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Original Article

Exploring Moral Categorizations and Symbolic Boundaries Around People Living With HIV in a Correctional Setting

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ABSTRACT

For people living with HIV, correctional facilities, such as jails, prisons, and remand centers in Canada are complex environments at the intersection of health, justice, social, and criminal systems. Turning toward experiences, I explore my stories and observations of working with people living with HIV as a registered nurse in a large correctional facility in Western Canada. Based upon a narrative understanding of experience, I inquire into these stories and observations through the application of Mary Douglas' theoretical work on purity versus impurity and Michèle Lamont's symbolic boundary work. I engage in a reflective dialogue with the newfound meanings and understandings produced and discuss significant personal, practice-based, social, and policy-based insights within the context of my nurse researcher-practitioner role. This dialogue draws attention and raises questions about social practices, HIV-related stigma, correctional nursing, and the particularities of life evident within correctional facilities. Clinical implications for correctional nurses are discussed.

KEY WORDS:

Boundaries; correctional nursing; HIV-related stigma; impurity; morality; narrative

This article is the result of an inquiry into my correctional nursing experiences as a researcher-practitioner with persons living with HIV (PLWHs) in a Western Canadian correctional facility. From a narrative understanding of experience, I will apply the theoretical lenses of Mary Douglas (1966) and Michèle Lamont (2000) while generating reflective questions of personal, practice-based, social, and policy-based significance. For example, what is my role, as nurse practitioner or researcher, toward HIV-related stigma when it is likely I perpetuate or misunderstand some of the issues because of my position of power and authority? I seek to draw attention and raise questions about the social practices and the particularity of life evident within correctional facilities.

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HIV, Stigma, and Correctional Facilities

For PLWHs, correctional facilities in Canada are complex environments. Within Canada, incarcerated populations have a disproportionately higher rate (about 10 times) of HIV than the general Canadian population (CATIE, 2015). Acquiring HIV is marked by a life-changing diagnosis directly tied to significant disparities, including an increased rate in morbidity, mortality, and stigmatization when compared to the general population (Public Health Agency of Canada, 2015; World Health Organization, 2017). Before antiretroviral therapy (ART) was accessible, HIV was viewed as a "death sentence," but with the availability of treatment, HIV is often seen as a chronic, episodic, and manageable condition that is untransmissible when someone adheres to ART and achieves and maintains an

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undetectable viral load (Centers for Disease Control and Prevention, 2018; Public Health Agency of Canada, 2015). Despite the advances in HIV care, high levels of HIV-related stigma within correctional facilities in the United States and Canada remain (Erickson et al., 2021; Muessig et al., 2016). HIV-related stigma has been conceptualized as a mechanism and manifestation of social inequality (Parker & Aggleton, 2003). HIV-related stigma in prisons stems from a perceived high risk of transmission (i.e., exposure to blood, a perceived lack of control over the environment, or sharing of kitchen utensils and clothing), lack of HIV knowledge, and the perception of other inmates as "dirty or diseased" (Muessig et al., 2016, p. 112).

Exploring Experiences

Turning toward experiences, I explore my stories and observations of working with PLWHs as a correctional nurse. These experiences reflect ordinary occurrences by providing a description and compilation of repetitive accounts and interactions that I have encountered since 2014.

> **Story 1.** It is 0830 and I am standing with a medication cart behind a thick, plexiglass window on a general population unit. One by one, inmates come up to the window. Some inquire about their medications: "Is this my heart pill?" or "did the doctor up my meds?" I answer their questions; they swallow their meds, show me their mouth, and move on. An inmate comes up—they're on ART. They look in their medication cup for the obnoxiously large, colorful pills; swallow their meds; and move on. No words are ever exchanged about these medications in the lineup.

> **Story 2.** While working on a small unit, I am sorting through health service request forms. One request states: "I want to get my blood checked for STDs, AIDS, Hep. There are some guys on this unit with AIDS and I want to be careful. Thanks." Later in the day, I bring the man into the assessment room to speak with him. He responds he just wants to be careful and get checked. I go through a series of questions, and he has no clinical risks of HIV transmission. Specifically, I ask about any history of intravenous drug use (IVDU). While gesturing to an HIV-positive inmate on the unit who is walking past a group of inmates playing cards, he says to me that he doesn't inject like him.

Turning Toward Narrative Understandings of Experience

My understanding of narrative is strongly influenced by the work of Clandinin and Connelly (2000). Although this is not a narrative inquiry study, their work helps ground my understanding of experience. Narrative inquiry as a methodology aims to understand and make meaning of experiences through understanding people as leading storied lives, with story being the portal through which a person enters the world and makes sense and meaning of their experiences (Clandinin & Connelly, 2000). In the field, a narrative inquirer seeks to cocreate meaning by coming alongside participants in the midst of their storied lives; this involves exploring how they interact within their social context and engage in sense-making activities while they construct meaning and identities (Clandinin & Connelly, 2000). A key part of the sense-making of others' stories involves making meaning of my past experiences as they intersect with the lives of others (Clandinin & Connelly, 2000).

Retelling the Experiences

Moving forward I will inquire into the above experiences to elicit newfound understandings. At the same time, I will apply Mary Douglas' (1966) work on the theoretical ideas of purity versus impurity. Second, I will further inquire into the impure moral categorizations created by inmates toward PLWHs through the application of Lamont's (2000) symbolic boundary work. Third, I will engage in a reflective dialogue with the newfound meanings and understandings produced through applying these theoretical lenses within the context of my nurse researcher-practitioner practices.

Applying a Purity Versus Impurity lens

Mary Douglas' (1966) theoretical work on purity and impurity may be applied to the above experiences to discuss how inmates in a correctional facility create moral categorizations in their social and cultural contexts toward PLWHs. Douglas presents the idea of impurity (i.e., dirt, immorality, and taboo) versus purity (i.e., moral) as a social relational mechanism that allows groups to justify their often-negative practices of inclusion and exclusion toward certain types of things (i.e., humans, practices, and objects) in a specific society. The ideas of purity and impurity are socially constructed orderings, and the resulting categorizations manifest in values based upon the perceived morality of certain things (Douglas, 1966). It is easier to understand "social pollution" (i.e., impurity) when we draw from our own experiences (Douglas, 1966, p. 74).

The practices represented earlier, such as an inmate requesting an HIV test after pointing out that other inmates have HIV, may be understood as a "ritual," whereby they "enact the form of social relations and in giving these relations visible expression they enable people to know their own society" (Douglas, 1966, p. 129). Several rituals, based upon my observations, contribute to how PLWHs are categorized into an immoral group within facilities: (a) a lack of knowledge, perpetuated through words and practices, around HIV transmission; (b) the association of IVDU with

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HIV; (c) the categorization of an IVDU as someone who is impure; (d) PLWHs engage in practices of self-protection from the social ordering effects of an impure categorization; and (e) people without HIV engage in practices of self-protection to reduce their perceived risk of HIV transmission.

There is a lack of knowledge around HIV transmission among the correctional population in Canada, which has been echoed in the United States (Muessig et al., 2016). Inmates believe they may contract HIV by being in the same room or sitting at the same table as a PLWH. As I think with these experiences, I can see the sun-worn faces of some PLWHs who have experienced this and been ostracized from social events, such as playing cards with other prisoners. These common-place experiences show a lack of knowledge about HIV transmission, which serves as a backdrop to my reflection associating HIV with IVDU and categorizing IVDU as "impure."

The association of HIV with IVDU and IVDU as impure (i.e., immoral) is important. In my experience, when discussing HIV transmission with an inmate and he denies IVDU, but negatively gestures to an HIV-positive inmate on the unit as an "other," it may be interpreted as creating a link between IVDU and HIV. I remember the individual who gestured to the PLWHs on the unit and our many conversations. He was currently awaiting sentencing for charges stemming from his methamphetamine use; however, he did not inject "meth," preferring to smoke it like many others I have met. This suggests Douglas' (1966) concept of purity and impurity as relative and contingent: An inmate may use illicit substances traditionally defined as immoral by the greater Canadian society, such as meth, but still place injection drug users in an immoral category. It has also been demonstrated that new HIV infections in Canada and within Canadian prisons are also strongly associated with IVDU (CATIE, 2015). In the described experience, links are made between HIV and IVDU and IVDU as impure; this may be interpreted as the following: When someone has HIV on the unit, the perception among fellow inmates is that they are an IVDU and thus placed in the categorization of impure.

Understanding how PLWHs practice self-protection through an awareness of their immediate social structure is important. Douglas (1966) describes a social structure as "particular situations in which individual actors are aware of a greater or smaller range of inclusiveness" where actors "behave as if moving in patterned positions in relation to others" (p. 101). In the experience I describe in my first story, the medication line constitutes an immediate social structure where self-protective practices must occur. When a PLWH comes up to the line and I turn the page to their meds, I can begin to feel an uneasiness as suddenly there seems increasing awareness toward the lack of conversation between us. Other inmates may ask questions somewhat freely in the medication line, yet PLWHs are not afforded this opportunity because of their immoral positioning. I wonder if a lack of awareness by health services staff of the social structure within corrections infringes upon or threatens the self-protective practices of PLWHs? Although it may be inconsequential to my life, it would be potentially devastating to the PLWH. Based upon the previous understandings, a PLWH does not bring attention to their diagnosis in an open, social environment, because HIV is associated with IVDU, and IVDU is associated with impurity.[1] This statement is supported by the U.S. prison context, where inmates living with HIV were afraid of disclosing their status as they may be labeled an "addict" when they were not (Swan, 2016).

Embedded in the experience of inmates living without HIV is a display of rituals of self-protection to reduce their perceived risk of acquiring HIV (Douglas, 1966), such as testing for HIV even if it is clinically inappropriate or by ostracizing PLWHs from playing cards. Perhaps, based upon a backdrop of health illiteracy around HIV, this elevated perceived risk is understandable. As I talked with the inmate about his health request relating to sexually transmitted blood-borne infections testing, it became clear that he was *genuinely* concerned that he may be at risk for contracting HIV by being in the same room as a PLWH. I wonder what or who had shaped his knowledge about HIV and HIV transmission—how have different life experiences shaped these understandings?

Regardless of whether or not someone is an IVDU, their diagnosis of HIV designates their status as a dangerous "social outcast" (Douglas, 1966). Once someone has acquired HIV or has the label of an IVDU, they pose a danger to others through their perceived risk of HIV transmission. Overall, based upon these experiences and their associated rituals, when someone has the diagnosis of HIV or the accompanying label of an IVDU, they are morally categorized into an impure group. Thus, those without an HIV diagnosis or the label of an IVDU are by comparison placed in the pure group. To make sense and protect themselves, two things occur: (a) inmates without HIV segregate PLWHs (and by association IVDU) as impure, setting off a series of social ordering mechanisms embedded with a backdrop of health illiteracy on HIV (e.g., requesting unnecessary HIV testing and excluding PLWHs from playing cards), and (b) PLWHs respond to the social ordering by being aware of their immediate social environment, staying "quiet" about their HIV diagnosis. Based upon my experiences, the social ordering and visible relations that occur through the classification of HIV as impure develop boundaries, which may be further understood through the lens of symbolic boundary work (Lamont, 2000; Lamont & Molnar, 2002).

[1]Based upon my own experiences and the work of others, I acknowledge that HIV has, and continues to be, associated with homosexuality within a correctional setting. This association beckons questions around sexuality, masculinity, and sexual orientation behind bars, which are important but not the focus of this reflection.

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Applying a Symbolic Boundary Work Lens

Based upon the moral categorizations that inmates place upon PLWHs as impure, I apply Lamont's (2000) boundary work to understand how inmates without HIV construct a sense of self-worth and perceive their social differences between themselves and PLWHs and IVDU. Lamont's boundary work may be understood as symbolic, whereby symbolic boundaries can be conceptualized as "distinctions made by social actors to categorize objects, people, practices, and even time and space" (Lamont & Molnar, 2002, p. 168).

Boundary work itself may be described as a mechanism whereby the application of moral criteria is through relations; individuals justify their own position and self-worth while forming a self-identity within a specific social order (Lamont, 2000). In my experiences, the moral criterion as the basis for boundary work is pure versus impure. Within these working conceptualizations, morality is defined by Lamont (2000) as "norms and prescriptions thought of as having universal value and pertaining to personal responsibilities and duties towards others" (p. 279).

Boundary work is also specific to certain small societies (Lamont, 2000); for example, within corrections, inmates draw upon their available cultural resources (e.g., street economies, urban life, and parenting) within their specific conditions of living (i.e., the prison unit) to engage in boundary work. As I attempt to understand how symbolic boundaries are created through Lamont's (2000) boundary work, I explore how inclusion and exclusion functions based off the moral typification system of purity versus impurity (Lamont, 2000; Lamont & Molnar, 2002).

When I reflect upon my nursing experience using Lamont's (2000) boundary work, I recognize that the inmate stated a part of his self-identity as not an IVDU and then associates the diagnosis of HIV as having a collective identity of IVDU. Although this experience is not necessarily demoting PLWHs to a lesser social stratum, it sets the context for responding in a derogatory way toward IVDUs by "othering" them. I remember the PLWH who the man gestured toward in my experience in Story 2. He was experiencing HIV wasting syndrome—his body was composed of mostly sinew, muscle, and bone, and he often required a mobility aide. The PLWH was excluded from cards and also never had a roommate, which is interesting, as inmates regularly have roommates and often form strong bonds and friendships with them. Being wakeful that irreconcilable views toward personal and cell hygiene are commonplace in corrections, which usually results in fights, I wondered about possibilities. Did the PLWH not have a roommate partly because of his known HIV diagnosis and IVDU status? Within the specific social order of the unit, would rooming or playing cards with a PLWH or IVDU have a negative effect on a person without HIV's self-worth and potentially place them into a lower social stratum? Being excluded from social gatherings and relationships (e.g., playing cards or sharing a living space) may demonstrate the conception and maintenance practices of a collective identity that revolves around not being labeled an IVDU or PLWH in a correctional environment (Lamont, 2000). In my nursing experiences, incarceration is a social process that skirts the borderlands of prison culture and larger societal cultures. Based upon the ideas of boundary work, where individuals attempt to maximize the traits *available* to them, such as not injecting drugs or having HIV, and since I understand a correctional environment as a limiting place that is cramped and lacking in anonymity, I begin to see how PLWHs are demoted to a lower social status through the immoral categorization (Lamont, 2000).

In addition to these experiences, there may be another reason why inmates without HIV engage in boundary work toward PLWHs. Applying the idea presented in Lamont (2000) regarding how workers kept their distance from the poor in fear of being "pulled down" (p. 143) helps one gain insights. I have had many experiences where I have infringed upon an individual's self-identity and social position by moving toward, through my clinical questioning, a possible history of IVDU. In response to these questions, I am often told: "I don't do that shit" or "I'm not a junkie." Often the response is emblematic. When this occurs, I am often taken aback, surprised at the response to questions that are ingrained into health assessments, and I at times ask without a second thought.

In summary, inmates without HIV develop symbolic boundaries through engagement in boundary work based upon the application of an immoral categorization for PLWHs. Through this boundary work, inmates without HIV may justify their own identity and social positioning in a correctional facility through their practices of social ordering, such as derogatory comments toward IVDU and the ostracization of HIV-positive inmates. Although my experiences do not speak to the upper social boundaries people without HIV create, it does attempt to understand how boundaries function toward PLWHs, which may be able to generate questions for future insights into social processes (Lamont & Molnar, 2002).

Tying Together

While inquiring into my nursing experiences and exploring the lenses Douglas (1966) and Lamont (2000) offer, I came to newfound insights and produced meaning that can shape future relations with PLWHs and other correctional populations. These insights include how inmates without HIV may make and perpetuate a moral categorization of impurity toward PLWHs by associating them with a transmissible disease and IVDU, which is further exacerbated by an underlying HIV health illiteracy. In addition, inmates without HIV may use symbolic boundaries as social ordering mechanisms through boundary work to not only justify their own collective identity and drug use but to also demote PLWHs and IVDU to a lower

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social status, attempting to protect themselves from HIV transmission or becoming an IVDU themselves.

Returning to Narrative

Utilizing Douglas' (1966) and Lamont's (2000) work provided two novel lenses applied to the complex and particular lives of PLWHs while incarcerated. Turning toward my correctional nursing experiences, I discuss significant personal, practice-based, social, and policy-based insights.

Insights of Personal Significance

From my experiences as a nurse researcher-practitioner in a correctional facility, I have heard numerous times the word "junkie" used to refer to an IVDU. The ritual/statement, "I'm not a junkie" is visceral; it evokes a bodily response from me, generating feelings of frustration while sparking an "eye-roll." "Junkie" is slang that labels someone as experiencing substance misuse, yet it does much more than rudely indicates reliance upon a narcotic or some sort of "fix." Rather, the label of junkie carries with it the moral categorization of impure, taboo, and the allocation to a subhuman status in many societies and subcultures. This word is commonplace inside and outside correctional facilities. To apply the word "junkie" to someone disregards the particularity of life—it is a cop-out to recognizing engrained inequities found both inside and outside correctional facilities. The use of the word perpetuates addiction, HIV, poverty, incarceration, and other social issues. When I hear the word "junkie," I am deeply troubled. Degrading someone to the status of a "junkie" absolves not only all personal responsibility to the individual but also the social determinants of health that perpetuate social inequities.

As I engage in this inquiry, when I approach my nursing experiences through the lenses of Douglas (1966) and Lamont (2000), I begin to see my individual beliefs toward what constitutes moral versus immoral practices and how I justify and carry out my self-positioning. To me, no one is independent from these sociorelational mechanisms. In the genesis of our inherent biases and views toward difference, I argue that Douglas' and Lamont's work may act as a starting point to unpack inherent racisms, sexisms, biases, and other "taboo" views toward how we view, construct, label, and perpetuate our self- or group identity and how and what things we categorize as pure versus impure.

Insights of Practice-Based Significance

A key social practice that my nursing experiences anecdotally speak to is HIV-related stigma. HIV-related stigma is not only a mechanism but also a manifestation of social inequality that creates and perpetuates difference (Parker & Aggleton, 2003). As I previously discussed, inquiring into my experiences from these sociological perspectives allows me to produce and understand the meaning in my life in relation to people I work with and care about.

Through inquiring into these experiences, I have become increasingly attentive to what happens to someone when they become excluded because of their label of HIV or IVDU. What sense-making activities go on for them to bring meaning to their life when they are socially marginalized within a group that, when compared to the general Canadian population, already face structural marginalization and are placed into an "impure" category? How does an incarcerated PLWH make sense of their experiences as immoral among the "impure"? What is my role, as nurse practitioner or researcher, toward HIV-related stigma when it is likely I perpetuate or misunderstand some of the issues because of my position of power and authority? How can I come close to understanding what it is like to face structural marginalization—to be seen as "different" and therefore a source of discomfort that must be silenced?[2] What rituals do I enact in my clinical or research practices that display the boundary work I am taking part in or what I view as pure or impure?

It is with these lines of questioning that I more closely attend to social justice and equity in the contexts I live, work, and study (Clandinin & Caine, 2013). When correctional/forensic nurses hand out medications to patients or complete health assessments in response to requests, we are not some arbitrary, inertia-laden figure; rather, we are complicit in the world and lives of others. When nurse practitioners dismiss their taken-for-granted, daily activities as being inconsequential in the lives of people who face structural marginalization, such as PLWHs, we are essentially turning our back to social issues. By applying Douglas' (1966) and Lamont's (2000) theoretical lenses to HIV-related stigma and differences within the correctional environment, different perspectives and starting points for novel lines of questioning on large and intimidating social mechanisms and issues are opened.

Insights of Social and Policy-Based Significance

Inquiring into my experiences as a correctional nurse and the relations I have had with myself, PLWHs who are incarcerated and those without HIV may be viewed as seeing people "big," whereby big implies a concern with an individual's "intentionality and concreteness of everyday life" (Greene, 1995, p. 10). If I share in how people make plans, take initiatives, and face uncertainties, I need to view people as big, which involves positioning myself to see from the point of view of the other, as they are in the midst of their lives (Greene, 1995). Viewing people as big contrasts with viewing people as small, from a position of particularity rather than a system perspective concerned with trends and tendencies (Greene, 1995). In my nursing experiences, incarcerated

[2]Goffman's (1961, 1963) ideas on total institutions and the discrediting effects of social, behavioral, and physical attributes are relevant to PLWHs in incarcerated settings and can offer additional insights into these lines of questioning. Correctional nurses may find his work to be of interest and complimentary to the discussed sociological perspectives.

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populations and PLWHs are accustomed to being viewed and framed as small: the latest mortality, morbidity, or prevalence statistics surrounding HIV and the populations disproportionately affected. People and relationships in these instances lose their particularity and individuality. In such experiences, the people are currently in the processes of incarceration: Their social networks, employment, parent–child dyads, and life-course are disrupted while their voices are silenced, and essential complexities amalgamated by orange jumpsuits. To me, making visible a person's life and their experiences are one approach in the attempt by correctional nurses to view people as big and full of particularities, rather than small and full of tendencies and patterns (Greene, 1995).

Linking Policy and Experience: Part of elucidating the silences, disruptions, and complexities in people's experiences and how nurses intersect with these involves bridging the gap between viewing a person as big and viewing a person as small (Clandinin & Caine, 2013, p. 175; Greene, 1995). This may begin by exploring and pointing out the "complexities, contradictions, and inconsistencies" usually found within policies and their implementation and effects on people's lives (Clandinin & Caine, 2013, p. 175). When I elucidate the particular by reflecting upon my nursing experiences with people, I can start to create links between the intentions of relevant policies versus their real-life implications and results for those accessing and utilizing the services governed by these policies.

In the experiences involving HIV-related stigma, playing with the sociological ideas presented, I am able to further elicit newfound lines of questioning. For example: how do HIV treatment policies in corrections value certain "types," mannerisms, and social practices of PLWHs over others? Do healthcare or correctional policies for PLWHs appropriately reflect the social hierarchy and mechanisms, such as the purity versus impurity and boundary work discussions, found within penal systems? Or do they disrupt these? These lines of questioning represent an attempt to view people as big and particular while pointing out the complexities, incongruencies, and contradictions in policies affecting individual lives in corrections (Clandinin & Caine, 2013).

Implications for Clinical Forensic Nursing Practice

This inquiry into the described experiences is not only relevant to correctional nurses but also to all those who practice in these fields. Nurses should acknowledge and respect that they operate within the social boundaries of the correctional facility and are complicit in how HIV-related stigma is constructed and carried out by inmates and others. Practitioners should be aware of their physical and social settings; concerns of confidentiality and anonymity are vital when the attention of incarcerated individuals is on you and your interactions with others. If you implicate someone as an IVDU or living with HIV in your care, there will be effects not only for your relationship with that person but also for them on their living unit. When engaging in health promotion and conversations regarding potentially "impure" topics, such as HIV or IVDU, acknowledge and alleviate the individual's concerns—these are often genuine and coming from a place of health illiteracy. Relationship building should emphasize honesty, respect, and understanding while originating from a place of viewing inmates as "big," that is, acknowledge inmates are in the midst of their lives and disconnected from their cultures, social supports, and resources that provide meaning and identity (Greene, 1995). Furthermore, practitioners should critique the guiding policies, clinical practice documents, and institutional processes (e.g., medication administration) that guide HIV-related care in their facilities: Are there any patterns to how HIV care is provided that may identify those who are HIV positive? What observable and repetitive actions do you do—or not do—in your nursing practices with PLWHs? Are these different than those without HIV? As our diverse roles intersect with the lives of incarcerated PLWHs in their social systems, the discussed sociological vantage points and these lines of questioning can begin guiding our nursing practices to provide ethical and evidence-informed care.

Conclusion

In this article I have laid out the background of HIV-related stigmatization within correctional facilities. By inquiring into my nursing experiences speaking to HIV-related stigma within a Canadian correctional facility through the theoretical lenses of Douglas (1966) and Lamont (2000) and further inquiring into these experiences, I have highlighted social practices warranting questioning and outlined how we may think about their social significance. The next stages involve going beyond my own voice and experiences toward cocomposing understandings of PLWHs as they make sense and construct and interpret meaning in their life course and experiences of incarceration. Relational methodologies that focus on individual experience, such as Narrative Inquiry, would be suitable. Integrated throughout should also be relationship building with health, social, and justice services, alongside peer-led efforts to knowledge mobilization.

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