

Courtesy stigma: a hidden health concern among front-line service providers to sex workers

Rachel Phillips¹, Cecilia Benoit^{1,2}, Helga Hallgrimsdottir² and Kate Vallance¹

¹*Centre for Addictions Research of British Columbia, University of Victoria, British Columbia, Canada*

²*Department of Sociology, University of Victoria, British Columbia, Canada*

Abstract Courtesy stigma, also referred to as ‘stigma by association’, involves public disapproval evoked as a consequence of associating with a stigmatised individual or group. While a small number of sociological studies have shown how courtesy stigma limits the social support and social opportunities available to family members of stigmatised individuals, there is a paucity of research examining courtesy stigma among the large network of people who provide health and social services to stigmatised groups. This article presents results from a mixed methods study of the workplace experiences of a purposive sample of workers in a non-profit organisation providing services to sex workers in Canada. The findings demonstrate that courtesy stigma plays a role in workplace health as it shapes both the workplace environment, including the range of resources made available to staff to carry out their work activities, as well as staff perceptions of others’ support. At the same time, it was evident that some workers were more vulnerable to courtesy stigma than others depending on their social location. We discuss these results in light of the existing literature on courtesy stigma and conclude that it is an under-studied determinant of workplace health among care providers serving socially denigrated groups.

Keywords: courtesy stigma, sex work, non-profit health service organisations, workplace health, Canada

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 range from difficulty engaging in normal social interaction because of secrecy or shame to a societal discrediting of the stigmatised individual or group of individuals (Corrigan *et al.* 2004, Link and Phelan 2006, Scambler 2004). Expanding on Goffman’s social interactionist definition of stigma, Link and Phelan (2001) conceptualise stigma as the co-occurrence of labelling, stereotyping, separating, status loss and discrimination. Their definition, with its more explicit focus on structural contexts, has fostered stigma research in two additional areas:

(i) the translation of stigmas into broader sociocultural traditions and institutions, including social welfare policies and (ii) the interaction of stigmas with other determinants of health advantage and disadvantage (Link and Phelan 2006, Stuber *et al.* 2008). Given this more recent structural focus, stigmas emerge as a wide-ranging social determinant of health affecting not only identity formation and social interaction, but also access to a range of health and social welfare resources (Pescosolido *et al.* 2008, Stuber *et al.* 2008).

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 those who are closely associated with stigmatised individuals and groups: 'the problems faced by stigmatised persons spread out in waves of diminishing intensity among those they come in contact with'. Despite this initial foray into the concept of courtesy stigma (also called stigma-by-association or associative stigma), relatively few studies have attempted to study its impact on the everyday life of those who support stigmatised people.

There is small body of work addressing the courtesy stigma experienced by family members of stigmatised individuals, including, most notably, people affected by cognitive disability, HIV/AIDS, or psychiatric illness (Birenbaum 1970, Corrigan and Miller 2004, Gray 2002, Green 2003, Khamis 2006, Turner *et al.* 2007). In one of the first studies on the topic, Birenbaum (1970) observed that social interaction between mothers of children with cognitive disabilities and other parents was inhibited in social settings as parents tended to either draw attention to, or conspicuously ignore, their child's disability in order to manage others' potential biases and judgments. More recent studies of parents of children with a disability also emphasise how courtesy stigma, much like primary stigma, contributes to inhibited and negative social interactions with others as parents may perceive judgment and blame from others with regard to their child's disability and related behaviour, or the manner in which they care for their children. Perceptions of judgment and experiences of discrimination lead to strained social interactions, which in turn contribute to reduced social support, isolation and associated health outcomes such as increased stress and depression (Gray 2002, Corrigan and Miller 2004, Green 2003, Khamis 2006, Thomas 2006, Turner *et al.* 2007, Norvilitis *et al.* 2002). Courtesy stigma has also been shown to place pressure on the relationships between stigmatised individuals and their family members, ultimately impacting on the capacity for care in families (Green 2004).

A few authors, however, have found that experiences of courtesy stigma vary (MacRae 1999, Kusow 2004). These authors show how the relationship between courtesy stigma and health may be moderated by the nature of the relationship, stigma content and relative access to social resources such as income, education and protective social networks (Corrigan and Miller 2004, Green 2004, Kusow 2004, MacRae 1999, Turner *et al.* 2007). While one might expect higher socioeconomic status to be associated with reduced courtesy stigma, Phelan *et al.* (1998) found that better educated individuals were more likely to report experiencing avoidance on the part of others because their family member had a stigmatised condition. The authors interpreted this finding as possibly the result of the greater perceptiveness of stigma processes due to education or the diminished tolerance of stigma among more affluent individuals (Phelan *et al.* 1998). This research suggests that there is a great need to better understand the various factors that interact to produce variations in courtesy stigma.

Corrigan and Miller (2004) note two underlying narratives tend to give rise to courtesy stigma: blame and contagion. Parents, especially mothers, of individuals with stigmatised health conditions and related behaviour are especially likely to experience feelings of blame and guilt related to their child's stigma (Green 2004, Owens *et al.* 2008). These perceptions

have a sociocultural foundation. In the first half of the 20th century, especially among proponents of eugenics, mental health and disability were publicly regarded as the outcome of poor parenting (either unfortunate procreating or bad parenting skills) and these dated assumptions continue to be embraced by many members of the general public (McLaren 1990). Narratives concerning a socially or biologically damaged family of origin do not necessarily apply to the professional associates of stigmatised individuals; however, contagion, contamination and corruption narratives may. These narratives call into question the moral orientation as well as physical hygiene of individuals who are professional associates of stigmatised groups.

Supporting the relevance of corruption and contamination narratives, another tenuous dimension of courtesy stigma identified in the literature concerns the ascription of characteristics of the stigmatised group to their associates – ‘being known by the company we keep’ (Kulik *et al.* 2008, Neuberg *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 to be homosexuals. Kulik *et al.* similarly found that employees who associated with stigmatised co-workers were regarded negatively due to automatic processing:

[T]he 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. (Kulik *et al.* 2008: 219)

The extent to which a relationship is perceived as voluntary or involuntary, susceptible to contagion (which can also include contagion of ideas or behaviour) and the degree of similarity of descriptive information between stigmatised individuals and their associates (in terms of age, gender, social status and perceived moral orientation) can all have an effect on the degree of courtesy stigma ascribed (Kulik *et al.* 2008).

A very small number of academic studies have taken up the topic of courtesy stigma and professional service provision to stigmatised groups. Using a longitudinal, multi-questionnaire design, Snyder *et al.* (1999) examined higher rates of turnover among volunteers supporting people with AIDS than other hospice volunteers. In contrast to the vast literature exploring social support as a buffer to stress, the authors found that social support was negatively linked to the duration of volunteerism because volunteers who experienced courtesy stigma in their social networks were more likely than those who did not to experience psychic distress in relation to their volunteer role (Snyder *et al.* 1999).

In another study focusing on healthcare environments, it was observed that nursing students had negative perceptions of both mental health professionals and their patients (Sadow *et al.* 2002). 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 may be managed is by using professionalisation narratives to emphasise the social difference between those who receive service, and those who provide it (Baines *et al.* 1992).

Several scholars have also noted that primary stigma goes hand-in-hand with the systemic provision of underfunded and inferior health and welfare services (Birenbaum 1970, Link *et al.* 2008, Scambler 2009). Since the 1970s governments in many high-income countries

have implemented a series of reforms in their healthcare systems to improve efficiency and effectiveness. Many of these reforms have been of a market-oriented character, involving the deregulation of key services, the creation of competitive markets and the privatisation of health and social care (Benoit *et al.* 2010a, Harvey 2005). Among the hardest hit by these neoliberal reforms are services to vulnerable groups and the workforces who provide those services (Benoit and Hallgrimsdottir 2011, Hall and Banting 2000, Saunders 2004). In times of fiscal restraint, the efficacy of public support services for vulnerable groups may be questioned and governments are especially inclined to experiment with cost-cutting measures (Benoit and Hallgrimsdottir 2011). One such measure has been the downloading of responsibility for health and social services from government agents to the community where non-profit organisations are increasingly being called upon to provide front-line support for groups such as poverty-stricken families, homeless youth and adults and people affected by mental health and addiction-related conditions (Benoit and Hallgrimsdottir 2011). A large body of scholarship on responsibility for the care of vulnerable groups has developed in response to these trends (Armstrong and Armstrong 2003, Benoit and Hallgrimsdottir 2011, England 2005). This literature reminds us that to understand the experiences of workers serving stigmatised groups it is necessary to take into consideration the structural backdrop in which care work exists. Doing so raises the question of how courtesy stigma and processes of neoliberalisation may be interrelated determinants of health among workers who serve stigmatised groups. This article explores this question by examining the experiences of workers providing services to one highly stigmatised group: adult sex workers. We now turn to the research design followed by a description of the research sample.

Research design and methods

The research reported below is drawn from a mixed methods study that combined participant observation, semi-structured interviews and a short self-administered questionnaire. The research was approved by the Human Research Ethics Board at the University of Victoria. A single research site – Peers Victoria Resources Society (PEERS) – where services are provided to sex workers in the Canadian city of Victoria, BC, was chosen because of the deeply negative stigmas associated with the ‘prostitute’ identity and because of an existing community academic collaborative relationship with this organisation (Hallgrimsdottir *et al.* 2006, Jansson *et al.* 2010). Further, PEERS has remained a largely female-dominated organisation over the course of its existence, lending an important gender perspective to the study. 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 stigmatised groups (Hochschild 1983: 13).

Given the rarity of studies on courtesy stigma among professional service providers, an exploratory research design involving repeated, open-ended interviewing was chosen (Guba and Lincoln 1994). The first author engaged in two rounds of participant observation and face-to-face interviews over a three-year period at PEERS. The research was conducted using a community academic collaborative model that involved the following features: the primary author volunteering at the organisation, the employment of a knowledge translator who was familiar with the research site and the standards of academic inquiry and extensive discussion of the findings with expert informants, both within and outside the organisation (Jansson *et al.* 2010).

Table 1 *Data summary*

	2006 <i>n</i>	2009 <i>n</i>	Total <i>N</i>
Interview 1	11	1	12
Interview 2	N/A	8	8 (of 12 noted above)
Questionnaire		17	17

Sample selection was based on theoretical selection, which focuses on ongoing, selective recruitment with the aim of reaching saturation in relation to the main research objectives (Glaser and Strauss 1967). In total, 12 employees participated in repeated qualitative interviews and 17 employees completed an additional questionnaire. The open-ended questions explored their work experiences including their job satisfaction, job autonomy, stress and social support, while the more closed-ended measures were used to describe the socioeconomic characteristics of the workforce at PEERS and for a general indicator of workplace health and experiences of stigma. The questionnaire measures were primarily drawn from standardised tools – including the Maslach burnout inventory (MBI) for human service workers, the Beck depression scale and the stigma scale (Beck *et al.* 1979, Link 1987, Maslach and Jackson 1981).¹ A summary of the research sample is presented in Table 1.

The data were collected using analogue recording equipment and transcribed by a professional transcriptionist. Analysis of the qualitative interviews was facilitated by the use of NVIVO. The questionnaire data were analysed using SPSS. The qualitative analysis focused on identifying themes and concepts repeated in the data, case-to-case comparison to highlight variations in experience, and sorting the data according to overriding theoretical questions and research objectives. Interpretation and verification was established through extensive discussion with expert informants and academic colleagues, including those involved in the authorship of this article.

Findings

Socioeconomic characteristics

Table 2 summarises descriptions of the age, gender, race, household income and family composition of individuals who work, or recently worked, at PEERS. It is noteworthy that all individuals who took part in the interview were women or male-to-female transgender. This finding mirrors other estimates that suggest that over three-quarters of paid and unpaid workers in the non-profit and care sectors are women (Benoit and Hallgrimsdottir 2011, Federation of Community Social Service Strategic Initiatives Fund [FCSS] 2009a, Mellow 2011, Saunders 2004). The median age of individuals 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 comparable levels of educational achievement with those in the broader social service community (FCSS 2009a). Despite their educational achievement, 77 per cent of the participants indicated that their annual household income was equal to, or less than, the census metropolitan area average. In addition, it is noteworthy that 35 per cent of the participants indicated they were single mothers, while only 12.7 per cent of families in the region are classified as female single-parent families (Statistics Canada 2011). These statistics support the available literature on the over-representation of marginalised identities in the front-line care work sector (Benoit and Hallgrimsdottir 2011).

Table 2 *Characteristics of PEERS staff compared with census metropolitan average (CMA)*

<i>Variable</i>	<i>PEERS staff (n = 17)</i>	<i>Victoria (CMA)†</i>
Median age	44	N/A
Female (%)	94	52
Visible minority (%)	6	10
Aboriginal (%)	6	3
Completed high school (%)	82	91
Completed university degree (%)	35	28 (people aged 35–64)
Household income (median)	\$38,000	\$53,310 (all households)
Report being a female single parent (%)	35	13 (among census families)

Source: †Statistics Canada (2010)

Workplace benefits and constraints

As other studies of personal service work have found, front-line service workers at the research site liked being able to provide care for those in need (England 2005, Zeliser 2002). The workers stated that providing tangible assistance resulting in improved wellbeing was one of the foremost rewards of their line of work, underscoring the notion that for some people, service work has significant normative implications which impart meaning and dignity to their work.

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 the workers over the long haul. When asked about the greatest challenges of the job, most participants pointed to a systemic dearth of meaningful support for their target group and the feeling that their services could do little to address the structural origins of their clients' cultural and economic marginalisation. Several workers noted that the current pattern of short-term contingent funding in the non-profit sector meant not only that staff resources were unduly directed at preserving organisation revenue but also there was a widespread sense that the organisation was perpetually involved in defending its value. As one worker noted:

You're fully responsible for finding all the money and then to discover that that happens every year ... 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. (R#2)

While unstable funding is a common stressor in the non-profit sector, at PEERS funding is inexorably linked to the fiercely contested moral and ideological views associated with the prostitution stigma. The funding available to the organisation was, in turn, described as pivotal to workers' experiences on the job. The workers described that there were inadequate resources to support human resource needs and programme development, as well as a sector-wide lack of allied resources to which to refer clients for complementary support. The emotional and clinical resources of PEERS' staff were taxed by their responsibility to help their clients navigate seemingly insoluble support needs. Feeling charged with the task of helping people in a context where the resources required to provide meaningful help were not perceived as available left many workers with a heightened sense of responsibility and tension regarding the limits of their workplace responsibility and rights. Evidence of this tension was demonstrated in the common talk of workplace boundaries – personal limits that workers develop in order to allow them to offer support without being harmed themselves:

I never found that I could ... go in, do a good job [and] go home' 'job well done'. I mean, somebody might go homeless tonight [or] 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 [but] if you care for people, you take them on. (R#2)

This quote typifies the great responsibility and associated stress that respondents described in conjunction with their role helping clients facing health crises and other hardships. Bearing in mind these contextual issues, the following section provides a closer look at how courtesy stigma is experienced by individual workers in their day-to-day work activities and at the intersection of their job and private lives.

Contexts of perceived and enacted courtesy stigma

Table 3 contains a selection of questionnaire responses to measures of perceived and enacted stigma (Link 1987). It is clear that research participants perceived that others questioned their knowledge and authority because of their association with the sex industry. These quantitative findings support the qualitative results presented above on funding support, and offer evidence that respondents felt stigmatised because of their work.

The participants noted a variety of contexts in which they experienced perceived and enacted courtesy stigma, both at home and on the job. While most participants noted that their friends and families accepted that their work was important, in many cases they reported that family members were either not comfortable talking about their work or found such conversation wearisome and value laden. 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)

Not being able to talk openly with family and friends about their job for fear of disapproval or a reluctance to burden others with the tension that surrounds the work resulted in a sense of isolation for some workers. These findings echo that of Snyder *et al.* (1999) who found the

Table 3 *Perceived and enacted courtesy stigma (questions adapted from Link, 1987)*

<i>Question</i>	<i>% agree (N = 17)</i>
Funders are supportive of the work conducted by PEERS Victoria	29
I have been treated unfairly by others when they have learned I worked at PEERS Victoria	35
I worry that others see me unfavourably because I work at PEERS Victoria	59
Most people think less of a person that works at PEERS Victoria	76
Once they know a person works at PEERS Victoria, most people will take their opinions less seriously	88

subtle and overt forms of disapproval from family and friends were implicated in high staff turnover rates.

Shifting from the family to the employment environment, the staff at PEERS described their experiences of both perceived and enacted stigma when representing the organisation in public education forums, when accompanying clients to appointments and when speaking to others about their employment. Enacted stigma was most often experienced when interacting with other professionals, leading to a heightened sense of vigilance when representing PEERS or accompanying the agency's clients into the community. Lending credence to the power of contamination narratives, many workers noted that they expected others to treat them negatively as representatives of PEERS. In particular, workers at PEERS felt that others made assumptions about their history and background because of their association with an organisation providing services for sex workers:

I saw the look on her [the 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)

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

As predicted by the literature, stories of enacted stigma were less commonly reported by respondents than descriptions of perceived stigma (Cree *et al.* 2004, Norvilitis *et al.* 2002, Scambler 2009). A pervasive theme among the participants was a general sense of not being perceived as an equal member of the social service community:

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)

Public response to the idea of working in an organisation that supports sex workers was reported to be varied and unpredictable, ranging from being valorising, belittling, disdainful or voyeuristic. Anticipating discrimination, the participants described the pressure to frame their work in particular ways to potential funders to increase the likelihood that their funding requests would be successful:

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)

This strategy, which Goffman (1963) referred to as impression management, also occurred when presenting the work of PEERS to the community:

When talking about [sex workers'] strengths and de-criminalisation, 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. (R#11)

It was evident, however, that not all workers were equally vulnerable to courtesy stigma. Given the small sample, it was not possible to examine this variation statistically; however,

the qualitative data revealed three primary factors that interacted with courtesy stigma: education, occupational position and experience, and co-occurring stigmas. Perhaps the most striking finding was that workers who held formal educational credentials used their training to establish their 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 and they were also in the best position to advance counter-narratives regarding others' ignorance and misunderstanding (Phelan *et al.* 1998). 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)

This example of impression management supports the available literature that argues that workers use professionalisation – including attempts to distinguish themselves from those served – as a strategy to distance themselves from the stigmas associated with their clientele (Baines *et al.* 1992). Similarly, workers who held management positions showed more confidence with regard to managing stigma and several workers said that their confidence increased over time.

Regardless of credentials and experience, participants whose lives were marked by co-occurring stigmas – which in this project were most likely to be due to the personal history of one or more of sex industry work, problem substance use and poverty – were more likely to speak very negatively about the stigma surrounding their work, 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 the case of people who did not have a background similar to the PEERS clientele, it was easier to distance oneself from the stigma associated with working at PEERS:

Now, for me, it is a bit different because I came from a position of [employment prestige] and I carry the benefits of that ... into this job. (R#2)

However, as will be shown below, even workers who said they had assets with which to counter the negative effects of courtesy stigmas reported workplace health challenges. These findings lend support to the relevance of an intersectional approach to understanding courtesy stigma as a variable concept (Hankivsky and Cormier 2009). The findings presented here suggest that education, co-occurring stigmas and work experience moderate the effects of courtesy stigma, but it is likely that a range of other variables – including gender, age, ethnicity, income – also interact with courtesy stigma.

Health implications of courtesy stigma

As noted earlier, while the participants described the emotional rewards associated with providing front-line services, as well as a high degree of skill discretion and autonomy, the work was also described as very stressful, with stress and fatigue being commonly associated with a decision to leave the organisation:

I do like working on the front line 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 support in the community, it's the systemic issues. (R#6)

Table 4 *Health indicators*

<i>Measure</i>	<i>PEERS staff (N = 17)</i>
Report work to be 'quite a bit' or 'extremely' stressful (%)	65
Report health-related leave of absence (%)	41
Report 'five or more sick days' in last six months (%)	29
Mean emotional exhaustion (27 or greater = high)	27
Mean personal accomplishment (39 or greater = low)	42
Mean depersonalization (7–12 = moderate)	7

The questionnaire findings support the descriptions provided by PEERS staff of the health consequences of courtesy stigma. As reported in Table 4, a significant minority of the participants (41 per cent) reported taking a leave of absence for health reasons while at PEERS, and experiencing five or more days of sickness-related absence (29 per cent) in the previous six months.

According to the results of the Maslach burnout inventory, workers at PEERS demonstrated, on average, high levels of emotional exhaustion and a low sense of personal accomplishment; a finding that 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. As a point of comparison, workers at PEERS reported higher mean emotional exhaustion and lower mean personal accomplishment than sex workers and healthcare workers in Denmark. Both of these factors are known to be related to employee departure (Vanwesenbeeck 2005). Despite these indicators of workplace burnout, workers at PEERS did not report high levels of depersonalisation; a third indicator of burnout, which refers to the tendency of stressful working conditions to result in service providers' alienation from service recipients (Maslach and Jackson 1981). This finding fits the notion that front-line workers draw rewards from providing help to those in need.

Discussion and conclusion

The findings presented here indicate that courtesy stigma is a discernible feature of the everyday reality of employees at PEERS. The participants described inconsistent social support from family and friends over the services they provided sex workers, as well as perceived and enacted stigma from other professionals and the public at large. Yet many workers, armed with a strong belief in their mission and service philosophy, treated courtesy stigma as part of the job and developed various strategies to manage others' misinformation and stereotypes. These coping techniques included expressing disdain for the rules and traditions that govern other social service work environments as well as narrative traditions that underscore the necessity of providing services for sex workers, the providers' expertise on the subject of sex work and the innovative nature of the PEERS' service model.

As has been found in other research, not all individuals working at PEERS experienced courtesy stigma equally (Corrigan and Miller 2004, Khamis 2006, Kusow 2004, Green 2004, MacRae 1999, Turner *et al.* 2007). Those with better education and longer job tenure showed the most confidence in advancing counter-narratives in the face of perceived and enacted stigma, whereas workers who had less experience on the job or limited education and training appeared more likely either to withdraw from social interaction with others who may discriminate against them or to respond with anger when faced with perceived stigma.

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 stigmas as acutely stressful because of the implications for their personal identity. For these people, working at PEERS contained many benefits, including being able to fulfil the comparably more socially acceptable role of 'service provider' and 'advocate', and the chance to reframe a denigrated identity, but it also meant that the stigma associated with their identity as a former sex worker remained in the forefront of their employment experience (Sanders 2007).

The implications of a perceived courtesy stigma might easily be underestimated because actual instances of discrimination were relatively uncommon and many workers did not appear to internalise negative messages about their work, even if they found them bothersome. In addition, the effects of courtesy stigma may be considered to be relatively inconsequential, taking into account the fact that service providers at PEERS cite many sources of stress in their work environment, and there was the common perception among people within (and outside) the organisation that its hiring practices – in particular, hiring women with a background in the sex industry – meant that many employees would have health problems and stresses that preceded 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, was a minor and transitory determinant of workplace health compared to other stressors.

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 and one that cannot be reconciled here given data limitations (Benoit *et al.* 2010b, Link and Phelan 2002). However, the insights of stigma scholars who highlight the interconnectedness of various axes of marginalisation, as well as the interaction between social determinants of health, are useful in this context (Corrigan *et al.* 2004, Link and Phelan 2001, 2006, Scambler 2009). 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 experiences of demoralisation, Link (1987) hypothesised that perceptions of devaluation and discrimination would be correlated with poor employment and unemployment. Goffman (1963) similarly noted that individuals who perceive stigma will withdraw to a group of their 'own' and the 'wise', a strategy that may be helpful in reducing the stress associated with stigma, but is associated with limited social and economic opportunities (Miller and Kaiser 2001).

Viewed from this angle, courtesy stigma may be more pivotal to the organisational culture of PEERS than it would appear to be on the surface. It is likely to have played a key role in the low sense of accomplishment reported by PEERS' staff, the strained social relations among workers and between PEERS workers and other allied service organisations and ultimately, their reduced opportunities for organisational success.

The interconnected nature of the primary and courtesy stigma can also be seen at the structural level in government funding patterns across the sector. Primary stigmas against PEERS clientele are likely to combine with broader forces of neoliberalisation to intensify the well-documented pattern of limited funding across the health and social service sectors (Benoit and Hallgrimsdottir 2011, FCSS 2009b). The under-resourcing of services to vulnerable, often stigmatised groups was arguably deepened at PEERS as the seemingly specialised nature of their services, and the misinformation circulated about the service needs of sex workers, narrowed the scope of their claims for public support. At the same time, their

clients faced seemingly insurmountable barriers to optimal health due to the multipronged effects of stigma (Strike *et al.* 2004, Link and Phelan 2006, Link *et al.* 2001).

Workers at PEERS were especially vulnerable in the face of these strains as many reported limited alternative employment opportunities due to a 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. It is also arguable that PEERS provides an example of how the effects of neoliberalisation and devaluation of care work in the social services sector is disproportionately borne by marginalised groups and the vulnerable workers who serve them (Benoit and Hallgrimsdottir 2011, Dolan and Thien 2008, Purkis *et al.* 2008). However, the sensational aspects of sex work stigma are also associated with sustained public interest in public programmes and policies targeting the sex industry (Hallgrimsdottir *et al.* 2006). By emphasising aspects of sex work that resonated with common stereotypes, workers at PEERS gained social support for their work, while they actively participated in the reification of sex work stereotypes. For example, in order to secure funding in the current economic climate, which has prompted cutbacks to health and social services, workers at PEERS had often emphasised how their service group was associated with risks to public health, an assumption which is challenged by the sex industry literature (Benoit and Shaver 2006). Another implication of funding patterns for the organisation was that employment positions at PEERS were experienced as insecure. This insecurity was compounded by the pressures arising from working in a sector that is marked by an uneven and disjointed continuum of services. In this unstable climate there is little opportunity to invest in human resources and strategic planning, as there is an overriding need to direct resources to front-line service provision.

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, unhealthy working conditions for service providers are transmitted to service recipients through various sub-optimal service delivery practices (Benoit and Hallgrimsdottir 2011, Yoo and Brooks 2005). High turnover is also associated with significantly reduced service capacity (FCSS 2008). In sum, our findings suggest that primary and courtesy stigmas intermingle at PEERS, resulting in a reduction in service capacity via multiple routes, including funding, service provider health, organisational conflict and turnover, and strained collaborative service relationships with other providers in the community.

This study is not without important limitations. The foremost of these is that the small, single site sample did not allow statistical investigation of predictors of courtesy stigma. In addition to a need for research with a larger sample of workers, there is a great need for comparative research on workers serving more and less stigmatised groups and among workers who experience different levels of structural disadvantage. Future studies could examine the independent impact of courtesy stigma among workers in two service sites, one caring for a highly stigmatised group (for example, sex workers) and one that is less stigmatised (for example, seniors). With further research, the findings presented here could have long-range implications for various professions across both the health and social service sectors where people with disabilities, blood-borne diseases, drug and alcohol problems and other stigmatised conditions seek social welfare support.

Despite their preliminary nature, the findings of this research support a number of policy and programme recommendations. Firstly, echoing others who have suggested that health and social service sites are a primary location for stigma remediation, this research suggests that it is crucial to not only educate the staff serving vulnerable groups about stigma in service environments, but also to invest in employee wellness strategies that take into

consideration the vulnerability of front-line workers, particularly those with limited education and workplace autonomy (Lee *et al.* 2005, Link *et al.* 2008, Wieloch 2002). In addition to educating and supporting workers in specific sites where stigmatised groups are served it is also crucial to take a collaborative, inter-sectoral and coalitional approach to stigma, not only because such an approach is likely to have a greater impact on public awareness and public policy, but also because it helps both to overcome the tendency for essentialist discourse to emerge regarding stigmatised identities, and to address more effectively the complex interconnections among processes of social and economic marginalisation (Scambler 2009).

Address for correspondence: Rachel Phillips, Centre for Addictions Research of BC, University of Victoria, PO Box 1700 STN CSC, Victoria, British Columbia, V8W 2Y2, Canada
e-mail: rachelph@uvic.ca

Acknowledgements

We are indebted to the staff of PEERS Victoria Resources Society, who kindly gave of their time and views. This research was supported by funding from the Canadian Institutes of Health Research, Institute of Neurosciences, Mental Health and Addiction.

Note

- 1 The MBI was developed by Christine Maslach and Susana Jackson (1981). It measures three dimensions of burnout: emotional exhaustion, depersonalisation and sense of personal accomplishment. The Beck depression inventory (BDI) was developed by Aaron Beck and colleagues and is a 21-question self-report inventory of depression symptoms (Beck *et al.* 1979). Due to length considerations, the results of the BDI are not reported in this article. The stigma scale is a 12-item measure of perceived devaluation and discrimination developed by Bruce Link (1987).

References

- Armstrong, P. and Armstrong, H. (2003) *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford University Press.
- Baines, C., Evans, P. and Neysmith, S. (1992) Confronting women's caring: challenges for practice and policy, *Affilia*, 7, 1, 21–44.
- Beck, A., Rush, A., Shaw, B. and Emery, D. (1979) *Cognitive Therapy of Depression*. New York: Guilford Press.
- Benoit, C. and Hallgrimsdottir, H. (eds) (2011) *Valuing Care Work: Comparative Perspectives*. Toronto: University of Toronto Press.
- Benoit, C. and Shaver, F.M. (2006) Critical issues and new directions in sex work, *Canadian Review of Sociology and Anthropology*, 43, 3, 243–52.
- Benoit, C., Zadoroznyj, M., Hallgrimsdottir, H., Treloar, A., *et al.* (2010a) Medical dominance and neoliberalisation in maternal care provision: the evidence from Canada and Australia, *Social Science & Medicine*, 71, 3, 475–81.
- Benoit, C., Shumka, L. and Barlee, D. (2010b) *Research brief 2: stigma and the health of vulnerable women*. Vancouver: Women's Health Research Network.

- Birenbaum, A. (1970) On managing a courtesy stigma, *Journal of Health and Social Behaviour*, 11, 3, 196–206.
- Corrigan, P. and Miller, F.E. (2004) Shame, blame and contamination: a review of the impact of mental illness stigma on family members, *Journal of Mental Health*, 13, 6, 537–48.
- Corrigan, P., Markowitz, F. and Watson, A. (2004) Structural levels of mental illness stigma and discrimination, *Schizophrenia Bulletin*, 30, 3, 481–91.
- Cree, V.E., Kay, H., Tisdall, K. and Wallace, J. (2004) Stigma and parental HIV, *Qualitative Social Work*, 3, 1, 7–25.
- Dolan, H. and Thien, D. (2008) Relations of care: a framework for placing women and health in rural communities, *Canadian Journal of Public Health*, 99, Suppl. 2.
- England, P. (2005) Emerging theories of care work, *Annual Review of Sociology*, 31, 1, 381–99.
- Federation of Community Social Service Strategic Initiatives Fund (FCSS) (2008) *Factsheet 1.3: Recruitment and retention initiative. The cost of worker turnover*. Victoria: Federation of Community Social Service Strategic Initiatives Fund.
- Federation of Community Social Service Strategic Initiatives Fund (2009a) *Factsheet 1.1: recruitment and retention initiative. Labour profile: British Columbia's community social services sector*. Victoria: Federation of Community Social Service Strategic Initiatives Fund.
- Federation of Community Social Service Strategic Initiatives Fund (2009b) *Factsheet 1.7: Recruitment and retention initiative. Joining, staying and leaving: factors that influence labour movement in the social services workforce*. Victoria: Federation of Community Social Service Strategic Initiatives Fund.
- Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.
- Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Prentice Hall.
- Gray, D.E. (2002) 'Everybody just freezes. Everybody is just embarrassed': felt and enacted stigma among parents of children with high functioning autism, *Sociology of Health & Illness*, 24, 6, 734–39.
- Green, S.E. (2003) 'What do you mean "what's wrong with her"?: stigma and the lives of families of children with disabilities, *Social Science & Medicine*, 57, 8, 1361–74.
- Green, S.E. (2004) The impact of stigma on maternal attitudes toward placement of children with disabilities in residential care facilities, *Social Science & Medicine*, 59, 4, 799–812.
- Guba, E. and Lincoln, Y. (1994) Competing paradigms in qualitative research. In Denzin, N. and Lincoln, Y. (eds) *Handbook of Qualitative Research*. Thousand Oaks: Sage.
- Hall, M. and Banting, K. (2000) The nonprofit sector in Canada: an introduction. In Banting, K. (ed.) *The Nonprofit Sector in Canada: Roles and Relationships*. Kingston: Kingston School of Policy Studies: Queen's University.
- Hallgrimsdottir, H., Phillips, R. and Benoit, C. (2006) Fallen women and rescued girls: social stigmas and media narratives of the sex industry in Victoria, B.C. 1980–2005, *Canadian Review of Sociology and Anthropology*, 43, 3, 265–80.
- Hankivsky, O. and Cormier, R. (2009) *Intersectionality: Moving Women's Health Research and Policy Forward*. Vancouver: Women's Health Research Network.
- Harvey, D. (2005) *A Brief History of Neoliberalism*. Oxford: Oxford University Press.
- Hochschild, A. (1983) *The Managed Heart: The Commercialization of Human Feeling*. Berkeley: University of California Press.
- Jansson, M., Benoit, C., Casey, L., Phillips, R., *et al.* (2010) In for the long haul: knowledge translation between academic and non-profit organizations, *Qualitative Health Research*, 20, 1, 131–43.
- Khamis, V. (2006) Psychological distress among parents of children with mental retardation in United Arab Emirates, *Social Science & Medicine*, 64, 4, 850–7.
- Kulik, C., Bainbridge, H. and Cregan, C. (2008) Known by the company we keep: stigma by association effects in the workplace, *Academy of Management Review*, 33, 1, 231–51.

- Kusow, A.M. (2004) Contesting stigma: on Goffman's assumptions of normative order, *Symbolic Interaction*, 27, 2, 179–97.
- Lee, S., Lee, M., Chiu, M. and Kleinman, A. (2005) Experience of social stigma by people with schizophrenia in Hong Kong, *British Journal of Psychiatry*, 186, 153–7.
- Link, B. (1987) Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection, *American Sociological Review*, 52, 1, 96–112.
- Link, B.G. and Phelan, J.C. (2001) Conceptualizing stigma, *Annual Review of Sociology*, 27, 363–85.
- Link, B.G. and Phelan, J.C. (2002) McKeown and the idea that social conditions are fundamental causes of disease, *American Journal of Public Health*, 92, 5, 730–2.
- Link, B. and Phelan, J. (2006) Stigma and its public health implications, *Lancet*, 367, 9509, 528–9.
- Link, B.G., Struening, E.L., Neese-Todd, S., Asmussen, S., et al. (2001) Stigma as a barrier to recovery: the consequences of stigma for the self-esteem of people with mental illnesses, *Psychiatric Services*, 52, 12, 1621–6.
- Link, B., Castille, D.M. and Stuber, J. (2008) Stigma and coercion in the context of outpatient treatment for people with mental illnesses, *Social Science & Medicine*, 67, 3, 409–19.
- McLaren, A. (1990) *Our Own Master Race: Eugenics in Canada, 1885–1945*. Toronto: Oxford University Press.
- MacRae, H. (1999) Managing courtesy stigma: the case of Alzheimer's, *Sociology of Health & Illness*, 21, 1, 54–70.
- Maslach, C. and Jackson, S.T. (1981) The measurement and experience of burnout, *Journal of Occupational Behaviour*, 2, 2, 99–113.
- Mellow, M. (2011). Voluntary caregiving? Constraints and opportunities for hospital volunteers. In Benoit, C. and Hallgrimsdottir, H. (eds) *Valuing Care Work: Comparative Perspectives*. Toronto: University of Toronto Press.
- Miller, C.T. and Kaiser, C.R. (2001) A theoretical perspective on coping with stigma, *Journal of Social Issues*, 57, 1, 73–92.
- Neuberg, S., Smith, D., Hoffman, J. and Russell, F.J. (1994) When we observe stigmatized and 'normal' individuals interacting: stigma by association, *Personality and Social Psychology Bulletin*, 20, 2, 196–209.
- Norvilitis, J.M., Scime, M. and Lee, J.S. (2002) Courtesy stigma in mothers of children with attention-deficit/hyperactivity disorder: a preliminary investigation, *Journal of Attention Deficit Disorder*, 6, 2, 61–8.
- Owens, C., Lambert, H., Lloyd, K. and Donovan, J. (2008) Tales of biographical disintegration: how parents make sense of their sons' suicides, *Sociology of Health & Illness*, 30, 2, 237–54.
- Pescosolido, B.A., Martin, J.K., Lang, A. and Olafsdottir, S. (2008) Rethinking theoretical approaches to stigma: a framework integrating normative influences on stigma (FINIS), *Social Science & Medicine*, 67, 3, 431–40.
- Phelan, J.C., Bromet, E.J. and Link, B.G. (1998) Psychiatric illness and family stigma, *Schizophrenia Bulletin*, 24, 1, 115–26.
- Purkis, M.E., Ceci, C. and Bjornsdottir, K. (2008) Patching up the holes: analyzing the work of home care. Finding dignity in health care and health care work, *Canadian Journal of Public Health*, 99, Suppl. 2, S27–32.
- Sadow, D., Ryder, M. and Webster, D. (2002) Is education of health professionals encouraging stigma towards the mentally ill? *Journal of Mental Health*, 11, 6, 651–665.
- Sanders, T. (2007) Becoming an ex-sex worker: making transitions out of a deviant career, *Feminist Criminology*, 2, 1, 1–22.
- Saunders, R. (2004) *Passion and commitment under stress: human resource issues in Canada's non-profit sector – a synthesis report*. Ottawa: Canadian Policy Research Networks.
- Scambler, G. (2004) Re-framing stigma: felt and enacted stigma and challenges to the sociology of chronic and disabling conditions, *Social Theory and Health*, 2, 29–34.
- Scambler, G. (2009) Health-related stigma, *Sociology of Health & Illness*, 31, 3, 441–55.

- Sigelman, C.K., Howell, J.L., Cornell, D.P., Cutwright, J.D., *et al.* (1991) Courtesy stigma: the social implications of associating with a gay person, *Journal of Social Psychology*, 131, 1, 45–56.
- Snyder, M., Omoto, A.M. and Crain, A.L. (1999) Punished for their good deeds: stigmatization of AIDS volunteers, *American Behavioral Scientist*, 42, 7, 1193–211.
- Statistics Canada (2011) *Community Profiles 2006*, available at <http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E> (last accessed 17 September 2011).
- Strike, C., O'Grady, C., Meyers, T. and Millson, M. (2004) Pushing the boundaries of outreach work: the case of needle exchange outreach programs in Canada, *Social Science & Medicine*, 59, 1, 209–19.
- Stuber, J., Meyer, I. and Link, B. (2008) Stigma, prejudice, discrimination and health, *Social Science & Medicine*, 67, 3, 351–7.
- Thomas, F. (2006) Stigma, fatigue and social breakdown: exploring the impacts of HIV/AIDS on patient and carer well-being in the Caprivi Region, *Namibia, Social Science & Medicine*, 63, 12, 3174–87.
- Turner, J., Biesecker, B., Leib, J., Biesecker, L., *et al.* (2007) Parenting children with proteus syndrome: experiences with, and adaptation to, courtesy stigma, *American Journal of Medical Genetics*, 143a, 18, 2089–97.
- Vanwesenbeeck, I. (2005) Burnout among female indoor sex workers, *Archives of Sexual Behaviour*, 34, 6, 627–39.
- Wieloch, N. (2002) Collective mobilization and identity from the underground: the deployment of 'oppositional capital' in the harm reduction movement, *Sociological Quarterly*, 43, 1, 45–72.
- Yoo, J. and Brooks, D. (2005) The role of organizational variables in predicting service effectiveness: an analysis of a multilevel model, *Research on Social Work Practice*, 15, 4, 267–77.
- Zelizer, V. (2002) How care counts, *Contemporary Sociology*, 3, 2, 115–19.