

Marginalization of Sex Offender and Vacuum of Social Space: Critical Study from Sociology of HIV/AIDS

JOYDEB PATRA

Doctoral Research Scholar, Department of Sociology, Vidyasagar University

**Corresponding Author: Joydeb Patra, Doctoral Research Scholar, Department of Sociology, Vidyasagar University*

ABSTRACT

Present article examines how the sex offender perceived and response as a marginalized group to their stigmatized status within their limited social space. Being marginalized and sexual assault ruins their social spatial life. This social damaged accelerated by feelings of guilt, shame and social distance that accompany the excluded, abused and that prevent the victims from reporting the offence rather offender. Sex offender occupies a social space in which public opprobrium and disdain follow their every social movement In cases that is justifiably. However, social constructivist point of view, space is socially produced and that are offer as a lenses through which to find out how social and structural inequalities shape the behaviors of sex offender to HIV/AIDS vulnerabilities and generate to produce social vacuum socio-spatial gap. The article concluded that there are theoretical arguments from sociology of HIV/AIDS for substantial's socio-cultural and symbolic elements to understand of sexual offender.

Keywords: *Marginalization, Sex Offender, Social Space, Sociology of HIV/AIDS.*

INTRODUCTION

Marginalisation describes the position of individuals, groups or populations outside of 'mainstream society', living at the margins of those in the centre of power, of cultural dominance and economical and social welfare. It is defined as, "a process by which a group or individual is denied access to important positions and symbols of economic, religious, or political power within any society...a marginal group may actually constitute a numerical majority...and should perhaps be distinguished from a minority group, which may be small in numbers, but has access to political or economic power". (Marshall, 1998) "To be marginalized, ..., is to be distanced from power and resources that enable self-determination in economic, political, and social settings...It is an inherent characteristic of 'those in the margin', that they have poor access to economical and other recourses like education and social services, meanwhile participation and self determination are on a low level. However, definitions of what is regarded as marginalized are highly depending on the historical and socio-economical context of a society." (Daniel, Fletcher, Linder, 2002). In the last decennia, globalization, migration, economical developments – e.g. in the area of

communication technologies – have had a major influence on the economical level of millions of people and consequently, on their place in the society. Gender, culture, language, race, sexual orientation, lifestyle and the socio-economic position or class are factors, which influence the position of an individual or a group in the society. Vulnerable groups like migrants and ethnic minorities, homeless people, drug addicts, sex workers, youth with risk behaviour, isolated older people or people with disabilities face higher risks of social exclusion and marginalisation. Their problems can be related to homelessness, unemployment, poor access to social and health services, low health status and poor living conditions. Social inclusion 'Social inclusion' refers to the position, in which someone can access and benefit from the full range of opportunities available to members of a society. The term is not a fixed theory or concept, but continuously under development, regarding the challenges and problems in different situations and circumstances. Social inclusion has a value as process and as a goal, and should be approached pro-actively, not as a passive defending of rights, but as active interventions, rooted in community (self) organization and leading to real policy changes by transforming given structures. "Social

inclusion is the political response to exclusion. Most analyses of racism and sexism, for example, focus on the removal of systemic barriers to effective participation and focus on equality of opportunity. These analyses tend to be essentialist and consequently are unable to develop a comprehensive vision that cuts across all the areas of injustice. Social inclusion is about more than the removal of barriers, it is about a comprehensive vision that includes all. Social inclusion, by virtue of the fact that it is both process and outcome, can hold governments and institutions accountable for their policies. The yardstick by which to measure good government becomes the extent to which it advances the well-being of the most vulnerable and most marginalized in society. Social inclusion is about advocacy and transformation. It is about the political struggle and political will to remove barriers to full and equitable participation in society by all.” (Saloojee (2001) . Even if there is still a gap between policy statements and what is happening in practice, in the last decennia more and more awareness and attention has been given to improve social inclusion of disadvantaged groups and people, also by international bodies as the United Nations (UN Millennium Goals) and the European Union. National governments and NGO’s installed measures and projects to improve the situation on different levels. Usually, the overall aim is to “ensure the marginalized and those living in poverty have greater participation in decision making which affects their lives, allowing them to improve their living standards and their overall wellbeing” and “to remove barriers for people or for areas that experience a combination of linked problems (...)” (Combat Poverty Agency Ireland, 2007).

Marginalized individuals, including sex trade workers and homeless individuals, are among the most highly victimized members of society (Salfati et al., 2008; Wenzel et al., 2000). However, victimization tends to be more frequent when marginalized individuals have a dependency such as drug use, as they are more inclined to take greater risks (Salfati et al., 2008). Aside from substance abuse, sex trade workers and homeless individuals share a number of similar lifestyle characteristics that increase their risk of victimization, which often includes a lack of shelter, physical proximity to high crime areas, engagement in high-risk behaviors (i.e. sex work), as well as previous

victimization, and mental illness (Quinet, 2011). Therefore, a lifestyle composed of dependency and vulnerability evidently makes them attractive targets to offenders, including sex offenders. Marginalized victims are additionally at a significantly increased risk of victimization compared to general society. According to Perreault (2015), violent victimization rates are on the decline throughout Canada. In 2014, approximately 20% of Canadians over the age of 15 reported at least one violent victimization within the year, which decreased from 25% in 2004 reports (Perrault, 2015). However, victimization rates among marginalized victims remain much higher. For example, Meinbresse et al. (2014) found that approximately 85% of their homeless sample has been a victim of violence during their homeless period and Tyler et al. (2004) found that 35% of homeless youth reported sexual victimization specifically while on the street. Similar rates of violent victimization occur toward sex trade workers. In a study by Kinnel (2002), findings showed that 82% of sex trade workers had experienced a serious violent attack on the streets, and that 37% of the incidents involved a sexual assault specifically. According to an interesting analysis conducted by Brewer et al. (2006), the frequency of sex trade worker homicide steadily increased in the late 1980s and early 1990s, which has been hypothesised to be linked to the rise in the use of crack cocaine. In addition to being violently victimized, sex trade workers also have an increased chance of being victims of lethal violence. Research shows that sex trade workers have the highest homicide victimization rate of any group of women (Brewer et al., 2006). Additionally, those who solicit on the street are more frequently at risk than those who work indoors (Raphael & Shapiro, 2004). For example, Potterat et al. (2004) found that being a street prostitute in the US made women 18 times more likely to be murdered than non-prostitute women of similar demographics. Finally, a Canadian study by Lowman and Fraser (1995) report that street prostitutes are 60 to 120 times more likely to be murdered than non-prostitute females and sequentially found that homicide is the leading cause of death among sex trade workers. When investigating cases against marginalized victims, a number of investigative challenges have resulted in a high number of unsolved cases. For example, Kinnel (2001) reports that 69% of sex trade worker homicide cases within the UK have yet to be solved. Additionally, Brewer et al. (2006) found

that 41% of sex trade worker homicide cases took longer than one year to solve, and 17% of cases took longer than five years to solve. As there is no scientific evidence indicating that police devote less time to the investigation of sex trade worker homicides (Beauregard & Martineau, 2016), we believe that differences in crime scene characteristics and offender behaviours consequentially affect the number of unsolved cases. Pathways to Sexual Offending Sex offenders constitute a heterogeneous population of individuals, but have been classified into typologies based upon their characteristics and motivations. Typologies, or classification schemes, have been created to better understand distinctions between types of offenders, which utilize offender characteristics and/or victim-choice information to outline a framework for analysis. The most common classification types are those that differentiate between rapists, child molesters, female sex offenders, juvenile sex offenders and cybersex offenders (Robertiello & Terry, 2007). However, research has progressed to understanding that offenders within each classification are not alike, and therefore can be further differentiated through a number of different pathways, which often include the offenders' development and the commitment of their crimes. Inspired by Marlatt and Gordon's conceptualization of the relapse process in individuals with addictions, the Relapse Prevention Model (RPM) by Pithers, Marques, Gibat and Marlatt (1983) details the sequence of cognitions, emotions and behaviours in sex offenders. As the first pathway to sex offending, Pithers et al. view offending not as a dichotomy that is due to lack of control or fate, but as "as an inappropriate coping behaviour that results from a long series of decisions which slowly approach the final decision to perform a sexually aggressive act" (pg. 228). They additionally argue that following rehabilitation, when the sexual aggressor is in a state of abstinence from sexual crimes; a five-stage process occurs which leads the offender to lapse and relapse. Not only have further versions and refinements been made to Pithers' Prevention Relapse Model, but studies have evaluated the validity of the model and whether it is the 9 only pathway in the offending process of sexual aggressors (Ward, Loudon, Hudson & Marshall, 1995; Proulx, Perreault, & Ouimet, 1999). As a response, these findings demonstrate that there is more than one pathway in the offending process of sexual aggressors, concluding to

further diversity in offending. From this point, a number of studies have identified pathway models within subtypes of sex offenders (Ward & Siegert, 2002; Knight & Prentky, 1990), and their specific choice of victim. Pathways in the offending process of extra familial sexual aggressors against women. Using a total of 180 men who were convicted on at least one sexual offence against an extra familial woman (at least 16 years old), Proulx and Beauregard (2014) analyzed pathways in the offending process of this offender type. Using modus operandi, precrime factors, sexual lifestyle, general lifestyle and personality disorder as categories of variables in the offending process, Proulx and Beauregard developed profiles for each category and further, overall pathways through the combination of all preceding profiles. They found three distinct pathways. The sadistic pathway is characterized by an anxious personality profile, which includes avoidant, dependent and schizoid traits, as well as deviant sexual preferences. These individuals suffer from low self-esteem and believe that the people they meet, especially women, reject and humiliate them. This leads the sadistic aggressor to have a general lifestyle dominated by distress (nightmares, insomnia, phobias, headaches, self-mutilation), anger (temper tantrums, rebelliousness, reckless behaviour) and avoidance (drug and alcohol abuse). In addition, the sadistic aggressor uses both deviant and non deviant sexual behaviours as coping strategies for negative emotions. Their sexual lifestyle is considered as hyper deviant, as the sadistic aggressor often turns to deviant sexual fantasies during compulsive masturbation, as well as consumes pornography, and frequents strip clubs and prostitutes. Additionally, they are sexually unsatisfied, which is often due to the fact that their deviant sexual fantasies lose much of their gratifying power over time. As a result, this leads the offender to have more violent and intense deviant sexual fantasies and therefore, commit more violent behaviours. Additionally, sadistic aggressors present low self-esteem in the year prior to their offence and report conflicts with women in general, including marital problems. They also report idleness prior to the crimes, which favours a strong investment in both their sadistic fantasies and the planning of sexual assaults. Finally, sadistic sexual aggressors have overwhelming deviant sexual fantasies, which constitute their motivation to offend and additionally shape the modus operandi. Aggressors in the angry pathway

present a dramatic personality profile, which includes high levels of narcissism and dependent personality disorders. These individuals are involved in an intimate relationship, and because they consider themselves as special, they expect their partners to fulfill their sexual and emotional needs. When they feel that their partner do not do so, or abandon them, the offenders feel that his world is ending and become depressed, anxious and angry. The angry aggressor has a chaotic and unstable general lifestyle; characterized by substance abuse, temper tantrums, rebelliousness and chronic lying. In order to cope with this distress, they have promiscuous sexual lifestyles (i.e. frequenting strip clubs, and prostitutes, consuming pornography). In the year prior to their index offence, the angry aggressor is lonely and has lost his sense of self-worth, usually as a result of the end of an intimate relationship. The offenders typically deal with these failures through substance abuse and the construction of revenge fantasies. Finally, their modus operandi is characterized by their intense anger, which steam from their need for revenge. Overall, sexual assaults of women represent coping mechanisms for their anger. Finally, aggressors in the opportunistic pathway are characterized by a dramatic personality disorder profile, including narcissism and antisocial. This offender is similar to that of a psychopath, who is convinced they are superior to other people, have no empathy for others, are self-confident and see life as a party, with few limitations. The opportunistic aggressor reports their only life conflicts are with the judicial system or women, which are never the fault of their own. The opportunistic sexual aggressor additionally reports general sexual dissatisfaction. However, since they expect to have a willing partner at their convenience, they are at a risk of being sexually unsatisfied, despite the fact that they do have an active sexual life. Finally, his modus operandi is shaped on minimal planning. Specifically, the majority of the aggressor's assault women they already know, and therefore likely do not anticipate a criminal charge. Although interesting, the pathways identified by Proulx and Beauregard (2014) looked at women in general, neglecting to investigate if offenders who target particular groups of women could present different pathways as well. Pathways in the offending process of sexual murderers against sex trade workers. Beauregard and Martineau (2016) identified three pathways taken by sexual murderers who target sex trade

workers. The researchers conducted classification analyses on the forensic awareness, victimology, crime locations and modus operandi of the offenders. Combining the results from each category, they developed three distinct pathways in which these offenders use when committing their crimes. In the first pathway, the sexual homicide offenders are mainly concerned with getting rid of any DNA, particularly semen, and moving evidence, including the victim's body. In addition, they target a victim who is likely a drug-loner, including those who abuse drugs and alcohol, and engage in minimal social interaction. They use either a risky contact location to contact their victims - one in which there is great potential for others to hear and/or see what is happening or an outdoor to indoor type of location, in which the offender will initially contact and attack their victim outdoors, but dispose of the body indoors. Finally, their main strategy to commit the crime is manipulation. This offender typically uses a con approach but also beats, stabs, and strangles the victim. The second pathway is also characterized by the use of a manipulative modus operandi but the setting is somewhat different. Sexual murderers from this pathway target victims who are alcohol/drug social, including those who abuse drugs and alcohol, but have a social lifestyle. Additionally, these offenders are more likely to commit their crimes in a risky location and typically use multiple forensic awareness strategies, and dispose of the victim's body (i.e. conceal it). Finally, the third pathway is similar to the first pathway in that these offenders are mainly concerned with removing DNA and moving evidence, as well as targeting a victim who is a drug-loner. However, these sexual murderers select a completely safe location, one in which an effort is made to minimize the risk and includes dumping the body at an outdoor deserted location. Additionally, they adopt a sadistic modus operandi. These individuals fully remove the victim's clothing, commit unusual acts, insert foreign objects into the victim's body cavities, take items from the victim, and engage in excessive violence. As suggested by Beauregard and Martineau (2016), although the three pathways have been identified from sexual homicide of sex trade workers, they present different areas of focus by the offenders. For instance, in the first pathway, although the offender selects a risky location to get in contact with the victim, he makes sure to target a victim under the influence of drugs who is all by

herself. The second pathway is similar, but instead of targeting a victim who is alone, the offender targets one who is more socially invested and although this may first appear as more risky, all of the offenders from this pathway use multiple forensic awareness strategies in order to avoid police detection. Finally, the third pathway is very different in that the offender chooses to employ a sadistic script instead of manipulation. These offenders are primarily concerned with ensuring no DNA evidence is left at the crime scene and making sure that the crime locations are low risk in terms of being interrupted or detected.

In this paper we take a broadly social-constructionist perspective, whereby people perceive the world the way in which they do because they interact with the world through participation in socially shared practices, which transmit, reproduce, and transform meaning systems through direct and symbolic social interchanges (Dittmar, 1992). Therefore, people's understanding of the world is different across time and culture, and they accept a particular conception of the world not because it is empirically valid but because it seems to work (Gergen, 1985). The way in which people classify themselves, others, objects, settings, events, and periods of time is defined by conceptual categories. Although these classifications may feel natural or appear to be arbitrary, the practice of categorisation is usually consistent with cultural norms in a specific society at a specific time. Boundaries are used to define our daily affairs and restrict and regulate the interactions of people and the use of spaces. Spatial meaning is therefore expressed by unwritten social rules and conventions (Lawrence, 1984; 1996), and a focus on boundaries helps us to understand the way in which people use social space.

On the another aspects at community level can serve as social spaces in which people can formulate local responses to marginalized group/ HIV/AIDS. We use a 'social space' perspective to shed light on some of the resources and processes within social community level (understood as potential social spaces for debate, discussion and the negotiation of new social norms) that can challenge HIV/AIDS-related stigma and facilitate supportive attitudes towards PLWHA. According to Buttimer the concept of social space was first used by Durkheim in the 1890s where he referred to social space as the social

environment, or group framework, in which one is located. Within psychology, 'social space' has been used to refer to the symbolic and interactional sites in which social representations, shared knowledge and meaning, social identifications as well as 'recipes for living' (socially negotiated behavioural possibilities and options) are constructed and reconstructed through the process of communication as social actors go about their daily lives .

In this regards, Campbell and colleagues point to six features of supportive social spaces:

- The presence of HIV/AIDS-related knowledge and skills;
- Opportunities for critical dialogue and debate about HIV/AIDS;
- A sense of individual and collective ownership of the problem and responsibility for contributing to its solution;
- Confidence in the existence of individual, group and community strengths which could be mobilised to fight the epidemic;
- A sense of solidarity amongst group members around tackling HIV/AIDS; and
- Strong links with potential support agencies in the public and private sector outside of the community (bridging or linking social capital).

Stigmatized social rituals maintain a particular (aspect of) culture or a particular underlying assumption through a visible performance (Douglas, 1966). A particular activity takes place in a particular space; and this gives meaning to social space (Goffman, 1959). A ritualised activity, especially a routine in the home, underpins and organises the social system, reflecting or expressing discriminatory culture (Bourdieu, 1977). Thus, even when physical possibilities are numerous, the actual chores may be severely limited by social conventions and taboos (Rapoport, 1969). Boundaries (physical, socio-cultural, and psychological) are constructed and maintained by ritualised practices. They are basic forms of social structure (Pellow, 1996) and the analysis of the three levels of boundaries will therefore lead us to a better understanding of the socially constructed meaning of social space. Peter Leonard (1984, p.180) defines social marginality as 'being outside the mainstream of productive activity and/or social reproductive

activity'. This includes two groups, firstly a relatively small group of people who are voluntarily marginal to the social order - new age travellers, certain religious sects, commune members, some artists, for instance. Here, however, we are concerned with a second group, those who are involuntarily socially marginal. Leonard (1984, p.181) characterises these people as remaining outside 'the major arena of capitalist productive and reproductive activity' and as such as experiencing 'involuntary social marginality'. The experience of marginality can arise in a number of ways. For some people, those severely impaired from birth, or those born into particularly marginal groupings (e.g. members of ethnic groups that suffer discrimination - the Roma in Europe, Indigenous people in Australasia and the American continent, African Caribbean people in Britain), this marginality is typically life-long and greatly determines their lived experience. For others, marginality is acquired, by later disablement, or by changes in the social and economic system. As global capitalism extends its reach, bringing more and more people into its system, more communities are dispossessed of lands, livelihoods, or systems of social support (Chomsky, 2000; Petras & Veltmeyer, 2001; Potter, 2000; Pilger, 2002). Marginalization is at the core of exclusion from fulfilling and full social lives at individual, interpersonal and societal levels. People who are marginalized have relatively little control over their lives and the resources available to them; they may become stigmatised and are often at the receiving end of negative public attitudes. Their opportunities to make social contributions may be limited and they may develop low self confidence and self esteem. Social policies and practices may mean they have relatively limited access to valued social resources such as education and health services, housing, income, leisure activities and work. The impacts of marginalization, in terms of social exclusion, are similar, whatever the origins and processes of marginalization, irrespective of whether these are to be located in social attitudes (such as towards impairment, sexuality, ethnicity and so on) or social circumstance (such as closure of workplaces, absence of affordable housing and so on). Different people will react differently to marginalization depending on the personal and social resources available to them,. Nevertheless, some common social psychological processes can be identified. We pay particular attention to processes that

facilitate or prevent collective social action (see Burton & Kagan, 1996).

After presentation of the above considerably different notions of marginality, we need to consider how are they related to geographical research of marginality where the spatial aspect should play the most important role. The question is: "Do we practice geography of marginalization or geography of marginal regions when we research different aspects of marginality and marginalization from geographical point of view?". If we chose the later then we obviously practice a sub-discipline of human geography with strong emphasis on the regional aspect. It can be thus compared with rural or urban geography. In order to do our job we need to define the vital characteristics and the extent of marginal areas. That means that we need to delimit them from the rest of the territory. As in case of urban-rural division this is a more or less impossible task. No single definition of marginal areas can be so accurate and precise that we could simply draw a line between marginal and non-marginal areas. As we presented above, marginality is too complex and approaches so different and always at least partly subjective. Marginality is therefore, by my opinion, not objectively measurable. We can state that a certain area or region is (at least partly) marginal using appropriate set of indicators that can show the presence of certain characteristics of marginality in the area (region). However, it is not very common that researchers of marginality would first try to objectively define the case study area's marginality. Rather they choose it on the basis of their subjective judgment. Very often this includes only one or two aspects of marginality, such as remoteness, usually connected with lower economic status of the case study area (low economic output or high share of people living under the threshold of poverty etc.) However, this is a subjective choice made by experts, knowing the topic is usually not problematic. Besides, through the research of the problem, their focus on the characteristics of marginality usually becomes more and more obvious.

"Health sociology is no longer, nor should [it] be, the simple contribution of techniques to the health care service but, on the contrary, should mean methodological independence [for dealing] with health from an interdisciplinary view- point, in which the biomedical aspect is

only an additional component, however important it may be”.

Currently, it is widely recognized that the correlation of sex offender and HIV constitutes a complex social phenomenon in which there is an interrelation between multiple social, economic, political, cultural and environmental factors in those communities where the pandemic develops and spreads. For instance, although HIV is a chronic disease in some European countries, in some African countries it is a deadly disease. Therefore, insofar as the epidemic influences the lifestyles, practices and subjectivities of a population, it is necessary to study it by utilizing tools that provide a more qualitative and in-depth knowledge of the phenomenon. Consequently, social sciences have begun to study the complex connections established in relation to the HIV phenomenon with the aim of providing knowledge for its understanding and comprehensive. However, despite existing evidence, the epidemiological method has been the benchmark for most of the approaches in the study of issues concerning public health in general and HIV in particular. In this respect, it is worth noting that, currently, the epidemiological method cannot cope with the complexity of the HIV phenomenon on its own. Therefore, there is a need for HIV to be studied by different disciplines in order to address the complexity of the problem. For instance, the positivist method involves the limitation of not being able to grasp the qualitative aspects of health and disease. Thus, neither the subjective aspects of the disease nor the cultural factors influencing the HIV epidemic are present in epidemiological studies. In this sense, there is a need to generate qualitative information to help guide the design of prevention policies, particularly in regions heavily affected by the epidemic, such as African countries. Social sciences provide a wide range of research theories and methodologies that can be extremely useful for studying HIV in general and in particular, its prevention and treatment. The sociological discipline, insofar as it seeks to explain and understand collective behaviour within a social context, the meanings of actions and the multi causality of phenomena, constitutes an essential tool in the construction of knowledge for an in-depth understanding of the HIV pandemic. Therefore, sociological theories constitute fruitful ground for investigating health and disease within the current context, as will be

discussed throughout this chapter. Health sociology, as a discipline, is a pertinent tool for the study of HIV. One of the reasons for the emergence of this discipline is the crisis of medicine, not as a science, but as a model of social practice. One of the basic premises on which sociology is based is the need to focus on the analysis of health and not of disease, as opposed to the biomedical model that has primarily focused on disease. Such a fundamental purpose is in accordance with the need for placing greater emphasis on HIV contact and prevention rather than treatment, in order to eradicate the pandemic. Therefore, assumptions that involve focusing on health from a sociological perspective constitute basic assumptions for prevention when applied to the field of HIV

Preventative action holds keeping people healthy as a central objective and is based on actively guiding willingness and ability, considering health as a process and not as a state; emphasizing the dynamic role of the subject as a pole of active reciprocity in respect of medical and health care institutions and roles.

To expect a permanent engagement with lifestyle changes focused on health, not only on behalf of the individual, but also on behalf of the social and health care system; planning and programming to prevent the disease both at an individual and collective level.

To expect health to be promoted and safeguarded by all social actors, firstly, by all individuals, and in all cases, not wholly delegated to specific specialized places and centre. Some aspects that are likely to be investigated from a sociological perspective: As will be discussed below, the different theoretical contributions of sociology will enable public health to approach health issues from a wider perspective, providing pertinent tools. For designing effective action in the fight against HIV. Additionally, sociology provides a multidimensional perspective for the study of behavior of sex offender towards HIV, the social roles that are played in professional-patient interaction, as well as the role of health care institutions and the social networks that influence the prevention of HIV. Finally, theoretical contributions of sociology are also relevant for designing and implementing health promotion programmes in relation to HIV. Sociological approach to HIV research among the multiple sociological theories that offer a

suitable approach for the study of HIV prevention, three relevant theories will be outlined: symbolic interactionism theory, ethno-methodology and phenomenological sociology. All of these are essential analytical tools for further exploring the above-mentioned aspects. Symbolic interactionism theory. This theory focuses on explaining how people create their own identity and define themselves through their social experiences, that is, through their interaction with other people. Society is understood as a result of everyday, face-to-face, interaction among people. Through this interaction, people define and give meaning to the social world in which they live. Symbolic interactionism is based on multiple premises. The most relevant and useful scenarios for the study of HIV are: Human beings react in one way or another depending on their perception of the object, person or situation they face, that is, the meaning they prescribe to a situation. The individual (subject) adopts an active role in creating meanings. Things do not have an inherent meaning; the meaning of things arises or emerges as a consequence of the social interaction established between people. Meanings are handled in and modified through an interpretative process carried out by the person. Common meanings make communication between human beings possible. In summary, according to this theory, social reality is symbolically created during the course of social interaction and is therefore subject to change. Human behaviour is social and is based on communication; therefore, people create and interpret social situations and their meanings during this communicative process. It is during the course of social interaction that objects gain meaning for the person or persons. These social meanings are created and modified during the dialogue of social interaction. Thus, the symbolic interactionist perspective is especially useful in the construction of behaviour, as it gives a primary role to the concept of the interaction that occurs between the members of a social group. Furthermore, "human beings interpret or define the actions of others, without being limited to simply reacting to them. Their response is not directly elaborated as a consequence of the actions of others, but is based on the meaning they give to such actions". Therefore, in relation to health and disease, and the prevention of HIV, this theory constitutes an important theoretical perspective for studying and explaining the social conduct of people and groups of people who interact with each other

on the basis of sharing symbolic meanings. In the field study of HIV, symbolic interaction theory has been extensively applied. This theory is useful for studying the stigma that exists among people living with HIV. Recently, it has been published a meta-analysis about ART non-adherence. The results of the study suggest that the existence of stigma is a factor of non-adherence. This systematic review identified 34 studies that applied this theory. These studies indicated existing intrapersonal, interpersonal and structural barriers as a result of stigma as factors of non-adherence. The process of social interaction constitutes a fundamental aspect in the study of the doctor-patient relationship. Since communication does not have a unidirectional character, the emission and reception of messages does not occur in a passive way. Such constant feedback creates a process that influences the way in which the disease and the person's subjective experience are created. This theory has been used to study the relationship between people infected with HIV and health professionals. Recently, an interesting study conducted in Spanish health services analysed the relationship between people living with HIV and physicians as it concerns interventions developed within the areas of sexuality and safe sex. Hence, symbolic interaction allows for a broader view of the approach to sexual marginalized and normal people interaction, because it enables an understanding of the processes of social interaction that take place during the course of the relationship. Subsequently, it also allows for an analysis of the role of the patient and health professionals in their encounters throughout the disease process. Furthermore, the communicative process that is established motivates the participation of other people, the family and the community. Therefore, the meanings and the subjective experiences of HIV-positive people are created during the social interaction process, not only with health professionals, but also with other individuals and groups with whom the HIV-positive person interact in normal everyday life. In this sense, studying doctor-patient interaction is useful for identifying the potential cultural barriers that can arise from this interaction. For instance, Spain recently conducted a research study, the objective of which was to understand and analyse the experience of immigrant HIV-positive women with health professionals and treatment services.

The fundamental contribution of symbolic interaction to the field of social cognition is the consideration that mental processes are the product of symbolic interaction and not of internal individual processes. Emotions are an example of mental processes that have been studied from a symbolic interaction approach, given that they are expressed in response to social relationships or situations, or both. Human interaction possibly plays the most important role in the activation and expression of emotions. Thus, emotions are biological responses to social situations and the interaction between the people involved in such situations. From this perspective, health and disease are understood as human constructions perceived in a subjective manner by the population. It entails analysing peoples' everyday views of disease, the ideological connotations that health professionals attach to diseases, and the construction and application of medical knowledge. Altogether, according to this theory, it is possible to analyse aspects that are relevant for the study of the HIV phenomenon, such as the different constructions created by people in their interaction with others, the meanings, perceptions, life experiences, beliefs, values in relation to HIV, guilt feelings for being HIV-positive, stigma, risk perception, as well as reasons for abandoning treatment. Phenomenological sociology focus of analyzing this theory is how meanings are created in the individual's consciousness. In other words, how life experiences influence and form part of the interrelationships established between two or more actors in everyday life and how these meanings can be revealed to an observer. In the field of HIV research, this theory has been applied for studying the social about of the virus. The study of social representations of HIV has been extremely relevant to understanding the perceptions and meanings attached to the disease by the general population. A series of key notions that summarize the author's thoughts and that constitute analytic tools for the study of the HIV phenomenon are described below: Life world (*lebens welt*): the life world concept is an essential category for understanding the reality of the world of common-sense, as well as the reality of social action and interaction. It refers to the intersubjective social world inhabited by the actor in daily life by applying a "natural attitude". This lifeworld is characterized as being an intersubjective and public world for the individual, and hence shared by and accessible

to everyone. One of its main defining characteristics is that it is a pre-existing world. It is an intersubjective world that exists before being born and is given to the individual to experiment with and to interpret. In essence, it constitutes the horizon that embraces all possible ways of living and experiencing (where the fulfilment of humans in their human condition takes place) and of constructing a social life, transcending the vital experience of a particular actor. In the field of HIV research, this theory has been applied to the study and understanding of the different perceptions and meanings of the virus, as well as its influence on how people live and experience the disease.

- Intersubjectivity: this concept is essential for assimilating the mutual understanding that occurs between people during their interaction. It is defined by Alfred Schutz as "simultaneity... for it means that I grasp the subjectivity of the alter ego at the same time as I live in my own stream of consciousness... and this grasp [of] simultaneity of the other as well as his reciprocal grasp of me, makes possible 'our' being in the world together". The foundation of this concept is based on the social world, on the lifeworld; therefore, it is an intersubjective world, not a private world, one that is common to all. However, the intersubjective world is not only composed of subjective sensitivities, that is, what is received by the senses, but also of subjects' interpretations of those sensations. Therefore, it is based on how the subject interprets his/her surrounding world, as well as on the elements that condition this surrounding world and that make it possible to change or maintain the subject's interpretations and actions.
- Typifications and recipes: in the social world or lifeworld, people have a store of knowledge. A great part of this knowledge comprises what are known as "typifications" and "recipes". Typifications are schemes of reference, "knowledge that the world we live in is a world of more or less well circumscribed objects with more or less definite qualities, objects among which we move, which resist us and upon which we may act". Typifications exist in society; they are socially approved and are acquired through the socialization process and throughout the course of life. In contrast, recipes concern the knowledge used to understand or control aspects of experience, in other words, aspects that are related to situations and actions in the lifeworld, whereas typifications refer to the knowledge used to understand people or objects.

- Meanings and motives: action constitutes a human conduct consciously projected by the actor; hence, social action is that which involves the attitudes and actions of others, and is aimed at them during the course of the action. Meanings refer to the way in which actors determine what aspects of the social world are important to them, whereas motives attempt to reveal the reasons that explain the actions of the actors.
- Roles: defined as the typifications of what actors (Sex offender) are expected to do in certain social situations. In the field of HIV research, the study of gender roles, both male and female, has been used to understand the reasons for why people maintain unsafe HIV behaviours
- Reification: this concept is an analytical tool used by the authors from an integral perspective of the social world. Reification is the tendency to perceive human products “as if they were something other than human products – such as facts of nature, results of cosmic laws, or manifestations of divine will”
- Legitimizations: these centre on the knowledge of reality in order to legitimize their existence.

In short, phenomenological sociology constitutes an important conceptual tool for approaching the study of HIV. This is the case because it is a theoretical perspective that permits for capturing the subjective meanings that people attach to their actions; additionally, it serves to describe and understand interpretations of meanings within the world, as well as for gaining a sense of the actions and interactions of people who are HIV-positive.

Ethnomethodology The primary objective of this theory is to analyse the individual's actions (Sex Offender) in daily life. Thus, it analyses how people define and construct, face-to-face (through interaction), each social situation. The traits that constitute social order are products of the activity itself. This order is “produced by the participants” and essentially carried out by means of verbalization. Therefore, the study of language (the decoding of cultural meanings) acquires great importance. The study of social representations of HIV has been very relevant for understanding the perceptions and meanings related to HIV among the general population. For instance, a study recently conducted in South Africa analysed the discourse on risk perception that adolescents have in order to assess whether the contents of HIV prevention campaigns were suitable. For an ethnomethodology, social reality is above all a reflexive and interactive activity that is socially

constructed. According to this theoretical model, human society is the result of repeated interpretations that occur during the course of interaction. Ethnomethodologists' concern is that which Weber calls “significant behaviour”. In order to understand this theoretical approach and its relevance for the study of the HIV phenomena on, it is necessary to know how it views social reality, the most significant premises in this context being the following five situations

Everybody, through our thoughts and actions, is immersed in a process of creating social reality. It is a process of which we are not aware. The social construction of reality is constantly happening. Sex offender in their daily lives, people organize the world in coherent realities and this social reality depends on the participants' incessant reciprocal interaction and social construction of reality. Given that this interactive and reflexive work constitutes reality, such a reality cannot be sustained without it. Therefore, each social reality is not a solid structure, but a very fragile creation that can break. People live in diverse social worlds and they may move from one reality to another. Thus, sex offender behaviour that might be considered reprehensible in a certain social context may be acceptable in a different one. Authors such as Caballero (1991) have described and analysed some basic concepts developed by ethnomethodologists, which constitute highly useful analytical tools for understanding and studying the HIV phenomenon namely:

- Explanations: by means of the explanation process, people make sense of the world. Explanations are used by actors to do things such as describing, analysing, criticizing and idealizing specific situations. As such, this theory has been applied for identifying the reasons why people living with HIV leave treatment services with marginality identity. Additionally, this theory has been applied for identifying the reasons why certain preventive practices, such as making an early diagnosis, are not acquired by certain population
- Reflexive action and interaction: the concept of reflexivity refers to how people who are interacting maintain the presumption that they are guided by a certain reality. In other words, humans interpret signals, words, gestures and information provided by other humans in a way that supports a certain view of reality. Even contradictory evidence is reflexively interpreted to maintain beliefs and knowledge.
- Indexicality: this term refers to phrases in which

meaning varies depending on the context. It is therefore considered that all explanations must be interpreted within their specific contexts / social space

Marginality research can therefore take place almost everywhere, but it can focus on many different topics, considering the scale and the type of marginal region that the research is dealing with. The regions with traces of marginality, with clearly observable marginality issues and with severe marginality problems will probably attract the research interest for the following: • who is marginal (identification of marginal individuals or social groups), • what are the manifestations of this marginality (identification of the type of marginality), • what are the consequences of this marginality (identification of consequences), • what is causing this marginality (identification of marginalizing factors), • what is the role of geographical (geo-spatial) factors in marginalization process (identifying the role of geographical factors). Ideally a geographical research of marginality in certain marginal region would involve all of the above, but in practice. In this sense we should probably talk about the geography of marginalization rather than the geography of marginal regions. In cases where the researcher focuses only on one problem, no matter how important its role in the process of marginalization is, we cannot talk about geography of marginal regions, it may only be considered as a partial study within geography of marginalization.

FINAL REMARK:

Marginalization and HIV is a complex phenomenon in which many aspects (social, cultural, etc.), not only sociological, clinical and biological, are interrelated. Intervening factors in the and sex offender and HIV phenomenon include social, economic, political, cultural and environmental aspects. The HIV phenomenon interacts with lifestyles and practices, as well as with the subjectivities of the sex offender in communities where it develops and spreads. Therefore, it is currently a fact that the epidemiological method is insufficient for providing holistic and hermeneutic knowledge on the issue. For this reason, a primary conclusion of this study is the need for applying other methodologies and theoretical tools to study the phenomenon with the aim of providing such knowledge. Furthermore, this knowledge is a key element for assuring efficient and

effective HIV prevention policies and strategic planning for sex offender in particular and population in general . In this sense, sociology and in particular health sociology constitutes a pertinent conceptual and methodological tool for studying the marginalization and HIV phenomenon in all its complexity. In this sense, it seeks to explain and understand the collective behaviour that occurs in a social Space, the meanings of actions and the multi causality of phenomena. The theories that have previously been explained are relevant methodological and theoretical tools for comprehending the complexity that defines HIV. Though these instruments differ, they do have certain common characteristics that should be taken into consideration. A common premise is: conceiving human action in terms of its intentionality, autonomy and reflexivity. All these characteristics share a subjective view of human behaviour, because they define its discourses. Consequently, the relevance and contribution of these theories to the study of health and disease, and specifically to the study of HIV, is now a fact. The advantages of this are multiple: • Enabling the understanding of the health-disease-attention process and ultimately, the behaviour that results from the interaction between those involved in this process, as well as offering coherence to these conducts. In this sense, it reveals conducts towards both the diagnosis and the treatment of HIV. • Knowing and understanding how sex offender and groups participate in the construction of social representations of HIV. • Knowing and analysing the social control mechanisms that arise in relation to sexually marginalized people with HIV, such as stereotypes, prejudices, stigma and discrimination. • Analysing the different meanings that exist in the construction of the relation of marginalized sex offender and HIV phenomenon; a construction that is built on perceptions, life experiences, images, ideas, representations and social control mechanisms. These meanings enable us to understand how people relate their way of thinking to their way of acting towards HIV. These theories are relevant and pertinent for obtaining useful knowledge to guide the design of effective and efficient health promotion policies and strategies, specifically for the prevention of HIV, as they focus on the problem of how actors in different contexts create a view of reality. Finally, a series of methodological tools were discussed whose validity and pertinence for the study of HIV are currently beyond any doubt.

This has been evidenced by multiple studies in the field of HIV prevention, which have been conducted using this qualitative methodology.

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