


# Stigmatization Among Drug-Using Sex Workers Accessing Support Services in Dublin

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## Abstract

Findings from 35 qualitative interviews with drug users who were engaging in or who had engaged in sex work in Dublin, Ireland, illuminated how, because of a result of felt stigma and internalized shame, they tried to hide their drug use, thus endangering their own lives. This group carried multiple layers of stigma because of sex work, drug use (including injecting drug use), and having contracted human immunodeficiency virus (HIV) or hepatitis C virus (HCV). This stigma was powerfully reinforced by the language routinely used by health professionals. To improve the effectiveness of harm-reduction interventions, it is recommended that service providers change their language, in particular in recognition of the human dignity of these clients, but also to help attract and retain drug users in services, and to help reduce the unacceptable mortality levels among drug users.

## Keywords

addiction / substance use; Europe, Western; health care professionals; hepatitis C; HIV/AIDS; qualitative analysis; sex workers; stigma

In this article we present selected findings on the felt stigma experienced by drug-using sex workers in Dublin, Ireland. We completed a field study for the Irish National Advisory Committee on Drugs (NACD) on sex work among drug users in Dublin. That research was conducted in response to Action 98 of the Irish National Drugs Strategy, which required the NACD to carry out research into problematic drug use among prostitutes because they were seen as an at-risk group (Cox & Whitaker, 2009). The role of the NACD is to advise the Irish government on problem drug use in Ireland in relation to prevalence, prevention, consequences, and treatment based on analysis and interpretation of findings. In his classic study on stigma, Goffman (1968) propounded that the stigmatized are disqualified from full social acceptance. In this article we unpack, analyze, and identify the multiple layers of stigma experienced by intravenous drug-using sex workers in Dublin society. The myriad of ways in which drug-using sex workers (both men and women) are stigmatized in Irish society are identified throughout the article. These multiple layers of stigma have also been referred to as multiplicative stigmatization because of poverty, drug use/abuse, positive human immunodeficiency virus (HIV) status, sex working, and so forth (Mosack, Abbott, Singer, Weeks, & Rohena, 2005). Reidpath and Chan (2005) suggested that

it is only through the understanding of the complexity of stigma, in particular the entanglement of the stigma attached to being HIV positive and to injecting drug use, that effective policies and interventions can be developed. Marginalized groups, such as drug-using sex workers who embody the risk factors for the transmission of HIV, are particularly stigmatized.

## Drug Use and Sex Work in Irish Society

It is difficult to estimate either the number of drug users who engage in sex work or the number of sex workers who use drugs in Irish society, because both activities are illegal, clandestine, hidden, and highly stigmatized. From the findings of the longitudinal research study “Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness” (Comiskey & Cox, 2007), in which subjects were selected

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from both inpatient and outpatient settings and from three modalities (methadone maintenance, structured detoxification, and abstinence-based treatment programs;  $n = 404$ ), the authors revealed that 9% of opiate users starting a new treatment episode reported having ever solicited/sold sex, and 4% reported recent (previous 90 days) involvement in sex work. Self-reported involvement in sex work among women was substantially higher: 23% of the women reported having ever sold sex and 14% reported recent involvement in sex work (Comiskey & Cox). In response to the threat of HIV, an outreach program was set up in 1988 by a statutory service to promote safer injecting techniques and safer sex. In 1991 a specific health project, Women's Health Project (WHP), for women working in prostitution, was established (O'Neill & O'Connor, 1999).

Many of the studies that have been conducted in Ireland have involved the WHP and have been Dublin based (Lawless, Wayne, Murphy Lawless, & Lalor, 2005; O'Connor, 1994; O'Connor, 2004; O'Connor & Healy, 2006; O'Connor, O'Neill, & Foran, 1996; O'Neill & O'Connor, 1999). Through research carried out with 84 women involved in prostitution in 1994 (O'Connor et al.), it was learned that a substantial number regularly used some kind of substance (alcohol 43%; cannabis 17%; ecstasy 11%; cocaine 8%; heroin 6%; methadone 5%; and sedatives, tranquilizers, or antidepressants 20%). Most of the women were taking more than one drug; three women who were on methadone maintenance were also taking heroin; three were injecting drug users (O'Connor et al.). However, a survey conducted 5 years later among 77 women prostitutes (95% were working on the streets) showed an increase in drug use: 87% had a history of drug use and 83% had injected drugs in the previous month (O'Neill & O'Connor). Of those surveyed, 38% were receiving methadone maintenance, 86% were injecting heroin, 10% were using street methadone, 52% cocaine, 21% ecstasy, 66% benzodiazepines, 27% antidepressants, and 43% cannabis. Women were asked to list their reasons for entering prostitution; 83% stated that it was to make money for drugs. These figures could reflect the greater availability of heroin in Dublin working-class communities in the early 1980s (Dean, Bradshaw, & Lavelle, 1983). These communities also suffered high unemployment, low levels of educational attainment, social deprivation, and economic marginalization (Murphy-Lawless, 2002). Participatory action research was conducted with a cohort of 19 women who had experienced prostitution to develop a model of support and intervention for marginalized women. The number of women who were using drugs was not given; however, it was evident from the findings that drugs and alcohol were sometimes used as a survival mechanism to work in prostitution: "The women would habitually get drunk or stoned or use prescription drugs in order to work

and then use drugs and alcohol to numb the pain of prostitution" (Lawless et al., 2005, p.4).

Two studies were carried out among men sex workers in Dublin (McCabe, 2005; Quinlan & Wyse, 1997). Research on 27 men sex workers found that the majority (90%) took drugs (alcohol, hashish, and poppers), and most were poly-drug users. Hashish (hash) is a form of cannabis derived from female marijuana plants. The street name for various alkyl nitrites, including isobutyl nitrite, butyl nitrite, and amyl nitrite, is *poppers*; they are used as a stimulant, producing a brief euphoric effect. Other drugs used were antidepressants, cocaine, acid, speed, Valium, methadone, glue, heroin/naps, and ecstasy. More than a third injected or had injected drugs in the past, of whom 5 had shared needles, whereas 6 stated that they had availed themselves of a needle exchange service. The majority of those who currently or formerly injected drugs had also had treatment for drug use (Quinlan & Wyse). It was revealed in a study of 12 men street prostitutes in Dublin that all 12 were drug users (7 of whom used heroin), and that they had commenced drug use prior to engaging in prostitution. Ten of the 12 men interviewed described themselves as heterosexual (McCabe). This finding supports findings from research carried out by the World Health Organization (WHO), that men who sell sex might not identify themselves as homosexual, and could have overlapping identities (WHO, Regional Office for the Western Pacific, 2001), such as being gay or heterosexual, bisexual, and transgendered (Sarma, 2007).

### Stigma in Irish Society

Stigma has been defined as an attribute that is deeply discrediting which leads an individual to occupy a tarnished and discredited identity and place in society (Goffman, 1968), leading the stigmatized to be disqualified from full social acceptance and also leading to the internalization of shame, self-hate, and self-derogation. These emotions arise from the individual's perception of one of his own attributes as being a defiling thing to possess. The unstigmatized or "normals" exercise varieties of discrimination through which they effectively and unthinkingly reduce the life chances of the stigmatized (Goffman, p. 15). Attributes such as drug addiction, imprisonment, homosexuality, and prostitution are deemed to be blemishes of individual character. Scambler (1984) differentiated between ascribed and achieved deviants. People who fit in the category "ascribed" are those who are born with a disability and who achieve their deviance independently of any purposeful activity, whereas those with an "achieved" deviance are those who, through their own actions, have broken the rules of society and who have achieved or earned deviance. Scambler (1984) suggested that there is greater stigma attached to achieved deviance.

It has been shown in international research how marginalized drug users not only experienced high levels of discrimination and stigma, but how these multifaceted experiences were associated with poorer physical and mental health (Ahern, Stuber, & Galea, 2007). Previous research has shown how certain groups such as drug addicts, prostitutes, those with an HIV diagnosis, gays, and unmarried mothers elicited a degree of prejudice in Irish society. Mac Gréil, in his study (1996) of prejudice among Irish people ( $n = 1,005$ ) in 1989, learned how severely drug users are stigmatized; he found that 34.9% of people would deny citizenship to "people with AIDS," and 43.7% would deny citizenship to "drug addicts." This has serious implications for the acceptance, support, and rehabilitation of this group. Other "out" groups subjected to negative attitudes included Travellers, gays, and those with HIV (Mac Gréil). Travellers are a White, indigenous, nomadic ethnic group in Ireland who are socially excluded and marginalized (Fountain, 2006).

Other more recent research highlighted the enduring stigmatization of those with an HIV-positive diagnosis. Among those living with HIV, 84% agreed that people with HIV are viewed negatively by Irish society, whereas 54% of the general public agreed with this judgment: they ranked people with HIV third, after drug users and Travellers (National Stamp Out Stigma Campaign, 2006). One in five people were worried about eating a meal that had been prepared by someone with HIV, and 37% agreed that if a family member were to contract the virus, they would keep the HIV status a secret. In a Dublin hospital setting, drug users who were HIV positive felt stigmatized by nurses (Surlis & Hyde, 2001). HIV was not the only blood-borne virus infection to elicit stigma. It was shown in previous Irish research that those with hepatitis C virus (HCV) have also been stigmatized. A study of 87 people awaiting interferon treatment for HCV in a Dublin hospital felt stigmatized and socially isolated, in addition to experiencing a fear of disclosure. High levels of stigma were experienced by those whose disease was associated with injecting drug use (Golden, Conroy, O'Dwyer, Golden, & Hardouin, 2006).

The stigma attached to prostitution has been well documented. O'Neill argued that sex work brings fear, violence (which can result in death), criminalization, stigmatization, and reduced civil rights (O'Neill, 1997/2007). Even in countries where prostitution has been legalized, it is argued that the prostitutes carry the stereotype of whore stigma (Scambler, 1997/2007). Petro argued that the isolated and stigmatized nature of sex work could be the greatest contributing factor to it being a dangerous profession (2010). Sanders (2005, p. 25) suggested that sex workers construct a "hierarchy of harms." Health risks and the obligatory use of condoms were considered a controllable aspect of their work; however, other aspects were out of their

control, such as the emotional and psychological consequences of being discovered (Sanders).

It has been suggested through the results of international research that the stigma attached to sex work and the deviant social status conferred on drug users has resulted in many people remaining invisible to services (Ahern et al., 2007; Day & Ward, 1997). Drug users who received treatment for their drug dependency often found it difficult to reintegrate into society. In three studies done in the United Kingdom, 76% of drug users described themselves as either drug free or in control, yet their common experience was one of feeling stranded and socially isolated within a drug subculture, unable to break through the wall of social exclusion and afraid to be with the nondrug-using population (Buchanan, 2004). Furthermore, the stigma attached to HIV is regarded as one of the major barriers to the development of effective prevention and care programs (Reidpath & Chan, 2005). Research shows that sex workers often experience discrimination and stigmatization, which in turn leads to abuse, violence, criminalization, denial of services, and low self-esteem (Rekart, 2005; Vanwesenbeeck, 2001).

## Methods

We utilized a qualitative methodological approach to explore the micro-risk environment within which problematic drug-using sex workers in Dublin live and work, because qualitative methods focus on the meanings, perceptions, processes, and contexts, and offer ways of understanding drug use and responses (European Monitoring Centre for Drugs and Drug Addiction, 2000; Marshall & Rossman, 2006; United Nations, 2004). A topic guide was developed through which we sought to elicit information on background, early years, initiation to drug use and sex work, involvement in drug treatment, the physical and social drug-use setting and sex-work setting, perceived risks of drug-use behavior and sex work, and the risk-reduction strategies (if any) drug-using sex workers engaged in. The primary research tool used to collect data was the individual, face-to-face, in-depth interview.

In line with previous NACD research, a research advisory group was set up, comprised of representatives from various agencies (including those working with drug users and those working with sex workers). The primary role of the research advisory group was to advise, guide, and manage the research project, to assist the researchers in locating respondents, and to help develop recommendations. Ethical permission for the study was sought from and granted by the Drug Treatment Centre Board in Dublin, on the condition that data would only be gathered from those over the age of 18 years. The Irish Prison Service Research Ethics Committee also gave ethical approval for the research, and access was granted to the women's

prison (Dóchas) in Dublin. An investigator brochure with information about the research was sent to all relevant agencies who participated in the research.

A research information sheet was given to respondents. Strict ethical guidelines were adhered to in that informed consent was sought; the study was explained to interviewees and all signed a confidentiality statement. Respondents were assured of anonymity in all published material. To be eligible for inclusion, all respondents had to be over the age of 18 years, and had to self-identify as a problematic drug user in that their drug use caused them social, psychological, physical, or legal difficulties. Respondents also were required to be currently engaged in sex work or have exited sex work after a sustained period of involvement. Respondents were compensated for their time with a €20 voucher. Internationally and nationally, payments for participation precedents have been set from previous research with those working in prostitution. In a study conducted in the United Kingdom, each participant was paid £20 in recognition of his or her contribution to the study (Cusick & Hickman, 2005). Respondents have also been paid in Canada (Erickson, Butters, McGillicuddy, & Hallgren, 2000) and the United States (Heckathorn, 1997; Inciardi & Surratt, 2001; Shaver, 2005). In Ireland, precedents for paying respondents have also been set (O'Connor, 1994; O'Connor et al., 1996), and in previous studies carried out by the NACD (Lawless & Corr, 2005). Respondents were happy to engage in the research and felt that they were doing a favor by participating. Interviews took approximately 1 hour.

Access to this group was through specialist agencies (drug treatment and homeless services, and services providing health treatment for sex workers). Agency workers approached drug-using sex workers and asked them if they would like to participate in the research; if they agreed, the researchers were contacted. To improve participation, posters and postcards containing information about the study were placed in all the drug treatment agencies in Dublin city center. Some respondents contacted the researchers independently. The final purposive sample consisted of 35 drug users who were currently engaged in or had exited sex work after a sustained period of involvement. The first author and lead researcher (Whitaker) conducted all of the interviews (31) with the women, and the second author (Ryan), conducted the remaining four interviews with the men sex workers. A short questionnaire that elicited information on current drug use, drug treatment, health and housing status, and involvement in crime was also administered. This asked about their sex work involvement and drug use in the previous 90 days.

Interviews were conducted in a variety of social settings, including an agency, a respondent's car, the office of the NACD, prison, a shopping center, and a pub. The agency that provided services for drug-using women who

were working in prostitution gave the lead researcher the use of a room in the agency at night during periods when outreach was being carried out for data gathering purposes. Most respondents were interviewed alone; however, in three cases two respondents (friends) presented together and asked if they could be interviewed together. These interviews had a different dynamic in that they increased the sense of empowerment experienced by respondents.

All interviews were audiorecorded and subsequently transcribed. We immersed ourselves in the data by listening to the tapes and reading the transcripts repeatedly. Recurring themes were identified and interpreted. Stigma was identified as increasing health risks because it influenced risk behavior; the myriad ways in which it did are presented below. Analysis of data was also facilitated by the qualitative social research computer software program NVivo (QSR International, 2006), and by the Statistical Package for the Social Sciences (SPSS).

The data were limited in a number of ways. All of the interviewees had been involved in both drug use and sex work for a long period of time, and had learned and implemented risk-reduction strategies; no interviews were conducted with new entrants to sex work who would not yet have learned risk-reduction strategies. Because interviewees were recruited through agencies, they might not have been representative of all drug-using sex workers in Dublin, or drug users who did not engage with services. Despite these limitations, the findings from this research are aligned to international literature, and this study provides rich descriptions of the living and working lives of this group.

Mason (1996) suggested that qualitative researchers should practice critical self-scrutiny or active reflexivity. Based on the belief that a researcher cannot be neutral, objective, or detached from the knowledge that he or she is generating, a researcher should seek to understand his or her role in the process. Using this definition of active reflexivity, as researchers we were acutely aware of the controversy surrounding sex work; however, we followed Scambler & Scambler's (1997/2007, p. xv) presumption of willful rationality, and their suggestion to respect the right of a sex worker's agency and right to self-determination, and that the starting point for any analysis be the respectful attribution of agency.

### *Profile of Sample*

The sample of drug-using sex workers interviewed in this study was comprised of 31 women and 4 men, 3 of whom self-identified as being gay. The average age was 32 years (median age = 29 years). All were White, indigenous Irish people; the majority from Dublin. More than half of the sample was actively involved in sex work at



the time of the interview; the remainder had not sold sex in the previous 90 days for a variety of reasons. Some were in prison, some were pregnant and had exited for the moment, one had recently had a baby, and some had exited for good after a sustained period of being involved in sex work. With regard to housing status, 4 of the women were in prison at the time of the interview; 4 had just been released from prison and were living in transitional accommodation. More than one fourth were living in emergency accommodation, mostly in city center hostels, and more than one third were renting in the private sector.

In terms of health status, the majority were accessing health care services, with less than 75% reporting having had a health check in the 90 days prior to the interview. The majority ( $n = 26$ ) self-reported as being HCV positive, whereas 7 reported being HIV positive. Only three respondents reported having a sexually transmitted infection for which they were receiving treatment.

The majority of respondents ( $n = 30$ ) were on methadone treatment; they were asked about their other drug use in the 90 days prior to the interview. Self-reported drug use was high among this group: 24 reported using street methadone, 22 used heroin, 16 took nonprescription benzodiazepines, 12 used cannabis, 10 used cocaine, and 5 used crack cocaine. All participants had a history of injecting drug use, and more than half the sample had injected in the previous 90 days; most were polydrug users.

Many of the respondents had legal issues: one fourth reported being on probation or community service, 13% were in prison on remand or serving a sentence, one fourth had outstanding fines, 19% had outstanding warrants, and 13% were on bail awaiting a hearing or sentencing. In short, this group was marginalized: they were dependent on illicit substances, had criminal records, were infected with HIV or HCV, and many were living in emergency accommodation. In addition, the majority of the sample were parents (24 mothers, 1 father); many of the mothers did not have custody of their children, which, for some, substantially added to their distress.

## Results

### *Drug Use and Sex Work*

All respondents were drug users prior to entering sex work. The median age of first drug use was 13 years (range 7 to 39 years). The average age at which they had entered sex work was 19 years (range 13 to 34). For most, entry into sex work was through friendship or family networks, and work was conducted on the streets. Two respondents moved from working in agencies to working on the street. A small number (4/35) were coerced or pimped into sex work, but as soon as they were able they either left sex work or continued to work alone. Three women worked

from city center apartments; two worked together. In addition to the money they earned from sex work, all were receiving welfare benefits.

Most respondents had experienced adversities in their early years, relating to some of the following issues: parental and/or sibling substance use, family conflict or breakup, chaotic home environment, child physical and/or sexual abuse, experience of being in care and/or youth homelessness, early withdrawal from school, bereavement(s), and other traumatic life events. Many had grown up in socially and economically deprived areas of the city where illegal drugs were easily available. They had also grown up during a period of economic recession in Ireland, in the 1980s and 1990s. Despite the normality of drug use in their lives, many felt stigmatized by it and used various strategies for coping with it.

### *Passing and Symbols of Stigma*

According to Goffman (1968), visibility and perceptibility are crucial factors in making stigmas apparent to others. "Passing" describes how those who are stigmatized try to conceal their stigma from others. Stigma symbols such as scarring from intravenous drug use can be hard to conceal; many of the research participants described how they tried their best to conceal the scars attached to puncture wounds and to pass as noninjecting drug users. They also tried to inject in less-conspicuous areas of the body, areas that are not on public view; thus, in some cases increasing the risks and dangers attached to injecting drug use. Some identified scarring as the worst legacy of drug use: "Oh yes, scarring on my body, that would be the main thing." To reduce the visibility of scars some respondents tried to inject in less-visible areas of their bodies, such as their necks, which could be hidden by long hair, or their feet, which could be hidden by shoes. For example, one respondent explained:

I inject in my neck because you can't really notice and then me foot, but your feet get very sore. But, it's like in my gaff [home], they think that I'm off it, so I have to inject, sort of away from the obvious so, you know what I mean like, so I don't get scars . . . so I try and go for anywhere but my arms.

Conversely, another respondent injected in her arm, which is a less dangerous injecting site than the groin, but injecting in the arm leaves tell-tale bruises which identified her as an injecting drug user:

Look at me arms [she pulled up her sleeve and showed a large bruise on her arm]. That was I couldn't get me groin the other night, and that's just from one little thing, hit, fuck it. The bruise is just spreading.

Years of injecting drug use inevitably left scars on their bodies, appearing like immoral stigmata. One respondent believed that these scars identified her as a drug user:

I think I'm prone to abscesses and scars. I've marks all over me. You know I've still got them. Marks from abscesses that I did have, you know that way, you see the abscesses left big marks, you know that way. Like what needles does, is it? . . . It's embarrassing, like, you know. It's only when you get older, you say, "What the fuck did I do that for?" There are people looking at you, and I never shoplift and I wouldn't shoplift, but I get followed everywhere. It's just that look, you have that look.

Whether or not they had scars, some believed that drug users are easily identifiable: "You know by the look of people whether they're on drugs or not."

### Covering

Goffman (1968) explored how the discredited manage information about their stigma through the management of impressions. A mother hid her drug use from her daughter by inventing the following cover story: "The only thing I will always remember is, I have scars physically and mentally; [physically] in the veins, from injecting. I just tell my kids I fell through a table." Two women who worked together invented cover stories for their respective husbands to explain why they were out all night:

Respondent (R) 1: We go together. A lot of times we would meet fellas [clients] in hotels and go for drinks with them first.

R 2: Some nights we used to dress up and go out with them for dinner, and then go back to the hotel, and then you can stay in the hotel. [laughter].

R 1: And you have to make up this excuse, "I'm off on a hen's [women's] night," or something. Ah, Jesus, the stories we have. We have got away with some of the stories.

### Stigma and Heroin Use

As already reported, the majority of the sample were either current injecting heroin users or had used heroin in the past. The stigma attached to drug addiction is not universally attached to all illicit drugs; some substances are more stigmatized than others. For example, respondents believed that heroin is more stigmatized than cocaine; in fact, one drug-using man was of the opinion that cocaine users were not stigmatized at all:

I have escaped, luckily, semi-unscathed. Most of the harm that has been done to me is emotionally, and in

terms of being left there to the side. You know, because I'm a social reject, because heroin is a social reject drug. It's okay to sniff a load of coke [cocaine], and act like an arsehole in a pub, but when you use heroin, you're a social reject. So, that's what really, really caused the significant damage.

Another young woman who used cocaine only when she was going out to [sex] work also shared this opinion:

And that was, it was only kind of a bit, if I was going out, I'd take it. That's what I'm saying, like, a lot of coke users think, ah like, you're only a junkie, you're only this and that and the other. At the end of the day, they're using class-A drugs as well. They've no business being hypocritical, putting anyone else down. I feel the stigmatism around heroin, you see, because coke is sociable and heroin is not. If you're taking heroin you're the scum of the earth, you know what I mean, the way people look at it. That's why I don't like the lifestyle that comes along with it.

### Using Alone

The internalization of the stigma attached to heroin use can result in the person eschewing other drug users, using (injecting or smoking) alone and increasing his or her own risks:

Well, I'd rather smoke alone because I don't like the whole circle, do you know what I mean, because there's a, with heroin there's like the stigma around it, it mingles together, I don't know. I find it dirty or something. I can't describe it, it's just, you know what I mean, like, the word "junkie," I don't like that. I class myself, "I'm an addict." I hate the word junkie. There is junkies. I believe that a junkie is a person that goes out and mugs people and things like that, that's a junkie. Well, that's my belief and my opinion. I don't like the circle that comes along with it, so I'd rather do things on my own and have me smoke.

Two women who presented together for the interview also preferred to use drugs alone:

R 1: It is a very hard thing to describe. You can just describe the psychological part and that, but, as in getting when you're in doing it and that, it's just so hard, you can't put it into words.

R 2: I like my own company.

R 1: I'm the very same

R 2: I love my own company.

R 1: I'm always on my own when I am smoking crack. Love my own company. They say you use

it as a sociable drug. I'm always on my own when I do it.

R 2: So am I. I choose to be on my own.

R 1: That's the way I do it.

R 2: I like to go, score my balls, whatever, go home, sit with a pipe on my own. I love my own company.

### *Fears of Exposure and Feeling Judged*

Goffman (1968) suggested that every stigmatized group will have a battery of tales of embarrassing exposures. This is exemplified in the following quotation from a widow who was embarrassed having been seen taking condoms from the clinic:

Or when I'm in my methadone clinic, when I'd be talking I'd pull a few out of a box on the counter without the girls knowing, you know, because it can be embarrassing as well. 'Cause my partner's dead now, so they would probably say, "Oh condoms, what does she want condoms for?" You know?

In other studies, drug users with HCV have described their experience of health services as poor, discriminatory, and stigmatizing (Treloar & Rhodes, 2009). Scambler (1984) differentiated between enacted and felt stigma. Enacted stigma can be defined as discrimination against the stigmatized person because of their social unacceptability, whereas felt stigma refers to the internalization of shame because of the stigma (Scambler & Hopkins, 1986). Respondents in the current research had experienced enacted stigma and reported feeling judged by agency workers:

And when my brother passed away, that time Dr. [name] turned around and said to me, "Do you know what? It should have been you instead of your brother. You're nothing but a dirty fucking junkie. You are a drug pusher." And I snapped, and I jumped up, and I grabbed him by the head and bounced his head off the table. And then all the GAs [general assistants] came running in and grabbed me, and then I got fucked down to [name] Street, I did, over it and that's how I ended up in [name] Street. It was over assaulting Dr. [name].

### *Biographical Others*

Personal identity, like social identity, organizes the individual's world for him or her. There are two phases in the learning process of stigma. First, learning that the normal point of view is that drug addiction is deviant, and then realizing that he or she is disqualified from social acceptance because of it (Goffman, 1968, p. 101). The next

phase is learning to cope with the way one is seen (perceived) by others. Hilbourne (1973) noted that stigmas can spread to despoil the identities of friends and relations. Drug-taking mothers not only have to cope with the way others see them, but also have to ensure that their children are protected from the taunts of other children. Sanders (2005) reflected on how the sex workers she studied pretended that they worked in other occupations as a way of concealing their sex work from their children. This was also visible in our findings:

Kids have said to my kids, "Your ma is a junkie." Do you know what I mean? First they will ask me that, and then they will say, "Well, blah blah says that you are a junkie. Are you a junkie, Mammy?" It is so horrible to explain, and you don't want to explain to them what is a junkie. I just say, "No I'm not! Go and tell blah blah that. Tell him to run around and tell his ma!"

Another strategy used by those attempting to pass was to present the signs of their stigmatized failing as signs of another attribute, one that was less of a stigma. One interviewee, for example, pretended to her daughter that she was down on the street buying cocaine rather than admitting that she was down on the street soliciting sex work:

Yes I do, I work a lot from my phone, and I'm trying to sort of broaden that so I don't have to come down onto the street. I'd rather not have to come down onto the street. My daughter told me that she heard that I was down on the street. I said I was scoring crack; I'd rather her think that than that I was out soliciting. I was scoring crack; she knows I have a problem, had a problem. So, she's living in X trying to get her own life together. So the less she knows the better. I'm trying to work from my phone so I don't have to go out on the street, and I do have a lot of regulars. When I say regulars it might not be every week, it might be twice a month. I don't have the same ones every week; if I did, I wouldn't have to come out on the streets.

Identity information has a special bearing on relationships. Trust and mutual commitment are built up in relationships by the disclosure of intimate facts about each other, and that means that one partner might acquire discrediting information about the other. This carries a high psychological price that can lead to psychic anxiety (Goffman, 1968, p. 108). This anxiety was manifest in a sex-working man's relationship with his partner when his partner discovered that he was HIV positive:

But then he came in [to the hospital] and same thing. Like, carefully he said, "You look like somebody

with full-blown AIDS, you scumbag, like get your fucking life together.” He says, “You’re nothing but dirt.” And you know, I’m wasting away in the bed, and saying, “I don’t fucking need this.” This was brought up in our relationship all the time, like how dirty I was, like what I was doing. I was nothing, I was dirt. You know I didn’t, I didn’t, I had no role in society, as in being a bit of energy walking around. You were just a piece of dirt. Muck, shite, that would have been the stuff I would have been getting off him.

Allport (1954) defined prejudice as a hostile attitude toward a person simply because he or she belongs to a group to which one has allocated undesirable qualities. He distinguished five levels of antipathy to out groups in terms of the extent of energy displayed by the perpetrator. The first level is antilocution—usually people who have prejudices talk about them with their like-minded friends and express their antagonism freely. This can lead to name calling (“junkies,” “whores”) of specific out groups. This name calling can lead to intergroup hostility and the violent expression of prejudice. In this study, respondents were aware of the names they had been called, and many had also been victims of violence.

### *Stigma of Gay Identity*

Mac Gréil (1996) suggested that the level of homophobia in Irish society is alarming; 25% of Irish people would deny citizenship to “gay people,” with men being more negative toward gay people than women. However, being gay and also being a sex worker adds another layer of stigma. Three of the men sex workers interviewed self-identified as being gay, and disclosed that they had been rejected by the gay community in Dublin. One gay man explained:

I’d be inclined to get more punters [customers/clients] than any of the rest of them, and we all carried each other, you know. And, say I was with you; I’d get two punters now. Instead of hanging around for the night, I’d say, “Come on, we’ll go off and get sloshed [drunk] and try and get into a gay bar,” but that never happened, because the gay scene just, we were all totally excommunicated from the gay scene, like, “Go away.”

There are specific issues associated with men who engage in sex work. If they are gay they might risk being ostracized from the gay community, but if they are not gay then they might not access health services that target gay sex workers. Currently, there is one statutory service in Dublin that directly targets gay men; this service also provides services for men involved in sex work.

### *Stigma and Blood-Borne Viruses*

Injecting drug users are at risk of contracting blood-borne viral infections, in particular HIV and HCV, through sharing contaminated works (equipment, such as syringes, that have been previously used by someone else). Much research has been focused on the stigma attached to HIV diagnosis; indeed, 60 scholarly sociological articles between 1995 and 2001 were identified on the topic (Monzo, 2004). The Euro HIV Index 2009 ranked Ireland tenth out of 29 countries, scoring 736 points from a potential 1,000 (Gantly, 2009). Figures published by the Health Protection Surveillance Centre (HPSC) on newly diagnosed HIV infections in Ireland in 2008 showed that there were 405 new HIV diagnoses, which was an increase of 3.6% compared to 2007. This brought the cumulative total number of HIV infections reported in Ireland to more than 5,000. Of these, 102 (46%) were through heterosexual transmission, 25% were men who have sex with men, and 9% were intravenous drug users (HPSC, 2009).

In this study, 7 research participants self-identified as being HIV positive and described their feelings of being stigmatized. One mother who had contracted HIV as a result of being raped described it as “a manky [filthy, dirty] disease,” whereas another woman’s experience with her siblings was explained this way: “Some of my brothers and all was afraid to drink out of a cup after me.” Others spoke about the detached manner in which the HIV diagnosis was communicated, either through a fax to the hostel in which the respondent was staying, or being given the information without an explanation of what HIV means. It has been shown in other research that women worry about seeking HIV testing, and how stressful they perceive these tests to be and the importance of anonymous testing (Ransom, Siler, Peters, & Maurer, 2005). One woman had received an HIV-positive diagnosis 4 months prior to the interview. She was devastated by the way she received the news:

Interviewer (I): Did they give you any counseling before the [HIV] test?

R: No.

I: Did they explain it to you?

R: No, nothing, just actually, “You have HIV.” They didn’t tell me any “ifs or buts” about it, or nothing, just, “You have to go and see Dr. [name].” It’s a disgrace the way they go on about it. It really is a disgrace, like my doctor didn’t even say to me. I don’t know anything about it. I only know I have HIV, and that’s it.

Less work has been focused on the stigma attached to HCV. This could be because of its ubiquity and the inevitability of contracting it if one is an intravenous drug



user (Davis & Rhodes, 2004), because injecting drug use is the primary route of HCV transmission. Treloar and Rhodes (2009) conducted a meta-analysis of 25 published articles representing 20 unique studies which generated three overlapping themes: social stigma, biographical adaptation, and medical and treatment encounters. They found that interactions with health systems could reproduce stigma linked to drug injecting and HCV.

Findings from international studies have indicated that between 30% and 60% of people who inject drugs (IDUs) are HCV positive (Aceijas & Rhodes, 2007). However, there was a higher incidence of HCV among injecting drug users in Ireland; approximately 70% of injecting drug users in treatment in Ireland tested positive for the antibodies to HCV (Long, 2006). Most (26/35) of those interviewed in this study were also infected; others did not have the test done and consequently did not know whether or not they were HCV positive. On being asked if she had been tested for HCV in the clinic, a woman retorted, "No, I won't go for those." Another justified her position by explaining:

I was meant to go back, but I never went back. I'll have to go back. I'll have to do something about it. I don't think it is affecting me. I don't think I have it anymore. I don't get any symptoms, see. I don't drink, so my liver wouldn't be as bad as someone that drinks, do you know what I mean?

Those with advanced liver disease found it hard to conceal their HCV-positive status, as one man explained:

The only thing you were afraid of in them days was hepatitis, you know, the "janders," the yellow jaundice. If you got yellow jaundice you'd know everyone would be looking at you and saying, "He's on drugs, she's on drugs." Because that was the only thing that people knew by, being on drugs.

A young woman who had recently had a baby reacted very emotionally, and was very distressed to hear the news that she was HCV positive:

I am hepatitis C positive. I was in bits. I was [starts crying]. I was so upset . . . when I told people that I had it, I was upset about it. And they'd say, "Why are you upset? I have it, and she has it, and we all have it." I said, "Yeah, you all have it, but now I have it, that's why I'm upset, that's the point." They couldn't understand why I am getting upset about it. We all have it, but I don't want it.

Of those participants who had received a positive HCV diagnosis, only one was receiving treatment. There

are many obstacles that reduce the likelihood of past and current injecting drug users receiving combination interferon and Ribavirin HCV treatment (Cooper & Mills, 2006). In this study, participants were critical of health care professionals because they believed that they (the health professionals) weren't taking HCV seriously and because of the lack of information they received:

I have had to ask my doctor anytime I wanted to get my liver checked. They gave me nothing. You are just told you have hepatitis, that's it. "Do what you want." . . . I went to see that top guy in [name] hospital, and I made an appointment with him. When I got there I saw probably a, I don't know, a first-year doctor, or something. He asked me about my diet and all, and that was it. I actually must, when I go to see my doctor, I must ask him for an appointment. But, no, no, you're not, as regards hepatitis. I don't know about HIV, I know with hepatitis, they don't, unless you ask for treatment, and unless, you're not kinda pushed, and which like, with addicts they don't look after their health, so it is not good.

Another man commented,

Nobody tells you anything. You have hep [hepatitis] C and that's the end of it. There's no one telling you what hepatitis is, or anything like, and to get to the doctor now you ring the doctor and you have to wait three months to see the doctor. When you go into the doctor you're only in there and you could have a list of questions, and they only want you in and out real quick because of the way it runs. So many behind you. It's ridiculous.

Unlike a positive HIV diagnosis, some felt that HCV was not to be taken seriously. This trivialization of HCV has also been reported in other studies (Treloar & Rhodes, 2009), and leads to stigmatizing those in search of treatment, care, and a legitimizing illness identity:

R: About four months ago I got screened for everything, and everything came back all right, except hepatitis, hep C, Genotype 1.

I: So you have that, have you?

R: Yea.

I: Did they give you counseling?

R: No, I didn't want it, 'cos I don't need it, like.

I: Why do you think that you didn't need it?

R: 'Cos it's not HIV.

Such is the stigma attached to having HCV that when the interviewer tried to give a respondent an information booklet about the virus (Keating, 2003), she declined the

offer because she did not want to be seen with it: “No, because then I’d have to bring it home and they’d be reading it and they’d say, ‘Where did you get that?’”

Davis and Rhodes (2004) suggested that HCV can be considered *inter alia* an infectious disease with public health imperatives; a social and structural responsibility; a disease of blame; a chronic illness; one component of a constellation of poverty, disadvantage, marginalization, and drug dependence; and a highly stigmatized and hidden condition. Treloar and Rhodes (2009) suggested that health-promotion literature that focuses on self-protection and surveillance of the potentially infected “other” reinforced an individualizing discourse of blame and stigma, rather than fostering an understanding of shared responsibilities for preserving safety from infectious disease.

### Stigmatizing Language (*Dirty and Clean*)

Goffman’s (1968) treatise on stigma can be criticized for its lack of discussion around the harmful effects of name calling. Language is an important vehicle through which stigma is perpetuated and reproduced. Agency workers (doctors, nurses) referred to urine samples that had traces of illicit substances in them as being “dirty.” The excerpts that follow reveal how this language was then internalized by the drug users when referring to their own urine and themselves:

Eight years ago, when I was 21, I finished it and stayed clean for two years. Then I had three slips over the time, and then went back on it at 23, on methadone. . . . I feel I have cleaned up a lot since Christmas. I’ve been very clean. I have been trying, I had to get clean so that I could get away from my partner, that is the only way I could get away from him, ’cos he was very abusive.

A woman who was interviewed in prison explained why she wanted to keep her urine “clean”: “But no, I haven’t been smoking hash now in a while. I’ve given clean urines and that, so ’cos I’m trying to get out [of prison] as well, I want to get out for Christmas.” Another woman who was also interviewed in prison was alarmed to discover that traces of cannabis were found in her urine:

Yea, all urines are clean. So I thought they were clean. But, they call cannabis dirty. Well, the judge did, anyway, because he was going to give me an increase in the sentence. He was like giving me another three years to start afresh when this was over, which I thought that was so unfair, all because, and I thought my urine was spotless, just there was cannabis. To me that’s not a drug. You can get that through passive smoking, anyway.

Getting clean involves not being on methadone: “I got clean and got off everything, no methadone, nothing.” Furthermore, one research participant described herself as being clean because she had been tested for both HIV and hepatitis, and had been diagnosed as having neither virus:

I: And just thinking in terms of HIV, have you been tested for that?

R: I have, I’m clean.

I: And hepatitis?

R: Yes, clean.

The terms *dirty* and *clean* were used by respondents in this research casually, in a matter-of-fact way, and in an unselfconscious manner to describe whether or not their urine contained traces of illicit substances. They were unaware of how they had internalized the language of the clinic professionals and how, by using this language, they continued the stigmatizing cycle. Institutional stigma is perpetuated through the use of language, which in turn is internalized by those who are stigmatized, and the stigmatizing cycle continues.

### Agency and Resistance

Many of the drug-using sex workers in this study might have been marginalized, but they certainly were not powerless to exercise their agency against their clients. They did this in a variety of ways, by having the ability to say no to clients’ requests and by insisting on condom use.

*Saying no to client’s requests.* There were many examples in the data of respondents’ ability to say no to a client’s requests if these requests offended their sense of what was on offer and what wasn’t:

I: Do you ever get pressured into doing something you really didn’t want to do?

R: No. I’d say no, and tell them to go and fuck off.

Some of the sex workers were quite quick to judge as disgusting some of the requests of their clients:

I: And are you ever asked to do things that you wouldn’t be happy about?

R: Yea. Yea.

I: And have you done them?

R: I have in me a[ss]! [sarcastic, disdainful voice] No way! Are you joking? No. I think it’s disgusting some of the things they have asked me.

I: You haven’t been forced into it?

R: No, if I wasn’t comfortable, I’d tell them to fuck off, “Look for someone that’s into doing what you’re into.”

One respondent reported not having “full” intercourse with clients:

R: But, you see, I’d never have full sex. I’ve never had sex with a punter, even with condoms. I’d be terrified, terrified of me life. So I was going out. And I wasn’t making that much money. I was happy with even, say, two jobs, because, you know, it was €160 I was going home with. You know what I mean? I wouldn’t have to worry then about me habit for two or three days, I’d be sorted.

I: And so when you say you never have full sex, so it’s oral, is it?

R: Oral or hand.

I: And the punters are happy with that?

R: Yea, yea. Some punters, that’s all they’re looking for.

I: Is it?

R: Yea.

Some clients asked for anal sex, but most of the women interviewed would not do it, as exemplified by the following exchange:

I: Yea, and so from the point of view of services, most of the other girls say it is oral sex, vaginal sex, anal sex?

R: I don’t do anal sex

I: And if a punter asks you, do you say, “No way?”

R: Yea, “No way!”

Some of the sex workers had a menu of services on offer: “Sex, oral sex, or hand relief. Not into anal sex or bondage or anything mad or showering with people or mad things, [laughs] or group sex or anything like that.”

*Negotiating condom use with clients.* Despite the pressure that was placed on them by clients not to use condoms, for the most part respondents were very responsible in the use of condoms and in promoting safer sex:

Like there’s a guy driving around in silver Porsche and saying like, “I’ll give you €200 if you have sex with me without a condom.” And you’re like, “Get a grip.” And he says, “I swear to God I’m clean.” Ah, there’s loads. That’s just one example, there’s loads of them, ah Jesus yea, and that’s why, they might look clean, they might be driving big bloody whatever, all the A4s, Porsches, big cars, you know, Mercs, but if they’re prepared to do that with me, they’re prepared to do it with the other girls. And I know I’m clean, but I don’t know about all the other girls. It’s not even that, the way that I do put it to them is, “God, you have a wife or girlfriend,

you don’t know me from Adam. I could have anything, and you are prepared to do stuff with me, without a condom?” I don’t think so, and that kinda makes them think. Where, if I’d say, “I don’t know you, I could catch anything off you,” it kinda gets their backs up a bit, you do have to kinda put it, phrase things in a certain way.

This quotation also illustrates that sex workers talked to clients in a measured way, so as not to offend them, but to get them to realize the risks they took if they had sex without a condom. Condoms were used not only for penetrative sex, but also for other types of sex:

R: But when it comes to condoms, you would get some punters or clients, whatever you call them, who try to take the condom off, but I’d always be aware of that. I’d always make sure. I’m aware of that.

I: Sorry to ask intimate questions. Is it vaginal sex, or do people want anal sex?

R: Yes, they would ask for anal sex, but no, I wouldn’t do it. Sex, oral or hand relief, but you’d mainly give people oral.

I: And you do use a condom for that?

R: Yes, yea, yea.

One sex worker reported that if she didn’t have condoms she would ask her first client to drive her to the store to pick them up, or else she would get some from a friend:

Always, always, there was sometimes that even I just had my bus fare into work, I’d get the bus in. I’d wait for the punter to come along, and I’d say, “Right, we have to stop to get condoms on the way,” because I had no money for them, ‘cause I couldn’t get to the [needle] exchange, ‘cause the exchange give out the free condoms. So I would just say, “Right, you have to stop and get condoms.” That’s the way I worked it. If there was another girl out, “Give us a condom,” and you get one off her, and I don’t know what the thing is, but if you are giving someone a condom, you kiss it for luck.

## Discussion

Goffman’s (1968) treatise on stigma provided a useful framework for understanding how stigma is produced and perpetuated. However, his work has been challenged for its failure to address the possibility of agency, mobilization, and empowerment in stigmatized groups and persons; for example, the emergence of pressure groups to combat popular stereotypes (Ablon, 1981). Since the 1970s, sex workers have become involved in collectively organizing

for their social and political rights, with some aligning themselves with other marginalized groups, and others joining the trade union movement (Lopez-Embury & Sanders, 2009). In 1973, a group called COYOTE (Call off Your Old Tired Ethics) was established in San Francisco, with the goal of decriminalizing all voluntary adult prostitution. In 1975, prostitutes in France went on strike and occupied churches as a protest against the lack of attention by police to the murders of several prostitutes. This was followed in 1982 in Britain by a 12-day occupation of the Holy Cross Church in Kings Cross in London by a group of English prostitutes in defense of sex workers' legal and civil rights (English Collective of Prostitutes, 1997/2007).

In 2005, 120 sex workers and 80 allies from 30 countries participated in the European Conference on Sex Work, Human Rights, Law and Migration in Brussels. From this conference, two documents were published: "Sex Workers in Europe Manifesto" and "Declaration of the Rights of Sex Workers in Europe" (Garofalo, 2010). There is now a global network of sex work projects. Official unionization has happened in countries where the rights of sex workers have been recognized; unions exist in seven countries: United Kingdom, Germany, The Netherlands, Australia, New Zealand, Canada, and the United States. The Secretary General of the United Nations urged governments to cease persecuting prostitutes, and to eliminate harsh laws against them (Lopez-Embury & Sanders, 2009). Research from India showed how commercial sex workers rejected and resisted being represented as "agency-less" masses, and through local community participation managed to empower themselves (Basu & Mohan, 2008). The Durbar project in India is an organization of 65,000 male, female, and transgender sex workers; they introduced a peer education project for educating sex workers and preventing the spread of sexually transmitted infections and HIV. In those brothels where the project was introduced, the percentage of people in brothels using condoms rose from 2.7% to 81.7% between 1992 and 1995, when other brothels in India were reporting a rate of 55% (Lopez-Embury & Sanders).

The importance of attracting and retaining drug users into treatment cannot be overemphasized because of their high mortality rate. Ireland has the fourth highest rate of drug-related deaths (poisonings) in Europe, after Estonia, Denmark, and Luxembourg, with 54.2 deaths among every one million in the population. Over the 8-year period of 1998 to 2005, 2,442 people died directly or indirectly from drug use in Ireland (Health Research Board, 2008).

Drug-using sex workers are not "cultural dopes" (Garfinkel, 1967), but actively engage in resistance by saying no to their client's demands, and also by their insistence on using condoms despite being offered more

money for sex without a condom. A number of the respondents in this study had positive HIV diagnoses and continued to engage in sex work. This raises implications for the spread of the disease. Up to the end of 2009, the cumulative total of HIV infections reported in Ireland was 5,637, with a total of 395 new HIV diagnoses; the total number of deaths among AIDS cases reported up to the end of 2009 was 414, with reports of two deaths in that year (Jackson, O'Donnell, Moran, & O'Hora, 2010). Certain vulnerable groups (men who have sex with men, people living with HIV and AIDS, injecting drug users, sex workers) have been identified as key priority population groups for HIV/AIDS education and prevention efforts (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2009a, 2009b). A key action for preventing new infections would be for all services working with sex workers to provide condoms. In a global strategy to reduce HIV transmission associated with sex work, UNAIDS (2009a) has urged member states to implement policies and programs that support a comprehensive, rights-based approach to HIV and sex work. Member states are encouraged to introduce and implement programs for health care providers to reduce and eliminate stigma, discrimination, and gender-based violence toward sex workers. UNAIDS' efforts to address HIV and sex work are based on three essential pillars (2009a, p. 7):

Pillar 1: Assure universal access to comprehensive HIV prevention, treatment, care, and support.

Pillar 2: Build supportive environments, strengthen partnerships, and expand choices.

Pillar 3: Reduce vulnerability and address structural issues.

## Conclusion

Irish government policy is committed to tackling the spread of HIV and HCV, and is also committed to harm-reduction policies by providing drug users with needle exchange programs, methadone maintenance, and rehabilitation; however, the government's efforts to reduce harm might be unwittingly hampered by service providers, because the taken-for-granted language they use assigns drug users to a "dirty" category. The prevalence of HCV and the ignorance of its consequences results in it not being taken seriously by drug users, thus increasing their risk of death. Moreover, respondents felt that service providers did not take HCV seriously, either. Their feelings of self-worth were damaged because of their fear that they looked like drug addicts. This lack of worth was also reflected in the insensitive manner in which some health professionals conveyed the news to clients that they were HIV or HCV positive, and also by the lack of a continuum of care and treatment. Drug-using sex workers themselves acted



as health promoters by their insistence on the use of condoms in commercial transactions; however, gaining access to condoms was not always easy. To respect anonymity, it is recommended that drug treatment agencies place condoms and lubricants in easily accessible private places such as rest rooms or toilets. Government policies and strategies to reduce the level of HIV infection might unwittingly be thwarted by frontline service providers (doctors, nurses, social workers, and other personnel), who, in their everyday interactions, continue to stigmatize this vulnerable group.

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