a role as well. Loneliness is a tool that destroys the human being completely. I don't think there's a blow that hurts people more than loneliness. I know what jail's like. I've been on the street and slept in trashcans, but nothing has hurt more than loneliness. Loneliness really hurts.

It destroys more than cancer, and I don't think there's any other disease that hurts more than loneliness.... Also, all of that comes from being rejected.

Feelings of Worthlessness—Various members of the IDU sample agreed that rejection led to strong feelings of worthlessness and low self-esteem:

... There have been times that I have been rejected, and my self-esteem has been affected, and I have started to feel that I am not worth anything.

It feels horrible; as if the person is not worth anything. Your self-esteem is low because they see you are not stable or not well off economically, like other normal people.

Feelings of Hopelessness—Various female sex workers also referred to rejection as inducing hopelessness and an unwillingness to get better. Some women, for example, described feeling “weak, unwilling to get help”; “with no desire to keep going”; and “no desire to improve.” Another agreed, indicating she felt “horrible, weak, not wanting to look for help. I'm totally indifferent.”

Impact on Self-Schema

Young, Klosko and Weishaar (2006) define a schema as “a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide their responses” (p. 6). They suggest schemas can be positive or negative, adaptive or maladaptive, and formed in childhood or later in life. Essentially, they believe “schemas

result from unmet core emotional needs in childhood” and “most are caused by noxious experiences that are repeated on a regular basis throughout childhood and adolescence,” and which may later be activated during adulthood. As they describe, an individual who frequently experiences criticism early on in life, for example, might eventually trigger a defensiveness schema when in contact with others, as he or she may already view the self as being defective, bad, unwanted, inferior, or invalid. Through analysis of inductive material emerging from the participants' discourse, researchers were able to identify a negative self-schema as a precipitating factor for many of the participants' behaviors and affective states. For those who experienced early criticism and rejection, an additional burden is faced and added to the construction of the self. Following are quotes from both populations that describe the impact of early rejection and negative self-schemas on their affective states and behaviors.

Construction of Self-Schema During Early Development—The participants' discourse indicated that members from both populations identified having negative self-schemas as a result of rejection and maltreatment during their early development. Participants appeared to hold negative beliefs about themselves that were recreated in their adult lives, having an impact on their feelings, thoughts, and actions. For example, notice how in the quote that follows a sex worker describes how early criticism made rejection part of her “self”:

Well, from the day I was born, my mother did not want a girl. And when the nurse took me to be in her arms, my mother said: “Take her away, take her away; I don't want her here.” And that's how I was raised, with that label. It's like rejection has become a part of me.

Likewise, a member of the IDU sample blamed early criticism for his low-self esteem and consequent drug addiction:

Not everybody has a high self-esteem or comes from homes that help strengthen it. Most of us come from broken and poor homes. Even growing up, our mothers would say, “You're good for nothing.” And that stayed in our minds. At some point in our development, something happened to us that led to this.

Regarding maltreatment, the following statement comes from a female sex worker who claims that her drug addiction was a direct result of having been initially exposed to drugs by her stepmother:

Since I was little, my stepmother would sell drugs in my home, and she would leave me when she drank, and the bastard would come and hit her; and me, being young, I didn't know. She got me out of there when I was 9 years old because of him; he was an animal.... And her husband would rape me, and she wouldn't say anything; she'd laugh. She got me out of there, and even though I pressed charges, they didn't do anything. Plus, he sold drugs in my home, and I would see the drugs from the time I was a kid. She even used them with me.

Self-Rejection—During the discussions, several participants displayed a negative self-concept resulting from self-rejection and a loss of self-value:

A label that one even uses to describe oneself. You reject yourself with what's happening.

There have been times in which one does not speak well of oneself.

That's something very.... It deeply affects you because to get to the point of rejecting yourself, it's because you're very pressured.

Consequences of Felt Stigma

High-Risk Behaviors—We were also able to better understand how felt-stigma leads to a negative self-schema, which itself appeared to increase the likelihood of participants engaging in high-risk behaviors. The following quotes demonstrate self-schemas that activated specific beliefs of the self, producing a repertoire of maladaptive behaviors that include high-risk and self-destructive behaviors. Participants reported behaviors ranging from hygienic degradation to a cascade of automatic drug-seeking behaviors (such as needle sharing and continued drug use). Other participants also reported having thoughts of death.

The following participant, for example, recalled not caring for his hygiene as a result of the rejection he experienced from others. Notice how he describes living in subhuman conditions:

Everything comes because of rejection: you don't care at all about your health, your hygiene; you don't care about anything, whether you ate or not. You live like animals, sometimes.

On the other hand, a member of the IDU sample specifically indicated that being rejected produced hatred to the point of losing all fear in life, consequently leading to this person using fearlessness as a mechanism of self-protection, which in turn led to maladaptive behaviors. The following quote from a member of the IDU sample rationalizes that individual's willingness to share needles despite his knowing that the other person might be HIV positive. Notice how he blames his carelessness on his hatred towards others:

That's why people often become infected with HIV, because we hate so much that we lose fear of anything in life. It comes to the point where you are getting your fix and your needle gets stuck, and because you're not afraid of anything, you use the needle of the person next to you. Since that person is infected and feels the same hatred as you, he doesn't tell you that he's HIV+, and since you're having problems with your works, you're not afraid of getting infected; you're not afraid of getting infected with the syringe. That's where transmission comes from.

A member of the IDU sample reported that his feelings of loneliness and rejection from others have pushed him further into drug use:

What I feel right now is as if I didn't have anybody, alone, on the street to take refuge, to addiction, I stay with my addiction. And the money I keep making, I use it for drugs and forget that I have a family.... It's not that I want to be like this, they [my family] know what the problem is. I have to hold on to this [drug use] and keep doing it. I don't have anybody else to help me. Like they say, my best friend

right now is the drugs, which shouldn't be that way because my best friend is God, but I have to hold on to this because that's [drugs] what I have right now.

Similarly, the following quote from a female sex worker and drug user who began treatment illustrates how rejection caused her to abandon treatment, opting instead for further drug use:

... When I was in the meth program and I was calm, I wasn't using drugs, I was doing well in the program, and I felt rejected anyway, and I was doing things the right way; so I started doing things the bad way. That's what it leads you to.

Finally, various members of the IDU sample admitted to engaging in self-destructive behaviors, such as further drug use, and to having recurrent thoughts of death. One participant admitted to subjecting himself to further drug use and to living on the streets without any motivation to find a safe place to stay:

Thoughts of hurting yourself come to mind. We can't fight because we've tried twenty thousand ways, and when these rejections come, we escape further into drug abuse. I realized that when my mother rejected me; I stayed on the street for over a week using drugs, I was self-destructive. Because being rejected by your mother, my own blood, would make me feel so horrible; you know, the only thing I loved in life, you, like, destroy yourself. You go out there to destroy yourself. You stay on the streets without having a place to sleep.

One member of the IDU sample suggested he has considered committing suicide as a means to escape his reality, while another admitted he purposely overdosed, putting his life at risk. Notice how the first participant suggests having a wounded self-concept, which promotes the notion that even *he* should reject himself:

Sometimes I start trying to find an explanation for this. Man, a lot of things have gone through my mind, even taking my own life, you know. Things like that that aren't really in you. What happens is that it makes you reject yourself and try to leave the world once and for all, run away from the situation.

Consciously, I have overdosed to just go to a "better place," you know; I want to stop feeling like this.

Discussion

The main objective of our study was to explore experiences of felt-stigma in groups of people traditionally marginalized by society, such as IDUs and SWs. Our study was directed at gaining deeper knowledge about the possible mechanisms by which felt stigma could be linked to high-risk behaviors, as suggested in the literature (of which much is centered on the topic of HIV). We particularly aimed at filling the gaps in our current (incomplete) knowledge of felt stigma and its impact on high-risk behaviors among the Puerto Rican population.

As has been the case in other studies (Center of Addiction and Mental Health 1999; Fick 2005), members of both groups studied, IDUs and SWs, often reported *feeling* stigmatized in different life contexts (e.g., family and community). When defining the word (stigma),

participants coincided in using descriptive statements such as “they label you” and comparing themselves to people diagnosed with health conditions that are traditionally marginalized (e.g., leprosy). Likewise, they equated stigmatization to being “marked,” validating initial research that defined the word as being a socially imposed stamp or mark (Crawford 1996; Goffman 1963).

The actual process of stigmatization, however, has brought the “mark” from an external level to an internal one in which the person stigmatized goes from *being* marked to *feeling* marked. The following quote clearly illustrates the different components of the definition of felt stigma, which refers to feelings of fear or shame, of attitudes or acts of discrimination, real, potential, or imaginary:

It's happened to me that I'm meeting some girl or a buddy and I'm afraid that they'll exclude me without getting to know me.

Similarly, when exploring the concept of stigma with the participants, the term *devaluation* was often utilized. Stigmatizing experiences have been found to be profoundly linked to feelings of devaluation, which has been recognized as one of the most pronounced consequences of stigma (Alonzo & Reynolds 1995; Dovidio, Major & Crocker 2000). Within our study, the perception of being stigmatized was strongly associated with feeling devalued, which supports earlier findings.

Two particular types of emotion were also identified among those who felt stigmatized: those derived from sadness and depression (e.g., loneliness) and those related to hostility and aggression. Emotional reactions to stigma seemed to vary according to gender. Women were more likely to report feeling depressed, while men described feeling anger and rage. As was observed, men who reported more symptoms associated with depression appeared more likely to engage in self-destructive behaviors, while those who experienced rage or anger were inclined to externally expressing their emotions and potentially producing harm to others. This supports other studies that suggest depressed men are more likely to engage in such self-destructive behavior as suicide as well as display aggressiveness and other dangerous or life-threatening behaviors that are released through anger and/or violence (Brownhill, Wilhelm, Barclay & Schmied 2005; Danielsson & Johansson 2005).

Likewise, participants often reported feelings of shame, guilt, and low self-esteem, all of which indicate self-devaluation and a negative self-perception. Some authors have considered a negative self-image as a dimension of felt stigma (Berger 2001). We opine that this negative self-image could be a consequence of the internalization of stigma and may have a very profound impact on the structures of the self.

The concept of schema has helped us explain how the self-image is affected by the internalization of stigma. Young et al. (2006) propose that within cognitive psychology, a schema may be considered an abstract plan that serves as a guide for interpreting information and solving problems, while at the same time playing a role in how individuals feel, think, act, and relate to others.

During the focus group sessions, several participants related experiences of exclusion that are associated with current feelings of rejection. Participants often mentioned early experiences of abandonment, abuse, neglect, and rejection during infancy, which may have affected their self-schemas. As described above, one participant, for example, verbalized how rejection became part of who she is because of earlier experiences, producing an afflicted self-schema: "... and that's how I was raised, with that stamp.... It's as if rejection were a part of me" People who live with such afflicted self-schemas appear more vulnerable to experiences of rejection or stigma. This internalization of stigma is added to people's previous noxious life experiences, producing a synergistic effect that has an even greater impact on redefining their self-schema (Young et al. 2006). This suggests our schemas are developed through both previous and current life experiences.

As the concept of self-schema relates to felt stigma, we believe felt stigma redefines the person's preconceived notion of his/her self-schema, producing a negative self-schema and leading to maladaptive behaviors and negative affective states. This helps explain our participants' reports of self-destructive behaviors such as drug use and syringe exchange, regardless of the possibility of their becoming infected with diseases such as HIV.

The results of our study confirm the importance of examining more profound psychological aspects, such as the structure of the self-schema, at the time of evaluating the process of internalization of stigma in populations vulnerable to HIV infection. Likewise, the results suggest the importance of developing intervention models directed at reducing stigma.

Acknowledgments

With this study we intend to communicate our participants' voices, their emotions and life experiences. We would like to thank participants who took part in this study and *Iniciativa Comunitaria* of Puerto Rico who helped with recruiting efforts. This study was sponsored by the Puerto Rico Comprehensive Center of Health Disparities: NCRR 1-U54RR019507.

Notes: This study was sponsored by the National Institute of Health (NCRR 1-U54RR019507).

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Table 1
Participants' sociodemographic data Persons who practice behaviors that place them at risk of becoming infected with HIV

Age (years)	Men	Women
21-29	2	4
30-39	7	3
40-49	8	4
50 +	0	2
unknown	0	4
Marital Status		
single	8	10
married	2	0
separated	0	0
divorced	6	3
widowed	1	1
other	0	3
Educational Level		
elementary school	0	1
middle school	3	1
high school	13	10
college	1	2
unknown	0	3
Region		
urban	17	17