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Feminism and Bourdieusian Social Theory in a Sexual Health Empowerment Project with Incarcerated and Recently Released Women

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Abstract

Theory is often downplayed or omitted in the research and scholarly literature around public health interventions in carceral settings. Our Sexual Health Empowerment (SHE) project was an education intervention and ethnographic study that aimed to reduce cervical cancer risk among women with histories of incarceration. In this article, we describe our application of concepts from feminist theory and bourdieusian social theory to the design, planning, and delivery of SHE. We outline how theory-driven practice both underscored and helped us meet challenges in implementation in three urban jails over a two-year period, 2014–2016. Our approach provides a model for others who wish to bring critical theory and research practice together in health interventions with populations that are marginalized in multiple ways.

Keywords

Feminist theory; Bourdieu; trauma; incarceration; reproductive health

The Sexual Health Empowerment (SHE) project was a federally funded longitudinal cervical cancer intervention study that began in 2014 with women recruited from three Kansas City-area jails. The SHE project applies an education model to a public health initiative to increase women's understandings of *human papillomavirus* (HPV) and cervical cancer. The

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goal of the study was to help women identify barriers and develop strategies to increase HPV screening, Pap tests, and follow up (Ramaswamy et al., 2017). In this article, we share our experiences planning and conducting an intervention study in a manner consistent with principles of feminism and concepts from bourdieusian theory of practice. The SHE project brought theory into the foreground of a cervical cancer public health study, and we believe the feminist and bourdieusian theoretical touchstones that impacted every level of the study made our work stronger, both scientifically and humanistically. In this article we outline our integration of the theory and the ways in which the institutional and ideological contexts in which we worked posed unique challenges.

As a team, we came to this research with over two decades of combined study and work in jails. Our professional backgrounds lay in public health, sociology, women's studies, and nursing, and we included a master of public health (MPH)—trained sexual health educator, a sociologist, a licensed substance abuse counselor, an advance practice nurse, and several public health, nursing, and medical students at the graduate and undergraduate levels. Team members were joined by a commitment to feminism and critical social theory, which influenced the inception and design of the study and its implementation. Feminism and bourdieusian theory informed SHE at every step, not always harmoniously, as we will show, but always productively.

The Place of Theory in Public Health Research

We have elsewhere documented the importance of disclosing the influence of theory in trauma-informed intervention studies with women in jails (Emerson and Ramaswamy, 2015). As we have argued, interventional researchers build better arguments, add coherence to their work, and optimize connections within a field of study when they set forth in explicit terms the conceptual and theoretical frameworks that govern their choices and assumptions (Emerson and Ramaswamy, 2015). One objective in the following discussion is not to propose or espouse any one theory—not even the particular ones we used—nor even to develop a new one, but to contribute to the argument for more transparency and consistency in the application of theory and to report how challenges were navigated in an exemplary case.

Theory means different things in different research and scholarly contexts and often functions in several ways at once. In many scientific contexts, theory signals a set of formal constructs and propositions such as those applied and tested in studies to discover or systematize relationships between phenomena (Creswell, 2014). In this sense, researchers routinely use theory when they operationalize and test the propositions that support hypothesized explanations. Researchers test theories repeatedly, gathering credence for a theory as the weight of evidence accumulates. We have used theory in that way in our work (Ramaswamy and Kelly, 2015), but here we are interested in a broader application of theory as a rationale, basis, or perspective, one that provides direction for decisions at the front end and all the way through a study, motivating the choice of problem, population, setting, and methodology in a research project (Creswell, 2014). Theory as a framework may involve propositions, but they function less as testable notions than, in a more constructivist sense, as boundary setting, the creation of an ideational field within which a researcher gauges the

relevance of findings, the suitability of methods, and the formulation of connections to other knowledges (Sandelowski, 1993). The absence of theoretical frameworks in health research can mask an unacknowledged defaulting, a falling back on unexamined positivism. This is an especial problem in interventional behavioral research, where the impulse to mimic clinical investigations leads to stripped down studies with hypotheses, results, and conclusions and only a superficial gesture at the beginning and end to acknowledge the conceptual drivers that lie behind choices made throughout the study. Such an approach assumes a kind of anti-theory in which facts are thought to speak for themselves. Theory should comprehensively inflect the research decision-making process, not just organizing procedures, methods, measures, and analysis for a report, but inhabiting the activities of research at all points along the way.

Our Theory Guides

SHE was a five-day cervical and sexual health empowerment educational program delivered weekly to small groups of women ($n = 184$) in three metropolitan jails over two years. The study used random assignment to groups, with wait-list control, and included pre- and post-intervention surveys to assess knowledge, attitudes, and self-efficacy for prevention with follow up surveys administered at six-month, one-, two-, and three-year time points (Ramaswamy *et al.*, 2017). A second aim of SHE was to learn more about how participants navigate health care systems following incarceration and for this we performed ethnographic interviewing and participant observation with a subset of women selected from the intervention. In planning the SHE intervention and study design, conducting the pilot, implementing the program, and collecting and analyzing data, we adapted ideas from two broad, interconnected traditions in critical theory—feminist relationality and bourdieusian notions of habitus, field, and social capital.

Feminism

SHE is a project influenced at all levels by feminist theory (Ramazanoglu and Holland, 2002; Sprague and Kobrynowicz, 2004). In our work, feminism means that we view women's involvement in crime, their experiences during incarceration and reentry, and the effects on health in ways that are gender-specific, relational, voiced, embodied, and trauma-informed. Even while we have found these domains useful in shaping our research practice, we also recognize the importance of guarding against essentialist entailments of the categories (i.e., that women are uniquely embodied or by nature more relational) (Haraway, 2014; Jaggar, 2015). We have been attentive as well to the dangers of romanticizing women's experiences and empowerment in ways that might obscure the need for systemic change (Murphy, 2015).

Gender-specific—Putting gender at the center of inquiry and action is foundational to feminism. Feminism emphasizes recognition of gendered modes of power and systemic patterns of privilege and assumes that gender makes a difference both structurally and individually (Smith, 2004). With Joey Sprague (2005) and Sandra Harding (2004), we considered gender to signal a social and epistemological standpoint related to sex identity but not reducible to it, one that influences the interactions a person has in the world. It is not

that gender alone makes a difference, or that the differences gender makes are always more important than or completely discrete from other identifications (Cho *et al*, 2013; Richie, 2013). Nor are the differences that gender makes always and everywhere the same. What our adoption of a feminist conceptual framework meant was that we acknowledged how identifying and being identified as a woman in much 21st-century U.S. society serves as a strong though variable refractor of both power and knowledge. Feminist criminology holds that this is particularly meaningful in research that addresses health care for incarcerated women (Belknap, 2007).

For SHE, a feminist perspective meant recognizing that current political and social formations are predicated on assumptions about gender. These play out in a variety of health-impacting ways for women in our sample, including sexual abuse and the sexualized treatment of women in jail, as well as matters tied to gender after incarceration: struggles over income assistance, health care access, child custody and endangerment, reproductive choice, and health stigma. While the terms *victimization* and *oppression* have unfortunately come to function as slogans in many contexts, they also correspond to very real and complex factors that shape how women with criminal justice involvement live their lives (Green *et al*, 2005), how, in the bourdieusian terms discussed below, women perceptually and practically inhabit the fields that structure the world in which they move. SHE encouraged women themselves to explore some of that complexity by facilitating open discussions about the links that connect gender inflected systems of knowledge and power to the field of options that come to be perceptible to individuals. SHE was insistent about acknowledging the elements of gender oppression that affect women, while also attending to opportunities and evidence of empowerment.

Relational—The gender-specific focus in SHE underscored a relational emphasis in the project. We worked from a perspective based on feminist cultural-relational theory as developed by Gilligan (1982), Miller (1986), and Jordan (1995) and articulated more specifically by Covington (2008) and Van Voorhis (2014) for correctionally involved women. These theorists postulate that for many women the development of a healthy sense of personhood depends more on building and maintaining supportive relationships than establishing a sense of self as thoroughly self-reliant. Relational theory holds that as a result of historically based, gender-specific socioeconomic structures women often make choices and form judgments based not on abstract principles but on how their decisions affect others in their social networks (Comstock *et al.*, 2008; Covington, 2008; Naffine 2013).

A criminal justice system attuned to women's needs from a relational perspective develops programs that enhance supportive community among inmates and between inmates and staff (Bloom *et al*, 2002). The SHE project was designed to operate in line with relational principles, specifically drawing on the community-building and collective consciousness raising that small-group formats can facilitate (Foy and Larson, 2014). For women who may feel isolated, stigmatized, or disenfranchised (in general or specifically in relation to obtaining care for reproductive health issues), this approach not only stressed the possibility of finding in other women a source of strength and solidarity but also, and perhaps counterintuitively, the importance of hearing and honoring women's individual experiences (Comstock *et al*, 2008; Jordan, 1995). The relational and communitarian aspect of SHE thus

points to the third component of feminism as conceived by SHE, the importance of agentic voice.

Voiced—Voice has long been a signifier for agency in feminist and other emancipatory discourse, though not an uncomplicated one (Fisher, 2010; Lipton, 2016). Representative of both individual and collective experience, voice acts as a metaphor, shorthand for how a person may exercise control over the construction of experience and self (Lipton, 2016; Schlichter and Eidsheim, 2014). Voice as a signifier for power has roots in the notion that voice represents a kind of ownership over experience, both individual and collective (Gammage, 2016). Because it also signals autonomy, theorists have at times associated voice with a patriarchal tradition while identifying silence as the historically more resonant term for women's presence in the world (Lipton, 2016). In some feminist liberatory discourse, however, voice is reappropriated to signal a means by which women can control the symbols that define the past in order to give shape to a future (Klugman *et al*, 2014; Lipton, 2016). We thought of voice dialectically, with the relational emphasis of the SHE intervention encouraging women to draw strength from one another and acknowledging the connections they shared while also reinforcing women's need to speak their singular truths. Moving past the seeming opposition, we sought to integrate expression of the personal with group exchanges about feminist health empowerment that focused on potentially transformative, collective facets of voice: discussions of political action, voting, and membership in community and group-interest movements to advance health care for women and their families.

Embodied—Developed diversely over the past three or four decades by cultural and more recently critiqued and reformulated by poststructuralist feminists (Pitts-Taylor, 2015; Smith, 1992), embodiment has a deep history in feminist and proto-feminist theory extending back at least to Mary Wollstonecraft's late eighteenth-century writing on the rights of women and arguably back to the religious writings of medieval female mystics like Margery Kempe (Castagna, 2011). For SHE, we found it useful to encourage participants to talk about their bodies in order to reclaim situated, lived knowledge and experience, both in the form of pain (abuse, rape, illness) and pleasure (sexuality, growth or maturation, nurturance, work). SHE drew on a materialist-inflected version of feminist embodiment, in which women are thought to share physical and social experiences in part because they hold the physical attributes of women *in* a particular historical and social context (Riley, 1987; Smith, 1992).

We were also very much attuned to the fact that experiences that follow from women's embodiment unfold variably along indices of race, nationality, income, education, correctional status, and bodily enablement. SHE embraced the intersectional thesis of Deborah King (1988) and Kimberlé Crenshaw (1989), who remind us that embodied experience exists neither in a vacuum nor as the predetermined outcome of a relationship in which race, class, gender, and other points of affiliation are joined sequentially or additively. Instead, these combinations tend to be synergistic, with the determinative weight or pull of various identifications changing as they mutually come to bear upon one another within a social context (Cho *et al*, 2013; Crenshaw, 1989; King, 1988). For SHE, the feminist concept of embodiment meant thinking of incarcerated bodies as a place to start, a common though

varied thematic ground for health exploration and an untapped means around which transitory communities may take form, social support may be cultivated, and women may become more empowered.

Trauma-informed—In every aspect of SHE, we took into account the high prevalence of rape, childhood sexual abuse, and physical abuse among jail incarcerated women (Grella, *et al.*, 2013). The SHE intervention was premised on assumptions about the potent impact that multiple, repeated experiences of abuse and violence have on incarcerated women's attitudes and behaviors related to their bodies. And, even more particularly, we were concerned to address the prohibitive force that a cycle of trauma can exercise over women's self-perceived capacity to do what, to many who will read this, may seem like the simplest of tasks: to obtain reproductive health screenings and to follow up on exam results.

The SHE curriculum invited participants to consider, in a group context, how relationships, life circumstances, and life choices prior to incarceration might affect their sexual and reproductive health. While our focus was not specifically on trauma, the women who participated in SHE voluntarily described events of violence and abuse, some of them by all appearances life-threatening. In these instances, team members introduced a variety of grounding and redirection strategies, including controlled breathing, mindfulness, and guided visualization exercises. While we did not shy away from promoting conversation that acknowledges the hurt that bodies hold, we also did not assume that every woman in our program suffered from trauma, and we were keen also to celebrate the pleasures our bodies bring.

Bourdieuian Theory

The second overarching theoretical framework that guided the SHE study came from Pierre Bourdieu's theory of practice, specifically the concepts of habitus, field, and social capital. For Bourdieu (Bourdieu and Wacquant, 1992), habitus names the "durable dispositions" (p. 55) or internalized cognitive, emotional, and behavioral habits that stem from the production and reproduction of the material conditions of living. Habitus takes form in the unconscious structuring of a person's sense of reality, informing what can be perceived as "reasonable" and "common-sense" and is based on position within a social field—for Bourdieu, class position (Bourdieu and Wacquant, 1992, p. 55; Bourdieu, 2013). Bourdieu is insistent about the fact that the deep-seated habitus springing from material relations not only structures the reality that persons experience but also that the resultant living in the world—the practice of living—turns back to inform the structures that constitute habitus (Bourdieu, 1990). While Bourdieu's writings about habitus thus suggest that unconscious orientations in thinking, feeling, and acting arise from embodied experience in a world structured by differential distributions of power—including, as feminist theorists have observed, pervasive imbalances in the gendered distribution of power (McNay, 1999)—Bourdieu also writes that within the bounds of habitus there exist infinite generative possibilities, a dynamism within which both agency and change develop (Bourdieu and Wacquant, 1992). Bourdieu argues that people live socially within various fields (e.g., work, family, religion, education), which are again structured by struggles for mastery or control. Individuals perceive the fields in which they are embedded through the lens of habitus and navigate those fields by drawing on social

capital, the resources that are available to individuals because of their membership in a group or network. Social capital impacts both group and individual capacity to achieve desired ends in a field (Baum and Ziersch, 2003; Bourdieu, 1986, 1990).

Habitus, field, and social capital are important concepts in approaches to social change and health promotion, particularly approaches that seek simultaneously to address the determining effects of social and economic relations (i.e., those elements that set the boundaries within which people can think, believe, and act), while also imagining how individuals might develop the *reflexivity* or awareness of self-within-structure necessary to reach beyond such horizons. As a praxis-directed, self-conscious reflection on one's position within a system, reflexivity may lead to working both individually and together to change the dynamics within fields (Pöhlmann and Halsall, 2016). The opener for such change in Bourdieu's thought was the idea of crisis, a moment when shifts in the social field lead to large-scale or sudden and extreme dissonance in habitus (Bourdieu and Wacquant, 1992). Such moments produce the conditions in which reflexivity might emerge, habitus become visible, and significant transformation of social and individual relations become possible (Bourdieu and Wacquant, 1992; Crossley, 2003).

Habitus, field, and social capital were crucial to the SHE team's understanding of oppression and empowerment and the possibilities of an educational program with incarcerated women. Habitus and reflexivity influenced the creation of the SHE curriculum and its implementation in the jails, since we operated under the assumption that women's experience of incarceration might act as a rupture or crisis on a personal level, a disruption in which women could be guided to develop critical awareness around the conditions that lead to social inequity and health disparity. During the crisis of a short jail stay, we surmised, women might generate social capital, learning from others' experiences and strategies of overcoming barriers to and accessing resources for health care. They might be guided to look with new eyes at 1) social structures and institutions and the ways in which they create unhealthy situations and environments; 2) the habitual, disempowering patterns of thinking into which these often structures translate on an individual level, particularly through their influence on health behaviors; and 3) how women might like themselves make changes in their own lives *and* organize collectively to put pressure on systems for broader change.

Feminism and Social Theory as Applied in the SHE Project

The theoretical frameworks that informed SHE were applied throughout the study. Feminism figured into the training of study team members around trauma-informed care; domestic abuse and violence against women; techniques for grounding and mindfulness; and the problems of sexual exploitation, including prostitution and pornography. Most trainings were conducted by the study coordinator, who was a licensed social worker and practicing substance abuse counselor with ten years experience working with criminal justice involved populations. The sexual exploitation training was delivered by a representative of a local community group, who was formerly prostituted. Training sessions included personal reflection, group discussion of readings, and role play with group critique. The trainings stressed the gendered nature of violence against women in its many forms; the potential for growth to come from women's speaking their experiences and hearing one another's stories;

the recognition of trauma triggers and techniques for de-escalation and management of distress; and the sharing of local resources, including needle exchanges, free clinics, free transportation, and prostitution exiting and other group support. In addition to training, SHE integrated aspects of feminism and bourdieusian social theory directly into delivery of the curriculum in the jail.

Curriculum Specifics

The SHE curriculum was designed to deliver lessons and lead activities organized around a group of themes in three domains—knowledge, beliefs, and self-efficacy—formulated through the feminist and social theory lenses. Major themes included empowerment, trust, stigma, and social support. As depicted in Table 1, SHE incorporated aspects of feminism and social theory through discussion of themes and other group activities (see Table 1).

- **Day One.** On the first day of each week-long session, facilitators provided interactive instruction in reproductive anatomy and HPV infection along with teaching on screening and follow up procedures. In Day One conversations, women were particularly encouraged to share what and how they learned about their bodies and the effects of that initiation on the ways they pass along knowledge and make choices (for instance, about vaccination) for their children.
- **Day Two.** During the second day, women were guided in exploring how relationships with others, including abusive and exploitative relationships, may be connected to sexual health risk. This was often the most difficult session emotionally for participants and gave the study team most opportunity to use tools of mindfulness and grounding. Day Two was also for many groups an important day of community building, when supportive ties surfaced spontaneously among the women as they offered affirmation to one another around shared experiences of molestation, rape, abuse, deprivation, loss of child custody, and frustrated hopes and plans. Day Two called into relief the connections between life challenges of abuse or trauma and women's attitudes toward obtaining sexual and reproductive health care for themselves.
- **Day Three.** In the third session, the facilitator led women in discussions of self-efficacy. The concept was introduced in practical questions about barriers, such as the transportation, time, affordability, and bureaucratic hurdles that women with few resources often have to overcome to obtain health services. During this session, study staff led a role play activity in which women were asked to respond to various forms of delivery of Pap test results and to then discuss strategies to prevent fear; anger; apathy; hostile, uncooperative partners; or contravening life events from preventing follow up. On Day Three, the facilitator distributed resource lists for the area and invited comments from participants about experiences they had had with various providers and service sites. Day Three ended with two important discussions, one about using the internet as a source of health information and the other a discussion of self-efficacy and political empowerment. The facilitator introduced information about voting, Medicaid expansion, and the Affordable Care Act and guided women in

recognizing links between political decisions, health care access, and health of women and their families.

- Day Four. Session Four in the SHE curriculum revolved around the concept of trust and the role that trust plays in a woman's willingness to obtain reproductive health care. In this session, we encouraged women to explore the barriers to health care they met with both in jail and out. The bulk of the day's activities addressed trust pertaining to health care providers in the community and the women's confidence in health information. We particularly attended to the effects of racial and other social prejudices on health care use and willingness to seek reproductive and sexual health services.
- Day Five. During the fifth session of the week-long intervention, participants worked together on an art project, using magic markers to draw a female figure on a six-foot length of roll-paper, which they then labeled anatomically and decorated with affirmative body statements and outlines of their own hand prints. Discussion of the illustration along with review of HPV and cancer risk and prevention information was followed by the end-of-intervention (post-test) survey.

Discussion

SHE was a public health-oriented health promotion study that used an education intervention to improve knowledge, attitudes, and self-efficacy for cervical cancer prevention among women during a brief jail incarceration. We took seriously a mandate to base practice on theory and were guided in that effort by a theoretical framework that combined aspects of feminist relational theory and bourdieusian notions of habitus, field, and social capital. Although the SHE project was mostly successful in its stated aims, we encountered challenges that shed light on both the general difficulty of applying critical theory in public health research as well as difficulties unique to the population and setting in which we worked.

Beyond Crisis: Trauma and Reflexivity in the Carceral Setting

Despite our grounding in Bourdieu's notion of crisis as an opening for change and our hopes of leveraging the moment of incarceration to build individual and collective health consciousness, we often struggled to get women to understand themselves as simultaneously situated within but not wholly disempowered by systems that create, maintain, or enforce social inequity. We came to understand, following Margaret Archer's (2010, 2012) work, that reflexivity might operate like a muscle strengthened over time, through alternating moments of rest and activity, stasis and change. We modified our thinking to consider that perhaps it is not the big crises but life itself, with its fluctuating patterns of upheaval and stability, that enables development of reflexivity. Archer's (2012) research suggests that women whose lives have been too full of crisis simply may not have had space between emergencies to develop reflexivity. That is to say, if structural elements keep legally and socially marginalized women in near-constant crisis, facilitating the very conditions in which drug use, violence, homelessness, unplanned pregnancies, and so on become prevalent, the

capacity to reflect with self-consciousness and creativity on new choices and alliances might take considerable time and effort to mobilize.

We eventually recognized that the difficulty of reflexivity for women in our program had much to do with the continual nature of crisis in their lives, often taking form as chronic interpersonal violence and trauma. Other researchers have documented the high rates of lifetime trauma reported by incarcerated women, including rape, attempted murder, and childhood sexual abuse (Fuentes, 2013; Grella *et al.*, 2013). During our two years of implementation, we heard numerous narratives of trauma. We understood that persons who suffer trauma from events such as rape, attempted murder, long-term abuse, captivity, and torture, often lose trust in the world as a comprehensible and mostly benevolent place in which individuals are intrinsically worthy of positive outcomes (Janoff-Bulman, 1992). Such loss of trust in the world's legibility and justness can complicate a woman's ability to form and maintain relationships (Herman, 1992; Janoff-Bulman, 1992), a difficulty only made worse by the vulnerability of relationships in the context of incarceration (Arditti, 2012, Siennick *et al.*, 2014). Indeed, with the many accounts of horrific trauma, the participants in our program frequently referenced tumultuous relationships with children, spouse, family, and friends. Under such conditions, building reflexivity and transformative community proved uniquely challenging.

One resource related to feminist-relational theory on which we drew to meet this challenge was the literature around trauma-informed corrections (Bloom *et al.*, 2002; Wright *et al.*, 2008; Van Voorhis, 2014). Feminist theorists of criminal justice in the area of corrections have for several decades championed the implementation of trauma-informed policies and procedures in women's jails and prisons (Bloom *et al.*, 2002; Covington, 2008; Harner and Burgess, 2011). Becoming trauma-informed in the corrections context means adopting policies and procedures and establishing the purposeful training of staff at all levels to counteract institutional practices of overt control, isolation, humiliation, and domination (Harris and Fallot, 2001; Van Voorhis, 2014). Trauma-informed corrections advocates the development of gender-responsive modes of intake and security-risk assessment for instance, so needs and risk levels are not misclassified as a result (Van Voorhis, 2014). Gender-responsive, trauma-informed corrections acknowledges women's needs for bonding as a source of psychosocial security and seeks to foster healthy relationship building (Bloom *et al.*, 2002). While we did not see much evidence of trauma-informed principles directly at work in the policies and procedures of the jails themselves, we systematically endeavored to incorporate non-hierarchical, supportive, relationship-building practices in the SHE curriculum and its implementation.

In thinking beyond crisis for ways to tap into or develop participants' latent capacities for reflexivity, SHE attempted each week to create a safe space within a hostile environment for a small group of women to reflect constructively on the forces in their lives that prevent them from obtaining health care. We observed many ways in which the jails seemed designed to hinder the embodied coming-to-consciousness, exercise of voice, and formation of relational ties for social capital that we promoted (e.g., cinderblock walls; one-way windows; locked doors; rooms crowded with mis-matched, decrepit furniture; lighting that was somehow unpleasantly bright and depressingly dim at the same time; presence of staff

during sessions; prohibition on touch; administrative and scheduling disorganization). Our experiences in the jails confirmed barriers identified by other researchers who have stressed the institutionality of the jail and prison system, its focus on advancing the security mission of incarceration through regulatory and bureaucratic processes (Cislo and Trestman, 2013; Quina *et al.*, 2007; Wakai *et al.*, 2009). We found much that we recognized as well from Stoller's (2003) work, which mapped the physical and psychological ways in which space is arranged and assigned meaning in prisons to blur particularity and diminish agency for inmates—occasionally with fatal results. Our work suggested that Stoller's (2003) central findings about prison space, the practices it enforces and the narratives it enables, carry over easily into shorter-term detention experiences of jail space.

At nearly all points, we found our two major conceptual frameworks running counter to the general ethos and practical exigencies of the carceral setting, including its purpose (separation from society, punishment), current philosophy (individuals can be managed as a form of risk), and physical qualities (walls, bars, locks, cameras, spaces, and movement dictated by bureaucratic and disciplinary flow and the need to divide and isolate). All were antithetical to but could not occlude absolutely our efforts to enact feminist relational principles or to bring habitus into visibility, inspire collective awareness, and mobilize social capital, so that, despite many challenges arising from the corrections environment, we found that our feminist and bourdieusian underpinnings facilitated the implementation of SHE. Women connected with one another around experiences of abuse, deprivation, and isolation and shared strategies for overcoming material, logistic, even emotional barriers to obtaining health care. Perhaps the area in which we were least successful in that respect was around women's drug and alcohol abuse.

At the Limits of Relationality and Reflexivity

As we knew from the feminist criminological literature on women's pathways to incarceration and from our own previous experience with this population, women's routes to incarceration very often involve drug- and alcohol-related offenses, which studies link to women's attempts to cope with trauma (Belknap, 2007; Grella *et al.*, 2013; Johnson and Lynch, 2012; Lynch *et al.*, 2014). To support drug and alcohol habits, many corrections-involved women turn regularly or occasionally to prostitution, which, along with entanglement in illicit drug economies, further exposes women to situations in which trauma and crime recur (Battle *et al.*, 2003; Lynch *et al.*, 2014). Substance abuse thus becomes the marker for a complicated web of factors that proves difficult to untangle and/or treat (Najavits and Hien, 2013). In group sessions with participants in SHE, we encouraged women to reflect on links in their own lives between the drug trade, sex trade, sexual violence, and elevated cancer risk as well as other health dangers. We prompted women to share experience, strategies, and resources in the hope of informationally or attitudinally arming women after their release, *via* a kind of social capital, for the challenges of making and keeping health-screening and follow-up appointments, using condoms, and adopting harm reduction practices to manage risk of disease and injury.

But the women were frank with us; many admitted that when they use drugs all bets are off: health considerations, safety, relationships, personal aspirations for recovery and growth—

all are subordinated to getting or staying high. There do exist evidence-based, trauma-informed, cognitive-behavioral programs for treatment of substance abuse that have been tested for effectiveness with women carceral settings, many of which are included in systematic reviews by Najavits and Hien (2013) and Tripodi *et al.*, (2011). Aside from participating in studies of program effectiveness with researchers, however, women generally have inadequate access to such programs in jails, which are typically short-term detention facilities with limited funding and staff (Fedock *et al.*, 2013). The lack of adequate, coordinated reentry services, including drug rehabilitation and safe housing, exacerbates this problem and might prevent brief health-focused programs like SHE from having lasting effect, since women tend to slip back into drugs and sex work in order to cobble together the physical and psychic basics for survival in the transition that follows even a short incarceration (Binswanger, 2011).

Whereas the correctional system is primarily concerned with holding offenders apart (from each other, from the community), our public-health oriented, cervical cancer health promotion curriculum followed the promptings of feminist criminology, recognizing women's pathways to incarceration and incorporating principles of a relational feminism to improve conditions for health. We specifically strived to prompt reflexivity and altered practice, including collective practice, by putting women in touch with themselves, other women, and the latent positive resources or social capital of their communities. In an environment of enforced isolation, tedium, and obedience, SHE emphasized connection, creativity, and consciousness to foster sexual health empowerment. Our integration of theory at all points of the study helped us as we confronted the unique challenges of the carceral setting in order to achieve our goals of promoting better cervical cancer prevention in individuals and laying a foundation for a sense of collective mission to address the structural conditions of a persistent health disparity.

Conclusion

SHE was a gender-responsive, trauma-informed public health project designed to improve knowledge, attitudes, and self-efficacy around HPV and cervical cancer in a legally marginalized and socially vulnerable group. The implementation of SHE benefited from our thorough and consistent application of a framework of guiding concepts adapted from feminist-relational theory and Bourdieu's theory of practice. Rather than bookending the research or hovering somewhere in the background, the theoretical framework of SHE was actively and self-consciously included in the design, planning, and execution of project components and in the analysis and interpretation of data. Of particular note, the theories that informed our project enabled us to minimize many of the negative impacts of an ideologically opposed carceral setting. We share our approach because it seems to us that our careful articulation and attentive and consistent application of theory could be a model for other researchers who strive to bring critical theory into the field of social research practice.

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Table 1

Feminist and bourdieusian social theory applied in project planning and activities

	Feminism Gender specific Relational Embodied Voiced Trauma-informed	Social theory Habitus Reflexivity Field Social Capital
Team training	Trauma-informed care Grounding and mindfulness Violence against women Sexual exploitation/Sex work	Guest speakers Community outreach with local organizations: Justice Project, CCO, KC Literacy, women's symposium Team retreats Team attendance at talks Weekly debriefings
Recruitment	Voluntary, benefit-based In the "pods"/housing units Word of mouth	Informal, on-site, drop-in recruitment sessions Use of language/code-matching, cultural references
Curriculum	Knowledge about bodies, cervical cancer Beliefs about sex, STDs, cancer, health Stigma around STDs/testing Trust in science, health care providers, partners, selves Empowerment as strength, courage, supporting one another	Building social connection; identifying commonalities Practicing action: role play Praxis – reflection + action Reflecting on strategies of individuals and group Voting
Implementation	Sharing experiences, barriers, strategies and resources Icebreakers Grounding Non-hierarchical Personnel Follow-up support	Group artwork Open, non-judgmental discussion Pooling positive and negative experiences with local services and resources
Retention	Family Birthday cards Community contacts	Establishing and maintaining community presence
Ethnography	Meeting family and friends Letting women lead No judgment Reflexivity – team meetings	Learning the social networks Participating in the community
Dissemination	Art display Protecting women's confidentiality, privacy Qualitative Women's conferences	Community dissemination Community partnership Participant authorship Web-based, social media