

**Courtesy stigma: a hidden health concern among workers providing services
to sex workers**

by

Rachel Phillips

B.A., University of Alberta, 1997

M.A., University of Victoria, 2004

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Supervisory Committee

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Supervisory Committee

Dr. Cecilia M. Benoit, (Department of Sociology)
Supervisor

Dr. Helga K. Hallgrimsdottir, (Department of Sociology)
Departmental Member

Dr. Karen M. Kobayashi, (Department of Sociology)
Departmental Member

Dr. Bonnie J. Leadbeater, (Department of Psychology)
Outside Member

Abstract

Supervisory Committee

Dr. Cecilia M. Benoit, (Department of Sociology)

Supervisor

Dr. Helga K. Hallgrimsdottir, (Department of Sociology)

Departmental Member

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Departmental Member

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Courtesy stigma is the public disapproval evoked as a consequence of associating with a stigmatized individual or group. While there are few examples of research applying the concept of courtesy stigma to the professional associates of stigmatized persons, courtesy stigma has been shown to limit the social support and social opportunities available to family members who come to share some of the shame, blame and loss associated with their family member's stigma(s). Research on the occupational health of persons performing frontline service work examines various sources of workplace demands and rewards, including the availability of public funding for the health and social service sectors, the devaluation of feminized forms of care-oriented work, and the downloading of responsibility for providing care to poorly paid or unpaid workers in the community and home. This research project blends the literatures on courtesy stigma and the occupational health of frontline service workers to understand the work experiences of those providing frontline social services to sex workers. A mixed methods design is used to study the workplace experiences of a small group of workers in a non-profit organization providing support and educational services to sex workers. The findings reveal that courtesy stigma is a discernable experience among this vulnerable group of service workers, affecting their work, community and family contexts. Courtesy stigma played a significant role in staff perceptions of others' support for themselves and their work activities, leading to diminished opportunities for collaborative relationships, emotional exhaustion, altered service practices, and a low sense of workplace accomplishment. Thus, courtesy stigma forms part of the package of conditions that leads to high turnover, diminished workplace health, and a loss of service capacity in the frontline health and social service sector. The dissertation concludes with a consideration of the implications of the findings for the literatures on courtesy stigma and frontline service work, arguing that courtesy stigma is an underestimated determinant of occupational health for frontline service providers serving socially denigrated groups.

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Dedication

This dissertation would not have been possible without the involvement of the current and former staff and volunteers of PEERS Victoria Resources Society and I respectfully dedicate this work to them and their ongoing efforts.

Chapter 1: Introduction

Sociologist Erving Goffman (1963) defined *stigma* as a social attribute that is discrediting for an individual or group. Stigmas are typically regarded as having a negative impact on self concept and identity formation, resulting in degrees of social exclusion that may span from difficulty engaging in normal social interaction because of secrecy or shame, to a societal discrediting of the stigmatized individual or group of individuals (Corrigan et. al., 2006; Corrigan and Watson, 2004; Link and Phelan, 2002; Scambler, 2004). Expanding on Goffman's social interactionist definition of stigma, health scholars Link and Phelan (2001) conceptualize stigma as the co-occurrence of labelling, stereotyping, separating, status loss and discrimination. These researchers add to recent scholarship on the socio-psychological impact of stigma in identity formation and social interaction by examining: 1.) how stigmas are translated into broader socio-cultural traditions and institutions, including social welfare policy; and 2.) how stigmas interact with other determinants of advantage and disadvantage (Link and Phelan, 2006; Stuber et. al., 2008). Viewed from this sociological angle, stigmas are a wide-ranging social determinant of health affecting not only various aspects of identity formation and social interaction, but also access to a range of resources and opportunities, including health and social welfare service environments.

While the bulk of social science literature on stigma has focused on those who experience stigma directly, Goffman (1963:30) suggested that stigmas not only affect the individuals bearing them but also, *by courtesy*, those who are in close association to these individuals and groups: "the problems faced by stigmatized persons spread out in waves of diminishing intensity among those they come in contact with" (1963:30). Goffman referred to those who are close to stigmatized persons as "wise": "persons who are *normal*, but whose special situation has made

them intimately privy to the secret life of the stigmatized”, thus affording them “a measure of courtesy membership” in the group (1963:28). Acknowledging the potential for variation in experiences of stigma and courtesy stigma, Goffman further argued that the capacity of stigma to spread from the stigmatized to their associates is structurally-embedded, and dependent on the social location of both the stigmatized person (or population) and their associates (1963:30). One of the reasons Goffman argued that those associated with stigmatized individuals were subject to social downgrading was that they provided a model of acceptance that breached established norms and social hierarchies. As Goffman stated, their acceptance of the stigma “confront[s] others with too much morality” (1963:30).

Despite Goffman’s groundbreaking work, relatively little attention has been paid to the concept of courtesy stigma (also called “stigma-by-association” or “associative stigma”). The available research focuses on the experiences of family members of stigmatized individuals, and the stigmas associated with physical and cognitive disabilities, HIV/AIDS, and psychiatric conditions (Birenbaum, 1972; Corrigan and Miller, 2004; Gray, 2002; Green, 2003; Khamis, 2006; Turner et. al. 2007). However, Goffman, and a small number of researchers since, argue that the premise of courtesy stigma also applies to those who have professional relationships with stigmatized individuals (Goffman, 1963; Birenbaum, 1972; Snyder et. al., 1999). For example, persons working in a wide array of health and social welfare services aimed at vulnerable populations – such as mental health and addictions services, disability services, homelessness and poverty related services, to name a few - may experience courtesy stigma in varying degrees because of their close association to stigmatized populations.

Looking beyond the stigma literature, existing scholarship on the occupational health of frontline service workers demonstrates how persons working in the health and social service

sectors - particularly those in the lower ranks of frontline service work - are likely to experience high stress, low employment retention rates, and a variety of health problems associated with the combination of demanding and poorly rewarded work (Baines, 2004; Denton et. al. 2002; England, 2002; Hallgrimsdottir et. al. 2008). The workplace strain experienced by these service providers is regarded as a confluence of the physical and emotional demands associated with the work, as well as the effects of changing funding and governance in the health and social service sectors as governments seek to tighten public spending (Hallgrimsdottir et. al., 2008; Saunders, 2004). Other literature regarding frontline service work links poor working conditions to the feminization and devaluation of this form of labour, arguing that frontline service work that resembles unpaid work performed by women in the home is unlikely to be highly rewarded in the economic sector (Baines, 2004; England, 2002; Benoit and Hallgrimsdottir, 2008).

By combining the key arguments that stigma is transmittable and that frontline service work is subject to devaluation in welfare states undergoing retrenchment, this dissertation project uses a single-site ethnography to address the following objectives: 1.) investigate the characteristics of courtesy stigma among frontline service workers serving a highly stigmatized client group - in this case, sex workers; 2.) examine the factors that interact with courtesy stigma in the workplace, leading to variations in experience among workers; 3.) explore how courtesy stigma impacts the service environment. This latter aim is a follow up to my Master of Arts thesis research that investigated stigma as a barrier to accessing health care among sex workers¹.

My MA thesis explored the significant role stigma plays in help-seeking patterns, patient-

¹ The term 'sex work' broadly refers to the commercial exchange of sexual services or fantasies for payment, including payment in kind. It encompasses a diverse grouping of activities and venues ranging from escort agencies, massage parlours and telephone services, to exotic dancing, street work, and home-based services. Although some activities associated with the sex industry are illegal in Canada, the act of selling sexual services is not illegal.

provider interaction, and the organization of specialized services available to sex workers (Phillips and Benoit, 2005). Research respondents noted that they engaged in varying degrees of information management when seeking health services, including not disclosing their involvement in sex work or other information pertinent to their health. Respondents also described fear of discrimination and actual instances of discrimination from service providers, which profoundly impacted the quality of services they received (Phillips and Benoit, 2005). Yet other respondents described service experiences where communication was more open with service providers who demonstrated both empathy and knowledge in regards to their life circumstances (ibid). This research underscored the well-established idea that stigma impacts service delivery because service providers, to a greater or lesser degree, enact stigmas in their work (Phillips and Benoit, 2005). Clients react to these stigmas by altogether avoiding service, not disclosing important information, or engaging in other behaviours which otherwise diminish their access to service (ibid).

My doctoral research goes beyond my MA thesis by exploring the more subtle ways that courtesy stigma may impact service delivery, focusing on the service provider - rather than the client - as the person managing stigma in the service context. While there is research to demonstrate that service providers may enact stigmas depending on their knowledge and values that inform their practice, there is little research examining how they may also be simultaneously managing stigmas. In summary, the first and second aims of this research project are to examine the role of courtesy stigma as a largely unacknowledged determinant of health among service workers to vulnerable populations. The third aim is to more specifically contribute to the literature regarding the impact of stigma on health care access by examining how stigma permeates patient-provider interactions, from the perspective of the frontline service provider.

This research project draws on a primarily qualitative mixed-methodology, combining ethnographic participant observation, individual open-ended interviewing, and a brief questionnaire. Using theoretical sampling, respondents were recruited from a single work site called PEERS Victoria Resources Society (PEERS)². PEERS is a community based organization where paid and volunteer frontline service workers provide support services specifically to persons who are currently, or were formerly, involved in the sex industry.

The findings from this project suggest that courtesy stigma is a common and significant determinant of occupational health, with the structural aspects of courtesy stigma having a profound effect on the occupational health of those who work at PEERS. Although workers develop various means to cope with courtesy stigma as it occurs in workplace and community-based interactions, structuralized stigmas, in the form of limited and contingent funding, and the impoverishment of allied services, result in systemic barriers to the objectives associated with frontline service work. In addition, workers at PEERS perceive discrimination from others in the community including diminished acclaim associated with the organization and the perspectives of those who work there. Theoretically, the findings suggest that *courtesy stigma* and *primary stigma* (the terms used in this project to differentiate direct stigmas from associative or courtesy stigmas) are closely related and there are few reasons to treat them as conceptually, or empirically, distinct. As Scambler (2009) argues, the mechanisms and effects of primary stigma (and courtesy stigma) are broadly similar across a wide range of theories and stigmas, suggesting that general processes of social status are at play regardless of the specific contents of one stigma or another. Drawing on theories of intersectionality, this research also explores how workers who experience multiple forms of stigma in the workplace are more vulnerable to courtesy

² PEERS Victoria Resources Society was formerly called the Prostitutes Empowerment Education and Resource Centre (PEERS)

stigma than those who are able to draw on other social resources to temper the effects of perceived and enacted stigma. While service providers at PEERS report many assets associated with their work environments, the quantitative indicators of workplace health suggest that the strains associated with courtesy stigma and other aspects of the work environment take a toll; lower workplace health is in turn associated with reductions in service capacity. Further research might test the validity and reliability of the major concepts and findings of this single-site project by applying the model used here to a larger comparative sample of frontline service workers who represent varied settings and clientele.

The outline of this thesis is as follows: Chapter 2 provides an overview of the pertinent literature including the literature on stigma, courtesy stigma, and frontline care work; Chapter 3 provides a detailed description of the methodology and methods used in this dissertation project; Chapter 4 provides an in-depth look at the history and salient characteristics of PEERS and its workforce; Chapter 5 focuses on courtesy stigmas experienced by service providers at PEERS; Chapter 6 focuses on the implications of the findings for the relevant literature, policy and practice; and Chapter 7 provides a summary of the project, its limitations, and concluding remarks.

Chapter 2: Stigma, Courtesy Stigma and the Occupational Health of Frontline Service Workers

2.1 Introduction

Chapter 2 provides a review of the literatures on primary stigma and courtesy stigma, including conceptualization of stigma, trends in empirical evidence, and stigma interventions. The literature on primary stigma is reviewed in order to set the stage for a discussion of courtesy stigma, which as I argue below, is in many respects a parallel concept, which may differ from primary stigma in severity, but not in terms of the basic social processes it is associated with. Another notable difference between primary stigma and courtesy stigma is that the latter originates from kinship, whereas the former originates from deviant behaviour, physical condition, or group identity. By considering the literature on stigma, the opportunities for conceptualizing and operationalizing courtesy stigma are expanded. Following this, a brief discussion of the stigmas surrounding the sex industry is included as it provides needed context to the work experiences described by those who work at PEERS. The chapter concludes with an exploration of the relevance of care work and occupational health literature to courtesy stigma. By bringing these literatures together, courtesy stigma emerges as a largely unexplored determinant of occupational health and a complementary addition to the nexus of issues researchers have identified as affecting those who provide frontline services to vulnerable populations in the public and private sectors.

2.2 Conceptualizing Stigma as a Social Determinant of Health

Stigma, which has etymological roots in the Ancient Greek practice of branding slaves, was defined by prominent stigma scholar Erving Goffman as the situation of the individual who is “disqualified from full social acceptance” and “reduced from a whole and usual person to a

tainted, discounted one” (Webster’s, 1913; Goffman, 1963:3). More recently, Link and Phelan define stigma as the co-occurrence of five components: labeling, stereotyping, separating, status loss and discrimination (Link and Phelan 2001a). Each of these overlapping concepts outlines how stigmas arise from the identification of a difference as socially relevant, which is itself a complex feat as most social differences are ignored or considered inconsequential (Link and Phelan 2001a). The process of identifying differences is bound up with oversimplification, or stereotype formation, as a necessary component of group differentiation (Link and Phelan 2001a). The cognitive processes involved in stereotyping ensure that identification of negative attributes are transformed into overarching beliefs and behaviours; these processes become finely tuned and ingrained and may be enacted without conscious intent on the part of actors (Kulik et. al. 2008). Group differentiation is the third component of stigma and involves the social processes associated with separating identified groups into specific social locations; this is, in part, achieved by elevating identified differences to a master status – that is stigmas become the primary lens through which individuals are viewed by others (Link and Phelan 2001a). The fourth and fifth components, status loss and discrimination, focus on the systemic downward trajectory experienced by those labeled as different – identified differences are parlayed into a range of social settings resulting a variety of secondary outcomes, which on their face, may have very little relevance to the original difference which formed the basis of group differentiation in the first place (i.e., the impact of gender and racial identity on social performance in tests).

Access to power is central to Link and Phelan’s (2006) conception of stigma, as unequal power relations are a structural precondition of stigma formation. For example, while labeling and norm- enforcement are ubiquitous aspects of social life, only groups with some advantage over another have the power to make labels consequential at political, cultural and economic

levels (ibid.). Thus, stigmas can be traced back to a pre-context of broader social inequities that enabled stigma formation (i.e. gender and sexual inequality are preconditions associated with sex work stigmas).

Stigmas are commonly organized into three main forms: tribal stigmas which are based on race or other identity categories, behavioural stigmas which are rooted in deviant conduct, and bodily stigmas which are often conceptualized as observable deformities (Goffman, 1963). Occupation-based stigmas, which are the focus of this research project, can most readily be classified as behavioural stigmas, but often, if not always, intersect with other stigmas depending on job content and the identities of those involved (Benoit et. al. 2010). In fact, one of the characteristics of stigmas is that they are flexible, accommodating an evolving range of social concerns which become co-linked, in a reinforcing manner, to the primary attribute or behaviour as a mode of stigma maintenance and perpetuation (Hallgrimsdottir et. al. 2008). For example research indicates that prior to an overarching concern with the health risks associated with sex work, sex workers were primarily feared as vectors of moral contagion – persons who might corrupt “good boys” (Hallgrimsdottir et. al. 2008).

There are a variety of theories regarding the social origins of stigma, but they are generally regarded as reflecting perceived threats to social order (norm enforcement) or survival (disease avoidance) or the outcome of one group’s desire to subordinate another for economic power or other gains (group competition) (Kurzban and Leary, 2001; Phelan et. al. 2009; Strangor and Crandall, 2000). However, it is important to note that despite general agreement regarding the origins of stigmas, there is a dearth of literature examining the historical evolution of stigmas, and researchers have identified this gap as problematic as such information is crucial to understanding both the ongoing social construction and disruption of stigmas and, relatedly,

the most effective interventions (Hallgrimsdottir et. al. 2008; Phelan et. al, 2009).

While specific stigmas are generally regarded as social constructs reflective of the concerns and fears in a particular time and place, the processes of disease avoidance, social norm enforcement, and competition for power are considered universal features of social life, and by those adopting a socio-biological stance, as evolutionary pressures (Phelan et. al. 2009; Scambler 2009). Stigma processes are thus considered to be normal features of society in which everyone is engaged, rather than abnormal processes. As Goffman stated: “the stigmatized and the normal have the same mental make-up...he who can play one of these roles...has exactly the required equipment for playing out the other”(1963:130-131). Stigma has been similarly conceptualized by Scambler (2009) as the antithesis of what is considered honourable, desirable and upright (cf. Wittgenstein, 1953). Thus, stigma and processes of stigmatization – defining the normal and the abnormal, or insiders and outsiders - can be considered alongside, and in relation to, other theories of social stratification.

The relationships between stigma and other aspects of social status, such as prestige, deviance prejudice, discrimination, and social exclusion have not been widely explored. However, each tends to be used to draw attention to the way in which social status influences health, with many parallels in the applications of these concepts to empirical inquiry. Further consideration of these relationships, particularly in regards to the degree to which these are the same or complementary constructs, is needed in order develop theoretical and empirical knowledge of stigma as a social determinant of health, and to link stigma to the broader concept of socio-economic status. A basic review of the parallels between these concepts is provided below.

Discrimination has been theorized as one aspect of stigma. Scambler and Hopkins (1986)

describe *felt stigma* as the *perception of devaluation* experienced by stigmatized persons, accompanied by a companion fear of facing discrimination during social interaction (becoming a stigma target). *Enacted stigma* refers to *observable acts of discrimination* or discomfort on the part of the non-stigmatized (or stigma perpetrators). This distinction is important, especially after the adoption of equal rights legislation in high-income countries, as it allowed subsequent research to examine how stigmatized groups are most harmed by felt (also called *perceived*) stigma, even in the absence of overt discrimination (Cree et al., 2004; Crocker and Quinn, 2000; Norvilitis et al. 2002; Scambler, 2009; Scambler and Paoli, 2008). While acts of discrimination (*enacted stigma*) can be profoundly damaging to health, felt stigma plays a powerful role in reducing self-confidence, inhibiting social interaction and reducing access to health resources as individuals engage in various forms of secrecy, covering, instrumental disclosure, and avoidance in order to limit their exposure to enacted stigma (Donkor et. al. 2007; Gray, 2002; Krieger, 1990; Scambler and Hopkins, 1986; McRae, 2000). Scambler and Paoli (2008) later added the concept of *project stigma* to the distinction between felt and enacted stigma; *project stigma* refers to felt (or perceived) stigma, but only entails a desire to avoid enacted stigma, without any accompanying sense of shame or guilt (ibid.). This third distinction helps account for individuals or groups who, for various reasons, exhibit resistance and defiance in the face of character attribution and associated prejudices, but who nevertheless, make efforts to avoid exposure to discrimination by adopting similar practices of secrecy and instrumental disclosure (ibid.). Scambler (2009) suggests that this three part model of stigma can be similarly applied to behavioural deviance, with the language of stigma more often invoked when the topic of study is identity (race) and health (disability), and the language of deviance more likely to be invoked when the topic of study is violation of moral-behavioural norms (substance use, commercial

sex).

In sum, research applying the concept of discrimination to the study of health is synonymous with research on enacted stigma. Similarly, deviance and stigma are parallel concepts with the first more likely to be used with stigmas that contain an element of moral-behavioural achievement (poverty, sex work, substance use), and the second more likely to be used with stigmas that are based on ascribed characteristics for which the bearer cannot be regarded as morally responsible (race, gender, disability). The consequences of this distinction are significant as achieved statuses garner *blame*, whereas ascribed statuses garner *shame* – bearing in mind stigmas, such as sex work, will often encompass both shame and blame as the discursive boundaries of sex work stigmas stretch to incorporate both achieved (promiscuous, drug user) and ascribed (victim) statuses (Scambler and Paoli, 2008; Hallgrimsdottir et. al. 2008). Ascribed stigmas (race, gender, disability) are more likely to be regarded as unjust, which has implications for the availability and design of interventions, specifically the manner in which interventions will be fused with moralization and culpability (Corrigan et. al., 2006; Heatherton et. al, 2003; Rozani et. al., 2009; Scambler and Paoli, 2008).

The distinction between felt/perceived and enacted stigma also contains parallels within definitions of prejudice. Prejudice is defined as felt or expressed antipathy based upon faulty and inflexible generalizations - a hostile attitude toward a person who belongs to a group and is therefore presumed to have the objectionable qualities of that group (Allport, 1954:9; Struber et. al., 2008). Following systematic comparison of a variety of influential models of stigma and prejudice, Phelan et. al. (2008) argue that they are the same constructs, with the major difference between the two being that stigma is used when the focus is on disease, disability, and deviance, or the unusual, and prejudice is used when the focus is on issues of race, ethnicity, gender, age

and sexual orientation – or the more commonplace axes of difference (Struber et. al. 2008). A further difference is that the stigma literature tends to focus on the experience of targets, whereas studies of prejudice are more likely to focus on perpetrators – a difference which subtly communicates how stigmas are considered natural properties of the stigmatized as opposed to the unjust perceptions of others (Struber et. al. 2008). Thus, stigma, deviance, and prejudice are interrelated concepts, which are used to address various axes of difference depending on whether the difference is regarded as a combination of usual, unusual, ascribed or achieved.

The relationship between stigma and prestige, though not systematically reviewed by scholars, is also a close one as they arguably represent, as implied earlier, opposite ends of the same construct. Prestige is generally defined as referring to achieved (but also ascribed) esteem and respect, and the ability to impress and influence, whereas stigma, as noted earlier, refers to the absence of these attributes to the point of discounting the individual (Webster's Dictionary, 1913). A further character of stigma, which might potentially set it apart from prestige, is that the disgrace associated with stigmas are to a greater or lesser degree indelible, and more attention is paid to how stigmas and associated prejudices are unwarranted social constructs. However, this is arguably another demonstration of parallels between the insights found among stigma and prestige literatures. Life course research demonstrates that social opportunity or prestige – generally based on education, income, or desirability of one's occupation - confers lasting and multitudinous benefits in much the same way that stigmas result in lasting and multitudinous disadvantages do (Marmot and Wilkinson, 2006; Raphael, 2008). The impact of social status – whether positive or negative – can therefore be regarded as indelible, interacting with subsequent changes in status, self-perception, and opportunity well beyond the observable occurrence of one status or another (Modin et. al. 2009). Thus, the emphasis on stigmas as a permanent mark of

disgrace is not entirely dissimilar to the broader social determinants of health literature addressing the impact of material and cultural advantage as fundamental determinants of health across the life course (Link and Phelan, 2005; Benoit and Shumka, 2009). A recent study demonstrated that reduced health outcomes could be measured across three generations after an illegitimate (born out of wedlock at the turn of the century) birth, demonstrating how stigmas and disadvantage become intertwined to affect not only health outcomes over one life course, but over multiple generations (Modin et. al., 2009). In addition, studies of occupational prestige and professional status attainment suggest that prestige is based on many of the same broad processes of in and out group competition over resources, norm validation, and desire for prosperity that have been cited as the basis of stigma and deviance (Friedson, 1970; Tremain, 1977).

Social exclusion, an increasingly popular term within the social determinants of health literature, also contains many parallels with conceptualizations of stigma. There is an increasing convergence between health research addressing issues such as marginalization, social exclusion and stigma, owing in large part to the trend towards examining imbalances in power and opportunity as fundamental determinants of health (Benoit et. al., 2010; Link and Phelan, 2002; Scambler, 2009). Galabuzi (2004:238) defines social exclusion as the inability of certain subgroups to participate fully in Canadian society due to structural inequalities in access to social, economic, political, and cultural resources arising out of the often intersecting experiences of oppression as it relates to race, class, gender, disability, sexual orientation, and immigrant status. Social exclusion is said to take place on a number of levels, including through structural exclusion from civil society (legal sanctions and relative or absolute exclusion from citizenship rights and protections), through denial of social goods (such as housing, education, and disability accommodations), through exclusion from social production (denial of opportunity

to contribute to social and cultural activities), and through economic exclusion (unequal access to forms of livelihood and economy) (Galabuzi, 2004; Jenson, 2000 & 2003; Saraceno, 2005). The parallels between the concepts of social exclusion and stigma suggest that these are also compatible constructs, with social exclusion differing perhaps in its overall focus on the structural contexts and intersectional nature of stigma and disadvantage, whereas stigma research has, until recently, maintained a focus on the micro-behavioral context and the impact of singular stigmas (Benoit et. al., 2010; Hankivsky and Cormier, 2009).

In sum, although additional systematic comparison of the literatures pertaining to stigma, prejudice, deviance, prestige, and social exclusion as social determinants of health is required, it is likely each of these concepts focus on different dimensions of the complicated relationship between social status and health. If this is the case, then models for each of these concepts should be similar or complementary, allowing a variety of status constructs – race, gender, disability, occupation, sexual behaviour, substance use, mental health etc. – to be considered interchangeably and, importantly, within their interactive context (Scambler, 2009; Hankivsky and Cormier, 2009). The implication is that these literatures may be brought together where it is useful to do so in order to advance theoretical and methodological understandings of stigma. Scambler (2009) argues that similarities in the social processes evoked by stigma as well as the outcomes associated with a wide range of stigmas, support the development of a generic, standardized empirical tool; the use of such a tool would be an advancement on the current trend of measuring stigmas idiosyncratically, a practice which neglects the larger structural processes at play (including processes that give rise to variance across stigmas and cultures) and the likelihood that stigmas are transmuted as they interact with other aspects of identity to produce effects that cannot be attributed to a single stigmatized identity alone (Corrigan et. al. 2004;

Havinsky and Cormier, 2009; Kessler et. al, 2001; Keusch et. al. 2006; Link and Phelan, 2001, 2006; Reissman, 2000). Bearing these conceptual facets of stigma in mind, the next section focuses on findings from the empirical literature, especially to the extent that this literature provides a predictive framework for the present study.

2.3 Stigma and Empirical Trends

Much of the stigma literature, following Goffman's (1963) highly influential dramaturgical approach, focused on how stigmas are relational and deployed most visibly in social interaction. Goffman differentiated between the *discredited* – whose stigmas were observable and therefore adopted practices of impression management – and the *discreditable* – whose stigmas could be concealed through effective information management (ibid.). Goffman's work focused on how stigmatized and non-stigmatized individuals arrive at working definitions of the rules of interaction, what happens when rules are broken and remedial exchange is necessary, and how the rules shift in different contexts (ibid.). Goffman was interested in the structures of interaction that formed around stigmas as actors engaged in anticipating each others thoughts via the *looking-glass self* (Camp et. al.. 2002). Following Goffman's work, a major stream of empirical work was developed that focused on how the stigmatized react to, and manage, stigmas or labels in the context of social interaction and societal norms (Scambler, 2004). This body of work adopted a modified version of labelling theory, focusing on how expectations of labelling, rather than labelling itself, have a strong negative effect on social participation (Link et. al. 1989). One of the main premises of the modified labelling theory that heavily influenced stigma research during this period was that individuals have internalized negative representations of various conditions and behaviours before they become labelled with them; once labelled, these internalized messages are activated

in personal identity formation and secondary deviances such as the “sick role”, which may, in turn, result in withdrawal from, or modified participation in, various aspects of social life (Link et. al. 1997; Pilgrim and Rogers, 2005; Rosenfield, 1997). The trend of applying modified labelling theory to stigma research spanned the period from the late 1970s to late 1990s (often referred to as the “personal tragedy era” of stigma research) and was heavily influenced by case studies of disability, mental health, and HIV/AIDS (Link et. al 1989; Scambler, 2004, 2009; Scambler and Paoli, 2008). Much of the research from this era accepted that stigmas involved loss of self and biographical disruption followed by the adoption of coping strategies and adjustment (Scambler and Paoli, 2008).

Schneider and Conrad’s (1983) typology of modes of adaption to stigma suggested that individuals fell into three categories of adjustment. The *pragmatic type* downplays their stigma by attempting to pass (discredited) or cover (discreditable), primarily by managing the manner in which, and to whom, their stigmatized attributes are revealed. The *secret type* opts for elaborate tactics to conceal their stigma reflecting an internalised poor self concept. The quasi-liberated type publicly proclaims their stigma in an attempt to sidestep any antagonism and to educate others (ibid.). These three basic responses of education, secrecy and withdrawal have been noted by others (Link et. al. 1989).

Also examining styles of adaption and coping, Miller and Kaiser (2001) similarly delineate two types: disengagement coping and engagement coping. Both can be further divided into voluntary and involuntary styles. Their findings suggest that persons at the greatest risk of stress are those who employ voluntary disengaged styles (denial, social withdrawal), or who are affected by involuntary responses (physiological arousal, rumination). Engagement styles – such as distraction (thought substitution, rather than thought suppression),

devaluation/disidentification with domains where a stereotype is of importance, and cognitive restructuring (reframing experiences) are associated with less stress (Miller and Kaiser, 2001). Acceptance of “one’s lot” was a cognitive engagement style not generally associated with positive outcomes, and the authors further note that disidentification – or withdrawal from social structures where stereotypes and discrimination are likely - can be maladaptive if it is also associated with limited opportunities (Miller and Kaiser, 2001.). The most advantageous styles of coping included problem solving through collective action and emotional regulation (learned or instinctive strategies that reduce feelings of anger and anxiety) (Miller and Kaiser, 2001). These findings suggest that collective organizing can be an effective stigma management tool, but only insofar as joining a collective group is associated with problem solving and acquisition of stigma reduction skills, and not taxing or associated with increased anger. The latter raises the importance of “stigma coaching” in private (family) and public (treatment) sites where various associates such as family, peers, service providers, and group leaders apply labels and mentor others in particular styles of stigma management and coping and therefore may play a role in either worsening or mitigating the effects of stigmas (Acker, 1993; Lee et. al. 2008; Jacoby, 2002 Pescosolido et. al. 2008).

In sum, documenting perceived and enacted stigma alongside the various coping strategies used by stigmatized persons has been of significant empirical interest because of the association with various levels of distress for the stigmatized. More recent investigations have expanded this model to focus on how coping and resistance practices, including passing, covering, withdrawal, and disavowal of others’ perceptions, are preconditioned and delimited by other contextual factors such as education, income, and group association, adding much needed nuance to Goffman’s assumption of singular normative order to which various groups uniformly

ascribe (Kusow, 2004; Miller and Kaiser, 2001; Scambler and Paoli, 2008; Reissman, 2000).

Research regarding identity formation and coping with stigma laid the groundwork for scholars to begin to consider the individual and public health implications of stigma. At least five pathways from stigma to health have been developed in the empirical literature, with an overarching focus on distress and opportunity exclusion as causal links (Krieger, 1990; Link and Phelan, 2006; Miller and Kaiser, 2001; Miller and Major, 2000; Struber et. al., 2008). First, internalized stigma or self stigmas refers to individuals who adopt negative prejudices leading to diminished self concept and self esteem (Rosenfield, 1997; Link 1987). Second, even in the absence of internalized or self stigma, those who attempt to avoid the enactment of stigma by withdrawing socially from various contexts and structures experience reduced quality and quantity of social networks and support (Corrigan et. al., 2000; Donkor and Sandall, 2007). Third, the stress and anxiety associated with perceived and enacted stigma has its own independent effect on mental health, often operationalized as depression symptoms (Fortney et. al. 2009; Ronzani et. al, 2009; Stuber et. al., 2008). Fourth, enacted stigma results in underutilization of health services, and activates a cascade of secondary problems in the realms of employment/income, housing, and education as service providers and members of the public enact both conscious and unconscious forms of discrimination (Dovidio and Gaertner, 2004; Dovidio et. al. 2008; Lee et. al. 2008; Link, 1997; Link and Phelan, 2001; Wahl, 1999). Fifth, in order to alleviate stress, stigmatized persons engage in behaviours (such as substance use) that pose further health risks, and are generally in a poorer position to engage in health promoting activities due to relative resource deprivation (Stuber et. al. 2008). The health implications of *stigmatization* may be more damaging than the condition or attribute itself, especially if the stresses associated with multiple stigmas attached to one individual are experienced in a

cumulative manner (Benoit et. al, 2010; Stuber et. al. 2008; Ronzani et. al, 2009).

Without questioning the strong contribution of the micro-behavioural-oriented research described above in laying the groundwork for critical reflection and growth, there are inevitable gaps in this line of inquiry. These gaps have been noted by a number of recent authors and include: 1) insufficient attention to the structural origins and contexts of stigma; and 2) inadequate examination of intra and inter group variation in stigma, with both lines of inquiry being central to a more critical examination of the effectiveness of different intervention modalities (Camp et. al 2002.; Corrigan and Watson, 2006; Kusow, 2004; Link et, al, 2001; Major and O'Brien, 2005; Scambler, 2006; Shultz and Angermeyer, 2003; Stuber et. al. 2008). For example, Stuber et. al. (2008) highlight how recent public campaigns to stigmatize smoking are perceived more acutely by those of relative advantage (white, higher education, and higher income); as advantaged subsets of the population are in a better position to modify health behaviours in response to these public campaigns (and do so), smoking stigmas are bolstered through their newfound association with lower socio-economic identity – a small example of how individuals and groups may be caught in an rearticulating web of stigmatization (Wailoo, 2006). Other researchers have used cross-national comparative models to highlight how stigmas shift in response to the economic and cultural particularities of different nation-states, including the various social control and social welfare interventions that are applied (Lemish, 2000; Scambler and Paoli, 2008). Authors seeking to redress gaps with regards to the structural origins of stigmas repeatedly highlight how stigmas become reified in social welfare regimes and other social institutions, reflecting the broader regimes of citizenship associated with different states (liberal, social democratic, conservative) (Pescosolido et. al. 2008; Link and Phelan, 2006).

Link and Phelan (2001) add to these gaps of insufficient attention to structural contexts

and variability a third weakness: an overemphasis on the perspective of the non-stigmatized, which is in turn linked with unsubstantiated assumptions that stigmas are experienced by stigmatized persons in a manner that is congruous with the ideas of non-stigmatized persons. A number of more recent works have focused, instead, on how stigmatized persons actively and critically engage with negative stereotypes and often do not accept them as valid. These works highlight how the degree and manner by which stigmatized ideas are mapped onto self concept are both complex and highly variable (Camp et. al 2002.; Corrigan and Watson, 2006). In fact, in the face of stigma, a subset of persons invariably formulate positive strategies and tactics, do not engage in self stigma, and are able to acknowledge, but not succumb to the risks of enacted stigma (Link and Phelan, 2006; Scambler and Paoli, 2008).

In short, more dynamic and pluralistic views of stigma are emerging that highlight the variability of stigma, both cross-sectionally and longitudinally, as well as the need to standardize conceptualization and operationalization of stigma in order to further comparative understanding (Mak, et. al. 2008). To some extent, new directions in stigma research have resulted in debates in the literature between scholars who continue to argue that the negative effects of stigma such as loss of self esteem are pervasive and the public health implications underestimated (Link et. al, 2001; Link and Phelan, 2006), and those who argue that a compromised self-image is not inevitable, but rather a mediated outcome influenced by a number of other variables (Camp et. al. 2002; Crocker and Quinn, 2000; Kusow, 2004). More importantly perhaps, drawing attention to stigma as a socially-contextualized variable has opened up opportunities for discussion of interventions in the perpetuation of stigmas and associated harms (Hallgrimsdottir et. al. 2008).

2.4 Intervening in Stigma

As noted earlier, examining the historical contexts and evolution of stigmas provides a

better understanding of how they are formed in interaction, but become embedded in structural and cultural systems; however, this type of inquiry forms a smaller part of sociological literature on stigma, which has instead primarily focused on how stigma influences the social interaction between stigma targets and stigma perpetrators, and more recently, on how social exclusion and marginalization influence access to opportunities such as health and well-being.

Given these emphases in the literature, corollary efforts to reduce stigma have focused on: 1) educating the public by dispelling myths; 2) increasing contact with stigmatized populations by encouraging integration and identification of personal experiences of stigma; and 3) teaching improved coping strategies in order to inoculate stigmatized populations against the damaging effects of perceived and enacted stigma (Lee et. al., 2005; Pescosolido et. al. 2008; Synder, 1999). Despite the face validity of these strategies, research on the effectiveness of recent efforts to de-stigmatize mental health conditions indicates that that while knowledge of mental health conditions, and the ability to identify personal connections to individuals affected by mental health conditions has increased (using strategies 1 and 2 noted above), the negative prejudices associated with mental health conditions have been undisrupted and potentially deepened (Pescosolido et. al, 2008). Similarly, Scambler (2009) reviews how the diversity and equal opportunity movements have resulted in more subtle forms of enacted stigma, and how efforts to empower disadvantaged groups – specifically via employment programming – are underpinned by top-down notions of education and self empowerment, which are pre-judged to be in the interests of devalued groups, but may be associated with more subtle forms of disempowerment. These unanticipated intervention outcomes implore researchers to more critically examine the conditions and trajectories of social change. If structural analysis, including examinations of inter and intra groups variation among stigmas, suggests that they do

not originate in public knowledge and attitudes, it is unlikely that public education or other social marketing strategies will have more than surface effects, especially if they are deployed as the primary mode of stigma intervention (Lee et. al, 2008). Similarly, interventions that focus on contact must also be approached critically and with caution. Short term, unwilling, unrewarding contacts, which may be fraught with tensions arising from interaction anxiety and unacknowledged power imbalances, can also deepen stigmas, particularly because negative stereotypes require little confirmatory experiences in order to be upheld, and comparably more disconfirming information to be disrupted (Pescosolido and Rubin, 2000; Pescosolido et. al., 2008). The latter information is especially relevant to “token” strategies aimed at “integration”, “normalization”, and the inclusion of “consumer” (or in the case of the sex industry, “experiential” groups) in collaborative program and policy formation (Jansson et. al., 2010).

While the education and contact strategies noted above, if utilized thoughtfully and strategically, may form an important part of the continuum of stigma interventions, recent research focuses on two additional environments for stigma reduction (Lee et. al 2008; Pescosolido et. al. 2008; Scambler, 2009; Link and Phelan, 2001). The first focuses on identifying contexts salient to the lived experience of stigmatized groups and transforming the policies and practices that govern these environments (i.e., transforming psychiatric care in the case of those with mental health conditions, transforming the work environments of sex workers, and transforming income assistance and health care coverage for low income individuals). Treatment and support contexts are especially important within this strategy as caregivers may unwittingly deepen stigmas by enacting coercive, regulatory interventions and by circulating messages that are not hopeful (Lee et. al. 2008; Link and Phelan, 2008). The second focuses on structural determinants of marginalization, including legislation and citizenship conceptions

which set the stage for the acceptability of acting on biases in a variety of downstream contexts (Pescosolido et. al., 2008). In order to combat stigmas, welfare state policies must be encoded with notions of civility, rights and concern (ibid.). Given this ambitious agenda, stigmatized groups and their advocates can be brought together within larger coalitions aimed more generally at improving the rights of marginalized populations; this latter strategy is also more befitting the models described above, which highlight the intersectional and intersectoral nature of stigmatization processes (Stuber et al., 2008).

In sum, the stigma literature can be divided into two traditions: a socio-psychological tradition focusing on the cognitive, motivational and interactional aspects of stigma and a sociological tradition focusing on historical, economic and political forces producing social structures that promote and maintain stigmas. Existing research most often falls into the first tradition, but there is increasing desire to link these traditions in order to understand the connections between structural and micro-behavioural aspects of stigma (Corrigan and Miller, 2004). The stigma literature suggests that there are a variety of responses to stigmas, including information and impression management strategies, which are most visible at the level of social interaction, but also become institutionalized in the discourses surrounding stigmatized groups. From a health perspective, the main insight emerging from this research concerns how stigmas shape social networks, social support and social opportunity structures. Stigmatized persons may internalize stigmas and prejudices resulting in self stigma, resist or reject prejudices privately or publicly, or exhibit a combination of these responses depending on the context. Thus, a further insight emerging from the social-interactionist research is that stigmas impact self-concept, but for some persons more than others, in part depending on the interpretive frames adopted, access to other forms of social advantage or disadvantage, and individual dispositional factors.

Intersectionality and life course research suggest the disadvantages associated with stigma (or advantages associated with prestige) are layered and interactive and must be attended to in order to understand not only variability in outcomes associated with stigma over time and between individuals and groups, but how stigmas are upheld by interconnected discourses and social structures. Research addressing stigma as a social determinant of health invites debate about the cultural and structural origins of stigma and the strategies that must be adopted to reduce stigmas.

2.5 Courtesy Stigma

In contrast to the relatively large body of literature on *primary stigma* discussed above, existing research on *courtesy stigma* - the negative impact that results from association with a person who is marked by a stigma - remains largely undeveloped. In one of the first studies on courtesy stigma, Birenbaum (1970) observed that social interaction between mothers of children with cognitive deficits and other parents was inhibited (Corrigan and Miller, 2004). Echoing the coping strategies reviewed above, Birenbaum noticed two main responses to courtesy stigma among parents with a disabled child: some parents chose to conceal, manage, and downplay stigma-related information, whereas other parents openly demonstrated their acceptance of the stigma (ibid.). In general, he noted that parents of children with cognitive disabilities limited their involvement with stigmatized communities because isolating oneself within the stigmatized community tended to undermine the appearance of a *normal life* (ibid). As expected, parents also limited their information-sharing to those they perceived to be sympathetic, and sought out those who would participate in their *fiction of normalcy* by politely ignoring the stigma (ibid.). Finally, Birenbaum (1970) noticed that parents attempted to emulate conventional parental roles and actively involved their children in socially valid, normalized activities.

Although some of Birenbaum's interpretations have become dated as social responses to disability have shifted, his observations continue to hold explanatory power, especially as they highlight how courtesy stigma, much like primary stigma, compels adjustments in social engagement and interaction among those who are associated with stigmatized persons. For example, more recent research indicates that parents of children with disabilities have been found to be at greater risk for depression and to attribute negative attitudes to other parents and service providers, even when there are no observable instances of discrimination (Norvilitis et. al, 2002). Other research suggests that family members of stigmatized individuals curtail their own social interactions in order to avoid instances of enacted discrimination, or the strain and stress associated with having to confront other's misperceptions (Gray, 2002; Green, 2003; Khamis, 2006; Turner et. al, 2007). Thus, one of the main points found within the courtesy stigma literature is that it leads, not unlike primary stigma, to social isolation and loss of social support, both of which are in turn linked to poor physical and psychological health outcomes (Corrigan and Miller, 2004; Thomas, 2006). In addition, courtesy stigma may impact the relationship between the stigmatized individuals and their family member. For example, considering the factors that influence parents' decisions regarding in or out of home housing for adult disabled children, Green (2004) discovered perceived courtesy stigma among parents was associated with both reports of care giving burden as well as the decision to transition a child to out-of-home professional care. This latter finding raises the issue of how the care giving relationship between the stigmatized and their associates may be negatively impacted as both experience reduced capacity and opportunity due to the strains associated with stigma.

The negative ramifications of courtesy stigma should not be considered an inevitable fact as family members of stigmatized persons undoubtedly have varying experiences (Khamis, 2006;

Turner et. al, 2007). In a study of the partners of persons with Alzheimer's disease, McRae (2000) found that courtesy stigma varied from fairly severe to almost non-existent. McRae's findings echo those noted earlier about primary stigma, which suggest that social capital has a mediating effect on both stigma and courtesy stigma. The authors note that the availability of social support networks, and other contextual variables, such as the ability of partners to draw on more positive interpretations of the illness may lessen experiences of courtesy stigma (ibid.). Corrigan and Miller (2004) similarly report that existing research on courtesy stigma among family members of persons with mental illness indicates that a good portion of these associates do not report experiences of courtesy stigma. Reviewing the available literature, these authors suggest that courtesy stigma – in particular reports of avoidance by *normals* of family members of stigmatized persons – varied by nature of family relationship (i.e. child, spouse, parent), and the frequency of contact between the stigmatized person and their family member (i.e. whether or not the stigmatized person and family member cohabitated). Phelan et. al. (1998) found that higher educated family members were more likely to report perceived avoidance, which the authors interpreted to possibly be the result of greater perceptiveness of stigma processes, or diminished tolerance within social networks of higher socio-economic status.

Corrigan and Miller (2004) report that a second dimension of courtesy stigma, one that is perhaps more prominent than reports of others' discrimination, concerns the notion that one's relationship with a family member with mental illness should be kept hidden as it is a source of shame to the family. The authors note two underlying narratives that give rise to courtesy stigma: blame and contagion. Parents, especially mothers, of persons with mental illness are most likely to experience blame as a common public perception; in the first half of the twentieth century mental health and disability were commonly regarded as the outcome of poor parenting

(either unfortunate procreating or bad parenting skills) (Corrigan and Miller, 2004). Spouses and siblings, in comparison to parents, are less likely to perceive blame for the onset of a mental illness, but experience blame with regards to their family member's compliance with interventions and the subsequent illness trajectory. The contagion and contamination dimensions of courtesy stigma have been revealed by experimental designs which demonstrate that family members of persons with mental illness are rated more negatively than persons who are not related to a stigmatized person. This tendency to stigmatize family members occurs among both members of the public at large and mental health professionals, echoing the point made earlier that professional associates of stigmatized persons are just as, if not more, likely to uphold stigmatized ideas (Corrigan and Miller, 2004). Corrigan and Miller's (2004) study raises a number of important issues about the origins of courtesy stigma that should be kept in mind in the context of the data presented below. First, with regards to family members they note two types of narratives that uphold courtesy stigma and give rise to associated responsibilities: poor genetics and dysfunctional familial environment. These narratives theoretically do not apply to the professional associates of stigmatized persons, however, contamination, corruption and contagion narratives may; these narratives call into question the moral fabric as well as environmental and physical hygiene of persons who are professional associates of the stigmatized. Following the stigma literature, it is likely that courtesy stigmas are upheld by a range of interactive narratives that span genetic, contagion, contamination, and corruption narratives resulting in range of associated responsibilities for those that bear courtesy stigma.

Supporting the above noted assertion about corruption and contamination narratives, another tenuous dimension of courtesy stigma that has been identified in the literature concerns the ascription of characteristics of the stigmatized to their associates – “being known by the

company we keep” (Kulik et. al, 2008; Nueberg et. al, 1994). Sigelman et. al. (1991) found that students intolerant of homosexuality tended to assume that the voluntary associates of gay students were also likely homosexual, even when there was no direct evidence to support this assumption. Kulik et. al. (2008: 219) similarly found that in a work environment, employees who associated with stigmatized co-workers were regarded negatively due to automatic processing: “the stereotypes used during this automatic processing stage need not be the most appropriate; they need only be readily accessible in the perceiver’s memory. Thus, physical proximity may be enough to link two individuals in a perceiver’s mind and result in the perceiver’s negative evaluations of one person spilling over onto the other.” They later note that such initial impressions may be modified depending on the perceiver’s motivation (their values and tolerance), the norms and values of the work environment (the extent to which it encourages or discourages such bias), and the reasoning applied to the relationship. With regard to the latter, the extent to which the relationship is perceived as voluntary or involuntary, susceptible, as noted above, to contagion (which can also include contagion of ideas or behaviour), and the degree of similarity of descriptive information between the stigmatized person and their associate can all have an effect on the degree of courtesy stigma ascribed. It is noteworthy in regards to this dissertation that the authors found that persons who are perceived to have similar descriptive characteristics to their stigmatized counterparts are more likely to be the recipients of negative stereotypes, as are persons who associate with persons/groups whose stigmas are of a greater magnitude.

The same phenomenon may apply to care workers of vulnerable populations; the supposition that one possesses similar characteristics to those being served, or the idea that one has personal, extensive knowledge of a stigmatized issue may form the basis of more subtle

forms of discrimination on the part of “outsiders”. While such assumptions of similarity may be unjustified at times, this issue is further complicated by the fact that it is also very likely that some persons working with stigmatized populations have first hand connections to the stigmatized identity as personal experiences and social networks may influence opportunities in career selection.

A small number of academic studies have taken up the topic of courtesy stigma and professional service provision to stigmatized populations. Using a longitudinal, multi-questionnaire design, Snyder et. al. (1999) examined higher rates of turnover among volunteers supporting persons with AIDS as compared to other hospice workers. A number of key findings are potentially relevant to the present study and warrant detailed review. First, noting five motives for volunteering - expression of personal values and beliefs, improved knowledge, desire to give something back to community, personal development and esteem enhancement - the authors observed that volunteers who endorse self-motivated reasons for volunteerism had a longer duration of service than those whose primary aim was to help others (Synder et. al., 2009). Second, potential volunteers were less likely to agree to volunteer with hospice clients with AIDS (as opposed to other conditions), even when the work, and work context, was described as exactly the same. Volunteers expected to experience courtesy stigmatization if they agreed to work with persons with AIDS, providing support for the idea that courtesy stigma dissuades professional involvement with stigmatized groups. Potential volunteers were, however, more likely to volunteer to help a child with AIDS in comparison to an adult male with AIDS, reinforcing the notion that culpability is a strong predictor of good will (Synder et. al., 2009). Third, as noted earlier, potential volunteers anticipated varying degrees of courtesy stigma. Those who did not anticipate courtesy stigmatization, but became aware of it in the

course of volunteering had shorter volunteer careers; however, courtesy stigma was associated with shorter duration of volunteering overall, even among those who anticipated courtesy stigma at the outset. Fourth, in contrast to the vast literature exploring social support as a buffer to stress, the authors found that social support was negatively linked to duration of volunteerism because volunteers who experience courtesy stigma in their social networks were more likely to experience psychic distress in relation to their volunteer role (Synder et. al., 2009); in other words, social support networks discouraged rather than encouraged volunteer association with stigmatized individuals. Thus, the study highlighted a number of liabilities associated with volunteer services to stigmatized groups.

In another study it was observed that nursing students had negative perceptions of both mental health professionals and their patients (Sadow et. al., 2002). Interestingly, the authors of this study also found that while education helped improve nursing students' attitudes toward mental health professionals, it deepened stigmas associated with mental health clients. This finding echoes other research which suggests that one of the ways that courtesy stigma is managed is by using professionalization narratives to emphasize differences between the those who receive, and those who provide, service (Baines et. al. 1992)

Finally, several scholars have noted that primary stigma goes hand in hand with the systemic provision of under-funded and inferior health and welfare services (Birenbaum, 1970; Crandall, 2000; Link and Phelan, 2001b; Link et. al., 2008). While all welfare states, including Canada, are struggling with escalating health care costs, there is a great deal of literature to suggest that services to vulnerable populations and the workforces who provide those services experience the most instability with regard to funding, and are the hardest hit by budget reductions (Hall and Banting, 2000; Saunders, 2004). In Canada, services to these populations

are often provided in the non-profit sector, and government funding tends to focus on short-term services and meeting basic needs, with little opportunity to address upstream health determinants – racial discrimination, family life, education, early childhood, housing, violence, income security - in a more comprehensive fashion (Raphael, 2004; Wilkinson and Marmot, 2006). The relevance of the latter point to the concept of courtesy stigma is that it suggests that one of the significant ways service providers experience courtesy stigma is in the very organization of their work environments, including having to carry out their work with stigmatized populations with inadequate resources and limited intervention modalities to draw on, a theme which will be reviewed in greater detail below in the context of the literature on care work.

Thinking about the work performed by those who paid and unpaid support to stigmatized populations, Corrigan and Miller (2004) importantly differentiate between direct courtesy stigma and vicarious stigma. This delineation highlights how the negative health effects associated with a relationship with a stigmatized person are only in part due to being treated badly by others. The other source of strain – vicarious stigma – refers to the distress one experiences as a result of witnessing the negative effects of stigma on relatives, peers and service recipients (Corrigan and Miller, 2004). The burden associated with being privy to the effects of stigma raises the need to think about how to discern between the double edged sword of caregiving burden and courtesy stigma (Corrigan and Miller, 2004). Wight et. al. (2007) similarly note that traumatic stress symptoms – operationalized as avoidant and intrusive thoughts - are common to persons diagnosed with HIV and their caregivers, further indicating that stress related to primary stigma is also experienced via association, even in the absence of courtesy stigma. The authors further note that this form of stress is experienced whether or not a caregiver has experienced personal trauma (in this case some caregivers also were diagnosed with HIV, whereas others were not).

These findings highlight how primary and courtesy stigmas intermingle in the strains experienced by those who are in close relationship to stigmatized persons.

As the available research on courtesy stigma is relatively small, there are several gaps in this literature, in addition to the lack of information regarding the presence of courtesy stigma among frontline health and social service professionals. One notable gap stems from the tendency to regard those who experience courtesy stigma as a uniform and distinct group - who would not otherwise experience stigma - except for their association with a stigmatized individual or group. It is more likely the persons working with stigmatized populations have varying levels of similarity to those they work with along a number of key demographic and socio-contextual variables such as gender, race/ethnicity, and family background. These relative similarities may have important implications for how the professional associates of stigmatized groups experience their work. Also relatively absent, is any discussion of the prospect of co-occurring primary and courtesy stigmas. For example, consider persons who work professionally with a stigmatized group and who also have a child or partner who bears the same stigma (e.g. a special education teaching assistant who has a child with a profound physical or cognitive disability). Alternatively, consider persons who bear a stigma (or multiple stigmas), but also work professionally with others bearing the same stigma(s). In addition to potentially providing insights into why some workers are harder hit by workplace health risks (such as courtesy stigma) than others, locating care workers and those they serve according to broader socio-economic categories reveals important information about how vulnerability is systemically organized among those who experience primary stigma and those who form their support networks. Addressing these questions will be a sub-area within the overall research objectives noted earlier.

2.6 Sex Work Stigmas

In Canada it is legal to sell sexual services; however, many of the practical activities associated with selling sex – communicating, operating a bawdy house, living off of the avails – are illegal (Lowman 1987, Lowman, 2005). The legislative framework surrounding the sex industry in Canada can be viewed as an ongoing compromise between conflicting historical discourses regarding the *real culprits* in the sex industry– sex workers, clients/johns or pimps – and calls for community order and control (Lowman 1987 & 2005; Shaver 1994). Tensions regarding culpability in the sex industry reveal how stigma formation is an active process that is continually negotiated amongst various stakeholder groups.

Academic scholarship, public policy and community interventions aimed at the sex industry have been similarly influenced by the stereotypes and generalizations associated with the prostitute identity, with the poles of debate defined by those who regard commercial sex exchange as inherently oppressive or risky to health, and those who regard it as a valid economic activity that is problematic largely because it is stigmatized (O'Connell Davidson, 1999; Pateman, 1988; Pheterson, 1989; Scambler, 1997; Shaver, 1994). The policy frameworks surrounding the sex industry range from *abolition* advocated by those who regard the sex industry as inherently oppressive, *regulation and surveillance* advocated by those who are concerned primarily with the health risks and crime associated with the sex industry, and *legalization* or *decriminalization* advocated by those who regard the harms of the sex industry as primarily the result of social marginalization.

What is especially important in the context of this dissertation is that the ‘expert’ and public stakeholder positions that have informed both the law, research and other forms of societal intervention into the sex industry are rooted in stigmatized constructions that have been

in circulation since before the turn of the twentieth century (Hallgrimsdottir et. al., 2006 & 2008; Vanwesenbeeck, 2001; Weitzer, 2007). For over a century, the sex industry has, to a greater or lesser extent, signified urban decay, disease, crime, community disorganization and moral failure (Hallgrimsdottir et. al., 2006 & 2008). Further, sex workers have been alternately and contradictorily cast as infantilized victims of pimps, abuse, and poor upbringing, to morally reckless, and financially shrewd sexual entrepreneurs – exhibiting how both shame and blame can be brought together to uphold stigmas (Scambler and Paoli, 2008). One of the ways that sex work has been titillating and fear-inducing for the public is through the co-linking of sex work narratives with other forms of deviancy and social stigmas based on race, substance use, disease transmission or the corruption of middle class morality regarding marriage, family and appropriate sexual behaviour, a process which, as noted above, is integral to stigma formation and maintenance (Scambler and Paoli, 2008; Hallgrimsdottir et. al. 2008). Importantly, narratives about the sex industry, especially those found in popular media culture, effectively construct female sex workers as “other”, characters who exist in a distant, criminal world where the same provisions and social rights expected in the “normal” world do not apply (Vanwesenbeeck 2001; Hallgrimsdottir et. al. 2008).

While it is the case that a minority of persons fit one or more of the stereotypes associated with the prostitute identity (i.e., some women and men in the sex industry do struggle with substance misuse and have experienced backgrounds of parental abuse, while others have not), what is problematic about the totalizing, highly negative stereotypes is that they limit what can be known, and by extension, what can be enacted in policy, program interventions and day to day interaction – that is the characteristics of the minority are ascribed to the majority (Phelan et. al. 1997). In addition, stigmas about the sex industry contain notions of causality that

do not take into account broader social processes and thus give rise to the impression that participation in sex work is a cause of an array of social ills and health risks (Phillips and Benoit, 2005). Marginalization is both produced and reinforced as negative, totalizing ideas about the sex industry are materialized in social welfare services, the law, the media, research and other important social institutions of knowledge (Weitzer, 2009). Further, the clandestine nature of the sex industry ensures that the vast majority of citizens both receive and propagate prostitution stigmas in the absence of any real empirical knowledge of, or contact with, the sex industry (Hallgrimsdottir et. al. 2008). Thus, frontline service providers to persons in the sex industry find themselves at the center of tensions regarding the seemingly incontrovertible stigmas associated with the sex industry, and the tacit, experiential knowledge they possess as a result of their direct contact with persons who work in the sex industry, either as service providers, or for many of the workers quoted below, as former sex workers.

2.7 Occupational Health Among Service Providers who Perform Care Work

The preceding sections outline that while there is much work to do to empirically capture the relationships between primary stigma, other key social determinants of health, and morbidity, it is clear that the health and health care consequences of primary stigma are profound, especially when primary stigma is regarded as a principle element of social status. In this regard, primary stigmas determine not only personal behaviour, self concept and access to personal social support, but also, on a more systemic level, lay and expert knowledge about certain populations as well as the nature and availability of public intervention and support services.

For the purposes of this dissertation, courtesy stigma is regarded, not only as a broad determinant of health that exhibits many parallels with primary stigma, but more specifically, as a determinant of occupational health, one that will conceivably interact with other identified

determinants of occupational health such as autonomy, sense of accomplishment, or other workplace rewards and stressors. The literature on determinants of occupational health can be further nuanced through reference to the literature on care work, which specifically addresses the gendered implications of neoliberalization of the welfare state on the workplaces of those who provide support services to vulnerable populations in Canada. By merging the literatures on care work and occupational health, a framework for considering the strains and assets that may interact with courtesy stigma takes form.

Care work is a sub-category of service work characterized by face-to-face emotional and physical service aimed at maintenance of daily life and betterment of capabilities in areas such as physical and mental health, cognitive functioning, and activities of daily living – such as that performed by teachers, nurses, childcare workers, and various types of crisis and support aides (England et. al. 2002; England, 2005). In this regard, service workers to sex workers are *care workers* as their work focuses on responding to crisis and related support work. Care work is highly gendered and predominantly performed by women in both paid and unpaid contexts (Armstrong and Laxer, 2006; Bolton, 2005, Benoit and Hallgrimsdottir, 2008; Dolan and Thien, 2008; Purkis et. al., 2008; Stewart and Armstrong, 2008). Although care work involves a variety of occupations, some of which are higher in prestige, such as being a physician, the majority of care work jobs are of moderate (nurse, teacher, social worker) to low (private sector cleaner, child care) occupational prestige (Nakao and Treas, 1994; Tremain, 1977) . The gender distribution in these jobs is such that women are disproportionately found among lower prestige, lower income positions (Stewart and Armstrong, 2008).

Three major contributions from the care work literature are especially relevant here. The first, the *feminization/devaluation thesis* argues that care work is gendered because the act of

providing care is regarded as something that women are especially suited to (Benoit and Hallgrimsdottir, 2008). The feminization of care work contributes to its devaluation because roles which resemble those performed in the unpaid context of the family out of moral obligation and love are considered non-specialized and of low economic value (Armstrong and Laxer, 2006; Benoit and Hallgrimsdottir, 2008; Hallgrimsdottir et. al, 2008; England et. al, 2002 &.2005; Purkis et. al. 2008). The economic devaluation of care work further ensures that those with other career opportunities will work elsewhere, leaving care work to be performed not only by women because they experience disadvantage in the economic sector, but also by particular subgroups of women (and men) who are more likely to experience multiple forms of social and economic disadvantage (England et. al. 2000). Provincial statistics of the labour profile of community social services workers bear witness to these broad assertions, with females making up 79% of the workforce and the average income of community social service providers (\$33,160) sitting 15% below the average salary in the province, likely due to the 45% of this workforce who earn \$11- \$18/hr (Federation of Community Social Services of BC (FCSS), 2009).

The second contribution emerging from the care work literature is a detailed examination of how *neoliberalization* of the welfare state is changing the workplace and delivery of care-oriented services, for both consumers and providers. Neoliberalization refers to variegated processes of economic and welfare state restructuring in higher income countries that prioritize the operational logic of “market-based, market-oriented, or market-disciplinary responses to regulatory problems; it strives to intensify commodification in all realms of social life; and it often mobilizes speculative financial instruments to open up new arenas for capitalist profit making” (Brenner et. al., 2010:2). Neoliberalization is supported by fluid, post-Fordist

international goods and services markets, escalating social welfare costs (driven primarily by public health care), and an ideological emphasis on cost containment, efficiency, and consumer choice (Brenner et. al., 2010). Neoliberal initiatives can be grouped into three broad trends: 1.) rolling back non-market arrangements; 2.) transfer of policy prototypes across jurisdictions; and 3.) encasing of individual and organizational activity within large-scale institutional arrangements and centralized regulatory frameworks (Brenner et. al. 2010).

In the health and social service sectors, neoliberalization provides an ideological backdrop to public sector management, and is most visible in government initiatives aimed at “streamlining” service provision, deregulation and regulatory experimentation, and downloading service from government to ostensibly less expensive non-profit and private sector competitors (Baines, 2004; Benoit et. al. In press; Hallgrimsdottir et. al. 2008; Bourgeault and Wrede, 2008). Neoliberalization can also be seen in increased emphasis on the discourse of evidenced- based decision making, health as an individual and family responsibility, and accountability and outcomes-based funding in program and contract reforms (Baines, 2004; Benoit et. al. In press; Hallgrimsdottir et. al. 2008; Bourgeault and Wrede, 2008). These initiatives, while they often appeal in a broad way to the values associated with a consumer oriented society, are, in fact, primarily driven by cost cutting and result in delimiting the kinds of claims citizens can make for welfare state intervention (Benoit, et. al., In press). Presented alongside neoliberal initiatives are simplistic media depictions of health care as “distended, inefficient and in continuous disarray” and social services as inefficient, disorganized and abused by underserving claimants (Hallgrimsdottir, 2008: S43).

The processes of neoliberalization that take place in meso and micro contexts (the places where people both provide and access service) are *path dependent* – that is, they are diverse, a

matter of perspective and social location, and vary considerably across geographical location and subsector of service as they interact with, and adapt to, the particularities of various cultures and institutions (Brenner et. al., 2010). The overall impact of neoliberalization on welfare states is nevertheless patterned and structurally embedded in systems of inequality based on race, class and gender that are not only impervious to neoliberal reform schemes, but often deepened by them in unexpected ways (Baines, 2004; Benoit et. al. In press; Hallgrimsdottir et. al. 2008). The care work literature has made a strong contribution in terms of documenting the gendered pathways through which neoliberalization has contributed to an increase in unpaid care by family members within the home, and progressively deteriorating working conditions within the care sector, including within the health and social service subsectors (Baines, 2004; Benoit et. al. In press; Treloar and Funk, 2008; Purkis et. al. 2008; Wrede et. al. 2008). Importantly, care work scholars have documented how the processes of downloading care to lower paid and unpaid, predominantly female workforces have resulted in increased occupational strain and corollary losses to care capacity. These trends have especially negative consequences, not only for care providers, but also for vulnerable care recipients who lack the resources to secure alternative supports in the private sector. The third contribution from the care work literature is thus a demonstration of how care providers and recipients are located in parallel and reciprocal processes of marginalization under conditions of neoliberal welfare state reform (Benoit and Hallgrimsdottir, 2008). This latter contribution is relevant to understanding the interconnections inherent in the double-edged sword noted earlier wherein families (and professional associates) of stigmatized populations simultaneously experience care giving burden alongside the negative effects of courtesy stigma.

Bearing this above discussion of devaluation and neoliberalization in mind, courtesy

stigma in the context of care-oriented services to stigmatized populations is significant for both theoretical and practical reasons. First, due to the interlocking nature of various axes of social and economic discrimination, persons representing stigmatized identities present intensified service needs to service workers because they experience complex – and very likely enduring - barriers to social participation/integration and acquisition of necessary resources such as housing and employment. Second, the structural and cultural marginalization of persons with stigmatized identities means not only that the demand placed on the service providers who support them is greater, and the likelihood of successful intervention more remote, but as outlined earlier, service providers themselves may experience less social and economic support for their work, particularly when the population receiving care is a highly denigrated one. Thus, service work to stigmatized populations is a multi-layered example of the “devaluation thesis” of care work, one which encompasses multiple modalities of status depreciation (Benoit and Hallgrimsdottir, 2008; Purkis et. al., 2008). It is multi-layered because it encompasses both the notion that providing care is a natural and moral female activity as opposed to a skilled, economic activity, and the notion that some populations requiring care are regarded as threatening, undeserving, or hopeless. The moral and political overtones normally associated with care work are intensified when providing services to populations who are variously constructed as less deserving (Strike et. al. 2004). Service providers in this context are charged with the task of managing or correcting perceived abnormalities or deviance, so that members of the broader community do not have to be burdened with the varying offenses often associated with stigmatized groups, while they are, at the same time, caught up in processes of downward social mobility.

Services providers to stigmatized populations are also potentially doubly disadvantaged with respect to the processes entailed in neoliberalization. Facing multiple and systemic barriers

to social participation, those that serve stigmatized populations are in a poorer position to advocate for service availability and provide evidence of service efficacy, not least because services to the most marginalized members of society are an ill fit for private/public cost sharing and social enterprise initiatives due to a structural lack of resources among the recipient population (and their advocates) to support such initiatives. Thus, services to vulnerable populations are particularly susceptible to contract restructuring and budget reductions in the health and social service sectors, as providers and advocates struggle to re-pitch the necessity and efficacy of their work in market- driven economic terms. Unlike consumer groups (such as pregnant women and those interested in alternative and complementary therapies) who, in theory, stand to benefit from deregulation strategies aimed at reducing medical intervention and increasing consumer autonomy, stigmatized groups (such as persons working in the sex industry or those experiencing addiction) have struggled to secure their place within the medical model as a move away from criminalization, where there are, few, in any, associated rights to care (Fischer, 2003; Conrad and Schneider, 1992). The latter point is meant to illustrate the shaky position of stigmatized groups as “consumers” of health and social services, rather than to be interpreted as a case for medical intervention for stigmatized populations. Thus, in the context of neoliberalization, service providers to stigmatized populations must grapple with the insecurity that accompanies their recipient groups’ tenuous claims to participate in publicly- funded social welfare provisions in the first place.

Taking into consideration the idea that services to stigmatized populations are both devalued and caught in processes of neoliberalization provides a broader context for thinking about the more generic determinants of occupational health affecting workers in a variety of occupations.

For most occupations, autonomy, decision-making authority, co-worker and personal social support, skill utilization, optimal work flow, role clarity, job security, and a balance between work and private sphere responsibilities have been found to contribute to occupational health (Marchand et. al, 2005; Pugliesi, 1995; Karasek and Theorell 1990; Wilkins and Beaudet 1998). Autonomy and skill utilization have been shown to be particularly robust determinants of occupational health (Edwards et. al. 2001; Tennant, 2001; Karasek and Theorell, 1990; Plaisier et. al., 2007); therefore, regardless of other workplace rewards and stressors, those who are able to exercise personal control over their work and draw upon their unique assets in the performance of their jobs, are more likely to have good occupational health. A balance between workplace demands and rewards is also an important determinant of occupational health, with rewards such as wages, benefits, social support, prestige, and personal fulfillment helping to buffer against stressful, dangerous or demanding work conditions (Siegrist, 1996). Imbalances in workplace rewards and demands lead to occupational strain, with typical indicators of strain including low performance, diminished sense of personal accomplishment, low job satisfaction, emotional exhaustion, depression symptoms, sick time, and high employee turnover (Baines, 2004; Cole et. al. 2002; Godin and Kitten, 2004; Marchand et. al. 2005; Parker and De Cotiss, 1981; Tennant, 2001; Warren et. al, 2008). Employee turnover has, in turn, been linked to steep economic costs to organizations and reduced service capacity (The Federation of Community Social Services for BC (FCSS), 2010). Not surprisingly, given earlier discussion of the feminization and devaluation of care work, women who disproportionately represent workers in lower prestige, lower reward jobs are less likely to report favourable working conditions, such as decision latitude, in comparison to men (Ibrahim et. al. 2001; Matthews et. al, 1998; Marchand, 2007).

Persons providing care work in high-demand contexts - including contexts where exposure to danger or abuse is prevalent, the work is characterized by psychological demands and conflict, lower wages, poor benefits, or the absence of other workplace rewards, such as feelings of efficacy and social recognition - are at the greatest risk for job strain and poor occupational health (Bennet et. al. 1996; Hodson and Sullivan 2002; Godin and Kittel, 2004; Jackson 2004; Lloyd and Chenoweth 2002; Marchand, 2007; Oktay 1992; Quick et. al. 1992; Reskin and Padavic 1994; Siefert and Chess 1991; Warren et. al. 2008).

For workers engaged in care-oriented service work specifically, a significant body of research suggests that the emotionally-laden nature of the work also creates strains for some workers, leading to low job satisfaction, workplace exhaustion, depression and anxiety, and reduced workplace efficacy (Acker 1999; Baird 1999; Coffey et. al., 2004; Lloyd and Chenoweth 2002; Hochschild, 1983; Maslach and Jackson 1981; Weinberg and Creed, 2000). However, other research suggests that the emotional content of care work is a source of workplace reward for some workers (Bennett et. al, 1996; Messing, 1998; Sharma and Black, 2001; Wharton, 1993). This apparent contradiction in the literature underscores the necessity of examining the specific conditions under which workplace demands, such as emotional care, become risks to health, or conversely, a workplace reward. At the same time, it is also necessary to look at the role restorative resources and support can play in minimizing the harms caused by emotionally demanding work.

Clients and client-interaction are popularly regarded as the primary sources of demands placed on care workers; however, there is some division in the literature regarding the degree to which these demands result from the severity of needs presented by the client population, or other contextual and structural workplace variables such as management practices and

organization of the work environment (Maslach and Jackson, 1981; Shoptaw et. al. 2000; Yoo and Brooks, 2005). While it is certainly the case that some client groups – particularly the most marginalized – present greater needs for support, combined with difficult histories of abuse and trauma, which undoubtedly emotionally impact the care workers who become privy to these experiences, a focus on client burden or needs is arguably unproductive to the extent that it “blames the victim” and provides few avenues for thinking about improving the occupational health of care providers, and relatedly, their service capacity (Glisson and Green, 2006). Given that some workers derive satisfaction from responding to those who require help, it is more likely that contextual and structural workplace variables, specifically limited rewards and resources for care workers, are the more fertile ground for improving the health and service capacity of service providers to vulnerable populations (FCSS, 2010; Parker and DeCotiss, 1983; Yoo and Brooks, 2005).

As already noted, care providers serving stigmatized populations may also derive many rewards from their work; perhaps foremost, they may see themselves as responding to a blatant and tangible need for support and social justice among those they serve. Further, despite stigma, care providers may also, at times, experience support for their work from the broader mainstream community. In fact, they may even achieve an elevated status due to the perception that they are especially good-willed because they work with populations that others fear, regard as dirty, or as hopeless. As Kulik et. al. (2008) note, popular figures such as Mother Theresa were valorized for associating with stigmatized populations. However, as will be discussed in this dissertation, there are often conditions attached to this valorization which emanate directly from the discursive boundaries of the stigmas associated with the client group. Specifically, social support for their care work pivots on their enactment of dominant narratives regarding how the

stigmatized group ought to be managed or fixed, and the degree to which members of the public view a care provider as possibly similar to the stigmatized group he or she is associated with (i.e. helping as a matter of religious duty may help to lessen the impact of courtesy stigma, whereas helping because one possesses similar values or experiences may deepen courtesy stigma). In fact, care workers to stigmatized populations because of their close association to stigma may, again depending on their association, gain a certain responsibility for the social problems associated with a stigma.

In sum, this dissertation is guided by a number of key insights from the literature which point to some of the unique challenges faced by service providers to vulnerable, stigmatized populations. Stigmatized populations, due to the intersectional processes of marginalization, experience more complex barriers to health and wellness, including perceived and enacted stigmas that operate at both micro-behavioural and structural levels. Thus, the work of service providers to stigmatized populations involves the responsibility to address complex, structurally-embedded support needs, but these workers often receive less social and economic support - both at individual and organizational levels - for their work because negative stigmas suggest that certain populations are willfully deviant, hopeless and/or burdensome to the community, and therefore undeserving of social resources. The marginalization of service providers to stigmatized populations is not only determined by the stigmas and interlocking modes of marginalization surrounding the client group, but also by the processes of neoliberalization and the feminization of care work. In the context of these social processes, service providers to stigmatized populations are potentially exposed to greater workplace risks and fewer workplace rewards than other types of service workers, with potentially negative consequences not only for their own occupational health, but also for service capacity.

Unlike the stigma surrounding populations such as persons with disabilities who have benefited from greater community integration, visibility, and a well-resourced advocacy network, the stigmas associated with the sex industry – the topic of the present research - are particularly negative and durable because sex workers remain a hidden and marginalized population about which the vast majority of the population have little empirical knowledge (Hallgrimsdottir et. al. 2008; Weitzer, 2009). Frontline service providers are uniquely located as potential advocates in this struggle due to their direct contact with sex workers, but they also experience considerable pressure to enact stigmas in the course of providing care, especially because only by doing so are they able to garner recognition of and social support for their work.

Chapter 3: Methods

As noted earlier, this dissertation is guided by three principle aims. The first aim is to investigate the characteristics of courtesy stigma among a group of workers who provide frontline services to sex workers in one geographical location. A second aim of this dissertation is to examine the factors that interact with courtesy stigma in the workplace. The intent is to contribute to the growing scholarship on stigma as a social determinant of occupational health. A final aim of this dissertation is to situate the findings in a broader discussion of frontline services to vulnerable populations; specifically, to apply the concept of courtesy stigma to the premise that dignity for service recipients is reciprocally linked to the working conditions encountered by service workers (Hallgrimsdottir and Benoit, 2008).

This chapter addresses the methodological considerations guiding the project, including the decisions made with regards to research sample, method, and data analysis strategies. Practical and ethical considerations that arose during the course of data collection are also reviewed with reference to the literature on community-academic collaboration as a means to effective knowledge translation (Jansson et. al., 2010).

The idea of examining courtesy stigma arose from my involvement in a larger research program - led by my supervisor, Dr. Cecilia Benoit – concerning primary stigma as a social determinant of health among lower- income service workers – hairstylists, food and beverage servers, and persons in the sex industry – in Canada and the US (hereafter referred to as the “Stigma Study”). As noted earlier, my Master of Arts thesis research focused, in part, on stigma as a determinant of health care access among sex workers (Phillips and Benoit, 2005). Given my work as a research coordinator on the Stigma Study, and previous research focus on social determinants of health for vulnerable populations, research on courtesy stigma seemed to be a

logical extension of my previous academic and professional experience. Another advantage of my connection to the larger Stigma Study was that a number of the community partners of the project provided services to stigmatized populations, and would therefore qualify as potential participants³ in the dissertation research. PEERS Victoria Resource Society (PEERS), in particular, emerged as a good candidate for research on courtesy stigma due to the often deeply negative and historically durable stigmas surrounding the “prostitute” identity (Hallgrimsdottir et. al. 2006)⁴.

In addition to having the research facilitated by existing community partnerships, an additional benefit of conducting research with a community partner of the Stigma Study was that the research could be reciprocally beneficial to the community agency I partnered with, particularly if the potential benefits could be negotiated at the outset of the partnership (Jansson et. al., 2010). For example, by documenting staff workplace experiences in the course of research, I would be able to provide to the partner agency much needed feedback for human resource planning and other development activities. As the research partnerships associated with the Stigma Study focussed on client health and access to care, this research would complement knowledge emerging from the Stigma Study about client needs with information regarding service provider experiences.

In addition to having research experiences and affiliations that would enhance the project, I had also worked and volunteered for many years in the context of frontline services for children and adults with cognitive disabilities, street-involved youth, youth in government care,

³ The community partners of the Stigma study at the Victoria site included: The Greater Victoria Child and Family Counselling Association, PEERS Victoria Resource Society, The Victoria Native Friendship Centre and the Victoria Youth Empowerment Society. In addition, in Sacramento, CA, a community partnership was established with an organization called Harm Reduction Services.

⁴ Harm Reduction Services in Sacramento, CA was also considered as a potential research site as they also provide services sex workers, but ultimately was not included due to resource limitations.

and families receiving child protective services. Having worked with these populations quite extensively, the notion of courtesy stigma resonated with me. I was initially skeptical regarding the notion of courtesy stigma as a key health determinant of occupational health for care workers serving stigmatized populations, as in my experience, providing support services to stigmatized populations was primarily considered a laudable, albeit modestly rewarded, form of work.

The lack of literature on the concept of courtesy stigma – especially as it applies to professional service providers to stigmatized populations - was perhaps the principle consideration when choosing a research method and sample as the research would necessarily be exploratory (Guba and Lincoln, 1994; Morse, 2003). Since I was aware of little extant literature to guide the research design, qualitative research seemed like a good fit as repeated, open-ended interviewing would allow for a gradual refinement of the concept of courtesy stigma as the research project progressed (Hochschild, 1983; Strauss and Corbin, 1994). Using an ethnographic framework was also suitable as there is a great deal of sociological research emphasizing how workplaces function as micro cultures (Adler and Adler, 2004; Fine, 1998; Hochschild, 1983). In addition, combining participant observation with interviewing – as is commonly done in ethnography – would allow for a layered, inductive analysis of the research phenomena, which I anticipated would be necessary given the lack of available literature to guide conceptualization and operationalization of courtesy stigma in the workplace (Lofland & Lofland., 2006). Given these factors, I decided to design the research as primarily qualitative, with an emphasis on the principles of ethnography.

3.1 Sample

In early research design plans, I considered conducting data collection in multiple sites for comparative purposes (i.e., with community partners of the Stigma Study in Canada and the

US, or in multiple sites in Victoria) in order to further the analysis of courtesy stigma as a variable that may be mitigated by organizational contexts, occupational status and other workplace and personal variables. In the end, I chose to conduct an in-depth, single-site study at PEERS Victoria Resource Society. The benefit of doing so was that I could invest more resources in the ethnography and my exploratory research efforts would not be complicated by a comparative sample and the introduction of additional variables that could be difficult to properly observe and analyze given resource limitations. Upon reflection, I feel that the single-site, in-depth study produced suitable data for a doctoral dissertation. My postdoctoral research will build on the dissertation findings reported here with a comparative element and a more diverse sample of persons working with stigmatized populations. Of course, the drawback of the single research site is that the findings are not generalizable and could perhaps be invalid outside the particularities of the specific research site. Specifically, the emphasis on hiring persons who were formerly involved in the sex industry at PEERS may mean that the experiences of PEERS staff better reflect the intersectional effects of primary and courtesy stigma, than the effects of courtesy stigma alone. Given recent assertions that the social processes of stigma are largely the same regardless of the type of stigma experienced, the negative experiences of courtesy stigma at PEERS might be deepened by, but not necessarily different from, courtesy stigma experiences in other settings (Scambler, 2009).

PEERS Victoria Resource Society stood out as a clear choice for the ethnography for a number of reasons beyond the established relationship as a result of the Sigma Study and the powerful prostitute stigma that surrounds this organization and its service work. More than the other community partners of the Stigma Study, PEERS has somewhat of a maverick reputation among local services providers because it was one of the first organizations in Canada to provide

services specifically to those in working in the sex industry, and one of the first to draw on, and advocate for, “experiential knowledge”⁵ in doing so (Rabinovitch and Lewis, 2001). As will be described below, in connection with its emphasis on “experiential” or situated knowledge and the practice of hiring persons who were sex workers, PEERS has a more explicit social movement agenda than is typical among social service agencies in the region. In addition, many of the persons working at PEERS have recently experienced poverty (commonly being recipients of income assistance prior to being hired), and have experienced other profound stressors such as violence, substance addiction, and family stressors such as involvement with child welfare agencies. Thus, I expected at the outset of the research that the courtesy stigma associated with working in the context of the sex industry might be intensified to the extent that PEERS’ hiring and program delivery practices ostensibly departed from the hegemony of “professional” or “clinical” approaches to health and social service delivery to vulnerable populations. Further, PEERS has remained a largely female-dominated organization over the course of its existence, lending an important gender perspective to the project. Given these characteristics, there was reason to presuppose that courtesy stigma would be exaggerated in this context and provide a “sharper point to the general case” of how stigmas spread to the professional associates of stigmatized populations (Hochschild, 1983:13). As noted above, the fact that many of the employees of PEERS had a personal history of sex industry involvement also presented a potential complication to the project. However, as will be discussed in more detail, it is possible that many of the persons who work professionally with stigmatized populations experience multiple forms of stigma; thus, the opportunity to examine the experience of stigma and courtesy stigma, or other forms of co-occurring stigmas among the staff population at PEERS was, at the

⁵ The concept of “experiential” at PEERS refers to persons who have a history of involvement in the sex industry. Valuing, and in fact, privileging, the experience and knowledge of those who have been involved in the sex industry is one of the characteristics of PEERS and a theme that will be explored throughout this dissertation.

same time, a potential advantage.

A fuller description of the history and characteristics of PEERS is provided in Chapter 4 so will not be provided here. At this point, it is important to note that in 2006, when my data collection began, PEERS employed 13 persons full time. There were also three part-time contractors who helped with the employment program curriculum. When data collection concluded in 2009, PEERS employed eight full time employees and three part-time contractors. It is also noteworthy that by the time data collection was complete – in the fall of 2009 – only one person who worked at the organization in 2006 remained with the organization. As will be discussed in more detail below, fluctuations in the number of employees and regular staff turnover is an ongoing feature of PEERS, in part due to the unstable nature of program funding, but also due to the stresses associated with the work environment.

Sample selection was necessarily guided by theoretical sampling which focuses on ongoing, selective recruitment with the aim of reaching theoretical saturation in relation to the main research objectives (Glaser and Strauss, 1967). Theoretical saturation is defined as the point in qualitative analyses where concepts and concept categories have emerged and been defined, relationships between concepts and categories have been specified, and the data is continuing to support the relevance and relationship between these concepts, with no new additional information emerging (Ritchie et. al. 2005; Strauss and Corbin, 1994). In simpler terms, at a certain point in the data collection and analysis process, the researcher becomes satisfied that sufficient information has been gathered because a framework for understanding the data has emerged, the research questions can be answered, and, perhaps most importantly, it is unlikely that the addition of data from further interviews with members of the same sampling frame will reveal any new information (Denzin and Lincoln, 1994). Within this strategy, sample

selection is often stratified with an attempt to recruit participants who represent various locations, perspectives, and experience in relation to an issue, and it is considered advisable to re-interview select persons whose experiences are theoretically relevant and/or who possess special insight into the research issue (Patton, 1990; Morse, 1994).

When I began the ethnography in 2006, all employees and regular contractors were invited to participate in a qualitative interview (Appendix 1). I conducted 11 interviews, one of which was with a former employee, and the remaining 10 with persons then employed by PEERS⁶. Although I did not interview all of the persons employed by PEERS in 2006, I was satisfied that the sample represented persons from the different program areas as well as different levels of experience and credentials. Among the few staff that did not participate in interviews, two likely did not participate because I did not have an opportunity to discuss the project with them directly. One individual was hesitant to participate, explaining that she was self-conscious about having to talk in a recorded research interview. I provided a little more explanation about the interview process, but left it up to this individual to approach me if she changed her mind as I did not want to appear to be pressuring staff to participate in case it jeopardized my access to the research site (Lofland et. al, 2006).

The first phase of research aimed to establish a basic understanding of what it was like to work at PEERS, including accounts of how respondents began working at the organization, job descriptions and rewards, and strains associated with the job (Adler and Adler, 1994; Charmaz and Mitchell, 2001). In addition to collecting preliminary data, the first phase of research was also aimed at developing rapport with key staff members in order to facilitate greater access to data collection opportunities (Adler and Adler, 1994; Bryman, 2004; Fine, 1994). Over a four

⁶ The person who was not employed by PEERS at the time of the first interview was working as a volunteer with the organization, but had previously been employed by PEERS.

month period in early 2006 (one month prior to and one month following interview data collection), I also engaged in approximately 60 hours of participant observation at the organization. Two to three times per week, I spent a few hours per day job-shadowing in the main programs, as well as volunteering to do various general tasks; these included making lunches, cleaning the outreach van, answering the phone, and entering program data in an excel spreadsheet. I then took a break from active involvement in the organization until 2007 when I was asked to contribute some academic literature to a report about the benefits of involving experiential persons in services and community development aimed at vulnerable populations (Other Voices Working Group, 2007).

After returning to the organization in 2007, and after conducting preliminary analysis of the first interviews, I was asked to consider joining the Board of Directors at PEERS. After consultation with my supervisor regarding ethical concerns associated with my having a position on the board, it was decided that I would join in a casual manner for the sake of research reciprocity, but would not conduct a research interview with new the Executive Director. The Board of Directors at PEERS has a supervisory role in relation to the Executive Director, and thus research with this person would constitute a “dual role” or “power over” relationship, which is defined by the University of Victoria Human Research Ethics Board (HREB) as “a position of authority or power over participants” (University of Victoria, HREB, 2010).

My experience participating in the activities of the Board of Directors is described later in more detail with regards to gaining access to the organization, but is important to note here as my involvement with the board allowed me to remain connected to the organization between 2007 and 2009. During that time I was not actively collecting data because I was completing other graduate student requirements and was also engaged in writing a publication on early findings

(Phillips et. al. In press).⁷

Two years later, in 2009, I invited the same group of individuals to participate in a follow-up mixed-method interview that included a short questionnaire with basic demographic, work and stigma measures (Appendix 2, 3, 4). The follow-up interview was similar, in many ways, to the first interview as it invited respondents to reflect broadly on their experience working at PEERS, but it also contained questions and ideas that more directly touched on the concept of courtesy stigma vis-à-vis the findings of the first interviews. The purpose of these interviews was to further enrich the findings collected in the first interviews regarding courtesy stigma as a variable condition that interacted with other workplace assets and vulnerabilities.

Seven of the 11 individuals who participated in 2006 consented to participate in a follow-up interview after being invited. An additional two persons completed the questionnaire, but did not complete an open-ended interview as I was unable to reach them until after the second round of data collection was complete. The final two individuals could not be reached following two attempts of email and/or telephone contact. Upon analysis, the original sample had underrepresented persons with little formal education or training when they began to work at PEERS, and since formal training emerged as an important determinant of experiences of courtesy stigma, I also added one additional respondent to the qualitative interview sample in 2009 that represented this subpopulation of PEERS staff. I did not seek to expand the sample any further as the sample of 12 persons was sufficiently representative for the goals of the project. Respondents represented all program areas, management and frontline personnel, persons with and without formal education, and persons who had, and who had not, previously worked in the sex industry.

⁷ I was also on maternity/parental leave during part of 2007 and 2008.

In 2009, I also administered the short questionnaire portion of the second interview (Appendix 3) to seven (out of 11) of the current employees and contractors of PEERS, primarily to increase the number of persons included in the descriptive statistical summary of the PEERS workforce reported in Chapter 4. I also spent an additional 12 hours job shadowing at PEERS in 2009 to augment the participant observation data collected in 2006. Finally, also in 2009, upon the advice of members of my academic supervision committee, I conducted eight interviews with individuals in the local community who represented various aspects of the health and social service sector in Victoria (Appendix 5). The purpose of these interviews was to explore how the organization was perceived by members of the broader social service community and lend a more ecological perspective to the courtesy stigma experiences reported by workers at PEERS. A summary of the sample of persons who completed the first and second stage research instruments is presented in Table 1.

Table 1: Data Summary

	2006	2009	Total
Interview 1	n=11	n=1	n=12
Interview 2	N/A	n=8	N=8 (of 12 noted above)
Questionnaire		n=17	n=17 (9 from interview 1 sample noted above and 8 respondents who were current staff in 2009 and invited to complete the questionnaire only)
Community Interview		n=8	n=8

Below I provide more detail about the how the practices associated with ethnographic research were incorporated into this project as well as additional details regarding instrument design and analytical procedures.

3.2 Method

Ethnography is understood as the practice of observing and recording culture and has its origins in Anthropology and Chicago School Sociology (Prus, 2005). There are many types of ethnography, but it is usually characterized by extensive fieldwork, with the researcher becoming immersed in a social setting while observing, taking notes, conducting individual interviews, and examining artefacts of the group in order to come to an understanding of a particular culture (Fine, 1993). The result of a traditional ethnography is a full description of a group of people operating as a social system, including a “behind the scenes” account of how they organize their behaviour in everyday life and the mechanisms that lie behind public presentation (Adler and Adler, 2004).

Ethnographic methods can be applied to large and small cultures, including health care sites or small populations of interest (Weppner, 1977). There is a long tradition in sociology of using ethnography to understand organizations and occupations, including those found in the health and social service sectors (Adler and Adler, 2004; Fine, 1996; Hochschild, 2003; Reiter, 1992; Savage, 2000). Ethnographies of work sites typically contain the following interconnected elements: a detailed description of the workforce including demographics and variations in skills, descriptions of the worksite, recruitment and socialization processes; descriptions of standardized workplace routines, temporal and other demands, and governance and decision making processes (Fine, 1996; Adler and Adler, 2004). They also often include a look at the unofficial practices such as approximations, shortcuts and tricks of the trade that lighten the burden of work, interpersonal interaction and presentation, including between coworkers and between coworkers and clients; and reflections on how the worksite and culture are embedded in larger social systems such as class, gender, ethnicity, culture, politics, and economics (Adler and

Adler, 2004; Fine, 1996; Hochschild, 2003; Reiter, 1992)

Ethnographies can be either post-positivist or interpretivist in their epistemological orientation, depending on the extent to which they are inclined towards regarding a culture as an external, predictable social system or the conditional product of specific research process, cultural context and related social interactions (Prus, 2005). The type of data extracted from these ethnographic orientations may differ with regards to emphasis with the post-positivist leaning toward identifying the social regularities in a culture and root causes and the other focussing on the contexts, products and consequences of meaning-making activities (Charmaz and Mitchell, 2001). Depending on epistemological orientation, ethnographies variously incorporate a mixed range of qualitative and quantitative data collection methods, most commonly including questionnaires, semi or loosely structured individual interviews, and field notes (Greene and Caracelli, 2003; Savage, 2000).

In many respects, the research informing this dissertation exemplifies the interpretivist tradition – inductive emphasis, exploratory research aims, theoretical sampling, small sample size, semi-structured interviews and a focus on in-depth description of courtesy stigma in one particular context (Greene and Caracelli, 2003). However, as noted earlier, this project also employed some closed-ended measures in a questionnaire format for descriptive purposes, and to pilot existing stigma and health measures to assess their validity for studying courtesy stigma. Given these different approaches, the research design might be best described as *mixed methods*, with an emphasis on qualitative design supplemented by a nested, concurrent quantitative component aimed at enriching description of the sample (Greene and Caracelli, 2003; Morse, 2003). For example, closed-ended measures were used to describe demographic characteristics of the workforce at PEERS, workplace health and stigma. The questions were primarily drawn

from standardized tools – including the Maslach Burnout Inventory for Human Service Workers, Beck Depression Scale, Job Content Questionnaire and Stigma Scale - or other questionnaires used locally in the Stigma Study in order to facilitate comparison of the small sample of workers at PEERS with other populations of workers (Beck et. al., 1961; Karasek et. al., 1998; Link et. al., 2001; Maslach and Jackson, 1986).

In addition to a mixed methods design, the overall methodological orientation of the project – from theoretical framework through to data analysis – was informed by the tenets of critical realism, specifically, the focus within this paradigm on situating individual and interpersonal contexts within larger structural systems of inequality (Lather, 1991). A critical ethnographic approach is especially fitting in ethnographies of vulnerable populations, where mixed tools are used, alongside participant observation, to understand vulnerable subgroups such as those who experiences of violence alongside other forms of marginalization (Bungay et. al. 2010).

The data were collected using analog recording equipment and transcribed by a transcriptionist. The transcription quality was checked by listening to the tapes while simultaneously reading the transcriptions during an initial review of the data. Analysis of the qualitative interviews was facilitated by the use of NVIVO, a software program that acts as a tool for sorting, coding, and retrieving text data. The questionnaire data were first entered into SPSS, a quantitative software program, to produce basic descriptive statistics and were then imported into NVIVO to facilitate case selection during the qualitative analysis.

3.3 Data Analysis and Rigour

Ethnography is more of an approach to data collection than a strategy for data analysis and therefore it is often paired with a specific rationale for data reduction and theory building,

such as Grounded Theory (GT) (Charmaz and Mitchell, 2001; Glaser and Strauss, 1967). GT is an inductive approach to theory development that involves carefully sorting data into discrete constructs, followed by the grouping of constructs into categories, followed by descriptively specifying the contexts and processes that bring these categories into relationship with one another. The goal of GT is to thematically sort information in a manner that will enable the identification of generalizable relationships as well as the parameters of these relationships (Miles and Huberman, 1994).

The sample selection, interviewing and data analysis procedures undertaken for my dissertation followed some aspects of GT, including theoretical sampling, repeated interviewing, concurrent analysis and interviewing, an emphasis on inductive theory development, and cases to case comparison; however, my coding process was broader and more thematic than the coding process associated with the more formalized and systematic variants of GT. Early interviews focused on asking interview respondents to describe the career paths and life experiences that brought them to PEERS, their experiences of work including service responsibilities, challenges and successes on the job and to illustrate the characteristics of PEERS as a workplace. In the course of the interviews conducted in 2006, certain ideas concerning stigma and courtesy repeatedly emerged, such as how courtesy stigma is experienced when talking about work to outsiders in various private and public contexts. Having a preliminary idea of the contexts and manner in which courtesy stigma is most commonly experienced by workers at PEERS, combined with a greater knowledge of the challenges and values that guide workers at PEERS, I was then able to ask more precise questions in the follow up interviews conducted in 2009, while still maintaining an overall focus on understanding the broader experience of working at PEERS.

As I conducted early analysis of the findings, I was able to approach staff for verification

or further information about certain topics and could revise or add to the emerging theories as the research progressed (Strauss and Corbin, 1990). While analyzing the research interviews, I alternated between a more inductive inquiry aimed at describing the experience of working at PEERS and instances of courtesy stigma, and a more deductive inquiry aimed at answering the questions contained with the existing literature, including questions regarding contexts and experiences of perceived and enacted courtesy stigma, stress associated with courtesy stigma, coping and management strategies, variability in experiences of stigma, and the linkages between structural and micro-behavioural instances of courtesy stigma. Analyzing the data with questions or objectives in mind can focus both the results and theoretical implications (Patton, 1990). In addition, when applying questions to data analysis, it is important to consider how the findings confirm, add to, or depart from the concepts and relationships that have already been identified in academic literature or popular thought (Patton, 1990). At the same time, it is also important to consider competing interpretations and possible flaws in the existing theoretical interpretations, including alternative interpretations that might arise if another analytic framework were applied (Bryman, 2004). For example, it was important to focus on instances where courtesy stigma was experienced in a more profoundly negative way alongside instances where it was noted, but presented as a minor challenge in the workplace – the strategy of identifying negative, positive and unique instances of the phenomena under study (Ritchie et. al., 2005). Similarly, I also applied questions to the data regarding whether or not experiences of courtesy stigma were internalized by workers, as both perceived and enacted stigma may be experienced without necessarily being internalized (Scambler, 2009). Similarly, I paid careful attention to how stigmas surrounding “prostitution” were embedded in the service practices and program goals of PEERS, including how workers at PEERS define themselves in relation to their counterparts who

conduct similar work in other organizations. In addition, I also made note of repeated ideas that I found perplexing; experienced ethnographers argue that inexplicable phenomena, paradoxes and contradictions often present opportunities for understanding the peculiarities of a certain culture because they challenge the ethnographer to revise assumptions and theories in order to understand what has happened (Katz, 2001). For example, I found the emphasis at PEERS on “experiential” and “non-experiential” knowers – the latter, who included myself, were sometimes referred to as “normies”, “straights”, or “squares” – both perplexing and contradictory to the aim of reducing both the primary and courtesy stigma that surrounds PEERS staff and clients. Similarly, I was sometimes perplexed by service providers’ reactions to perceived stigma, including not clarifying with others their thoughts and intentions before arriving at a conclusion. In addition, transformations within culture members, including moments where members come to know something differently, or perceive themselves, or others, differently are key points of interest within the data (Katz, 2001). For example, organizations such as PEERS that have high staff turnover may reveal much about trajectories, turning points, and organizational determinants of work place health (Morse, 2003). In the case of this project, I found that workers who had left the organization developed new perspectives about their work after having a chance to reflect on their experience and compare their work experience at PEERS with new experiences, including new work environments. Finally, using examples of other workplace ethnographies, I drafted a list of the common points of interest and periodically checked that my coding process would result in analytical categories that addressed these focal points.

A number of standards of rigour have been noted as suitable for qualitative ethnographic data analysis. Internal reliability (inter-observer consistency) is an important aspect of rigour in

qualitative research, and refers to multiple observers coming to some consensus on what exists in a social setting, or within interview data (Altheide and Johnson, 1998). Internal reliability is facilitated by a clear description of data collection and analysis techniques. In the case of the research informing my dissertation, inter-rater reliability was established by having a colleague broadly code segments of data, which were then compared with the author's coding to highlight any areas that required further deliberation. Assessing validity in qualitative research is often done by running the findings past key informants who ideally have first-hand knowledge of the research phenomena, and at the same time, are aware of standards of academic inquiry (Bungay et. al., 2010). In this case, I passed my research results and questions by four individuals – two of whom were respondents - who were all highly familiar with the research subject, the organization, and methods of critical, analytical inquiry. This was important because while at times I felt that I had achieved some level of “insider” status at PEERS, most of the time I felt like an “outsider” and struggled with the “chronic tension between the demands of involvement and withdrawal, of participation and detachment”, which included a range of feelings from identification, empathy, bafflement, and irritation with the organization, the actions of staff, and the wider context surrounding their work environment (Pollner and Emerson, 1983: 235). When grappling with these tensions, I found it especially helpful to run ideas past a core group of insiders at PEERS who could provide feedback about the validity of my interpretations, provide additional details when I was not seeing the full picture, or suggest alternative interpretations. Academic supervision from my supervisory committee and other individuals to whom preliminary data was presented also contributed to the external validity of the findings, ensuring that the research process was not only empirically valid, but that the analysis and findings were theoretically relevant and would provide an addition to the scholarly literature.

Further to responding to the basic research objectives established at the outset of data collection, an additional indication of the success of this project would be the theoretical renderings providing a basis for further inquiry, including statistical testing of theories about how courtesy stigma operates both as an independent and dependent variable in relation to the other factors identified (Guba and Lincoln, 1994). The next section of this chapter outlines some of the ethical and practical consideration I encountered, including negotiating access to the research site.

3.4 Gaining Access and Ethical Considerations

A number of practical ethical issues confront ethnographers. Gaining access to the research site is the first issue, as not all cultures are open to observation, and even when an official entrée to the research site is granted, typically there are several other subtle barriers to access that may need to be overcome. These can include distrust or cynicism towards research or reluctance to be open about aspects of the culture that not typically revealed to outsiders (Bryman, 2004; Fine, 1996; Prus, 2005). Thus, ethnographers describe access as tenuous and continually negotiated over the course of ethnographic work with uneven degrees of success (Lofland et. al., 2006). At the outset of the project, I entered into a research relationship with a “knowledge broker” at the ethnographic site, someone who was well known and well-liked among the current and former staff of PEERS Victoria Resource Society, and could therefore help me navigate access issues, act as an interpretive resource and lend credibility to my research as required (Jansson et. al., 2010). Establishing a relationship with a key insider or “knowledge broker” is common to ethnographic research and community academic research collaborations that aim to maximize knowledge transfer (Charmaz and Mitchell, 2001; Jansson et. al., 2010). I was also able to draw on my background in non-profit frontline service work, policy

development, knowledge of local child, family and adult services in the Greater Victoria Capital Regional District (CRD), and experiences interviewing persons in the sex industry as a research assistant in order to facilitate communication with respondents regarding their work experiences. Due to my background as a service provider, the service environment at PEERS was, in some ways, familiar to me, which helped expedite early access and preliminary data interpretation. As noted earlier, I also invested considerable time in volunteering at the organization in various capacities. Many scholars refer to developing a ‘front’ that will allow observation to appear natural, while allowing the researcher varying degrees of active or passive participation in the activities of the group (Berg, 1995). Volunteering, or otherwise helping, with the work load is not uncommon in ethnographic studies, and in the case of this research, greatly facilitated my access as members of PEERS are especially cynical towards “ivory tower” academic research and would therefore be less likely to invest in a research relationship that was not perceived as immediately reciprocal (Jansson et. al. 2010).

As briefly noted earlier, I was asked to join the board of directors between the first and second waves of data collection, a decision that potentially posed some ethical problems, primarily concerning inducement and coercion, which I discussed at length with my academic mentors. Although members of the board of directors do not have a supervisory role in relation to staff at PEERS and have little interaction with them, the board plays a governance role in relation to the society, and oversees hiring and supervision of the Executive Director. As noted earlier, the latter role of the Board of Directors put me in a position of power relative to a potential research participant – the Executive Director. While it was possible to obtain ethical approval in this context, it was my preference to avoid this complication by discontinuing recruitment of new respondents after I became involved in the work of the Board of Directors.

As I had already collected much of the data for the project by 2008, I agreed to join the board primarily because I felt this would be an opportunity to get to know the organization further while providing some services in return, such as helping with grant writing and outcomes data collection. Since joining in 2008, I have declined roles on the board that might have led to the cultivation of a perception that I considered myself to hold a position of authority with respect to the staff of PEERS. This included turning down an offer to become the board chair and avoiding involvement in any human resource issues involving staff disputes. Fortunately this decision did not pose a problem as the sample of persons established in 2006 met the requirements of theoretical sampling – that is, I was able to respond to the research objectives without having to invite current workers to the existing sample. As noted earlier, I invited the current PEERS staff to complete the questionnaire portion of the second interview to augment the sample of persons included in the description of the PEERS workforce. I was careful to emphasize that completion of the questionnaire was voluntary, confidential, and that answers to particular questions could be refused for any reason. One individual expressed reluctance to complete the questionnaire because she was new in her position, and another was on a leave of absence at the time the questionnaires were administered, so therefore, neither participated.

Looking back, I would not recommend joining a board of directors to others completing similar critical ethnographic work, and would instead recommend acting strictly as a volunteer, even a volunteer within the context of board activity. While participating in the activities of the board of directors I often felt like I was walking a tightrope – an experience commonly described by ethnographers – because I felt close to the organization and the ongoing stresses associated with program delivery and workplace relations, but was unable to participate in these issues to the extent that was expected of a typical board member. I was often asked for my opinion on

matters and was unsure how open I should be about providing opinions which were informed by my ongoing dissertation research. Wherever possible, I avoided, or minimally participated in controversial conversations that were germane to board activities because I did not want to be involved in discussions that might jeopardize my research access, even though I felt I could contribute to these conversations. As I became more aware of the values and tensions that characterize PEERS, I also realized, for reasons I elaborate on below, that the distribution of decision-making power was a tense subject in this environment, so it was naïve to think that I could participate in board activities and avoid power negotiations among management, frontline staff and members of the board of directors. Fortunately, these concerns were minor during the vast majority of time I spent in the field, and staff and members of the board of directors were supportive of my concern to be ethical in negotiating my roles as a volunteer and student researcher.

Another dilemma I encountered during the course of the ethnography was deciding which individuals should be engaged in informed consent while conducting participant observation. Specifically, I found that access to worksites may be formally granted by managers or owners, but individual employees and clients also take part in the interactions being observed, and it is often not clear if these individuals must also participate in informed consent (Bryman, 2004). In my case, permission to engage in observation activities was sought from the board of directors of PEERS prior to each data collection cycle. The research project was also presented in two staff meetings prior to conducting participant observation to inform staff about the project. In addition, I approached individual staff members to negotiate observation of them, and in some cases, their clients at work. In all cases, the staff members were happy to talk about their work and seemed open to my observation of them at work. With regards to clients, I obtained

informal consent when observing the employment program classes as the instructor was able to introduce me to the class and ask how the group felt about my participation prior to observation; however, I did not obtain any form of consent from clients when observing work activities in the reception area of PEERS, or when participating in the Night Outreach programs, which is a drop-in program offered from a Recreational Vehicle in the downtown area known to be the outdoor sex work stroll. I did not feel that consent from clients was required in these contexts, primarily because the field notes from these data collection activities were general and did not focus on identifying information about clients, but also because these were fairly open settings (Lofland et. al, 2006).

In sum, this project deployed a mixed-methods critical ethnography with the aim of using repeated interviewing and ongoing participant observation to gain an understanding of how workers experience courtesy stigma at one worksite. I now turn to a description of the workforce and worksite of PEERS.

Chapter 4: Workforce, Workplace Context and Structural Courtesy Stigma

This chapter focuses on a description of PEERS and its workforce. It is divided into three parts: 1.) a brief overview of the history of the organization; 2.) a description of the demographic background of the PEERS workforce, alongside a summary of how these individuals describe their work; and 3.) a description of the salient characteristics of PEERS as a workplace culture, including a detailed description of the programs and their sources of funding. Theories of neoliberalization, devaluation of care work, and structural stigma are applied to highlight how primary and courtesy stigmas intermingle at the structural level resulting in a particular kind of work and service environment at PEERS.

4.1 History

Located on the southern tip of Vancouver Island, Victoria (Capital Regional District) is home to just over 330,000 persons (Statistics Canada, 2010). A mild seaport, Victoria is a prime tourist destination as well as the home of the Legislative Assembly of British Columbia, many Northwest Aboriginal Cultures, and is a training environment for Canada's Naval Forces (c.f. Benoit and Miller, 2001). A city with many attractions, Victoria is also home to many retirees and has one of the most buoyant and expensive housing markets in the country (VREB, 2010). Affordable housing is a significant unmet need in the city and 13.9% of households in the CRD as classified as "low income" (Reitsma Street et. al., 2000; Statistics Canada, 2010). These forces, in particular a high cost of living combined with an active tourist industry, contribute to the sizeable sex industry in the city (Benoit and Millar, 2001; Hallgrimsdottir et. al., 2008; Rabinovitch and Lewis, 2001). One relatively recent estimate suggested that some 2000 persons work in Victoria's sex industry, with the vast majority of those in independent and private escort

agencies (Benoit and Millar, 2001; Benoit et. al, 2004).

Incorporated in 1995, PEERS has been in operation in Victoria for close to 15 years and was among the first of the sex worker advocacy groups in Canada, along with Stella in Montreal which also opened its doors in 1995 (Rabinovitch and Lewis, 2001; Stella, 2010). The idea for PEERS developed among a small group of women – some of whom had a background working in the sex industry. While working on a project to develop a women’s emergency shelter, a conversation ensued amongst this group regarding the need for a support service where women who had been in the sex industry could be open about their experiences. As one of the women who was instrumental in the conception of PEERS wrote:

“I had been “doing” community development for many years in Victoria and it was through a project with street women that I met a number of women who left prostitution... [they] weren’t exactly sure what was needed to help other women in their situation but were very clear [that it] didn’t exist” (Rabinovitch and Lewis, 2001:17)

Those who were part of the early formation of PEERS regarded the pairing of community development leaders with a number of supporters who had a background in the sex industry as the two key ingredients of PEERS’ inception and subsequent ability to survive the growing pains of a new organization offering a unique service (Rabinovitch and Lewis, 2001). During the early years, PEERS was located in a home-based office and funded by a handful of small grants and donations (ibid.). The organization was represented by a small group of women who spent their time connecting with the target population, networking with potential funders, and engaging in visioning work regarding the services PEERS would offer in the future.

The mission statement of PEERS, then and today, included the following goals: empower, educate and support sex workers, educate the public, improve working conditions for sex workers, provide alternative employment for those seeking to leave the sex industry, and

create a safe, supportive place for persons currently or formerly involved in the sex industry (Rabinovitch and Lewis, 2001). From the outset, PEERS was committed to being an agency not only *for* persons involved in the sex industry, but also *led by* persons who had experience in the sex industry, with the latter referred to as “experiential persons”.

“Everyone agreed that this new society they were creating had to be managed by current and former sex trade workers. They knew from experience that they had to ensure that it couldn’t be taken over by well meaning, do-gooder types.”
(Rabinovitch and Lewis, 2001).

At the end of 1997, PEERS received a commitment of annual core funding from the British Columbia Ministry for Children and Family Development. Shortly thereafter, PEERS received a federal government grant from Human Resources Development Canada for a training program to offer pre-employment education, officially inaugurating what would become a long-standing program focused on assisting sex workers to acquire the skills needed to find other employment. With core funding in place, the agency applied for, and received, several federal project grants to expand their program portfolio to include men involved in the sex industry, sexually exploited youth, other pre-employment programming funds, and special issue projects concerning topics such as: sexually exploited youth, men in the sex industry, Fetal Alcohol Spectrum Disorder, the indoor sex industry, the Criminal Code, and Aboriginal and public education (Rabinovitch and Strega, 2004). In fact, the early years of PEERS were characterized by rapid opportunity expansion – “everybody wanted to fund PEERS” (R#11). Private donations and foundation grants also helped to support PEERS’ programs and have remained a crucial supplement to government funding.

Between 1997 and 2004, PEERS was located in an older downtown building in the prime commercial district. The building had heritage charm, but was also known to house non-profit agencies because of the lower rent, which reflected the marginally adequate condition of

the building (Rabinovitch and Lewis, 2004). In 2004, following notification of another rental increase and a history of difficulties with the landlord, the board at PEERS made the decision to purchase a commercial property in a region of the city that was close to, but not within easy walking distance of, the downtown core. While some worried about access issues for clients, particularly clients who were homeless and needed to be proximate to downtown support services, the benefits identified with the move included the opportunity to own a building, acquire more space (including a division of service provision and administrative space), a kitchen for preparing meals for program clients, and the privacy afforded to clients by being located in the comparably quiet industrial sector.

Despite many funding successes over the years, like other non-profit organizations, PEERS constantly struggles to maintain program funding. In the early years, while most of the federal grants PEERS received were one-off, time-limited funding opportunities, PEERS could rely on the core funding provided by the provincial government to get them through times of scarcity. But in 2001, PEERS lost its core funding and primary source of provincial funding during a time of widespread government cutbacks to provincially-funded social services (Creese and Strong-Boad, 2005). Since then, PEERS has competed with other non-profit agencies for limited available government and private donor dollars to keep the organization afloat. There is widespread belief among those involved in the organization that funding opportunities are steadily diminishing alongside an increased emphasis on the language of innovation and outcome efficacy. This widespread belief among members of the organization, from frontline staff to board members, is typified by the following statements:

“After our [core] funding got cut...then we had to really start scrambling because after a while the [short term projects ended]. So then, all of a sudden, to write a proposal, it has to be new! ... We had to really get creative and [] it just got tighter and tighter.”(R#11)

“[It’s a matter of] who knows how to play the game [] of getting funding and raising funds ... and you’d better be good at it or [your organization] is going to fall apart pretty quickly.”(R#12)

“[The] government’s view is that this is not necessary work, but nice [work] so they come out [with] terms like “duplication of services”, [and]” we’re cutting back on unnecessary service”....why would the government fund unnecessary service in the first place?” (R#2)

The final phases of this dissertation research project were completed following the onset of the worldwide economic recession, which has only heightened staff and volunteer concerns about funding (Statistics Canada, 2010). Indeed, a review of funding over the years at PEERS (Table 2) demonstrates that while the organization has expanded its operating budget - primarily through foundation grants and donations - government revenue for core programming, while initially demonstrating a pattern of increase, appears to be in recent pattern of retrenchment. In addition, the impact of the recent economic recession can be seen in the operating budget of 2009, with further decreases taking place in the 2010 budget (PEERS, Board of Directors, Minutes, March 2010).

Table 2: Summary of Funding

	Total Revenue (Govt Revenue Core Programs)	% Total Revenue from Govt for Core Services
2002	964,646 (246,750)	26%
2003	844,164 (180,657)	21%
2004	654,891 (237,762)	36%
2005	663,486 (361,910)	55%
2006	683,882 (364,277)	53%
2007	1,049,439 (427,700)	41%
2008	1,238,638 (338,732)	27%
2009	892,012 (164,507)	18%

The stresses associated with funding instability and the limitations placed on service delivery via funding are felt throughout the organization, but it is at the level of executive management where this stress is experienced most acutely as these individuals are responsible for securing funding:

“You’re fully responsible for finding all the money and then to discover that that happens every year[.]. I’d sort of pictured going into it [that] we’ll spend a year stabilizing things [financially], but then I realized at the end of year one that all you can really do is reinvent the same year over and over again[.]. The place needed all my energy [] to deal with the problems of the staff and the people coming in the door [and] that was where my energy should’ve been...that was absolutely the hardest.” (R#2)

Patterns in program funding, such as how much money is available from whom, and for what kinds of services, are one of the key places that primary and courtesy stigmas are structurally organized, and thus a theme that will be returned to in more detail throughout the findings section (Benoit and Hallgrimsdottir, 2006; Hallgrimsdottir et. al. 2006; Link and Phelan, 2006; Struber et. al. 2008).

4.2.1 PEERS Workforce Characteristics

Table 2 summarizes a description of the age, gender, race, household income and family composition of persons who work, or recently worked, at PEERS. It is noteworthy that all persons who took part in the interview were female or male-to-female transgender. This finding mirrors other estimates which suggest that over three quarters of paid and unpaid workers in the non-profit and care sectors are women (FCSS 2010; Benoit and Hallgrimsdottir, In press; Mellow, In press; FFSA, 2010; Saunders, 2004). The median age of persons working at PEERS is 44 years (mean=42) suggesting that the work is predominantly performed by women in the middle years of their paid career. Workers at PEERS report high levels of educational achievement compared to those they serve, and comparable levels of educational achievement to

those in the broader social service community (FCSSA, 2010). Despite educational achievement, 47% of respondents indicated that their annual household incomes were equal to, or less than, \$40,000, while 77% indicated their annual household income was equal to, or less than, \$60,000; financial statements confirm that the annual income of employees at PEERS ranges from \$20,000 – \$57,000 per year for full-time work. In addition, it is noteworthy that 35% of respondents indicated they were single mothers, while only 13% of families in the region are classified as single parent families (Statistics Canada, 2010).

These findings support the assertion that the economic rewards for working with vulnerable populations in the health and social service sector are modest, and it is women who disproportionately bear the costs of this poorly rewarded work (Benoit and Hallgrimsdottir, 2006; England et. al. 2001; FFSA, 2010). Further, while the care literature suggests that minority women and women of lower socioeconomic status are more likely to work in the frontline service sector due to limited economic opportunity, at PEERS, women with a history of marginalization are more likely to work there specifically due to the hiring practices of the organization. Although the population of workers at PEERS may in part be based on their hiring strategy – as opposed to the trend wherein vulnerable workers occupy more demanding work positions for less reward for due to processes of structural inequality – this does not mean that the health implications of the work (explored in the next chapter) are any less for the staff at PEERS. As shown below, when the demands of the job became too great, workers with formal credentials and more varied employment history encountered better options for locating alternative work, whereas workers who developed their skills on the job and lacked employment credentials and experience, faced limited options for acquiring equally, or higher, paid work upon leaving PEERS. This pattern was summed up by one respondent who noted that she stayed

at PEERS long after it had begun to affect her health because she “didn’t really feel confident yet that [she] could get another job” (R#1). In fact, the research interviews conducted for this project confirmed that most workers who left PEERS moved laterally to frontline support work in other organizations in the CRD serving homeless and temporarily-housed populations, and many experienced periods of unemployment following their work at PEERS.

At any given time, there are approximately five or more active program volunteers and social work practicum students at PEERS, in addition to the regular staff, who help with the daily lunch program, housekeeping, outreach, and fundraising activities, as well as additional volunteers who are recruited for specific fundraising events. Practicum students, all of whom have been female in recent years, have become increasingly necessary to carrying out the essential duties of the organization, reflecting the sector-wide pattern of downloading care work to unpaid, female workers in times of funding scarcity (Baines, 2004; Mellow, In press).

Table three provides a summary of the descriptive characteristics of PEERS staff. Results from the Stigma Study (Benoit et. al. 2004) noted earlier are included for comparison purposes. The Stigma Study also included a predominantly female workforce engaged in personal service work such as sex work, hairstyling and food and beverage serving. While workers in these occupations, also on average experience high workplace demand and modest rewards, these occupations arguably require fewer formal skills than frontline social service work as none of these occupations require formal training (ibid.). However, while the work at PEERS might be associated with higher skill and greater educational attainment, workers at PEERS exhibit many similarities to workers in these personal service jobs, and as will be shown below, may be worse off with regards to some determinants of occupational health.

Table 3: Descriptive Characteristics of PEERS Staff

Variable	PEERS Staff	OHS ⁸
Median Age	44	34 (mean)
% Female	94%	78%
% Visible Minority	6%	7%
% Aboriginal	6%	11%
% Completed high school	82%	68%
% Completed University Degree	35%	14%
% household income below/equal to 60,000	77%	81%
% Currently in relationship	47%	59%
At least one child in home	65%	46%

4.2 2 Becoming involved in PEERS and Common Rewards and Challenges Associated with the Work

PEERS staff members described three common routes to beginning work at PEERS, which may exist on their own or in combination: previous experience in the sex industry, social work education and training, and a desire to participate in positive social change for persons working in the sex industry. The following quotes exemplify these routes to involvement with PEERS:

“Well I came to PEERS as a client. At that time, PEERS had very limited funding and I volunteered with them for their outreach for three-four months.” (R#10)

“I was hired to be supervisor for two group homes[] and that’s how I got into this line of work.” (R#5)

⁸ Benoit et. al. 2004 Service Workers Occupational Health and Safety Study. The research sample from this project includes 305 workers representing the following interactive service occupations: hairstyling (n=68), food and beverage service (n=125) and sex work (n=112). The data from this project was chosen as a comparison group because it represents another sector of female- dominated service work, but one where the educational requirements and associated skills, are comparably lower. Other comparison options not included in the final dissertation which might have been of interest include comparison with sex workers (the client group of the frontline service workers studied in this dissertation) and the population in the census metropolitan area. These additional points of comparison will be explored in the scholarly publications resulting from this dissertation project.

As discussed in more detail below, PEERS is a learning environment where people report making many mistakes, often due to minimal training and supervision or close mentorship; however, the upside is that it is also a work environment that presents many opportunities for growth and the application of evolving skills and ideas. Participant observation of paid and unpaid workers at PEERS confirmed that staff exercised a high degree of autonomy and skill discretion in the performance of their jobs with relatively basic paper work and service policies guiding them as they interacted with clients – in comparison to more bureaucratized organizations where documentation requirements often guide practice and are the primary evidence of “good work” (Mellow, In press). The seemingly high levels of autonomy and skill discretion among staff at PEERS likely contributes to positive workplace health and was featured among respondents’ descriptions of the attractive aspects of the job. Respondents made comments such as “*I am learning new skills*” (R#4), “*the mentorship that I’ve received is phenomenal*” (R#12), and “*I have experienced huge personal growth*” (R#7).

Before investigating some of the challenges reported by frontline service workers at PEERS, it is important to note that volunteer and paid workers alike articulated that the opportunity to help others, participate in social change, and be part of the PEERS community were the main attractions of the job. Workers described being drawn to the work in order to “*be able to give back to people that were still kind of stuck where I had been stuck*” and see “*shortcomings, like having an addiction problem, and having been involved in sex trade work all of a sudden became my asset*” (R#1). Workers stated that providing tangible assistance resulting in improved well-being was one of the foremost rewards they experienced in their line of work:

“We like hearing about the success of the clients, you know. It’s good to hear when a client moves on, you know, goes to treatment, when a client leaves an abusive relationship, when the client gets a job or any success in that person’s life, we love to hear. And they [successes] do happen, right, so that’s always

really rewarding.” (R#5)

“When you see someone get their life together and come back and um they are healthy and they are either in college or they’re working or they’ve got their children back if they’d had their children in foster care, just seeing that transformation.” (R#3)

Such comments underscore the notion that for some individuals, service work has significant normative implications which impart meaning and dignity to their work. This is especially the case at PEERS where the work is infused with moral and value-based ideas concerning emancipation of persons who work in the sex industry.

However, equally apparent was that the intrinsic rewards experienced by responding to others’ needs, developing relationships, and witnessing moments of client success were not enough to sustain workers over the long haul. A lack of opportunities to develop innovative and adequate services is widespread among services to vulnerable, stigmatized populations, so it is not surprising that when asked about the greatest challenges of the job, most respondents pointed to a systemic dearth of meaningful supports for their target population, and the feeling that their services could do little to address the structural origins of their clients’ cultural and economic marginalization. As one worker described:

“But then you start breaking down what supports they need, well, you can’t get them ... so the supports instead of being given to these people are taken away. It’s the opposite of the way it should be...The burnout comes from the system,[which is] so big that we feel totally powerless and helpless.” (R#11)

Another respondent similarly noted that:

“...to see these lovely people with completely solvable problems... but we couldn’t get the money to solve their problems.” (R#2)

Thus, workers at PEERS are not unlike other workers in the care sector who find that the extrinsic rewards and support associated with care work are lacking (Saunders, 2004). Feeling charged with the task of helping persons in a context where meaningful help was not available

left many workers with a heightened sense of responsibility and loss related to their work, both of which increase the emotional burden associated with the work. Respondents often talked about how they learned boundaries in the workplace that would allow them to help, without being harmed themselves. Others talked about how such a balance was not possible while working at PEERS:

“I never found that I could []go in, do a good job [and] go home “job well done”. [Instead] it was a feeling of dealing with peoples’ lives ...I mean somebody might go homeless tonight because you and your team couldn’t get it organized to help them that day and[]they could end up dying from a drug overdose because you couldn’t do enough to help them.[You can say] you have to set boundaries and these are not things that you should take on, [but] it doesn’t matter,[]if you care for people, you take them on.” (R#2)

Table 4 summarizes findings from the Job Content Questionnaire (Karasek et. al. 1979) and provides further evidence of the findings noted above regarding stress, autonomy, and job satisfaction. Workers at PEERS enjoyed a high degree of decision latitude in their work environments which is central to offsetting other workplace demands as workers can draw on their unique skills and needs to address stressful working conditions (Karasek et.al. 1985; Karasek , 1979; Theorell and Karasek, 1996). An additional asset among workers at PEERS is a high degree of job satisfaction, likely echoing the strong passion workers described for the social justice aspects of their work as well as the opportunities they perceive to make a tangible difference in the lives of their clients. Other assets that are likely reflected in high job satisfaction included the high workplace autonomy noted above as well positive co-worker relations. However, in contrast to these positive workplace conditions, workers at PEERS described a high degree of stress associated with their work as well as fairly high psychological demands (Karasek, 1979).

Table 4: Job Content

Variable	PEERS Staff	Comparison OHS
% Report Good or Very Good Job Satisfaction	88%	64%
Mean Decision Latitude (24-96)	66	55
Median Psychological Demands (possible range 12-48)	36	32
% Report work to be “quite a bit” or “extremely” stressful	64.7%	22.6%

4.3 Salient Characteristics of PEERS

This section begins with a summary of PEERS’ salient characteristics derived from a combination of participant observation and individual interviews. I believe these characteristics, alongside funding patterns, are among the defining aspects of PEERS and a description of them provides further context to the work environment and workforce characteristics described above. These characteristics have been grouped under the following overlapping headings: service philosophy, experiential learning environment, identity politics, gender, organizational change/temporal patterns, physical environment, and conflict. These headings are interpretive and reflect a sociological-ethnographic reading of the data as well as the themes raised by the workers at PEERS. When asked about the most defining aspects of PEERS, respondents noted ideas such as non-judgmental service delivery and a focus on experiential knowledge, but throughout the interviews a number of additional themes were raised. These included being under-resourced, inter and intra organizational conflict, organizational change, the gendered nature of the work, and constructions of the client group.

4.3.1 Service Philosophy

Respondents regarded PEERS as having a unique service philosophy, which emphasizes

“meeting people where they are at” and being non-judgmental. This philosophy is supported by service provision policies and practices with little eligibility criteria, except as will be discussed below, and policies which are imposed by funding bodies from time to time. Respondents typically described PEERS’ service philosophy as follows:

“[The] philosophy which I think is really important here is that you accept people where they are...they have the right to have service and I think that’s quite unusual.” (R#3)

“Our doors are open, [when] they may be closed elsewhere and [clients] are valued for their experience.”(R#6)

Several respondents noted that PEERS’ ability to enact this service philosophy was enabled by the associated philosophy of valuing situated knowledge:

“I feel really comfortable with this population of people because I really do know where they’re coming from, and on the other hand, they feel really comfortable with me ... I’ve been there, you know, it just opens them up so much more to know that I really do know where they’re coming from. I’m not just a professional that is trying to imagine what it’s like.”(R#1)

4.3.2 Experiential Learning Environment

As noted earlier, PEERS is characterized by their emphasis on first hand experience as the preferred source of knowledge for program design and service delivery. Rather than placing priority on hiring credentialed social service experts, PEERS emphasizes hiring persons who were formerly involved in the sex industry (some of whom are also formally educated, social service experts). This model is referred to as the “experiential model” at PEERS. The rationale for this model is three-fold: to provide opportunities to former sex workers seeking to expand their career opportunities, to increase the chances of meaningfully engaging clients in services by decreasing the social distance between service provider and client, and to subvert stereotypes about the sex industry by increasing community exposure to the first-hand knowledge of sex workers. In doing so, PEERS has joined with others who argue that first-hand, life experience is

key to effective service delivery and social change (Canadian HIV/AIDS Legal Network, 2005; Rabinovitch and Strega, 2004). Respondents felt passionate about the experiential model at PEERS because it provided a range of opportunities for growth that were not available in other service environments.

“I really identified with the idea of using experience as a basis for knowledge and I liked that we grew hope in our clients and even in the community. Many people came forward against the stereotypes and I don't think that ever would have happened without PEERS. We really helped many people to heal, both clients and outsiders.”(R#10)

“It's my dream come true to get to be who I am and not have to hide where I come from. Just to be able to be exactly who I am and have that be a bonus to other people is [amazing for me.”(R#1)

“[This model] leaves women with the message, look[] maybe one of you might be standing up here facilitating a group;[] it can happen to anybody, it happened for me so there's no reason why it can't happen for you.” (R#6)

The principle of leadership “by and for” is common to social movements, particularly where a subjugated, silenced identity is involved (i.e., women's health movement, organizations for those who use illicit substances, disability movement) because of the potential to raise awareness of silenced perspectives. PEERS strives for a mentorship model where persons who have little experience providing frontline social services are given employment opportunities with the goal of on-the-job mentorship from those who have more experience at the organization.

At PEERS, listening to the voices of those they serve is often an informal process which involves workers sharing information obtained from clients and from informal focus groups facilitated by staff with clients as participants. Service provider and client views are often fused as the staff of PEERS regard themselves as sharing a consciousness with their client population. Service providers at PEERS take great pride in the grassroots nature of their organization because there is a conscious attempt to narrow the gap between client and service provider

identities, rather than to use the role of professional helper to levy privilege and esteem vis-à-vis those they help (Baines et. al, 1992; Thobani, 2007). At times, this tendency to align closely with the target population is translated into a “gatekeeper” role, with representatives of PEERS often seeking to vet the attempts of others to access, or otherwise take an interest in, their target population.

The experiential hiring model poses a number of challenges to the organization alongside the obvious benefits of more informed and empathic service delivery and employment opportunities for persons with experience in the sex industry. Many persons hired at PEERS have little formal training in the organizational and clinical practices common to the frontline service sector, including in areas such as computer literacy, client documentation, advanced communication (which reflect the disciplines that govern health and social services), program outcomes monitoring, ethical considerations in service delivery, self care, and a range of other skills that might be deemed essential to frontline social service work. In addition, as will be described in further detail, many workers experience barriers to acquiring these skills due most often to a combination of limited education and the long-term health impact of violence and other forms of stress (Benoit et. al. 2010; Rabinovitch and Lewis, 2001). The downside is that workers report being launched into positions while lacking confidence and formal training and support opportunities, with potentially negative consequences for service delivery and the reputation of the organization within the broader community.

“I think there are difficulties sometimes around who feels they should have a right to have a say in the decision that gets made because they’ve got no experience and they feel we should do it this way, and then we’ve got new people coming in sometimes they’ve been clients, you know, sometimes I think that we aren’t always as ethical as we should be around certain things.” (R#3)

“You let them fall, you let them figure it out themselves...I did many, many times, [but] I really learned a lot...[however] if I do one thing wrong, its like “well,

[scoffs] what do you expect?" I grew in the public eye."(R#11)

"There was no training, it was basically, away you go, have fun, oversee this huge project that's funded by Heath Canada." (R#8)

The practice of hiring persons who have an experiential background, but lack experience in social service delivery is an ongoing human resource tension. There are a range of ideas present in the organization regarding the point at which former clients should be allowed to "jump the counter" (as one worker put it) from client to staff, and what kinds of performance concessions can or should be made as staff gain experience and skills on the job and combat ongoing health problems such as those related to substance use and histories of trauma:

"I'm not saying that Peers should be, like, "professional", because it is an empowerment [model], and it comes in stages and people learn at their own pace, [] but I think that their tolerance for really inappropriate and unhealthy behaviour is way too high." (R#1)

While developing the mentorship and training opportunities available to staff is a perennial goal of the organization – and an undeniably significant need in an organization that purportedly trains on- the- job – an overall lack of resources at the organization, combined with an emphasis on responding to emergent client needs, means that there are limited funds and energy left over to engage in proactive human resource development work. Thus, PEERS is a place where employees learn on- the- job and where mistakes are both made and accepted as a part of the learning process.

4.3.3 Identity Politics

PEERS' emphasis on being experiential as an identity category also contains the usual pitfalls associated with homogenizing identity politics (Davis, 2008; Hankivsky, 2009; Fraser, 2009). PEERS aims to be inclusive of the variety of experiences of people who work in the sex industry, yet dichotomizing between experiential and non-experiential persons not only lends

credence to the very stigmas that PEERS seeks to disrupt by reifying the notion that persons who work in the sex industry are a “different” category of persons, but it also eclipses important differences related to issues of race, education, cultural and political background, and health – all of which have important implications not only for identity formation, but for cultural and economic opportunity as well (Cole, 2008; Fraser, 2009; Hankivsky and Cormier, 2009). These tensions regarding which identities count is regularly evident at PEERS, not only when trying to establish the grounds for hiring practices and program knowledge production, but also in the difficulties associated with identifying the basis for solidarity and coalition-building, both within the organization and between PEERS and other organizations. Workers and clients at PEERS have varied experiences and opinions of the sex industry as well as varied social resources which have important implications for negotiation of power and advantage in the organization – i.e., Aboriginal status, education level, mental and physical health, and familial background. Management positions are typically held by persons with a bachelor or master’s level post-secondary degree, and as will be shown below, and it is arguable that there is an under-representation of Aboriginal staff in the organization given the significant over-representation of Aboriginal persons in the sex industry (Benoit and Millar, 2001). Rather than explore these sources of difference, and the identities and perspectives that may be under-represented in the organization, the primary dichotomy between being experiential and non-experiential is the most openly discussed axis of difference alongside gender, which is discussed below. In addition, as the only organization in its local social service sector to emphasize experiential knowledge while providing services to persons working in the sex industry, there is a tendency for PEERS staff see themselves as an isolated voice, even within contexts of interagency and intersectoral collaboration. This tendency to see themselves as set apart from others in the social service

community is perhaps heightened by the practice of focussing on experiential identities in group settings. While workers note that there are profound public education benefits associated with identifying as an experiential person in such contexts, it can also be a difficult experience:

“It was very, psychologically it was very difficult... I mean I really did not want to be identified in public as being experiential. So that was always very nerve-wracking.” (R#10)

“All of a sudden I became this token sex worker,... a lot of people got really [hurt by] that, including me, so we’ve had to really change the way we think about public education and who’s gonna go out and talk about their experience and who’s not.” (R#11)

Despite these challenges, which are common to groups that organize around identity politics, it is important to be clear that the emphasis on experiential knowledge as a source of epistemic privilege is a widely embraced and crucial practice at PEERS because it provides a means to effectively disrupt knowledge hierarchies, it opens a space for situated knowledge, and it is a strategy that empowers persons who might not otherwise be inclined to share or value their experience and related knowledge. Thus, many respondents spoke passionately about this characteristic of PEERS and its overall emphasis on being a grass roots model.

“[It is] actually pretty hard work to keep an organization on its grassroots focus. The drift tends to be towards professional service agency, [but] this place is about the people who come here for services and help and support and empowerment, and then become the next generation of workers, so that grassroots piece is really, really important.” (R#2)

“The fact that I have been allowed to try on so many different hats and really, really build my own capacity, in my own time, and have been given so much support and positive reinforcement from the people there, has been really, really incredible.” (R#11)

Calling attention to the experiential voice is thus a strategy that requires critical thinking and ongoing refinement, but it is also an essential aspect of the organization’s participation in social change. It is also a strategy broadly supported by the literature addressing stigma interventions (Boyd and Marcellus, 2007; Pescosolido et. al. 2008; Stuber et. al. 2008).

Another facet of the identity politics at PEERS concerns how the target population is conceived. Tensions regarding the (lack of) heterogeneity encompassed in the notion of an “experiential voice”, are mirrored in the array of opinions that can be found within the organization regarding the place of sex work and sex workers in society. Those affiliated with PEERS hold an array of opinions regarding the sex industry that resemble variations on the abolitionist, legalization, and decriminalization positions described in Chapter 2, but it is agreed that PEERS as an organization does not take a public position on these issues, and instead strives to maintain an exclusive focus on delivering services that respect, and build on, the choices of their clients, while at the same time reducing harm and building capacity (Rabinovitch and Strega, 2004). PEERS’ reluctance to take a position on certain aspects of the sex industry is both imperfectly practiced and limiting in terms of a social activist response to stigma, but has nevertheless proven essential to surviving internal conflicts and maintaining a focus on the primary goal of providing peer-based, frontline support services (Rabinovitch and Strega, 2004). Many would argue that in order to survive the tensions associated with how to perceive sex work, PEERS has predominantly taken the more “neutral” stance common to social service providers of positioning women as “victims” in the sex industry. The commonplace opinion among PEERS staff is that this is the most appropriate message they can convey about those who work in the sex industry - the message that is least likely to offend potential funders and donors, and the most likely to be met with social support (Weitzer, 2009). Not surprisingly then, while the organization strives to support all persons in the sex industry, the majority of clients are female, work in the outdoor sex industry, and are affected by a confluence of drug and alcohol use, homelessness, poor health and poverty. Thus, PEERS’ services have at times, depending on the leadership within the organization, been regarded as primarily serving persons who have

engaged in “survival sex work” (Chettiar et. al, 2010). While on the one hand it seems sensible that PEERS’ services should be utilized by those most in need of support, some members lament that the organization has not been able to develop services for women (and men) who may have more stable health and housing, and / or experience greater empowerment in the context of sex work, but would nevertheless benefit from a variety of support services (Casey, 2008). As one respondent commented:

“We need something for indoor workers, independent workers, dancers, who want to transition, but they haven’t saved any money.” (R#11)

However, respondents felt that there was little will within the community (or within the organization at times) to provide a range of services for the diverse needs of sex workers, in particular those who wished to remain in sex work. Emphasizing workers as victims was especially difficult for some respondents who felt that this was a dishonest portrayal of sex work:

“I think that if you’re an abolitionist you get a lot farther with getting funding because then you’re conforming and telling people what they’ve done wrong and this is what we’re going to do right this time around - but if you’re more liberal, I think it’s a lot harder.” (R#12)

“Well in certain funding applications, we certainly wouldn’t talk about supporting people who were in [the sex industry] because you have to get the money so, you know, in those applications we would have to fudge it to say - oh well, you know, these poor victims...that went against every grain of what I believe in.” (R#8)

“When talking about strengths and de-criminalization, lots of people are kind of angry, but when I talk about it in terms of women being victims, when I start telling these sad stories, then everyone is like “oh”, like there’s no animosity, very little. So it’s okay for me to present having been in sex work, [but] I have to come from a place of being a victim in order to get funding, and that’s huge.” (R#11)

Hand-in-hand with an emphasis on framing their clients as victims, the overriding reputation of the organization is that it encourages women to leave the sex industry, and is not therefore a suitable support service for those who, for a variety of reasons, wish to remain

involved in the sex industry. An example of this incongruence in the mission to provide for to diverse needs of persons working in the sex industry was visible in 2007, when one former and one current staff member spear-headed a plan to develop a cooperative escort service that would provide a safer working environment for women working in the sex industry, complete with health benefits and a more equitable distribution of revenue than is typically found in local escort services (Patterson, 2010). While arguably an innovative idea, one that was in keeping with much of the research literature concerning harm reduction for women in the sex industry (for example see (Abel et. al., 2009; Abel et. al. 2010; Benoit and Millar, 2001; Vanwesenbeeck, 1994), this initiative created considerable controversy among PEERS staff and board members. In the end, PEERS management and board members made the decision to publicly distance themselves from this initiative, so as to not offend current or potential funders, and to quell intra-organizational strife. Yet, it is arguable that the embedded message in this decision was that PEERS does not engage in service innovations that involve supporting women to improve health while remaining in the sex industry. This deeply-held belief that working in the sex industry is, in fact, undesirable is also evident in a relative lack of representation from those currently working in sex work among the experiential persons who are involved with the organization.

Thus, following the context set by funding and an internalized perception that the community at large is supportive of helping “victims” of the sex industry, the dominant messages that PEERS has conveyed about sex work and sex workers – that it is female problem, that it is undesirable, and that those involved are victims – while they are based in empathy, are nevertheless complicit with many of the common stereotypes about the sex industry; however, this should not be viewed as an example of poor support for the heterogeneity of experiences had by sex workers among individuals at PEERS, but rather an example of the powerful effect that

structuralized stigmas have on silencing, or co-opting alternative viewpoints, even within organizations that explicitly aim to disrupt them (Pescosolido, 2008; Stuber, 2008; Link and Phelan, 2006).

4.3.4 Gender

Gender, in particular female-dominance, is another characteristic that defines PEERS, one that I have chosen to address separately, but which contains much overlap with the previous discussion. With the exception of a one-year program offered for men in the sex industry and fleeting outreach to sites where males are known to work, throughout their history, PEERS has not demonstrated the ability to consistently serve men and transgender persons. (Rabinovitch and Lewis, 2001). A common view at the organization is that, apart from providing services to the occasional male client who requests service, PEERS does not have the resources - in particular the expertise - to develop programs for males in the sex industry, mostly because males present different support needs. In addition, the organizational will to pursue such expertise has, for the most part, been minimal. Further, as a recent response to the perception that males – in particular, the boyfriends and acquaintances of clients - pose a threat to client safety, PEERS recently became a “women only” environment with males only permitted to access the site on a special appointment basis.

On the one hand, the female-dominated nature of PEERS echoes the female-dominated nature of the sex industry where estimates generally suggest that over two-thirds of persons working in the sex industry locally are female (Benoit and Millar, 2001); on the other hand, the female-dominated nature of PEERS reflects the gendered nature of the prostitute stigma, which has historically highlighted socially unsanctioned female sexual behaviour as more problematic

and worthy of intervention than male sexuality (Hallgrimsdottir et. al. 2008). At the same time that it is a reflection of broader social views of female sexuality as constituting the “prostitution problem”, the female- dominated nature of PEERS also reflects, as noted earlier, the overall pattern of female dominance in the frontline service sector (Benoit and Hallgrimsdottir, 2010). In this regard as well, the lack of programming for males at PEERS is not only a reflection of a broader social view, but may also be due to the lack of male involvement in employment and governance at PEERS.

Other women-only service environments have been developed for vulnerable populations of women in an effort to enact specifically women-centred service delivery practices, and to overcome the subordination of women’s service needs to male norms (Benoit et. al. 2003). Such environments – including women’s shelters, women’s health clinics, and women’s substance treatment centres - offer multiple advantages, including greater potential for gender sensitive service (such as increased comfort and open communication in the service context) and employment practices (such as accommodation of work-life harmonization), but they are also associated with particular types of organizational conflict, including, as noted earlier, conflict arising from unacknowledged power imbalances (Warren et. al. 2002; Weigt and Soloman, 2008). These intersections are explored in more detail below in relation to organizational conflict and experiences of courtesy stigma.

4.3.5 Conflict and Turnover

Interpersonal conflict is also common at PEERS and likely a significant contributor to employee stress and turnover. In fact, between the beginning of the first and second wave of data collection - in 2006 and 2009 respectively - there was a 100% turnover in frontline and

executive management staff⁹. High staff turnover is a well-known feature of the non-profit human service sector, presumably due to fluctuations in program funding, the demands of the work, and the limited resources made available to care providers to offset workplace stressors (Saunders, 2004; Hallgrimsdottir et. al., this volume). Apart from the general demands and strains associated with the under-resourced non-profit sector, there are a number of additional factors that likely contribute to staff turnover at PEERS. First, as a training ground for persons who may have recently left sex industry work, it is likely that many PEERS staff move between positions within the organization, or in many cases, similar employment in other organizations in accordance with expanding skills and experiences. Interpersonal conflict undoubtedly also plays a significant role as workers often described PEERS as an environment where, despite the emphasis on inclusive decision-making, cliques were formed, gossip was rampant, and trust was often low:

“The only way you could get your own way was by to bully people or to get teams against each other, so it became like a war.” (R#11)

“You never knew, like, who your friends were, like you never knew.” (R#1)

“Let’s face it, every workplace has its own hierarchy, and if it’s not imposed by the workplace, it’s figured out amongst the people that are there.” (R#10)

Interpersonal conflict at PEERS is also likely shaped by the array of experiences, including violence, trauma, and resource deprivation, that have shaped the health of the individuals who work at PEERS (Benoit et. al. 2010). While workers at PEERS associate many benefits with their women-centred work environment, they also cite it as factor contributing to organizational conflict, not only because gender scripts likely have a hand in shaping interpersonal conflict, but also because the organization is largely populated by women who have experienced many forms of structural disadvantage in their lives. Drawing on the notion of

⁹ One individual who works in finance administration remained during this period.

lateral oppression – the idea that one manifestation of internalized oppression is the enactment of harms against other oppressed persons - workplace conflict is heightened in care work organizations serving stigmatized populations as workers and clients seek to manage and overcome the various forms of devaluation and resource deprivation they have experienced in their lives (Bishop, 2002). When considering her own emotional responses to the work, in particular when presenting her work to others in the community, one respondent noted:

“I feel defensive and then I become angry and then when I try to deliver something it comes from a place of anger... I think anyone [who] wants to do this kind of work has to be able to have a real deep understanding of conflict analysis.” (R#11)

Indeed, workers at PEERS often note that while their own gendered experiences of marginalization – including violence, addiction, poverty, single parenthood, limited formal employment and sex work –are, on the one hand, resources in their service practice, on the other hand, these same experiences may be implicated in poor work place health, including reduced capacity to effectively cope with the stresses associated with the work and co-worker relationships.

“I think it’s people with unresolved issues that are, you know, maybe not having the time away to become more healthy. And by healthy I mean emotional health, physical health, mental health, spiritual health, like all of those components, you really need to be able to take this kind of work on and not let it drive you crazy or [] push your way to the top, or put down other people to make you feel better - that’s common.” (R#8)

However, it should also be noted here that co-workers were described as a significant source of workplace support, suggesting that the unstable nature of relations among co-workers at PEERS contained both highs and lows. As will be explored in more detail below, it is also likely that courtesy stigma plays a part in staff turnover as workers leave to seek less controversial forms of work, for which there is greater widespread social support.

4.3.6 Organizational Change / Temporal Patterns

Finally, PEERS is also often described as a chaotic, unpredictable, ever-evolving organization, both by staff and by those who come into contact with the organization:

“Everybody there was most comfortable with drama and chaos... if you wanted order and serenity like that would just be a terrible fit.”(R#2)

“PEERS as an entity is extremely chaotic. It’s not like any other organization I’ve ever worked at because it always seems to move and change with the funding. It’s never just like, “o please have a seat and somebody will be right with you”.” (R#8)

Upon entering PEERS, it is immediately evident that this is not an environment where the traditional characteristics of office orderliness and ergonomics apply. The reception area is busy with notices, pamphlets and art pieces, including tribute pieces to clients who have passed away. The reception area is adjoined by a small kitchen and common area which are constantly accessed by staff, program participants and visitors for coffee and tea. Each day, volunteers and staff prepare daily hot lunches, which are consumed by staff and participants in the common reception area. A recent renovation initiative will enclose some of the kitchen area from the general reception and communal area in order to increase food safety practices by reducing open access to the kitchen.

The main floor also has two rooms which are used for program purposes, and behind the reception area, there are two offices which, while I was observing the organization, were typically used by frontline staff from the outreach and employment programs. These offices, in particular the outreach office, are often crowded with a miscellany of donations such as clothing, small household items personal hygiene products and outreach supplies.

Most worksites can be divided into front and back stages, especially if the work site is accessed by the public (Adler and Adler, 2004). PEERS is no different in this regard as the upstairs of the building contains a number of staff offices which are not immediately accessible

to clients. The upstairs at PEERS is regarded as a place where staff can seek reprieve from the unrelenting cycle of client interaction and interruptions that occur in the frontline service space located downstairs.

The furniture and computer equipment at PEERS are well-used, possibly a reflection of the inconsistent availability of administration and overhead funds. The shelves, nooks and crannies are often piled with a miscellany of donations, art and office supplies, computer equipment, and literature, all awaiting semi-annual spring clean-up.

Clients and staff mingle at full volume in the reception area and on the smoking patio at the entrance to the building – sometimes seemingly indifferent to the confidentiality practices that govern social services – talking about their day, upcoming plans in the programs, and other light conversation. Client and staff interaction is sometimes a contradictory mix of collegial and authoritative, reflecting the unique relations emerging from PEERS' status as a peer oriented social service site. The downstairs area is a busy and evolving space with the coming and going of program participants, most of whom are seemingly happy and comfortable in this environment. Yet, it is not uncommon to approach PEERS and encounter program participants in emotional distress from a traumatic event related to violence or substance use, or to see clients sleeping on the couch in the reception area, worn down by the combination of substance use, sleeplessness, and a lack of nutrition. One respondent recalled such a moment where a client had come to PEERS to seek help immediately following a traumatic event:

“I didn’t see her get dropped off [by the police], but all of a sudden she was outside on the patio and she was in very, very rough shape and crying, and you know.”
(R#1)

I often witnessed the emergent – or as staff refer to it, “chaotic” - nature of client needs at the organization while I was job-shadowing workers. Client appointments were often not kept,

walk-in appointments were common, and informal triage practices meant that workers might experience multiple changes in their plans over the course of the work day. While conducting the participant observation, my plans to meet with staff for job-shadowing were frequently shifted in one way or another by presenting circumstances. For example, while attending the employment program one day, I was asked to facilitate a focus group because the scheduled facilitator was attending to a client who had phoned the office expressing suicidal ideation at precisely the time the class was supposed to start. At other times, changes in program participation or scheduling – fewer or more participants than expected – simply meant that staff would amend their plans for the day.

Importantly, while evolving scheduling and triage practices at PEERS are, at times, a source of stress for PEERS staff, they are largely embraced by staff as evidence of the client-centeredness of the organization, with this characteristic of PEERS regarded as a reflection of the turmoil and instability experienced by their service population.

“It’s just constant because the women are in crisis...and you have to be able to switch hats, you know, somebody could come in and maybe they’ve lost somebody, you know, that somebody has just died [] and you’re helping them through that and then the next person that comes in is[] their dope sick and just pissed-off, so you have to be able to switch hats real fast, you know.” (R#5)

Delving further into a description of the work and service environment, the next section provides further information about the specific programs and service modalities offered by the core programs at PEERS.

4.3.7 Detailed Core Program Descriptions

PEERS runs two core programs at present: Outreach and Bridging Employment (formerly Elements). During the course of the ethnography, a number of time-limited projects

came to a close. These projects involved researching the service needs of women working in the indoor sex industry and providing supports to mothers affected by child protection services and / or Fetal Alcohol Spectrum Disorder. Program closures are common at PEERS as most program initiatives are supported by time-limited funding lasting one to three years, however, in various forms PEERS has been able to maintain fairly consistent, short- term funding for programs aimed at mothers affected by substance use and / or child-welfare monitoring.

Two programs are described in detail below as they represent what PEERS has come to regard as their service core: Outreach and Bridging Employment. The broad objectives of the outreach program are to provide one-to-one support, facilitate referrals to PEERS programs and other community services, provide basic comforts such as food and clothing, and reduce harm by increasing access to safer sex and drug use supplies (Rabinovitch and Lewis, 2001).

The outreach program consists of two services: Day Outreach and Night Outreach. It is noteworthy that the outreach team commonly employs persons who have completed PEERS services and who have few formal credentials. In this regard, the Outreach Program most clearly exhibits the hallmarks of peer-based service delivery. One of the current staff of the outreach program described how she was introduced to PEERS outreach while working on the stroll. She had never accessed the van because she feared that she might miss a client if she did, but one evening, the outreach workers locked the van and walked up and down the streets introducing themselves to workers and giving out Christmas care packages. She was taken by this gesture as it had been some time since she had received a Christmas gift, and her subsequent story of program involvement and later employment with the organization is an exemplar of the mentorship model PEERS strives to achieve.

The Day Outreach program is a service focussing on providing one-to-one appointments

in the community. A single staff member uses a mini-van to pick up clients for health appointments, court dates, groceries and other appointments where accompaniment by a support person and/or vehicle transportation will facilitate access to a required resource or appointment. The day outreach staff also pick up food for program participants and pick up donations of household items and clothing from various sources in the region. In addition, clients are helped to locate and view rental housing, and referrals are made (and facilitated) to various services in the community. During my time job-shadowing day outreach staff, I noted that the pace of work was frenetic, with a single staff member juggling a wide variety of support tasks and appointments, cell phone calls and driving trips. This program is very much community-based, with most of the work conducted from a mini-van.

While conducting participant observation of this program, tasks ranged from meeting a client at the courthouse for a social visit and picking up donations, to driving clients from their homes – or current location – to various appointments and the food bank. Day outreach was, in my observation, accessed by a range of clients, some of whom had stable living conditions (i.e., had recently stopped using substances and had permanent rental housing or were staying with family), and some of whom did not (typically women living in shelters whose daily schedule was driven by their dependency on substances and need to secure the most basic resources of food and shelter). Day outreach activities are scheduled via a cell phone which seemed to ring every few minutes while I was job shadowing. Clients often expressed gratitude for day outreach services as the main agenda of the program is simply to provide social contact and help clients access the community and various services as desired – it is very client-centred in this regard. This program maintains simple documentation focusing on the number of clients served and types of support services delivered each day.

The Night Outreach program is run out of a recreational vehicle (RV) that parks in two known locations throughout the course of the night, both bordering downtown in the vicinity of industrial commercial space where women working in the sex industry typically stand outdoors to attract clients. The night outreach van is run by two workers who provide information, food, clothing, and harm reduction supplies between 7pm and 11pm every night (the hours of service vary as funding permits). On occasion, comforts such as hygiene and beauty supplies, cold weather clothing, and cigarettes are given out. When donations and funding permit, the night outreach staff can provide fruit and other hot meals such as soups and stews, grilled cheese sandwiches, and pasta. Interactions are typically short with clients listing the “lunch” items they would like from the usual list of sandwiches, pudding, juice, coffee or hot chocolate. The outreach van is one of the only (or the only) services in town to offer meals to women working on the street who, for various reasons, may not have accessed the free food services provided in the downtown core during the daytime. Harm reduction supplies such as syringes, condoms, and related items are handed out upon request and a brief, friendly exchange between staff and clients usually occurs. Some clients quietly approach the van, make little eye contact, and show little interest in communicating beyond what is necessary to get the supplies needed, while others who are very accustomed to the outreach service and staff, approach with confidence and interact openly, commenting on the food available, clothes, and more generally on their work, health and other aspects of their lives.

The night outreach van fills a crucial service niche as it is the only support presence in the immediate vicinity of the Victoria sex work stroll, and is also an important symbol of support in an area which is otherwise without any formal safeguards to health and safety, and where women working in the sex industry are most vulnerable to violence (Benoit and Miller, 2001;

Bungay, et. al., 2010; Lowman, 1989). In addition to providing comforts to those working on the outdoor stroll, the other objective of the Night Outreach Program is to act as a monitoring program. Program documentation focuses on supplies given out, but the staff also keep notes about who accesses the van in case a client is reported missing, as PEERS' program documentation can be helpful to police investigation. Importantly, outreach staff collect and disseminate bad date reports and information regarding safety concerns to women working on the outdoor stroll to other service providers, and to members of Special Victims Unit of the Victoria Police Department. Another key function of the outreach van is to inform clients of street nurse services and other services offered by, or in partnership with, PEERS. In this regard, the Night Outreach program is a first point of contact for many of the clients of PEERS, and is an important conduit to a range of other community-based services.

The outreach staff at PEERS face a number of physical and mental occupational risks because of the community-based nature of their work and the vulnerability of many of those they serve. The PEERS outreach team – and to a lesser extent, the PEERS staff in general – are in close proximity to illicit activities, contagious disease, and clients whose lives are often marked by violence and poor physical and mental health. While the vast majority of night outreach shifts proceed without incident, it is also not uncommon to experience exposure to hazardous materials (in particular, pricks from contaminated needles), or to witness acts of violence, directed at both outreach staff and / or outreach clients.

One evening while visiting the outreach staff, I learned that they had been pulled over moments before and searched by police officers unfamiliar with the PEERS outreach vehicle and its purpose. While it is unclear why the police chose to pull them over (beyond the fact that they were in a vehicle on the stroll), asked them to exit the vehicle in a forceful manner, and

subsequently ran their license plate and personal ID through their database, it was clear that this was a highly stressful experience for the staff members working that night, not least because they were unsure if they would be arrested – a fear that is common to persons who have a history of arrest(s) and a related criminal record. While barely having had time to calm down after the incident with the police, a client, who had just been physically assaulted, entered the van with a laceration on her head after being hit repeatedly by a male acquaintance, apparently because of conflict over a drug debt. Outreach staff gave her new clothing, food, allowed her to use the phone and checked her laceration. The client was encouraged to go to the hospital, but refused saying that she needed to work, and was not interested in the poor treatment she felt she would receive in the emergency department of the hospital. After the client left, the outreach staff conveyed how this experience was stressful because of the nature of the violence the woman had experienced and her refusal to seek treatment, but also because the client, and the person who assaulted her, were well-known to the staff. One staff member noted that she had been friends with this client when she was “on the street”, that it made her feel bad to put latex gloves on (a universal precaution against blood borne pathogens and infection) to examine her friend’s laceration, and the anger she felt about this unacceptable, though commonplace, incident of violence. This story exemplified both that stress and safety are significant and regular concerns for outreach staff, but also that workplace stress intersects with the personal background of workers who were once in a similar position to those they serve. It also exemplified how primary and courtesy stigmas become intertwined via care giving roles (Corrigan and Miller, 2004)

The second core program at PEERS is an employment readiness program funded by the provincial government. Although it has undergone name changes (now called “Bridging”, but

formerly called “Elements” and “Rise”) as a result of changes in government contracts, Bridging is a program aimed at providing women working in the sex industry the skills necessary to transition to mainstream employment and/or education. This program has been a staple of PEERS programming since its inception, reflecting widespread agreement that training for work in the formal economy is one of the core service needs of PEERS’ target population. This contract is reformed by the government from time to time – including changes to the funding, curriculum, program logic and reporting requirements– and is therefore one of the more “top-down” programs delivered by PEERS. Service deliverables and outcomes are specified by the funding body and linked to funding instalments, with relatively little room for PEERS to adjust curriculum and program requirements. Staff positions in this program are not entry level and are often held by persons who have post secondary credentials or considerable experience in the field of social service delivery. Topics covered in the program include “exiting” sex work, substance use, computer skills, employment planning, emotional health, relationships, and other topics which are deemed to be barriers to participating in actual employment programs (hence the name “Bridging”). This pre-employment program is characterized by an ongoing need for PEERS staff to negotiate the pressures of contract requirements and the capacity of potential program participants. As one respondent commented, “*we run an employment program for the unemployable*” (R#11). While this comment reflects the dark humour that is common in stressful work environments, it also contains a modicum of truth as the pre-employment program at PEERS is often populated by highly marginalized women who struggle to meet the requirements of the program, and most of whom will not find work in the formal economy or become enrolled in education at the end of the program – the two of outcomes which warrant a final payment from the government. Based on my observations of the program, many

participants, if not most, could be described as middle aged. In addition, many had unmet dental and health care needs, chronic health issues, were in unstable housing, were actively using substances (or were in “early recovery”), and had not been employed in the formal economy for many years. Thus, the barriers to successful outcomes in this six month program are steep and the prescribed outcomes are achieved by only a small minority of participants. PEERS staff would like to enrol clients in this program as many times as participants are willing to participate to provide them more time to address enduring health and wellness concerns, but the government contract has narrow eligibility parameters that must be considered.

Outcomes- based funding in the Bridging Employment Program poses the problem for staff that they must vet interested participants based on the likelihood they can maintain participation and the outcome requirements associated with instalment-based funding. As many of the costs of the program are upfront, if too many clients who fail to complete the program are admitted, there is the potential that the organization will experience a net loss, a situation which recently occurred following the most recent round of contract revisions (PEERS Board of Directors Meeting Minutes, January 2010). In addition, as noted above, eligibility requirements stipulate that participants cannot repeat the program and must meet certain attendance requirements along the way – which in practice means that participants who are unlikely to complete the program and/or have poor attendance are withdrawn so they remain eligible to attend at a later date. In addition, participants must be enrolled in an income assistance program, which poses a secondary set of eligibility requirements. This program is closely monitored by the funding body with representatives of the funding body and PEERS staff working closely for ongoing reporting purposes.

The Bridging Employment Program is rich example of the neoliberal trend to offload the

responsibility and costs of care of vulnerable populations to the non-profit and private sectors. Government contracts of this sort - which non-profit organizations like PEERS are compelled to accept due to a combination of an insecure resource base and high client demand – create an untenable and highly stressful situation for program staff because they are financially and theoretically insufficient responses to complex support needs of the clientele PEERS serves. By contracting this work out to the non-profit and private sectors, the costs associated with the inevitable shortfall of such programs are borne by program participants and frontline service workers, while the public remains largely unaware of the broader societal costs.

In sum, the programs offered by PEERS, and the funding patterns that support these programs, reveal much about how stigmas are structurally embedded in health and social welfare service delivery opportunities and practices. While PEERS strives to offer programs that are inclusive of the experiences of women (and, at times, men) in the sex industry, the funding they have secured is limited to certain types of interventions which are congruent with views that working in the sex industry is a form of deviance, a health risk and a source of victimization to women that are already damaged. While staff at PEERS stretch these messages to better fit with their emphasis on empowerment, the absence of staff and volunteers who are openly and actively working in the sex industry, or programs supporting the safety of women and men working in off-street environments is telling

Revealing the relationship between symbolic and material stigma processes, a cycle of stigma reinforcement is created when persons working in the sex industry are depicted as victims in funding requests, service interventions based on these identities are secured, and service statistics and experiences further validate and emphasize the salience of these ideas, which generally depict women working in the sex industry as “multiple-barriered” (e.g., experiencing

homelessness, poor health, substance misuse), and victims of the sex industry. At the same time, while they are a valuable resource, the service interventions for which PEERS is able to secure funding, while they are aimed at this more vulnerable subgroup of women in the sex industry, are an inadequate response to the upstream or structural barriers to health that they face. PEERS staff must attempt to bridge these conceptual and financial incongruencies in their day to day practice which gives rise to a number of workplace strains and related human resource pressures.

In summary, this chapter focused on outlining the work environment and describing the workforce at PEERS. In doing so, it is evident that the structural forces of stigma can be seen in the limited funding and intervention modalities that workers at PEERS can draw on to perform their work of supporting sex workers, in particular highly-vulnerable sex workers who are also likely to be homeless or in poor housing, working in the outdoor sex industry, and suffering from complex health and support needs. In addition to struggling for ongoing funding and not being able to offer programming to meet the diverse needs of their target population, PEERS staff also experience stressors related to the inability to locate supports for their clients that would (most notably addictions and mental health treatment and housing) within the broader community because the resource deprivation they face in offering their services extends throughout the broader continuum of services available to vulnerable and stigmatized groups. Collectively, the workforce at PEERS also exhibit signs of vulnerability, with the majority of workers being single, existing on a limited income, and for a subset of workers, having a limited education. While service-providers at PEERS experience notable benefits from their work environments, including a high degree of decision latitude and job satisfaction, they also describe their work environment as stressful. Together, these characteristics suggest that workers at PEERS may be vulnerable to occupational strain (Karasek and Theorell, 1990). In the next chapter, individual

contexts of courtesy stigma are examined along with additional indicators of occupational health.

Chapter 5: Interpersonal and Community Contexts of Courtesy Stigma and Health Outcomes

The preceding chapter described how primary stigma and courtesy stigma intersect at the structural level. Prejudices against PEERS' client population combine with the forces of neoliberalization to determine the manner of funding available to organizations such as PEERS. Funding resources are in turn pivotal to establishing the types of demands, rewards, and strains associated with the work setting; workers describe inadequate resources to support human resource needs, program development, as well as a sector-wide lack of allied resources to refer clients to for complementary support. These findings can be viewed through the lens of structural courtesy stigma because the absence and erosion of good working conditions can be traced back to the content of the primary stigma surrounding the client group. As discussed in the literature, given the strains associated with the work, it is not surprising that this work is often performed by women with limited employment opportunities and histories of marginalization (Benoit and Hallgrimsdottir, In press). Thus, it is not surprising that the emotional and clinical resources of PEERS' staff are taxed by their responsibility to help their clients navigate seemingly insoluble support issues. One respondent summed up the experience this way:

“We have to work really hard here, a lot harder in this environment to get help for the clients or to move issues forward. We have to work way harder than other agencies or other causes do and...some days I will go home from work thinking did I get anything accomplished today?” (R#6)

Bearing in mind these contextual issues, the following sections provide a closer look at how courtesy stigma is experienced by individuals, including in their day-to-day work activities, and at the intersection of their work and private lives. Following a description of perceived and

enacted stigma among service providers at PEERS, indicators of health are presented alongside respondents' views of workplace health. The chapter concludes with a consideration of how PEERS is perceived by the wider social service community.

5.1 Contexts of Courtesy Stigma at the Individual Level

Respondents noted a variety of contexts in which they experienced perceived and enacted courtesy stigma, both at work and at home. In the private sphere, while most respondents noted that their friends and families understood the importance of the work, in some cases, they were not comfortable having an open discussion about it. Illustrating Goffman's (1963) assertion that stigma spreads out in waves of diminishing intensity, other workers described how working at PEERS was a source of shame, not necessarily for themselves, but for their family members:

"I have children and they know where I work and they know who I work with and they know what I do, but they don't want their friends to know where I work and who I work with." (R#1)

"You know, my mother has had to struggle with it too...I think my mother sometimes feels the stigma from me being in this line of work."(R#12)

"A couple of my [family members] are just horrified [that I work at PEERS]." (R#11)

"My family doesn't discuss [it]. I spent ten years as an activist [in regards to the sex industry], we don't discuss it." (R#8)

Other workers felt that their children were supportive of their work to the extent that it was aimed at helping others:

"I think [my son] accepts that I find being in a work setting that helps people live better lives is important to me." (R#10)

For those who had a background in the sex industry, working at PEERS went hand in hand with the difficult experience of disclosing to their children their own history.

“I told her when she was [age]. That was really, really hard ... it went really [] well, and, and she’s really proud of me, and I’m really proud of her, but you know, like she’s been really good about it.” (R#12)

Not being able to openly talk with family and friends about work because of disapproval or because you do not want to burden others with the impact of the stigma that surrounds the work, often lead to a sense of isolation with regards to work. As one volunteer worker described, friends did not want to talk about her work because she believed it challenged their lack of action towards helping vulnerable members of the community:

“Although my friends were very supportive of my involvement at PEERS, it seemed difficult for them to express interest in what I was doing there without needing to justify their own interests and busy schedules. Since guilt was never my intention, I seldom said anything to anyone unless they asked, so at times it felt like a lonely venture.”(Volunteer #1)

These findings echo that of Snyder et. al. (1999) who found the subtle and overt forms of disapproval from family and friends were implicated in high turnover rates as volunteers were more inclined to keep positions that were openly supported within their social network and did not pose costs to extended family.

Shifting from the family to the work environment, respondents described both perceived and enacted stigma when representing the organization in public education forums, when accompanying clients to appointments, and when speaking to others about their work. Enacted stigma was most often experienced when interacting with other professionals, leading to a heightened sense of vigilance when representing PEERS or accompanying PEERS clients into the community:

“The staff take on heavier burdens [here] like [name of staff] has other things to do today. The last thing [name of staff] needs to be doing today is sitting there in emergency all day to make sure that this [client] gets proper treatment, but that’s what she has to do, right.” (R#2)

“I’ve witnessed it with nurses, I’ve witnessed it with the front desk staff, I haven’t

always been treated with the sort of dignity that one would expect, and at the welfare counter, I was actually [] admonished in front of one of my clients while waiting for a worker, which I really didn't appreciate.” (R#3)

“The hospital is one of the worst places []. I know that firsthand. I went to visit a client [] and the nurse, I took her name, the time, the way she spoke to me, [because] I was disgusted.” (R#9)

At the same time that they noted that they had to work hard to help their clients access community resources due to the stigma surrounding sex work, workers also noted that venturing into the community as a representative of PEERS might mean that they too would be personally subjected to discrimination, especially if a question about their personal involvement in the sex industry was raised. One worker described her encounter with another social service worker and the information management strategy she used during the exchange:

“I saw the look on her (social worker's) face and I knew that if I gave her the 'yes' answer she would see me as less than professional, so I gave her a, “not everybody at PEERS has to [have a history] in the sex trade,” which is actually true. So I avoided answering her question.”(R#3)

Several respondents commented that anyone associated with PEERS could be subjected to assumptions about background and identity:

“Even identifying that I work at PEERS, right, has you know [implications]. Depending upon how much the population knows about PEERS already they will have formed an idea in their head of who I am and what my background is.” (R#9)

“I think a lot of people suspect I have a sex work background now, secretly have a sex work background.” (R#2)

Other respondents commented about how introducing themselves as a representative of PEERS, or in the case of the respondent below, as someone who had formerly worked at PEERS, was often met with a unusual silence:

“We went and did a presentation, and they wanted a little background on who we were and stuff, and I said where else I've worked, and I said I've worked at PEERS, which is an organization that works with sex workers, and my coworkers commented to me afterwards on the dead silence that hit the room when I said

[that].” (R#1)

As predicted by the literature, stories of enacted stigma were less common than descriptions of perceived stigma (Cree et al., 2004; Crocker and Quinn, 2000; Norvitis et al. 2002; Scambler, 2009). A pervasive theme among respondents was a general sense of not being an equal part of the service community, or a sense of being looked down upon:

“I just felt lots of times like [] we were looked down upon, like we were part of the problem, not part of the solution.” (R#1)

“Off the record, people don’t want to sit at the same table as sex workers... nobody really says anything completely to my face... you get body language messages or maybe indirect messages of no, we won’t do that, or no, I won’t be on your advisory board.” (R#12)

Perceiving that they were looked down upon, respondents often experienced stress when speaking about their work, and had little hope that the knowledge they brought to the table would be taken seriously:

“I’ve become very used to it now after all of these times.. someone has invited you so [] whoever invited you to speak is interested, right, but the rest of the room, half of them right away, they are not interested, in fact they are actively not interested... it’s been tricky to figure out how do you speak to that room.”(R#2)

“The experiential [voice] never really seems to get included, and if they do, it’s a token inclusion.” (R#11)

This experience led to defensiveness and anger for some respondents. Speaking about an incident that occurred while interacting with another social service professional one respondent commented:

“It was like it was very belittling and I didn’t actually engage because my language would have been too colorful (laugh). I just sort of backed off.” (R#3)

Another commented about how occasions when PEERS staff have been defensive have contributed to a broader reputation in the service community:

“We always have been known for being really confrontational, and even now still, you know, defiant, defensive and confrontational.” (R#11)

Others lamented that some of their co-worker’s reactions to primary and courtesy stigma, did little to raise the reputation and profile of PEERS:

“[We need to] be able to promote PEERS properly, instead of having people maybe sending mixed messages who mean well, but go out and do a talk and end up making PEERS look ridiculous. You know, we’ve had staff yelling at professionals [laughter] in meetings.” (R#8)

“I really think that a lot of us, because we come from places where we really haven’t had a voice, we haven’t had a lot of time to really learn assertive[ness] skills - and I mean I’m talking tough situations where you have to confront somebody that you feel is of power.” (R#12)

When addressing groups outside of PEERS, many staff told their personal stories of involvement in the sex industry because these would usually be met with interest, and were regarded as an effective way to confront the hegemony of expert knowledge . However, this strategy was also associated with stress because it made opened up the possibility of discrimination:

“What I often did was [] tell my story, and I think it opened up a bridge to conversation, but I also think it may have closed a door at the same time. Every time I do it [tell my story] I feel it takes a piece of me away - it’s, it’s a horrendous thing to do, and I won’t be able to do it forever.” (R#12)

“I remember giving a presentation at [name of place], and a couple of people were rolling their eyes...you know, they just roll their eyes like, oh God, you know, here we go again. They don’t want to hear it, and because it was part of my life, it was a double stigma... not only was it the organization, and the people [that are a part of it that was being rejected], but it was also me, right. So it was like[] taking away my experience in favour of what they wanted to believe to be the truth.” (R#8)

As noted earlier, respondents felt pressure to frame their work in particular ways to potential funders to increase the likelihood that their funding requests will be successful. This strategy of impression management also occurs when presenting the work of PEERS to the

community. In fact, respondents noted that they constructed and reconstructed their story in response to the perceived reaction of the audience using the knowledge they acquired over time about how others react to PEERS and ideas about sex work (Rabinovitch and Lewis, 2001),

Part of the difficulty associated with presenting their work to the public was that public response to their work could include varying, unpredictable views, which could be valourizing, belittling, openly disdainful, or voyeuristic, leading to reluctance to talk about work with others, and a tendency to develop strategic constructions of their work. One respondent who also described great pride and satisfaction in her work relayed a surprising experience where she felt hesitation to speak about her work in a public setting:

“I was in a store with my husband, [I] think it was an electronics’ store, and we were buying something and the guy said to me, “where do you work?”, and I said, “PEERS,” and he said “ what is that?”, and there was a lot of people at the counter and it was the first time that I stopped myself before right out saying prostitute, you know, and I could feel my face flushing bright red and I don’t know why that was...And it was quite embarrassing, it was really embarrassing.”(R#5)

Nevertheless, although respondents easily described the misunderstanding and prejudices surrounding the sex industry and PEERS in the community, they also noted that, while highly conditional, there was a great deal of community support for the agency, a finding which was confirmed by the environmental scan discussed at the end of this chapter.

5.2 Variations in Experiences of Courtesy Stigma

There was some variation in the degree to which workers believed that they were impacted by courtesy stigma. Intersectional theory tells us that the ones positioning within various axes of social status, in particular ones exposure to multiple vulnerabilities, may leave some workers more vulnerable to courtesy stigma than others (Cole, 2008; Dolan and Thien, 2008; Hankivsky et. al. 2009). Given the small sample of persons who completed the surveys in

this dissertation project, it is not possible to examine this variation statistically; however, the interviews and participant observation revealed three primary causes of variation in courtesy stigma: education, experience in the job, and co-occurring stigmas.

Perhaps most striking was that workers who held formal educational credentials used their training to establish professional authority when faced with courtesy stigma. At the same time these workers were more likely to notice and articulate their observations of primary and courtesy stigma (possibly due to training in social inequality), they were also in the best position to advance counter-narratives regarding others' ignorance and misunderstanding. One worker described how her professional education offset the stigma she might otherwise experience as someone with a history in the sex industry.

“But again unfortunately because I have letters after my name, there is a little more respect and that’s sad because sometimes I feel that I have to use that.” (R#8)

Another respondent described how it was necessary to present as educated when speaking to others in the community in order to be heard:

“The language you use [is important]. If you speak like you may have been university educated, you get results, otherwise you don’t.” (R#11)

Another worker, who did not have a background in the sex industry, similarly felt that she used her credentials to distance herself from the assumption that she had been a sex worker. However, doing so felt like a betrayal to those she served as it revealed her own reluctance to bear the prostitution stigma. This example of impression management supports available literature which argues that workers use professionalization – including attempts to distinguish themselves from those served - as a strategy to distance themselves from the stigmas associated with their clientele (Baines et. al. 1998).

“People are really open when I speak to them on a professional level they... just don’t know how to react to that personal piece.” (R#5)

Transitioning from a client to an employee – which at PEERS often means limited formal education and are new to social service work – was also associated with less confidence in addressing stigmas:

“I find that I’m not really taken seriously because of the way that I’ve come from being a client and moved up like that like I sometimes feel like I don’t know if I’m imagining it.” (R#1)

When speaking with this same individual later, and after reminding her of her earlier comment, she described how she had acquired greater confidence at work over time and now had greater confidence when dealing with the discrimination surrounding the sex industry:

“The more I talk about it the less emotional attachment there is to it so in a sense it’s been very healing for me.” (R#1)

Regardless of credentials and experience, workers whose lives were marked by co-occurring stigmas – which in this project were most likely to be due to personal history in the sex industry and/or problem substance use – often demonstrated more emotion in reaction to the stigma surrounding their work, and their role as representatives of PEERS, suggesting that being located at the intersection of more than one stigma may be a source of vulnerability in a work environment such as PEERS. In particular, the negative viewpoints confronted in the course of might not only have personal implications, but also intersect with other existing stressors such as the process of recovery from substance addiction, an existing health condition, financial, or other stressors: One respondent, who also described how the various stresses associated with working at PEERS challenged her recovery from substance addiction, commented that:

“The perception [that] ‘oh so you’re saving those victims.’ ...it stigmatizes me because then I feel like I’m being put into the same category.” (R#8)

In the case of persons who did not have a background similar to the PEERS clientele, it was easier to regard the stigmas surrounding PEERS – at least at the micro-behavioural level - as

an external injustice:

“Now for me it is a bit different because I came from a position of [advantage] and I carry the benefits of that [] into this job... so it doesn’t affect me personally... well I can’t say that, I mean there have been some people don’t act the same way around me...who don’t phone me [since taking the job at PEERS].” (R#2)

It is therefore not surprising, that when leaving PEERS, workers articulated a desire for less controversial and more anonymous forms of work with fewer political and identity implications. These sentiments could be described as a desire to move away from the “master status” associated with either having been in the sex industry or being employed in an organization focused on the sex industry.

“It’s nice to have work that I can talk about. [] Part of what I wanted was to sort of square up, right. I have the skills now, I could work anywhere. Let’s go see who I am when I’m not connected to this issue.” (R#10)

“Being in that line of work where it’s always that focus, always that focus [on sex work]... when do you ever get away from it.” (R#11)

“For somebody like me who comes from the world and who had a chronic drug addiction, to have that in my face over and over and over. For me it was like reliving my past over and over and over, and I’m trying to move in a new direction now.” (R#8)

These findings support the need to adopt an intersectional approach when examining the variable impact of stigma on individuals. The preliminary findings here suggest that education, co-occurring stigmas, and experience moderate the effects of stigma, but it is likely that a range of other variables – including gender, age, ethnicity, income - interact with stigma. In addition, psychological dispositional factors, which are outside this scope of this project, also undoubtedly affect how individuals respond to the presence of primary and courtesy stigma.

Table 4 contains a select number of the questionnaire responses to measures of perceived and enacted stigma. These quantitative findings support the qualitative findings described earlier, and offer stark evidence of the relevance of courtesy stigma to the occupational health of

persons who work at PEERS. In the table 4, the percentage of persons who agree with various statements is reported, with the most agreement occurring for items that concerned “taking opinions less seriously” (88% agreed) and “thinking less of” (76% agreed) persons who work at PEERS. In addition to reporting, the mean score for respondents on Link’s (1987) devaluation scale is 3.29 (1=least stigma; 6=most stigma). In Link’s (1987) study, the mean score for persons who had sought repeat treatment for mental health conditions was 4.15 demonstrating how the courtesy stigma experienced by those who work at PEERS, while lower on average than the primary stigma experienced by consumers of mental health services, was nevertheless observable using the same measure of devaluation.

Table 5: Perceived and Enacted Courtesy Stigma

Question	% Sometimes-Always (items 1-4) % Agree somewhat – Strongly Agree (items 5-6)	Comparison Link 1987 (study of persons who have repeatedly accessed mental health treatment)
1. Funders are supportive of the work conducted by PEERS Victoria	29%	
2. I have been treated unfairly by others when they have learned I worked at PEERS Victoria	35%	
3. I worry that others see me unfavourably because I work at PEERS Victoria	59%	
4. I have avoided telling people outside my family that I work at PEERS Victoria	11.8%	
5. Most people think less of a person that works at PEERS	76%	
6. Once they know a person works at PEERS, most people will take their opinions less seriously	88%	
7. Link and Phelan Scale – Mean Score (1-6)	3.29 (SD: .89)	4.15 (SD: .89)

5.2 Health Implications of Courtesy Stigma

As noted earlier, while those who work at PEERS described emotional rewards associated with providing frontline services, as well as a high degree of skill discretion and autonomy, the work was also described as very stressful, with stress and fatigue commonly associated with a decision to leave the organization.

“I decided to leave PEERS because of the stress. Now I work at [] and it is much less stressful.”(R#10)

“[Working at PEERS] took a tremendous toll on my health – [on] my mental health more than anything.”(R#2)

“There is no comparison. I’ve never done any work as stressful and as chaotic []. And I’ve worked in really stressful places.” (R#8)

“I do like working on the frontline full-time [but] it’s a very stressful place to be ...it’s not so much the clients that make it stressful, it’s the lack of supports in the community, it’s the systemic issues.” (R#6)

The questionnaire findings support the above noted views as a significant minority of respondents (41.2%) reported taking a leave of absence for health reasons while at PEERS, and experiencing five or more days of sickness-related absence (29%) in the last six months.

Table 6: Health Indicators

Measure	PEERS Staff	OHS
% report excellent or very good physical health (1=excellent, 5=poor)	41.2%	46.7%
% report excellent or very good mental health (1=excellent, 5=poor)	64.7%	48.6%
5 or more sick days last six months	29%	
Mean Emotional Exhaustion 27 or greater = high	26.7	
Mean Personal Accomplishment 39 or greater =low	41.7	
Mean Depersonalization 7-12=moderate	6.9	
Mean Depression Score (Range 0-60)	11	12.5

Health Related Leave of Absence	41.2%	
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A number of other interesting findings emerged from the questionnaire regarding health. First, symptoms of depression among the frontline service providers at PEERS who participated in the study were comparable to those of the population of persons studied in the Stigma Study; this is of interest as workers in the service study might arguably be regarded as more vulnerable due to the lower comparative prestige of these occupations, however some of the comparative health indicators suggest this is not the case (Benoit et. al. 2004). Second, using Maslach's Burnout Inventory for Human Service Providers, workers at PEERS demonstrated, on average, high levels of emotional exhaustion and a low sense of personal accomplishment, a finding which fits with respondents' descriptions of the job as being mired in systemic issues such as unstable and insufficient funding and poor public support for the work (Maslach et. al. 1996). However, despite these indicators of workplace burnout, supporting respondents' earlier descriptions of interactions with clients as a source of workplace reward, workers at PEERS do not report high levels of depersonalization - a third indicator of burnout which refers to the tendency of stressful working conditions to result in service providers' alienation from service recipients (Maslach et. al. 1996).

In sum, workers at PEERS experience courtesy stigma in a number of different interpersonal contexts – both at home and at work – with some workers demonstrating a greater resilience to these experiences than others. Overall, the health consequences of working at PEERS seemed to be severe, with workers quantitatively reporting high levels of emotional exhaustion, low levels of personal accomplishment, alongside qualitative descriptions of how the work negatively impacted both their physical and mental health.

5.3 Environmental Scan

During the second wave of data collection in the fall of 2009, eight interviews were conducted with persons representing various community groups in the research site. These interviews were conducted to provide an ecological perspective on the courtesy stigma experienced by persons working at PEERS as well as valuable feedback for PEERS to consider with regards to evaluating their community profile. The persons selected for these interviews represented organizations that interact with PEERS because they also have a professional interest in service provision to persons working in the sex industry. Persons who came forward for interviews represented local non-profit organizations, municipal police services, government policy-makers, and community interest groups. These individuals were asked for their perspective on the service needs of PEERS clientele; their experience interacting with PEERS representatives and members of PEERS' target population; the challenges and successes PEERS has faced; and opportunities for enhancing PEERS' contribution to the community.

All of the individuals who responded to the community questions noted that they had interacted directly with PEERS clientele and/or staff on multiple occasions. In addition, in all cases, respondents to the community interviews had some experience either directly delivering, or overseeing the delivery of, services to populations that included sex workers. While naming the organizations with which these individuals were affiliated could potentially jeopardize anonymity, the individuals selected for these interviews might collectively be described as persons quite familiar with the PEERS service population and PEERS as an organization. In this regard, these interviews do not represent broad community perspectives, but they do represent some of the perspectives that might be found among the associated professionals with whom PEERS (and representatives) would be likely to interact in the course of a work day.

When asked to talk about the role of PEERS in the community, respondents strongly identified with the unique and vital service contribution of PEERS as the only organization to specifically advocate for the needs of sex workers.

“That’s an incredible service that they offer to the community and I’m sure it’s hugely challenging work.” (CR#2)

“Peers is offering a unique service to the people in the sex trade industry to go for some help [and] support[]. Just being there with that agenda, with that intention, is obviously a huge [contribution].” (CR#8)

Respondents uniformly regarded PEERS’ focus on experiential knowledge as an asset in their service practice:

“It’s actually really useful frankly for former sex trade workers to bring the point home for people who really don’t get it.” (CR#5)

“If Peers did not exist somebody would have to... how [could] anybody in the health business,[justice] business, social service business have a direct conduit to people in the sex trade if it wasn’t [for] PEERS.” (CR#1)

“...just having someone there who was like “hey I did it, I’m still doing it and you know I’ve got it together I’m doing this as well.” (CR#6)

When thinking about PEERS’ contribution to the service community vis-à-vis their own work, or the continuum of services available, respondents additionally expressed positive regard for PEERS’ “open door”, nonjudgmental approach:

“A number of women have not been able to complete [their program] the first time, but [] PEERS keeps them coming back.” (CR#6)

Additionally, respondents appreciated instances where they joined their service with that of PEERS to co-support mutual clientele.

“If I find a woman on the street really needing help, I call PEERS, drive down there, and then they handle the ball and handle support.” (CR#3)

“It’s been really good [] coordinating together and supporting clients. [] PEERS can be supporting and accessing [] people that we may not normally access.” (CR#4)

Respondent descriptions of PEERS' service contribution suggested that they viewed PEERS clientele as highly marginalized and vulnerable, often linking their view of PEERS clientele with the outdoor sex trade.

"It's a difficult population to work with." (CR#6)

"I think that they are amazingly courageous and they're you know they're fighting the good fight and they're saving peoples' lives." (CR#5)

"I see PEERS as working at like the bottom of the chain... women who have reached a point of poverty where sex trade work is the only thing that will keep them alive... I see them as serving the more extremely abused or traumatized client group." (CR#2)

Respondents noted a number of challenges facing PEERS specifically, and the non-profit service sector more generally. Speaking of the broader service sector, a couple of respondents noted that inadequate, unstable funding meant that organizations, including those they represented as well as PEERS, did not have the opportunity to develop service capacity to the extent possible.

"We're all in a place of financially just working so hard to bring the money in at all that it's very hard to find time for those kinds of meetings that would [facilitate] more proactive long term kind of discussions." (CR#2)

"I've been through this [economic recession] in the eighties; it's easy to beat up a non profit group... it's easy for a government to say well you guys cut back you know you're not going to see an appreciable difference in the next year." (CR#1)

Other respondents echoed PEERS concerns about turning clients away who did not meet outcomes-linked funding requirements and the difficulties with providing evidence of the short and long terms effects of their services.

Speaking more directly about the challenges specific to PEERS, respondents noted that PEERS has faced special barriers to collaboration such as limited management and administrative resources, as well as a distrust of the values, philosophy, and priorities of other

organizations.

“It has taken quite some time [] to establish a good working relationship [with PEERS] ...this good relationship is not across the board.” (CR#7)

“Every time I interact with PEERS it feels like there’s crises all over the place and so it’s on the edge like a life and death situation every day.” (CR#2)

Respondents also noted that the specialized nature of PEERS’ services made them vulnerable to funding cuts and they felt that the organization had diluted its mission over time in order to secure funding.

“When there’s discussion about program [cuts], specialized programs [like those offered by PEERS] often will be the first to go.” (CR#5)

“Agencies have a big choice to make and that’s do they stay true to their original vision [] or do they try and grow and follow funding, and I feel like PEERS, especially of late [have been] following funding, and of course it does tie into their work somewhat, but they were never about child protection and child custody stuff and now that seems to be a big focus.” (CR#6)

Several respondents also noted that PEERS faced considerable challenges with regard to the stigma and controversy surrounding the sex industry, and would therefore likely always encounter persons who would not support their work, or who would support some aspects of their work, but not others. As one respondent noted - *“it’s a constant battle.”* (CR#2) Another noted:

“Unfortunately, there will always be people that are anti [sex work]. So long as both groups maintain their professionalism and work towards a common goal (SAFETY), they can co- exist.” (CR#7)

“I would suggest that the majority of our community doesn’t really understand who a sex trade worker is, and why they’re there, and therefore might not be able to empathize and truly feel charitable or support an organization like PEERS.” (CR#8)

“Nobody wants to talk about violence against women and nobody wants to talk about prostitutes because it’s really it’s touching on way, way too many taboos for them [so it is easier to talk about] prevention and prevention in its relationship to children...appealing to peoples’ guilt and shame and denial.” (CR#5)

In addition, respondents noted that the experiential model employed by PEERS was laudable and, as noted earlier, an integral aspect of PEERS’ service contribution, but a model that posed enduring challenges, particularly when there were scarce resources to support the model. Respondents questioned whether staff were adequately trained for their positions, if they possessed the communication skills to effectively navigate professional relationships, and whether adequate resources had been levied in support of the model.

“I would love to have a totally diverse staff here [in my agency, but] there’s two parts to our culture: one is that we value diversity, and the other is that we value professionalism, which we define as university degrees and you know a level of written communication and that kind of thing.” (CR#2)

“Just because you’ve been clean for six months does not equal I now have skills to be an executive director and I think that’s been historically the challenge with PEERS.” (CR#5)

“I think that that may be one of the challenges that they may face is that when you’re working with people that “have survived” ... it’s also really hard to create a cohesive team.” (CR#4)

“[You work] more on a hunch, an intuition ‘cause that’s the experience and so sometimes that can be misinterpreted by the traditionalists as people who are not informed.” (CR#1)

Thinking about their hopes for PEERS, respondents noted a number of areas that they felt were important for service expansion and organizational growth, both for PEERS and for the broader social service community. For example, two respondents focused on housing as an ongoing need of PEERS clients, while another mentioned the need for services for males in the sex industry. A number of respondents focused on building PEERS’ collaborative capacity:

“I say that there are barriers because there is a real lack of communication

between PEERS and [our organization]. We are dealing with people (at PEERS) who ...might not have a background of communication skills and [due to turnover] we keep losing that continuity [in a collaborative relationship].” (CR#8)

In particular, one respondent felt that local organizations should have service partnership agreements so that services could be more seamless between agencies.

“Let me draw a bigger picture for you which includes PEERS and others,[in which] we’d have more time to work together to collaborate [] to join our resources together so that we could really help the individual in front of us, so if someone comes on for a bus ticket PEERS could say yeah here’s a bus ticket knowing that [our organization is] going to help with that cost instead of [describes a process where a client has to go from agency to agency to acquire supports in a piecemeal fashion].” (CR#3)

Another suggested area for development included clear public education messages and media strategies aimed at developing political support for the work conducted by PEERS:

“[They need representatives that speak] the language of the politicians [and funders] and [are] able to go up to them in a public context and talk to them about the program and [bring] instant credibility to the program.” (CR#5)

Another respondent talked about simply expanding what they already do and suggested that they could engage in more public education and further develop their outreach program.

Finally, one respondent touched on ways that PEERS could expand its mentorship model so that more employment positions could be offered to clients:

“I’d like them to have some community economic opportunities for the people [that use their services] so[when] people come in, they can offer them a job.”(CR#1)

In sum, the community interviews suggest that there was broad support for the services provided by PEERS and persons in the community were eager to interact with PEERS staff, but noted that turnover of leadership at PEERS had led to fluctuations in community confidence in the organization. There was also some agreement between PEERS staff and community members regarding PEERS’ growth and development opportunities, but with different

emphases; community members talked more about the need for collaboration, whereas PEERS respondents talked about not being accepted in the broader community. Respondents, as might be expected, regarded PEERS as another service for street- entrenched(homeless) persons, for females, and for victims, again emphasizing the difficulty in assailing sex work stereotypes in the social services sector.

Despite widespread support for PEERS and a desire to work collaboratively, the community interviews collectively demonstrated reserved confidence in the skills of PEERS' staff, confirming the opinions of service providers at PEERS that relationships with allied service providers are strained. In this regard, PEERS' reputation precedes the actions of individual workers who must then confront and manage the reputation of the organization in a way that workers from other sites are not required to. Rather than suggesting that allied service providers consciously discriminate against PEERS representatives because of their close association to the sex industry – many of these service providers also have close ties to stigmatized populations- this finding is an example of the strained social relations that are common in contexts of primary and courtesy stigmas. PEERS' close identification with sex workers, including, but not limited to, their focus on elevating the experiential voice, challenges others to rethink and reconfirm their approach to health and social service provision. As Goffman (1963) noted, it confronts others with too much morality. At the same time, anticipating devaluation, workers from PEERS may treat others outside their culture with disdain, defensiveness, or withdraw from full participation in collaborative professional relationships (Miller and Kaiser, 2001). Of course, there are many instances of effective relationship building and interactions between PEERS and others in the community, however as Pescosolido et. al. (2008) noted, even occasionally negative interactions are sufficient to uphold primary and courtesy stigmas, and are likely implicated in

the strained relations described by community members who interact with PEERS.

Chapter 6: Discussion

6.1 Implications of Findings

This dissertation project has provided an in-depth study of the impact of courtesy stigma on individuals working for a non-profit organization that provides services to sex workers. Three aims were identified at the outset of the dissertation: 1) investigate the characteristics of courtesy stigma among service providers; 2) examine the factors that interact with courtesy stigma in the workplace, leading to variations in experience among workers; 3) focusing on occupational health as a determinant of service capacity, explore how courtesy stigma shapes the service context from the perspective of the service provider.

With regards to the first objective, the findings indicate that courtesy stigma is a discernible aspect of the work experience of the employees at PEERS. Service providers describe inconsistent social support from family and friends regarding their work, as well as perceived and enacted stigma from other professionals and the public at large. Courtesy stigma in this non-profit service organization is likely intensified by the deeply negative “prostitute” stigma, the organization’s practice of hiring specifically from within stigmatized groups, and the close advocacy- oriented relationship between PEERS staff and their clientele (Weitzer, 2009; Corrigan and Miller, 2004; Kulik et. al., 2008). However, most workers, armed with a strong belief in their mission and service philosophy, treat courtesy stigma as part of the job and develop various means of managing others’ misinformation and stereotypes about PEERS and sex work in general. These coping techniques include disdain for the rules and traditions that govern standard work environments, as well as narrative traditions that underscore the necessity of their work, their expertise on the subject of sex work, and the innovative nature of PEERS’

service model.

With regards to the second objective of the dissertation project, service providers with education and experience showed the most confidence in advancing counter- narratives in the face of perceived and enacted stigma, whereas workers who lack experience on the job, or who have not had much exposure to education and training, or who are structurally disadvantaged in other ways, appeared more likely to either withdraw, respond with anger when faced with perceived stigma, or ignore the stigma inflicted on them. Additionally, service providers who experienced co-occurring stigmas, including the primary stigma of having formerly worked in the sex industry, were more likely to experience perceived and enacted courtesy stigma as acutely stressful because of the implications for their personal identity. For these individuals, working at PEERS , while it contained many benefits including being able to fulfill the comparably more socially acceptable role of “service provider” and “advocate” and the chance to reframe a denigrated identity, ensured that their identity as a sex worker remained in the forefront of their experience.

However, regardless of background, all respondents readily identified with the notion of being devalued because they represented PEERS, with the starkest evidence of this arising from the questionnaire. For example, as noted earlier, nearly 90% percent of persons agree that most people think less of the opinions of someone when they are made aware that they represent PEERS. Similarly, close to 80% agree that most people think less of a person because they work at PEERS. The implications of this clear example of perceived stigma might easily be underestimated because actual instances of discrimination are less common than those of perceived discrimination, and many workers do not appear to internalize these negative messages (self stigma). In addition, the effects of courtesy stigma may be inconsequential when you

consider that service providers at PEERS cite many sources of stress in their work environment, and there is the common perception among persons within (and outside) the organization that its hiring practices –in particular hiring women with a background in the sex industry –means that many employees will have health problems and stresses that precede their employment and experiences of courtesy stigma. In other words, it might be argued that courtesy stigma, while it is a discernible and commonplace aspect of the work at PEERS, is a minor, transitory, determinant of workplace health, with other stressors such as workplace relationships, inadequate resources, client needs, and health issues originating outside the workplace being more important determinants of workplace health.

Assessing the relative impact of primary stigma and courtesy stigma vis-à-vis other determinants of health (which interact with and transmute courtesy stigmas) is a complex issue noted by other scholars, and one that cannot be reconciled here given the inherent data limitations associated with the small sample of persons studied in this dissertation project (Benoit et. al., 2010; Link and Phelan, 2002; Scambler, 2009). However, the insights of stigma scholars who highlight the interconnectedness of various axes of marginalization as well as the interaction between social determinants of health are useful here (Corrigan et. al. 2004; Havkivsky and Cormier, 2009; Link and Phelan, 2001, 2006). Link's (1987) conception of secondary deviance draws attention to the role of primary stigma (and by extension courtesy stigma) in activating a range of associated negative outcomes. For example, in a study of expectations of devaluation and discrimination on demoralization, Link (1987) hypothesized that perceptions of devaluation/discrimination would be correlated with poor employment and unemployment of persons with mental health conditions (a primary stigma). The author found that once labeled, mental health patients tended to withdraw from employment opportunities,

either because they no longer had the confidence to advocate for themselves, or simply because they sought to avoid circumstances in which their mental health condition might be exposed, or deemed relevant to assessing their capacity (Link, 1987). Further, anticipation of rejection by these individuals with mental health conditions lead to strained social interaction with, and negative evaluation, by others, a finding echoed in much of the literature on primary stigma and courtesy stigma focusing on loss of social support (Link, 1987, Corrigan and Miller, 2004; Wight et. al. 2007). These processes of social withdrawal occurred regardless of the severity of stigmatized mental health condition (Link, 1987). Goffman (1963) similarly noted that persons who perceive stigma will withdraw to a group of their “own” and the “wise”, a phenomena that while helpful in reducing the stress associated with stigma, may further limit opportunities available to members of stigmatized groups (Miller and Kaiser, 2001). Viewed from this angle, courtesy stigma may be more pivotal to the organizational culture of PEERS than it would appear on the surface; in particular, courtesy stigma may play a key role in the low sense of accomplishment reported by PEERS staff, the strained social relations among staff and between PEERS and other allied service organizations, and ultimately, it may reduce opportunities to optimize organizational functioning and intervene in the stigma that surrounds PEERS.

The interconnected effects of courtesy stigma and primary stigma can also be seen at the structural level in government funding patterns across the sector and the impact on persons providing frontline social services. Primary stigmas against PEERS clientele combine with broader forces of neoliberalization to intensify the well- documented patterns of limited and constrained funding across the health and social service sector (Benoit and Hallgrimsdottir, in press; FCSSA, 2010). The under-resourcing of services to vulnerable, often stigmatized, populations generally is deepened within PEERS as the seemingly specialized nature of their

services, and the misinformation circulated about the service needs of sex workers, narrows the scope of their claims for public support. Working at the intersection of stigma and diminishing support for the health and social service expenses across the sector means that service providers at PEERS are compelled to take on a greater care burden in order to manage the gaps in both their own services and those in the community, while at the same time, their clients face seemingly insurmountable barriers to health due to the multipronged effects of stigma (Strike et. al., 2004; Link and Phelan, 2006).

Workers at PEERS are especially vulnerable in the face of these strains as many have limited alternative employment opportunities due to the combination of limited education, co-occurring stigmas, histories of violence and trauma, and ongoing health needs, such as those related to recovery from dependent substance use. PEERS thus provides one example of how the effects of neoliberalization and devaluation of care work in the social services sector is disproportionately borne by marginalized populations and the vulnerable workers who serve them (Purkis et. al., 2008). However, it cannot be ignored that the sensational aspects of the sex industry benefit PEERS to some degree as the public at large is simultaneously curious about, and offended by, the harms associated with sex work. By emphasizing aspects of sex work that resonate with common stereotypes, workers at PEERS gain social support for their work, while they, at the same time, participate in the reification of sex work stereotypes. For example, in the current economic climate services to populations who present substantial public health risk (i.e., the needle exchange funding that supports the outreach program) are likely to retain funding, so PEERS, in order to secure funding, PEERS must emphasize how their service population presents obvious risks to public health. Another implication of funding patterns for the organization is that the employment positions at PEERS are experienced as insecure. This

insecurity is compounded by the pressures that arise from working within a sector that is marked by an uneven and disjointed continuum of services. Within this unstable climate, there is little opportunity to invest in human resources and long term planning as there is an overriding need to direct resources to frontline service provision, while staff have little reason to plan for their future at PEERS. Faced with unmanageable workplace strain, service providers who have opportunities to acquire work elsewhere are likely to do so, even if their prospects for securing other similarly remunerated work are limited – a situation which is common at PEERS because many staff do not have formal social service credentials (Hallgrimsdottir et. al. , In press).

Given the workplace stresses noted by staff at PEERS, combined with other sources of vulnerability such as limited household income, limited education, a history of stigmatization due to drug use and participation in sex work, and the emotional burden associated with confronting stigma and being privy to the harms experienced by their clientele, it is not surprising that many service providers at PEERS reported less than optimal health, high emotional exhaustion, and a low sense of personal accomplishment. While the service providers in this study reported a strong alignment with their service population, an autonomous work environment, and high job satisfaction – all of which are important assets in their workplace - it is likely that the pervasive health strains they face at work have a negative impact on service delivery. The available research evidence suggests that service providers' satisfaction with working conditions is correlated with client satisfaction and the attainment of desired service outcomes – that is, organizational contexts and workplace strain faced by service providers may be transmitted to service recipients through various sub-optimal service delivery practices (Yoo and Brooks, 2005; Hallgrimsdottir et. al., In press). In addition, the high turnover at PEERS also contributes to reduced service capacity. One estimate of the costs of employee turnover is that it

costs the organization the equivalent of an annual salary every time one worker leaves and another is hired (FFSA, 2009), suggesting that turnover alone is associated with reduced service capacity as resources are redirected to hiring and retraining employees. Thus, with regards to the third objective of the research project, the data presented here suggest that primary and courtesy stigma intermingle at PEERS, resulting in a reduction in service capacity via multiple routes including via funding, service provider health, organizational conflict and turnover, and difficulty establishing a collaborative service relationship with other providers in the community.

6.2 Recommendations

In light of these findings a number of short and long term recommendations can be made, many of which were elicited from respondents during interviews. These recommendations, which are tentative given the limited scope of the data, can be grouped into four broad categories: human resource development, social marketing, coalition building, and service delivery.

With regards to human resource development, PEERS might benefit from identifying positions associated with frequent turnover as well as the occupational health risks associated with various frontline and management positions. For example, considering the strains associated with fulfilling the responsibilities of being executive director, respondents noted a number of ways that the position could be reorganized to provide better support to incumbents and improve management capacity. Perhaps foremost, respondents spoke about the notion of developing an executive team that shares responsibilities associated with: financial management and administration, human resource management, funding applications, fundraising, and community networking. Working in a team environment would not only disperse the responsibilities (and associated stresses) of the executive director, but provide ongoing social

support and increased opportunity to address the ongoing needs of within the organization.

The Executive Director position is one of the primary sources of leadership within the organization and it is therefore crucial that this position be supported by an engaged and diverse board of directors. The management activities of the Executive Director and Board of Directors must be guided by a comprehensive set of relevant organizational policies that can effectively guide activities and program delivery as well as lend predictability and consistency to the work environment. Thus, opportunities for regular strategic management and organizational visioning work are necessary and should take into consideration the best practices emerging from management and governance scholars in the non-profit sector.

Frontline positions at PEERS, such as those found at the reception desk and on the outreach team, also pose unique health risks such as the unpredictable, emotional demands associated with helping clients who are in health crisis, exposure to dangerous working conditions, and irregular work hours. Further, the staff who occupy these positions often have the least employment experience and credentials in comparison to their counterparts in the employment program and management positions, and are the most likely to have recently been subjected to stressful living conditions, including those associated with substance use, poor housing, family disruption, criminal prosecution and violence. Staff occupying these positions will have first-hand knowledge of the stresses and risks common to their work as well as ideas regarding appropriate remedies, and would benefit from engagement in opportunities to improve health and safety aspects of their work. Strategies for improving health and safety practices for these staff members might include organized debriefing opportunities, development of safety protocols addressing various identified risks, a strong casual list to support the work of regular staff, and other measures which acknowledge the importance of the frontline work carried out by

these workers.

Across the organization, it is essential to invest resources in training, mentorship, and team building, and doing so should be seen as a precondition to effective service delivery, rather than an opportunity to be explored when resources permit. In addition to establishing a curriculum of fundamental training for all staff, the board and executive director might consider ways to highlight the contributions of individual staff members and tailor training opportunities to their specific interests and skill sets. At the same time, essential skills for various positions should be identified, along with concrete plans for acquiring these skills through training and mentorship if some are not present upon hiring. Consideration should be given to opportunities to strengthen and concretize the organization's mentorship training model to ensure that effective mentorship is readily available to staff at all levels of the organization. Strategies that enhance team cohesion, communication and conflict resolution should also be considered, including a system for complaints resolution and the incorporation of ongoing learning into organizational activities, especially so that common conflicts and complaints can be translated into opportunities for strengthening knowledge, policy and practice. Compensation and benefit packages should be reviewed at regular intervals to ensure they meet, or exceed, the standards for the sector. In addition, the benefit packages and policies concerning supports for common occupational health issues must be reviewed and further developed including paid sick days (including short and long term stress leave), supervision and debriefing, family leave, medical leave, and substance use problems. In undertaking these diverse human resource initiatives, it is also important to consult the available research literature as these human resource management issues are common to the frontline care sector and have likely been researched extensively considered by persons who specialize in these human resource concerns.

PEERS' service delivery model, while demonstrating some limitations, fills a crucial service niche by all accounts, and therefore expansion of services to under-served populations and improvements to existing services should be their focus. In doing so, it is helpful to carefully consider both the diverse needs of people who work in the sex industry, the international literature, as well as the way in which service delivery is intertwined with stigma production and reproduction. Staff and allies of PEERS, including clients, might consider organized opportunities to reflect on the ways that service delivery is complicit with sex work stigmas and strategies for addressing these practices (Lee et. al. 2008; Link and Phelan, 2008). In addition, information should be collected from active sex workers in various sectors of the industry to document the barriers these individuals face in accessing other health and social services; PEERS can use such information to educate and advocate for policy and practice amendments in other service environments as well as their own (Weiloch, 2002).

There is a current need at PEERS to refine the procedures for documenting program outcome and client satisfaction, both for informing ongoing organizational development and for public education and funding requests. In addition, as noted earlier in the discussion on coalition building, PEERS should consider the benefits of coordinating service and advocacy opportunities with other organizations that share their mission and service objectives; this strategy should be aimed squarely at redressing the fragmentation among social movements interested in vulnerable and stigmatized populations (Cole, 2008; Stuber et. al., 2008). In particular, it would be beneficial for PEERS to continue taking part in consortiums of persons, including from the political, academic and frontline service sectors who share an interest in aiding sex workers. PEERS has in the past, and should continue to, play a leadership role in forums that raise the oppositional capital contained within the experiential voice and facilitate networking and

knowledge dissemination opportunities among stakeholders on a local, National, and International scale (Wieloch, 2002). Organizations offering capacity building funds may be approached to support this work, especially if networking forums utilize a collaborative model aimed at extending the impact of reciprocal learning processes (Jansson et. al. 2010). Such coalition building, both among persons interested in the impacts of the sex industry, and among persons interested in social welfare interventions aimed at other stigmatized populations, is necessary not only to redress the tendency for PEERS and other social service agencies to work in isolation from one another, but also to strengthen the impact of stigma interventions (Pescosolido et. al. 2008).

PEERS has played a leadership role in public education in the community regarding sex work and is valued for their expertise in this area. Thus, the organization is in a unique position to participate in social marketing regarding the public impression of sex workers. However, existing research noted earlier suggests that social marketing should be approached with caution as it is associated with unanticipated effects, including the deepening of stigma (Lee et. al, 2008; Pescosolido et. al. 2008; Scambler, 2009). Public education messages disseminated by PEERS are best developed by a team that brings diverse perspectives and expertise to the design process in order to ensure that various aspects of public decoding are considered. The development and dissemination of public education messages is aided by building relationships with media representatives and government officials who are sympathetic to the need to develop messages that are both accurate as well as impactful (Benoit et. al., 2009). In designing social marketing messages, it may be useful to focus on messages that have a general focus rather than ones that focus on sex work specifically. This strategy may result in greater awareness among multiple audiences of the important role played by the health and social service sector in the well being of

vulnerable populations and the community as a whole.

In addition, ideas emerging from a recent workshop held in Victoria BC and attended by sex work experts and stakeholders from various backgrounds suggests that messages specifically about sex work might focus on any of the following four themes about which the public has little information: heterogeneity in the sex industry, clients, business practices and health (Benoit et. al., 2009). Rather than focusing on sensationalized risks which reflect public stereotypes, social marketing campaigns might focus more generally on dispelling myths about clients, encouraging awareness of diversity in the sex industry, and focusing on the health concerns that are most salient to sex workers themselves. These may include opportunities for improving working conditions in the sex industry and for building on the proactive health practices already adopted by sex workers (*ibid.*).

Finally, consideration should be given to the practice of personal story telling and the harms and benefits associated with this practice. While it is an important intervention into stigma as it increases public access to the first- hand experiences of sex workers from various backgrounds, it is also associated with stress for the story teller and reification of stigmas when story tellers feel pressured to construct their personal history in particular ways, or when stories do not reflect the diversity found within the sex industry. Again, strategies for improving this practice as a stigma reduction technique are most likely to emerge from discussion between persons representing various perspectives on this narrative practice (both speakers and audiences).

Chapter 7: Conclusion

7.1 Summary of Findings

The preliminary data analyzed for this dissertation demonstrate that workers at PEERS face similar challenges to care workers in other non-profit organizations during the current period of economic downturn. These challenges include the simultaneous erosion of good working conditions and coordinated supports for the clients they serve as well as additional indignities arising from courtesy stigma (Benoit and Hallgrimsdottir, 2006). The budgetary situation, including the increasingly targeted, short-term and outcome-oriented nature of program funding is a constant source of pressure and insecurity for program staff that must be balanced with their primary mission of providing responsive frontline services. Forces of neoliberalization in the funding sector detract from frontline service work by not allowing for the full maturation of programs, by leaving organizations without core operating support, by imposing stringent reporting requirements, and by discouraging grassroots development of program innovations that challenge the scope of existing funding initiatives (Armstrong and Armstrong, 2003; Hallgrimsdottir et. al., In press). For PEERS, funding for ideas that do not resonate with dominant stigmas about the sex industry, or focus on identities of lesser interest – for example, males and indoor workers – is harder to come by, as the public at large remains most interested in interventions that promise to respond to the most visible and startling harms associated with the sex industry (Weitzer, 2009). In addition, while private donations and public fundraising events can be a good source of income for smaller programs that cannot secure government funding, this arena is especially sensitive to controversy and thus is only appropriate for widely sanctioned program interventions. In fact, PEERS is disciplined by the knowledge that donors will withdraw support if the organization becomes involved in contentious initiatives

such as providing safer working environments for those who wish to continue working in the sex industry. Thus, due to stigma, PEERS must strategically market itself in public fundraising to maintain public interest and sympathy.

In addition, workers in non-profit organizations across Canada suffer from an imbalance between extrinsic and intrinsic rewards, high turnover, and limited resources for training and recruitment (Sanders, 2004). This is also the case for service providers at PEERS who are highly discouraged and disillusioned by the structurally under-resourced nature of the sector, including limited income, benefits and supports for workers (Baines, 2004; Benoit and Hallgrimsdottir, In press). Service providers at PEERS report frustration with the limited resources they must work with, and are especially concerned about a lack of allied supports and services in the broader community to complement their work. Aware of the discrimination their clients face accessing other services, staff feel additional pressure to push the boundaries of service responsibility to advocate for their clients in the health care and child and family service systems – places that should be sources of allied support (Strike et. al., 2008).

Service providers at PEERS are additionally disadvantaged by the distinct possibility that they too may be subject to derision and discrimination when accompanying their clients into other service environments. While public education presentations can be a positive experience for staff who derive pride from using their experience in the sex industry to educate others, it can also be very distressing for staff who are unprepared for the implications of speaking publicly about a stigmatized topic; this is especially the case because the discriminatory ideas they are often asked to respond to in public forums have immediate implications for their own identity. Perhaps more intensely than service providers in other non-profit organizations, staff at PEERS experience limited social support for their work and some feel devalued by others’

misunderstanding of the sex industry and their role as care providers. They are especially vulnerable to inadequate resources to support their work. The strains experienced by workers at PEERS which both emanate from the stigma faced by their clients, as well as from their personal social locations, exemplify how devaluation in the care sector is downloaded to the most vulnerable workers (Hankivsky and Cormier, 2009; Benoit and Hallgrimsdottir, In press).

7.2 Limitations of this Research

While this dissertation provides a novel contribution to the courtesy stigma literature as well as the literatures on care work and health and social service access issues for vulnerable populations, it is not without important limitations. These include the narrow scope and a comparatively small, possibly unique, sample. Thinking about overcoming these limitations provides many opportunities for further research on courtesy stigma. This dissertation research is exploratory and descriptive in nature, with an emphasis on conceptualizing courtesy stigma as it applies to workers in one service site. Thus, I was unable to explore the ways in which PEERS may be similar or dissimilar to other work sites where stigmatized populations are served. It is therefore difficult to ascertain what the influence of either the work context, or the specific stigma associated with the population served, might be on experiences of courtesy stigma and occupational health in other organizations. Research examining courtesy stigma in multiple services sites would allow for a better understanding of how varying work contexts influence experiences of courtesy stigma and occupational health. A comparative sample would have additional benefits, including observation of potential variances in courtesy stigma based on population served, organizational features, and/or the demographic characteristics of the service provider workforce. As noted earlier, while the processes of stigma and status reduction are similar across different populations, the effects are likely quite variable. Workers at PEERS are

also potentially unique due to the organization's emphasis on hiring persons with a history of involvement in the sex industry. Co-occurring stigmas (both courtesy and primary) are commonplace at PEERS, but are they in other worksites where service providers serve stigmatized populations?

While further research with a larger comparative sample could be conducted with a mixed methods, primarily qualitative design, it might be useful to carry out a primarily quantitative mixed methods design that focuses on questionnaire-based data collection with select qualitative questions administered to a subsample of respondents. The questionnaire used for this project could provide a useful starting point for such a project, and could be expanded to include additional standardized measures of occupational health determinants, health status indicators, and stigma measures, including facets of stigma not adequately measured in this project such as self-stigma. While stigma research has largely relied on one-off measurement processes, following the work of Scambler (2009), standardized measures that can be used across stigmatized populations are most useful. The primary stigma measures used in this project were suitable for this study of courtesy stigma, and might be expanded to include other common measures of prejudice, discrimination, and social status. Additional courtesy stigma measures might tap the "associative" facet of courtesy stigma, perhaps to investigate the possibility that different types of professional and personal associations result in different degrees of courtesy stigma. The development of measures that tap different coping and management strategies would also be a useful addition to the measures used in this project, allowing one to explore the effectiveness of different strategies in mitigating stigma related stress.

This research has also only begun to situate courtesy stigma in a broader social determinants of health model. Taking into consideration the principles of intersectionality,

lifespan, and micro through macros levels of analysis, there is much work to be done to fully explicate how courtesy and primary stigmas operates as social determinants of health in concert with other key social determinants that have been noted to be especially pertinent to understanding the experience of vulnerable populations. These include gender, education, employment and income, violence, housing, family context. This long range project is beyond the scope of a single study or researcher. It would instead require a larger team effort of interdisciplinary researchers working in the context of the social determinants model. Further research with a larger sample of persons would lend itself to statistical investigation of the impact of courtesy (and primary) stigma on health, particularly its relative effect on health vis-a-vis other co-occurring social statuses.

Finally, it is important to pay attention to the changing nature of stigmas and stigmatization processes over time, and the associated matter of stigma interventions. My dissertation has highlighted that staff at PEERS should not only be educated to dispel stigma in the course of their work, but should be trained to identify the operation of stigma in their workplace and personal lives, and should be provided with information on how to lessen the negative impact. Importantly, intervening in primary stigmas (and by association, courtesy stigma) is a project best accomplished by addressing systemic issues of marginalization across a variety of stigmatized groups (Cole, 2008; Pescosolido et. al., 2008). When focusing on upstream determinants of stigmatization and marginalization, service providers at PEERS have much in common with other groups – service providers in other sectors, academic researchers, special interest groups –whose collective project is to document the impact of current policies on the health of vulnerable populations and should seek collaboration in their efforts . Knowledge resulting from a collaborative project aimed at documenting the impact of current policies and

programs on vulnerable populations should be used to advocate for increased publicly funded support for vulnerable groups.

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Appendix 1: First Interview

First of all, I would like to thank you for taking the time to participate in this interview. This research I am undertaking also looks at the issue of stigma in service contexts, but the focus of my research is on those who provide care to stigmatized populations. Although I would like to talk more about stigma in the workplace in a future interview, today my main goal is to find out more about how you became involved in your line of work and your feelings and thoughts on the type of work you do. Then, if you are willing, I would like to interview you again to talk more about stigma, your workplace, and your health.

1. Can you tell me about how you became involved in frontline health and social care work? How did you end up working at PEERS? (attractions of the work, qualifications, personal work history, personal story leading up to this work, personal story leading to PEERS)
2. What is (was) your day to day work at PEERS like? (position title and nature, common activities and responsibilities, typical tasks, clients served, coworkers, principles, philosophies and values of the program, previous positions at PEERS for those who have had multiple roles). How long have you been doing this kind of work and how long have you been at PEERS (or how long were you at PEERS in the case of those that have left)?
3. What are/were the most fulfilling and attractive aspects of your work at PEERS? What are/were the most challenging or negative aspects of your work? Is the work what you expected when you began it? What surprised you about the work? What sorts of characteristics/skills are required to be successful in your line of work? (probe highs and lows of work). What factors prompted you to leave PEERS? (only for those who are former employees).
4. What kinds of supports and resources would help you to do your work?
5. What sorts of career goals do you have for the future? Do you plan to stay in this line of work?
6. Do you have any initial thoughts about how you or your organization is impacted by the stigma surrounding the sex industry? Is there anything further you would like to add?

Thanks again for taking the time to talk with me about your work. I will be following up with some additional interviews in the coming month. Would you willing to participate in another interview about your work and health. The follow-up interview will include talking about some of the findings from the first interview.

Appendix 2: Second Interview

Appendix 2a: Open-Ended Interview

First, I would like to thank for taking the time to meet with me again. Last time I asked some questions about how you came to work at PEERS-Victoria, what your work was/is like, and about some of the challenges and rewards associated with the job.

Today I would like to get a bit more information about these issues but also talk to you about how your work is perceived and supported by the broader community. These questions are related to information I gathered in the first interview.

- 1a. Can you give me an idea of how your work is going now (position, changes at work, feelings about the job, activities, current issues)?
- 1b. Can you tell me a little about your decision to leave PEERS? What are you doing now? What do you miss about PEERS? Are there any improvements in your life that have come about as a result of changing your work location?
2. How do you/did you describe your work to others who are not familiar with PEERS-Victoria?
3. What are/were the most fulfilling and attractive aspects of your work at PEERS? What are/were the most challenging or negative aspects of your work? How do/did you cope with these challenges?
4. What was it like to work in an all female (or mainly female) work environment?
5. What kinds of characteristics/skills are required to be successful in an all/mainly female work environment? in the job? .
6. How do you describe your work to friends and family. What do your friends and family think of the work you do? Are they supportive of your work?
7. Have you confronted negative stereotypes in the course of your work? Can you describe an instance and how you handled it? How would you describe community support for the work done by PEERS-Victoria? (probe positive and negative instances of support).
8. In an ideal world, what kinds of resources and supports would help/have helped you to do your work at PEERS-Victoria? What are the barriers to securing those resources?
9. Can you talk a little about work-health connections and what that means for you and for your co-workers? What kinds of things do you do to maintain work-health? Are there any health supports that you would like to see in place for those who do your kind of work?

Thanks again for taking the time to talk with me about your work.

Appendix 2b: Executive Director Supplement

1. How long did you serve as Executive Director at PEERS?
2. What are/were the main responsibilities of the Executive Director in practice? (we know there is a job description, but what really stood out for you as the main responsibilities?)
3. How did doing this job compare with other work you have done? What was it like to work in a predominantly female environment?
4. What were the most challenging aspects of the job?
5. What were the most rewarding aspects of the job?
6. What are some of the health and wellness considerations associated with the Executive Director position?
7. What kinds of supports would help the Executive Director position at PEERS-Victoria? Are there any gaps in the resources available to the job and what is actually expected?
8. What prompted you to leave the job? Looking back on the job, are there things you would have done differently?
9. What would you recommend to others taking on this role?
10. Do you have any recommendations for the board of directors about the Executive Director role?

Appendix 2c: Questionnaire

I have a few questions regarding your demographic background. Your answers to these questions will be combined with others in order to get a picture of the background and health of people at your work location. The answers to these questions are confidential and I will be careful to only present them in aggregate form in the research. You may refuse to answer any question for any reason.

Demographic Information

Q1. What is your birth date? Month: _____ Year: _____

Q2. What is your gender?

1. Female
2. Male
3. Transgender

3. In what country or region were you born?

1. Canada skip to Q5
2. Please specify: _____

Q4. When did you move to Canada? Year: 19____

Q5a. Are you an Aboriginal person?

1. Yes.
2. No skip to Q6

Q5b. If you are Aboriginal, are you:

1. First Nation - Status
2. First Nation - Non-Status
3. Metis
4. Inuit
5. Other: Please Specify: _____

Q6. The employment equity act defines visible minorities as persons, other than Aboriginal people, who are non-Caucasian in race or non-white in colour. Are you a visible minority member according to this definition?

1. Yes
2. No

Q7a. What is the highest grade of regular school that you completed? Grade: _____

Q7b. Have you completed any postsecondary training? Please mark all that apply.

1. Short Certificate Programs
2. Incomplete Apprenticeship
3. Complete Apprenticeship: Specify _____

- 4 Incomplete Trade School
5. Complete Trade School: Specify _____
6. Incomplete Diploma Program
7. Complete Diploma Program: Specify _____
8. Incomplete post secondary degree program: Specify number of years completed

9. Complete post-secondary degree program Specify _____
10. Complete graduate degree program (M.A./PhD) specify

11. Other _____

Q8a. How many *children* (18yrs <) currently live in your household for whom you are providing care (your children or another person's children)?

Q8b. How many children have you given birth to? _____

Q9. What is your marital status?

1. Single
2. Common law
3. Married
4. Committed Relationship (not living together)
5. Other: _____

Q10. What is your gross annual household income (including you and other income earners in your home)?

1. \$0-20,000
3. \$20,001-40,000
5. \$40,001-60,000
6. \$60,001-80,000
7. >\$80,001

Work

Q11a. When did you begin working at PEERS?

Month: _____ Year: _____

Q11b When did you stop working at PEERS?

Month: _____ Year: _____

N/A I currently work at PEERS **skip to Q12**

Q11c Where are you currently working if you are not at PEERS? _____

Q12. Do/did you work at PEERS

1. Full-time
2. Part-time
3. Contract - Specify average number of hours per week: _____

Q13a. Do/did you have any other paid jobs?

1. Yes.
2. No skip to Q13

Please list: _____

Q13b What kind of work do you do at your other job (place and job title)?

Q13c: Do/did you have any volunteer jobs?

Please specify _____

Job Content Questionnaire – (author Karasek et. al.)

The following questions are standard questions used to measure work place experiences. Please answer based on your experience at PEERS.

Q14. My job requires that I learn new things.(JCQ3)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q15. My job involves a lot of repetitive work.(JCQ4)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q16. My job requires me to be creative.(JCQ5)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q17. My job allows me to make a lot of decisions on my own. (JCQ6)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q18. My job requires a high level of skill.(JCQ7)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q19. On my job, I have very little freedom to decide how I do my work.(JCQ8)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q20. I get to do a variety of different things on my job.(JCQ9)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q21. I have a lot of say about what happens on my job.(JCQ10)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q22. I have an opportunity to develop my own special abilities.(JCQ11)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q23. My job requires working very fast.(JCQ19)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q24. My job requires working very hard.(JCQ20)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q25. My job requires lots of physical effort.(JCQ21)

1. Strongly disagree
2. Disagree
3. Agree

4. Strongly agree

Q26. I am not asked to do an excessive amount of work. (JCQ22)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q27. I have enough time to get the job done.(JCQ23)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q28. I am often required to move or lift very heavy loads on my job.(JCQ24)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q29. My work requires rapid and continuous physical activity.(JCQ25)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q30. I am free from conflicting demands that others make.(JCQ26)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q31. My job requires long periods of intense concentration on the task. (JCQ27)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q32. My tasks are often interrupted before they can be completed, requiring attention at a later time. (JCQ28)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q33. My job is very hectic.(JCQ29)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q34. I am often required to work for long periods with my body in physically awkward positions.(JCQ30)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q35. I am often required to work for long periods with my head or arms in physically awkward positions.(JCQ31)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q36. Waiting on work from other people or departments often slows me down on my job. (JCQ32)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q37. My job security is good.(JCQ34)

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q38. How steady is your work?(JCQ33)

1. Regular and steady
2. Seasonal
3. Frequent layoffs
4. Both seasonal and frequent layoffs
5. Other: Please explain: _____
_____)

Q39. During the past year, how often were you in a situation where you faced job loss or layoff?(JCQ35)

1. Never
2. Faced the possibility once
3. Faced the possibility more than once
4. Constantly

5. Actually laid off

Q40. Sometimes people permanently lose jobs they want to keep. How likely is it that during the next couple of years you will lose your present job with your employer?

1. Not at all likely
2. Not too likely
3. Somewhat likely
4. Very likely

Q41. One way or another, customers or clients can influence the kind of service I provide.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q42. I can affect what the clients or customers want.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q43. Satisfying the customer(s) provides me with an important source of challenges on the job.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q44. I am subject to hostility or abuse from clients or customers.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q45. I am appropriately rewarded for my work.

1. Strongly disagree
2. Disagree
3. Agree
4. Strongly agree

Q46. I am satisfied with my job

1. Strongly disagree
2. Disagree
3. Agree

4. Strongly agree

Q47. How often are you exposed to dangerous chemicals on your job?

1. Never
2. Seldom
3. Sometimes
4. Often
5. Very often

Q48. How often are you exposed to dangerous working conditions?

1. Never
2. Seldom
3. Sometimes
4. Often
5. Very often

Q49. Do you have access to protective gear or safety equipment/devices?

1. Never
2. Seldom
3. Sometimes
4. Often
5. Very often

Q50. How often do you use protective gear or safety equipment/devices at work?

1. Never
2. Seldom
3. Sometimes
4. Often
5. Very often

Health (OHS)

The next few questions are about your health.

Q51. How would you rate your physical health?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Q52. How would you rate your mental health?

1. Excellent
2. Very good
3. Good

4. Fair
5. Poor

Q53. In the last six months, would you say that most days at work were:

1. Not at all stressful
2. Not very stressful
3. A bit stressful
4. Quite a bit stressful
5. Extremely stressful

Q54. In the last six months, how many days did you not work (for part or all of your normal work day) because you were too unwell, either physically or mentally, to perform your work duties?

1. 0 days
2. 1-2 days
3. 3-4 days
4. 5-6 days
5. More than 6 days

Q55. Do you have dental benefits/coverage?

1. Yes
2. No skip to Q57

Q56. Where do your benefits come from?

1. Work sponsored plan
2. Spousal/Family member's work sponsored plan
3. Educational institution plan
4. Privately purchased plan
5. BC Benefits sponsored plan
6. Other: _____

Q57. Do you have extended health benefits/coverage?

1. Yes
2. No skip to Q59

Q58. Where do your extended health benefits come from?

1. Work sponsored plan
2. Spousal/Family member's work sponsored plan
3. Educational institution plan
4. Privately purchased plan
5. BC Benefits sponsored plan
6. Other: _____

Q59. Have you ever taken a leave of absence from work at PEERS for work related health reasons?

1. Yes

2. No

Beck Inventory (Beck et. al., 1979)

Please read each group of statements carefully then pick out the one statement in each group that best describes the way you have been feeling the past week, including today.

Circle the number of the statement you picked.

If several statements in the group seem to apply equally well, check each one.

Q60.1

0. I do not feel sad.
1. I feel sad.
2. I am sad all the time and I can't snap out of it.
3. I am so sad or unhappy that I can't stand it.

—

Q60.2

0. I am not particularly discouraged about the future.
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel that the future is hopeless and that things cannot improve.

Q60.3

0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. As I look back on my life, all I can see is a lot of failures.
3. I feel I am a complete failure as a person.

Q60.4

0. I get as much satisfaction out of things as I used to.
1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

Q60.5

0. I don't feel particularly guilty
1. I feel guilty a good part of the time
2. I feel quite guilty most of the time
3. I feel guilty all of the time

Q60.6

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.

3. I feel I am being punished.

Q60.7

0. I don't feel disappointed in myself.
1. I am disappointed in myself.
2. I am disgusted with myself.
3. I hate myself.
-

Q60.8

0. I don't feel I am any worse than anybody else.
1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.
-

Q60.9

0. I don't cry more than usual.
1. I cry now more than I used to.
2. I cry all the time now.
3. I used to be able to cry, but now I can't cry even though I want to.
-

Q60.10

0. I am no more irritated now than I ever am.
1. I get annoyed or irritated more easily than I used to.
2. I feel irritated all the time now.
3. I don't get irritated at all by the things that used to irritate me.
-

Q60.11

0. I have not lost interest in other people.
1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.
-

Q60.12

0. I make decisions about as well as I ever could.
1. I put off making decisions more than I used to.
2. I have greater difficulty in making decisions than before.
3. I can't make decisions at all anymore.
-

Q60.13

0. I don't feel I look any worse than I used to.
1. I am worried that I am looking old or unattractive.
2. I feel that there are permanent changes in my appearance that make me look unattractive.
3. I believe that I look ugly.
-

Q60.14

0. I can work about as well as before.

1. It takes an extra effort to get started at doing something.
 2. I have to push myself very hard to do anything.
 3. I can't do any work at all.
-

Q60.15

0. I can sleep as well as usual.
 1. I don't sleep as well as I used to.
 2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3. I wake up several hours earlier than I used to and cannot get back to sleep.
-

Q60.16

0. I don't get more tired than usual.
1. I get tired more easily than I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

Q60.17

0. My appetite is no worse than usual.
 1. My appetite is not as good as it used to be.
 2. My appetite is much worse now.
 3. I have no appetite at all anymore.
-

Q60.18

0. I haven't lost much weight, if any, lately.
 1. I have lost more than 5 pounds lately.
 2. I have lost more than 10 pounds lately.
 3. I have lost more than 15 pounds lately.
- I am purposely trying to lose weight by eating less. " Yes / " No
-

Q60.19

0. I am no more worried about my health than usual.
 1. I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
 2. I am very worried about physical problems and it's hard to think of much else.
 3. I am so worried about my physical problems that I cannot think about anything else.
-

Q60.20

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely

Maslach Inventory (Human Services Workers) (author Maslach and Jackson 1986)

The next few questions are about your feelings at work.

Please answer the following questions based on your work at PEERS.

Q61. I feel emotionally drained from my work.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q62. I feel used up at the end of the workday.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q63. I feel fatigued when I get up in the morning and I have to face another day on the job.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q64. I can easily understand how my clients feel about things.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q65. I feel I treat some clients as if they were impersonal objects.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q66. Working all day with people is really a strain for me.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q67. I deal very effectively with the problems of my clients.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q68. I feel burned out from my work.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q69. I feel I'm positively influencing other people's lives through my work.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q70. I've become more callous toward people since I took this job.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q71. I worry that this job is hardening me emotionally.

- 0 never

- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q72. I feel very energetic.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q73. I feel frustrated by my job.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q74. I feel I'm working too hard on my job.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q75. I don't really care what happens to some of the clients.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q76. Working with people directly puts too much stress on me.

- 0 never
- 1 A few times a year or less

- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q77. I can easily create a relaxed atmosphere with my clients.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q78. I feel exhilarated after working closely with my clients.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q79. I have accomplished many worthwhile things in this job.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q80. I feel like I am at the end of my rope.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q81. In my work, I deal with emotional problems very calmly.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less

- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Q82. I feel clients blame me for some of their problems.

- 0 never
- 1 A few times a year or less
- 2 Once a month or less
- 3 A few times a month
- 4 Once a week
- 5 A few times a week
- 6 Every day

Others Attitudes towards PEERS (adapted from Wahl, 1999)

Q83. I worry that others see me unfavourably because I work at PEERS-Victoria.

- 1. (Almost) Never
- 2. Seldom
- 3. Sometimes
- 4. Often
- 5. (Almost) Always

Q84. I have heard people saying unfavourable things about PEERS- Victoria.

- 1. (Almost) Never
- 2. Seldom
- 3. Sometimes
- 4. Often
- 5. (Almost) Always

Q85. I have avoided telling people outside my family that I work at PEERS Victoria.

- 1. (Almost) Never
- 2. Seldom
- 3. Sometimes
- 4. Often
- 5. (Almost) Always

Q86. I have been treated unfairly by others when they learned I work at PEERS-Victoria.

- 1. (Almost) Never
- 2. Seldom
- 3. Sometimes
- 4. Often
- 5. (Almost) Always

Q87. I have avoided listing my history as an employee of PEERS when filling out applications for jobs, housing etc.

1. (Almost) Never
2. Seldom
3. Sometimes
4. Often
5. (Almost) Always

Q88. Members of the broader community avoid PEERS-Victoria.

1. (Almost) Never
2. Seldom
3. Sometimes
4. Often
5. (Almost) Always

Q89. Society members treat PEERS-Victoria and its representatives according to stereotypes.

1. (Almost) Never
2. Seldom
3. Sometimes
4. Often
5. (Almost) Always

Q90. The community is supportive of the work conducted by PEERS Victoria.

1. (Almost) Never
2. Seldom
3. Sometimes
4. Often
5. (Almost) Always

Q91. Funders are supportive of the work conducted by PEERS-Victoria.

1. (Almost) Never
2. Seldom
3. Sometimes
4. Often
5. (Almost) Always

Link and Phelan Scale

Q92. Most people would willingly accept someone who works at PEERS as a close friend:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q93.. Most people believe that a person who works at PEERS is just as intelligent as the

average person:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q94. Most people believe that someone who works at PEERS is just as trustworthy as the average citizen:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q95. Most people would accept someone who works at PEERS as a teacher of young children in a public school:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q96. Most people feel that working at PEERS is a sign of personal failure:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q97. Most people would not hire someone who works PEERS to take care of their children, even if he or she had children of their own:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q98. Most people think less of a person who works at PEERS:

1. Strongly agree
2. Agree

3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q99. Most employers will hire someone who works at PEERS if he or she is qualified for the job:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q100. Most employers will pass over the application of someone who works at PEERS in favour of another applicant:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q101. Most people in my community would treat someone who works at PEERS just as they would treat anyone:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q102. Most young people would be reluctant to date someone who works at PEERS:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat
5. Disagree
6. Strongly disagree

Q103. Once they know a person who works at PEERS, most people will take their opinions less seriously:

1. Strongly agree
2. Agree
3. Agree somewhat
4. Disagree somewhat

- 5. Disagree
- 6. Strongly disagree

Appendix 3: Community Interview
Courtesy Stigma: A Hidden Health Concern?

Community Supplement

1. Can you tell me about where you work (paid employment). What is your role at work?
2. In what ways do you/have you worked with PEERS-Victoria or representatives? What have been the benefits and challenges of this involvement? Please give examples if possible.
3. Do you serve persons working in the sex industry in your line of work? In what ways? What kinds of success and challenges have you faced in providing services to this population and/or the population of persons you serve?
4. What are the contributions of PEERS-Victoria to the local service community in your opinion/experience?
5. What are some of the challenges that have faced PEERS Victoria in your opinion/experience?
6. Are you familiar with the “experiential” or peer-based employment model used at PEERS? What are some of the benefits and challenges of this model (generally and at PEERS).
7. In what ways could PEERS Victoria improve its services to persons working in the sex industry and contribution within the service community? (sub questions: barriers, issues affecting the non-profit service sector, and if relevant, your own work)