ORIGINAL ARTICLE

Conflicting experiences of health and habitus in a poor urban neighbourhood: A Bourdieusian ethnography

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Abstract

An ethnographic study of health and wellbeing was undertaken in a deprived urban neighbourhood in the UK Midlands. Drawing on Bourdieu's concepts of habitus, capital and field, we discerned three different, even conflicting, ways of understanding and acting on health: (i) older adults discussed their wellbeing in relation to the local context or field, walking the dog, helping at the community centre and visiting the off licence, (ii) young professionals and students who lived in the neighbourhood were oriented towards leisure facilities, career opportunities and supermarkets outside of the neighbourhood, disdaining local facilities and (iii) community activists and carers discussed health in terms of providing for others but not themselves. Bourdieu is frequently used in medical sociology to highlight how poor people's lifestyle is constrained by their habitus; we suggest paying more attention to its both enabling and differentiating contradictions as well as the constraints it entails. Empirically and in terms of health promotion findings suggest that supposedly healthy activities, such as going to the gym, may also be a means of rejecting the local community; similarly, older people's pottering about in the neighbourhood, which is not usually recognised as a healthy activity, may enhance wellbeing in this context.

INTRODUCTION

An extensive literature suggests that people of low socioeconomic status suffer more from ill health and have a lower life expectancy than affluent groups; these inequalities have also become wider in the UK in the last decade due to austerity politics (Marmot et al., 2020). Factors contributing to poor health in deprived neighbourhoods include lack of access to healthy food (Donkin et al. 1999; Morland et al., 2002; Stafford et al., 2007), crime and lack of safety leading to limited mobility (Saelens et al., 2003, Suminski et al., 2005, Burgoyne et al., 2008), poor services and infrastructures (Cattell et al., 2008) and stress and hopelessness fuelling mental health problems and substance misuse (Cummins et al., 2007). However, it has been observed that social belonging and networks and a sense of pride in the community promote health and wellbeing (Smith & Anderson, 2018).

In this paper, we will interrogate these observations by using a Bourdieusian conceptual framework (Bourdieu, 1979, 1990). Bourdieu is frequently used in medical sociology to highlight how poor people's lifestyle is constrained by their habitus (e.g. Abel & Frolich, 2012; Hoeeg et al., 2020; Oncini, 2020; Williams, 1995). The article discusses how patterns of habitus and distinctions in poor neighbourhoods complicate notions of healthy behaviours or lifestyles and also shine new conceptual light on the enabling, constraining and differentiating nature of habitus in relation to health.

Poverty, health and place

It has been established that place exerts an influence on people's health, over and above the composition of individuals living a specific neighbourhood. These place effects relate to both material or infrastructural aspects, such as quality of housing and environment and access to services, as well as social dimensions, such as community cohesion and levels of crime (Bridge, 2002; Cotter, 2002; Dorling et al., 2007; Macintyre, Ellaway & Cummins, 2002).

A recent meta-ethnography of lay accounts of the relationship between socioeconomic disadvantage and health (Smith & Anderson, 2018) found that residents' understandings closely mirrored research-informed theories about health inequalities (e.g. Marmot et al. 2020). Residents associated poor health with material circumstances and social issues. Strong social networks and belonging were seen as positives although tight knit relations were also identified as a problem in terms of normalising ill health (Smith & Anderson, 2018). Smith and Anderson (2018), Berg et al. (2019) and Bissell et al. (2018) have, however, also observed that whilst residents acknowledge the negative effects of poverty, they may also blame themselves for their ill health, reflecting internalisation of individualistic understandings of health.

Studies on how residents experience the material aspects of neighbourhoods have also revealed contradictions and complexities. A study in a deprived neighbourhood in Philadelphia, USA found that corner shops were perceived as purveyors of ill health by, for example, offering liquor (Cannuscio et al. 2009). However, the proximity of shops and perceived similarity and interaction with staff and other customers were important positives (Cannuscio et al. 2014). It has also been observed that older adults' walking is influenced not only by walkable routes, lighting and proximity of services, but also by interactions with other residents and visiting meaningful places, such as green areas and

pharmacies (Cattell et al. 2008; Day, 2008; Garthwaite & Bambra, 2017; Lockett, Willis & Edwards, 2005; Michael, Green & Farquhar, 2006; Richard et al. 2005; Wiles, 2003).

Overall, previous literature has illuminated material and social factors that contribute to better or worse experiences of health and wellbeing in deprived neighbourhoods. However, this literature rarely discusses how understandings of health may differ between groups in poor neighbourhoods and how these may themselves contribute to social divisions.

Bourdieu's Theory and Health

To make sense of the different ways in which our participants understood and acted upon their wellbeing, we employed Bourdieu's theory of habitus, capital and field. Bourdieu conceptualised how class-based 'objective conditions', such as access to goods, embodied actions, symbolic beliefs and aspirations amalgamate into habitus or socially ingrained habits and dispositions. Habitus makes exterior circumstances interior and renders alternative ways of being unthinkable or 'not for people like us', making a virtue out of necessity (Bourdieu, 1977 p. 77).

Bourdieu's theory on habitus has been used in sociology of health to explain the obduracy of class-based poor lifestyles, which articulate 'pre-disposed, yet seemingly "naturalised" ways of thinking, feeling and acting' (Williams, 1995: pp. 585–586, also Hoeeg et al. 2020; Oncini, 2020). Frohlich and Abel (2014) observe that different groups have different amounts of economic (material resources), social (networks) and cultural (knowledge, skills) capital, which are all implicated in habitus, and call for a shift in focus from individual behaviour to improving people's capital or capabilities for making health-enhancing choices.

A good deal of Bourdieusian health sociology so far has imagined that people enfranchise themselves in the field of health by equipping themselves with the kind of knowledge and capital broadly consistent with mainstream ideas in health promotion. Pertinent to this, we draw on Larsen and Morrow (2009), who remind us that the idea that the behaviour of certain groups of people is 'unhealthy' is not an inherently scientific object, but is constituted by popular culture and politics, and that a critical social science must not take these constructions for granted. They claim that social capital in relation to health has often been understood in a way which is consonant with neoliberalism and rational choice theory economics, as something that predisposes people to make the 'right' decisions. As we shall argue, a more pluralistic approach to understanding behaviour through using the concepts of habitus, field and capital may be useful in making sense of people's actions that appear to be at odds with contemporary health advice.

Shim (2010) has proposed a new term, cultural health capital, to illustrate the habitus and associated cultural capitals that endow middle-class people to gain the most from health-care encounters. Here, people empower themselves in the field of health by demonstrating neoliberal ideas and dispositions consistent with mainstream health promotion, such as use of medical knowledge and vocabulary, self-discipline and an enterprising stance towards health. Similarly, Roenn-Smidt et al. (2020) use Bourdieu's concept of hysteresis (a clash between habitus and a changing field) to illustrate how the habitus-infused expectations of relatives of stroke sufferers of having their needs met clashed with the stripped-down provision of the health-care field in Denmark increasingly focused on self-responsibility.

These observations draw attention to the double disadvantage highlighted by Bourdieu, which not only addresses how habitus and associated resources or capitals constrain people's behaviours but also how the habitus, capital and behaviours associated with underprivileged groups are denied value leading to further disenfranchisement in, for example, health-care encounters. Bourdieu observes how

the habits and dispositions of the dominant groups are exalted, hiding their conditions of possibility, and their scale of preferences are imposed on others, which he calls distinction (Bourdieu, 1990 pp. 139–140; Bourdieu, 1979).

This double-sided nature of habitus as articulating constrains and devaluing of non-dominant ways of being also illuminates how health promotion may be out of touch with the material realities and symbolic values of underprivileged groups. For example, Warin et al. (2008) discussed how obese working-class mothers related their weight to food scarcity as well as maintaining that providing for others, rather than being focused on diets and one's own appearance, was a sign of being a good mother. Similarly, Nettleton and Green (2014) have discussed a London scheme to encourage people to learn to ride a bike, which was met with laughter by female Asian participants who considered it unthinkable for embodied and material reasons, such as dress (wearing a jilbab), taking several small children around and living in a busy urban environment. Initiatives to encourage walking, including using self-tracking, have been found to be too focused on physical activity and ignore, or are detrimental to other dimensions of wellbeing associated with walking, such as togetherness, structuring the day or being in touch with nature (Copelton, 2010; Harries & Rettie, 2016; Wiles, 2003).

The aim of our study is to examine how residents of a poor urban neighbourhood understand and practice health and wellbeing, being mindful of material and symbolic constrains, alternative understandings and values and differences between groups.

This leads to the third Bourdieusian concept, that of field, which refers to a social space that structures and orients action and within which a habitus embodies a 'feel for the game', incorporating physical parameters or goal posts, rules and aims or what is at stake (Bourdieu, 1990: 66–68). St Ann's, Nottingham, where we conducted our study, can be seen a field, with specific exterior material parameters, which may become folded into interior habits, understandings and aims. However, St Ann's is not the only field in our study but, as will be seen, there are other fields and games at stake, especially those pursued by young, aspiring professional residents, who aligned themselves with the dominant, entrepreneurial notions of health. Thus, in what follows we will use the Bourdieusian concepts of habitus, capital and field to discern these differences and what they teach us about the double disenfranchisement of both limited material possibilities, symbolic visions and alternative habits and goals not acknowledged as worthy or healthy by the dominant paradigms in health promotion.

METHODS

The findings reported here derive from an ethnographic study of a poor urban neighbourhood of St Ann's, Nottingham, UK. St Ann's has a long history of interest from social scientists since Coates and Silburn's (1973) germinal work in the 1960 s. The neighbourhood of St Ann's was chosen primarily due to its ethnic diversity, urban nature and proximity to the city centre (Coates & Silburn, 1973; Mckenzie, 2015). Mckenzie (2015) during her ethnography in the area observed that the neighbourhood had a strong sense of community, belonging and community cohesion even if it was negatively perceived by outsiders. Statistically, St Ann's belongs to the lowest 10 per cent of neighbourhoods in the UK in terms of indices of multiple deprivation, including education, employment and health (Nottingham Insight, 2019). The area was rebuilt in the 1970 s, as part of 'slum clearing', where 19th century properties were replaced by new public housing. Our participants told us that the central plaza of the estate had once had a supermarket and even market stalls but at the time of the study the area had no supermarkets and no leisure centre.

The fieldwork consisted of approximately 150 hours of observation, most of which was conducted at the beginning of the project. The first author spent time in the fieldwork site talking to residents in places accessible to the public, such as the pub, community centre, library, food bank, church and nearby gyms and took part in meetings of various community groups, such as the patient group at the GP surgery, the church, Slimming World and the community centre. The observation also consisted of walking around and familiarising oneself with the neighbourhood and visiting the corner shop and other services and included taking pictures and making drawings to characterise the physical and social landscape.

We also interviewed a total of 30 residents. The interviews were guided by a topic guide that covered issues such as their daily lives, their health, their engagement with exercise, eating and drinking and their perceptions of St Ann's, including what health was like in the neighbourhood. Following ethical clearance, our sampling of interviewees was purposeful, aiming to capture a diverse range of residents. Sampling was predominantly opportunistic and participant driven, first contact was made with the young professionals in an educational event and a nearby gym, snowballing to other young professionals as well as older residents who lived in the same building. We recruited community activists and older residents initially from the community centre and food bank, and then made a concerted effort to recruit working-age adults who were mainly parents with young children. Table 1 provides a demographic breakdown of participants. Most participants were not in employment. This includes residents who were retired, students as well as working age people who were not in paid employment but were carers and/or did voluntary work within the community. The older residents had typically lived in the neighbourhood for a long time, the young professionals were all relatively new to the area; the activists also typically lived in the area but some paid professionals such as those who ran the food bank worked in St Ann's but resided in adjacent neighbourhoods.

The interviews were transcribed verbatim, anonymised and analysed for emergent categories using the constant comparative method (Glaser & Strauss, 1967). This drew our attention to three distinctive styles of habitus, corresponding to groups identified above, which characterised distinctive orientations to health, to self and others and to the neighbourhood.

TABLE 1 Characteristics of interviewees

Gender	
Female	15
Male	15
Age	
20–39	5
40–64	13
65 and over	12
Occupation	
Managerial and professional	4
Intermediate	3
Manual occupation	4
Not employed	19
Ethnicity	
White	25
Black and Mixed Race	5

Findings: Three habituses of neighbourhood life

Older adults and local rounds

During fieldwork and in interviews, older adults often related health to their daily routines, speaking about 'doing rounds' in the area. For example, Clive, a man in his seventies involved in the community centre, who had lived in St Ann's for most of his life, discussed his daily rounds walking the dog:

> Clive: Well I take me dog out about half past four in the morning… Cause' I've got a dog… Rocky…. I go down there up Burton Street, across where them lights are on the lift then under the subway and back … Then I come to work here upstairs for about what an hour, an hour and a half.

For Clive, his daily practices always involved walking his dog at specific times and visiting the community centre to help out and have a meal. Importantly, visiting and helping in the community centre were also occasions to socialise with friends and acquaintances. Later in the interview, when asked about health in St Ann's, Clive talked about being able to 'walk about fifty miles a week'. Clive's daily round of always taking his dog for the same walk and visiting the community centre for meals, companionship and volunteering illustrate what might be described in Bourdieu's terms as an unreflexive routine or practice. Yet at the same time it is practice of which he is self-aware and is a source of some pride, which echoes research on older adults underlining how walking is not merely physical activity but embedded in a sense of purpose and gives days a structure (Wiles, 2003).

Whilst Clive's walking could be considered a conventionally healthy activity, a group of older adults, who regularly spent their days in the communal area of a council property drinking lager and watching films, had more contradictory habits. They described their typical day:

> Sylvia: Pass me another can, will you Clyde! Well, we have fish and chips on a Friday.
>
> Clyde: Oh a Friday, yes, we do!
>
> Sylvia: Er, normally when I get up, I have porridge, then a bit of lunch and then I come in here and we watch a film… then something for tea.
>
> Phil: Everybody does their own thing.
>
> Clyde: It depends what they want. I mean I think most people, most people eat fairly well.
>
> Clyde: You've got one or two who don't but…
>
> Phil: … Who don't eat or… but they're normally looked after by somebody else like.
>
> Sylvia: 'Cause I just saw a carer, I guess there's nurses that come round and…
>
> Clyde: Yeah, she's come see Frank who's got (unclear).
>
> Sylvia: They come and dress 'em.

In the excerpt above example, the participants readily volunteered eating 'unhealthy' foods (fish and chips), even if the interviewer was attempting to focus on health. Participants referred to their other eating habits (porridge) and habitual watching of films together and made a distinction between themselves and those who could not take part in these routines as they had to be cared for in their homes. This distinction illustrates how for these older adults, health and wellbeing were associated with placemarkers in the day, such as being able to gather together, eat one's own meals of choice and get 'out and about' with references to visiting the corner shop to fetch essentials, including cans of lager for the gatherings, and to congregate with other residents.

A sense of local facilities being waymarkers in one's everyday rounds was present in Ethel's account:

> Ethel: Now I'm not working I've got a typical day of hospital appointments, doctor's appointments… I try and visit people, how I can help, because I can't manage the housework how I used to… But I love my garden, I try to do a bit, but I can't manage how I used to. I just use it as therapy, so my garden is very therapeutic at the moment. I pop to the shop for bits if I need to, and oh… to the bookies to put a bet on the horses… I take each day as it comes, you know, I do alright I suppose.

In one sense, these practices illustrate the constraining nature of the habitus of these older adult residents, both in terms of material possibilities (not being able to venture beyond their neighbourhood or enjoy other than simple pleasures, such as a can of lager) and imagining what is possible (there being a strong sense in the group interview of 'this is what we do'). For people in this group, the field engendering their habitus was geographically localised; place and neighbourhood provided the ready-to-hand resources or material, social and cultural capital, which enabled them to construct and find meaning in their lives and lifestyles. References to enjoyment, togetherness, helping out, autonomy (being able to eat what one wants) and the therapeutic effects of gardening illustrate how these practices were experienced as enabling, valued social and material capital in this context or field. The practices were also a source of distinction between participants and their home-bound peers supported by carers. Thus, rather than being redolent of unhealthy conduct, such as drinking and being sedentary, the activities described were part of a highly valued and often precarious ability to enjoy life in old age by being mobile, independent and able to socialise, and thus maintaining this habitus was an important signifier of wellbeing (see also Weedon et al. 2020).

Further, activities traditionally considered healthy were often perceived as alien and even a source of amusement by some older adults:

> Researcher: I mentioned I'm interested in health, so when I talk about health It's like what you eat, exercise, diet. What's your views on that? Just general?

> Vincent: Well, for me first thing in the morning, do 24 press ups (laughs) … And he [points at another person] can just about walk to that door! (laughs) And he just uses it now for fun, he could get up and run around if he can. (laughs). But no, we're not very good but you get by.

Vincent, in his 80 s, positions himself as 'not the sort' to do structured exercises. The idea of exercising was similar to Nettleton and Green's (2014) Asian participants' humorous reactions to the suggestion of riding a bicycle.

For the older adults interviewed in St Ann's, doing daily rounds in the neighbourhood such as walking the dog, visiting local shops and the community centre and socialising were associated with health and wellbeing. Some of these activities could be considered conventionally healthy (walking) yet even those which might appear less salubrious in terms of health advice, such as eating chips, drinking lager and watching films played important roles in their wellbeing. Participants' descriptions highlight how their socioeconomic and age-based habitus constrained their health and wellbeing in terms of circumscribing their physical, financial and imaginable access to places, services and activities beyond pottering about the neighbourhood. From the point of view of much conventional health advice, it could be argued that this habitus also perpetuated health inequalities in that the activities they described, such as sitting around with friends and acquaintances, enjoying unhealthy meals and alcoholic drinks, are not generally understood to lead to health and wellbeing in dominant health policy. Yet in many cases they were aware of the mainstream value ascribed to health-promoting activities such as exercise, it was just seen to be ludicrously inapplicable in their situation or at their time of life. Instead, they had defined health and wellbeing in terms of a pleasing, yet somewhat restricted round of daily activities, being mindful that they were not yet in the position of certain others who were housebound and relied on visiting carers. There is a discussion in Bourdieusian literature on health about whether Bourdieu emphasises determinism and does not allow for agency (Abel & Frohlich, 2012). Our participants' experiences illustrate how their habitus constrains possibilities available for them but they also highlight the residents' agency, resourcefulness and ability to carve out distinctive ways of being well and healthy, which deserves acknowledgement and should not be defined merely in terms of lack or deficit.

Young Professionals – working on themselves and avoiding the neighbourhood

The activities young professionals and students living in St Ann's associated with health and wellbeing were different from those of older adults. The participants often emphasised activities aiming to enhance their bodies in terms of fitness, and this aesthetic focus has been noted to be a particularly middle-class way of relating to the body or habitus (Williams, 1995).

For example, Sam had been to university and was now working in the city centre. He detailed that his daily routine involved visiting a gym, coaching children at the school where he worked, cooking and going out in the city centre. Sam's outlook on life was aspirational, seeking to enhance his fitness and improve his skills as a coach and organiser of children's sport. His activities were organised, timetabled and typically took place outside of St Ann's:

> Researcher: So tell me about your typical day living here?
>
> Sam: Well, I'm up about 7.30am and I have a good breakfast. … we've got our first rugby game next week so that plays throughout the Summer…Saturday home or away so we will have to travel either quite local to Leicester or Sheffield. Or, we go like South Wales or Oxford or places like that… I mean exercise is quite big we train two nights a week and the gym three, four times a week. Playing rugby on Saturdays and then bowling… In the week, well it's work at the minute… earning money and all that s**t.

In the above interview, not only were the practices carried out by Sam very different to the older adults: playing and coaching rugby, having a 'good' breakfast, working and going to 'shows' in Nottingham. Notably, most of these practices take place outside of St Ann's and are officially 'organised', such as rugby

coaching, rather than informal walking in the neighbourhood. Sam's activities also accrued, in Bourdieu's terms, bodily capital (playing sport) and social capital (meeting people across the country involved in young people's sport), which potentially enhanced his socioeconomic position. Sam thus had financial, physical and imaginable access to a range of activities that would have been impossible both in terms of expense, transport and aspiration for the older adults, underlining the privilege accrued by his socioeconomic position and associated habitus.

Lauren, a university postgraduate student living in St Ann's, described her typical exercise patterns as follows:

> Researcher: Do you exercise? If you do, where abouts do you go?
>
> Lauren: Yeah, okay it changes. I'm constantly like I need to be doing like some kind of exercise two or three times a week… I don't like exercise though. So I go through fads. I join the gym, I go for two weeks then I'll stop and three months later I'll cancel my membership. At the moment… if you've heard of these fitness DVD's called insanity? So that kind of program lasts for two months. We have one month in so far… once that stops I have a plan. There's like a performing arts place near here where they do different dance classes. That's the only kind of exercise that I actually enjoy so I have plans to join that.

Lauren's organised routine involved successive engagements with different exercise regimes, even though she did not enjoy them, as a type of investment in oneself. The self-conscious planning and organisation contrasts with the more casual routines of the older adults described above.

These young professionals and postgraduate students had a different orientation to the neighbourhood and its facilities, compared to the older adults. For example, Chevorne had this to say about corner shops:

> Researcher: So why is it that you probably wouldn't go to those corner shops that you mentioned for your shopping more often?
>
> Chevorne: Well the one [corner shop] that I top up my gas card it's… I really don't like going there like the people who run the shop are fine, but there's always like these hoodies hangin' around. And it's like right near an underpass and I really don't like going there (laughs). In terms of the other one it's literally because, I just find they don't have as good a selection … and you know in terms of other supermarkets there's Aldi.

Chevorne's negative comments about the corner shops in terms of danger and lack of choice contrast with the older adult's appreciation of them as places to frequent, highlighting what Cannusco et al. (2009, 2014) have observed about the contradictory role of corner shops as being both accessible and sociable as well as unhealthy and dangerous. In our study, these differing views were held by the different social groups, from the positive view of local shops held by the older adults who had lived in the area for a long time to the unfavourable view entertained by the young professionals. This highlights contrasts in their respective habituses, showing how different groups in a neighbourhood may have conflicting views and needs of specific places and services.

The alignment of habitus with patterns of social distinction was further underscored by the way that young professionals and students wanted to avoid association with the neighbourhood, as indicated by Dean's assessment:

Researcher: So, is there anything you think the council could do to improve the area?

Dean: … Yeah, brighten it up a bit! It seems messy… There's not that many places [in St Ann's] I say socialize especially for us around here … as I say Carlton's not far away but again you've got to leave St Ann's and like your local neighbourhood to go, like we tend to go into town if we're going out or going bowling or something.

Dean's and other comments frequently sought to disassociate themselves from the local community, seeing it as not offering services or opportunities to socialise. Thus, whilst the habitus of the young professionals might have been indicative of a conventionally healthy lifestyle with participation in sport and focus on varied and healthy foods, these aspirations seemed to draw them away from the neighbourhood and community. A sense of social belonging and cohesion mitigates health inequalities in poor neighbourhoods (Kapilashrami & Marsden, 2018; Smith & Anderson, 2018), so whilst rejecting the local community may be aligned with the aspirations of the young professionals and postgraduate students it may be detrimental to the community's health and wellbeing. This illustrates the fundamentally individualistic and competitive assumptions which underlie much health promotion that the aspiring young people aligned themselves with. However, the entrepreneurial and healthiest habitus of the young professionals and students did not only enable but also constrained their behaviour, making them embrace a pressurising, future-oriented performance logic in both work and free time. Moreover, the aspiring professionals are orienting themselves to a much wider field of young cosmopolitan leisure, accentuated by national sporting competitions and bespoke fitness clubs. This sense of aspiration contrasts with the hedonism and localism of the older adults where the pleasures of doing one's rounds in the local field, and enjoying fish and chips, their garden and a video in company with others were valued.

Working-age adults: Caring for others

The community workers and activists and parents of young children interviewed rarely discussed their own health, instead focussing on the health of others, such as residents in general, groups they helped with, and their own children.

For example, Keith cared for his disabled wife and four children and was involved in organising many community activities, including the community centre and the scouts. The following illustrates his routine:

Keith: 'Well, I wake up at 6 if it's a school day, because my son goes into a breakfast (unclear) school, so I can get him in about twenty to eight, and then I've got the day to do things for me wife if she wants any shopping. … Depending on what night it is, the Monday night I have cubs so run the cub group. Tuesday night me son has swimming so got swimming, err Wednesday night sometimes it's meetings, we have the Holding Hands community meetings and other CO meetings, Church Warden meetings … Thursday night we have beavers and scouts and explorers which are different. On the Friday night I usually hopefully have a rest and a drink with the wife; she likes my Friday night spare so we can do things or just chill out'.

This illustrates how Keith's habitus was oriented towards others, which gave him a sense of purpose and structured his weeks. Similar to Warin et al.'s (2008) account of overweight mothers, Keith's habitus foregrounded providing for others, and an individualist approach of taking care of himself was alien to

him. This illustrates how Keith's habitus both constrained him in that he did not focus on his own health and even if his activities were more varied than those of older adults, they were still oriented to the local environment due to his modest means and his habitus. However, Keith's activities were also enabling at the level of his community and his family, he facilitated his own and local children's activities, such as swimming and scouts, cared for his wife and organised various wellbeing and community-enhancing activities from parents' groups to religious services. This contrasts with many individually focused notions of taking care of one's health – here instead broaching the subject of health led to a discussion of how they addressed the needs of others.

The working-age residents in this group focused on their children and were often involved in community activities. They were however critical of other residents, as exemplified by a comment by Jerry, who was involved in the community centre:

> Researcher: So, we've mentioned health. Generally, what do you think people's health is like in the area?
>
> Jerry: Generally, I'd say it's poor, you name it. One thing I find really interesting is the amount of mobility scooters, there are so many of them. But I can tell you at least six people who've got them, got them off the NHS as well or paid by the NHS and they don't need them. It's just because they're fat and lazy. The lady up there, she'll even tell you, it's because I'm fat and lazy.

Jerry's views here illustrate a tendency to blame people for their poor health, in an individualist manner. Berg et al. (2019) and Bissell et al. (2018) both observed that people in poor neighbourhood acknowledged that their ill health was influenced by deprivation but still blamed themselves. In Jerry's case, this blame is directed towards others and there was a fair amount of bickering between groups in St Ann's whereby working-age people derided the older adults for poor lifestyle and older adults passed unfavourable comment about parents not taking care of their children. Whilst such commentary could endorse healthy behaviours, they also derided the habitus of other groups of residents as irresponsible and unworthy.

These perceptions of distinction, difference and division could be manifest in other ways too. For example, other people who helped out in community activities noted how some middle-class volunteers or donors could be out of touch with the realities and habitus of residents, as disclosed by Amanda, a food bank volunteer:

> Amanda: This one time … this woman comes in with a massive bag. She lifts the bag and puts it on the counter. Joyce said 'what's that?' She said 'It's 5kg of carrots for you all now, they can cook can't they?' (laughs) We was speechless. That happens all the time, there's this idea of lentil soup making and all sorts from some people.

Amanda critically reflects on a clash – or as Roenn-Smidt et al. (2020) might describe it, a 'hysteresis' – between the middle-class culinary values of donors and the habitus of residents, where the donors, in a somewhat disrespectful way ('they can cook, can't they?') seek to push the residents to eat healthy food, made from scratch (cooking with carrots and lentils) that is alien to their habits.

The comments about 'fat and lazy' residents or the desirability of cooking with carrots resonate with Southerton's (2002) findings on how individuals in communities establish boundaries between 'us' and 'them' defining the culture of others as lacking. In our study, these criticisms of others' habitus had a strong moral undertone; seeing them as bringing ill health upon themselves by lack of

industriousness. At the same time, some residents, such as Amanda, were critically reflective about such comments being out of touch with the neighbourhood realities and customs.

Overall, the habitus of community activists and carers was frequently focused on providing for the needs of others, including their health, and not discussing or prioritising their own health. In focusing on others, these residents are offering a different conception of health than the usual focus on one's own capacities – they are focusing on the needs of others. In this sense, the other-directedness could be seen as a constraining aspect of their habitus that subjugates itself to the needs of others; often typical of women (Bourdieu, 1977) and subscribing to a collectivist rather than individualistic conception of health. However, serving the community these residents also accrued themselves a sense of purpose, even status or social capital, as well as enabling themselves to be positioned as knowledgeable, such as knowing that people in the neighbourhood field would not want to cook carrots or lentils. The contradictory orientation towards both helping and criticising members of the community position the activists as straddling at the intersection of two fields. On one hand, they embodied the community-oriented habitus that valued togetherness and mutual aid, and on the other hand, they subscribed to more mainstream notions of health in terms of individual responsibility and were judgemental of residents at having brought misfortune and poor health upon themselves.

DISCUSSION

Our findings corroborate much research on health in poor neighbourhoods, such as lack of access to good infrastructures and services, the importance of local offerings in terms of leisure and food, which often are found wanting, as well as the positive role of community belonging and cohesion (Smith & Anderson, 2018). However, studies on health in poor neighbourhoods often tend to treat the residents as a homogenous group, whereas our findings illustrate significant group-based differences based on life-stage, socioeconomic position and the kinds of identifications and distinctions people make in defining themselves and others. Bourdieu's (1977, 1979) concepts of habitus, capital and field illuminate these differences and how different embodied ways of behaving constrain and enable health and wellbeing as well as run into contradiction, even conflict, with one another.

Bourdieusian research in sociology of health and illness has often focused on the constraining aspects of habitus to make sense of the prevalence and obduracy of unhealthy lifestyles among people from disadvantaged backgrounds. Work on how economic disadvantage becomes embodied in ways of being and thinking has been conceptual (e.g. Frohlich & Abel, 2014; Williams, 1995) as well as empirical, illustrated by two recent studies on how the eating habits of families with young children were shaped by necessities transformed into tastes (Hoeeg et al. 2020; Oncini, 2020). In this article, we have explored not only the constraining but also the enabling aspects of habitus in a poor neighbourhood, the latter being much less discussed. Further, as outlined by Bourdieu (especially 1979) the disenfranchised not only lack resources or capital, be they economic, cultural or social, but also the kinds of resources and associated embodied dispositions that they possess are often discredited by powerful groups operating in specific social spaces or fields, such as health care (Shim, 2010), as unworthy. This valuing of specific values came to particularly sharp relief vis a vis the differences between the long-term residents and the young professionals, aligned with hegemonic notions of individualism, self-investment and a disdain for the neighbourhood itself, and an orientation to a much wider field within which to play and define their worth.

A defining feature of many of our observations and interviews was the importance of the local setting, its services and activities, as well as social relations for the long-term residents. The residents' orientation towards the local setting or field illustrates their lack of privilege in that they did

not have physical and financial means to venture beyond St Ann's, although this was also something that for most of them was natural and convivial, or using Bourdieu's term they had made a virtue out of necessity (Bourdieu, 1977). Yet the 'choice of the necessary' (Oncini, 2020) in St Ann's is not solely constrained by economic necessity and represents considerable ingenuity in creating a sense of wellbeing from the resources available. In this respect for older adults, activists and those with caring responsibilities, the neighbourhood also provided them with important services and infrastructure, which contributed to their own sense of health and wellbeing, such as the community centre, food bank and walkways. Further, the older adult and working-age activists and carers actively contributed to their community in terms of helping to run voluntary services from food banks to churches, as well as companionships and cohesion through friendships and informal meetings.

Whilst some of the communal activities, such as gathering in the local off licence to fetch alcohol, put a bet on and touch base with acquaintances, would not necessarily conform to dominant notions of health and wellbeing; others, such as walking and running a food bank, might. However, the low-key pottering about and providing for the neighbourhood contributed to residents' wellbeing even if it did not seem healthy in the dominant sense of physical activity and eating low-fat, varied foods. Thus, health can be seen and understood by social actors in terms of norms specific to the local field (Hoeeg et al., 2020) – older participants here believing that mainstream notions of healthy living, such as structured exercise, was inapplicable to them. A need to invest in an imagined health future stipulated in health messaging (Dumas et al., 2014), after all, for the older adults, may feel inapplicable and even absurd. Being able to do one's rounds, get out of the house, visit the corner shop, socialise with and help out friends and so on was more prominent in this habitus than conventional health behaviour. It is not just that this habitus is difficult to change, as Nettleton and Green (2014) and Hoeeg et al. (2020) suggest, but that its health and wellbeing-enhancing aspects in this place and life-stage should be acknowledged and not solely defined in terms of what is lacking or deficient.

The field specificity of the older adults' and working-age residents' habits came into stark relief in comparison with the habits of the young professionals and postgraduate students living in the neighbourhood. This latter group was living in the area to take advantage of affordable housing in a specific life-stage, and their role in neighbourhoods like this has been largely ignored by health researchers. The young professionals' habitus conformed to mainstream notions of health in terms of taking part in organised sport and exercise, seeking varied foodstuffs and well-stocked supermarkets and venturing to leisure centres and activities far away. However, at the same time the professionals spent most of their time outside of the neighbourhood and often had a critical attitude towards local places and people as inadequate, alien and dangerous. Thus, whilst their individual health habitus accorded with much conventional health advice, their contribution to local community health and wellbeing was negligible. Indeed, many of their attitudes were aligned with more widespread cultural themes stigmatising low-income neighbourhoods and their inhabitants (see McKenzie, 2015).

The conceptual contribution of our article is to use Bourdieu to draw attention to multiple different types of habitus, fields and capitals at play in a poor urban neighbourhood. The varied embodied actions, informed by social contexts or fields, may articulate not only restrictions in terms of resources but also mundane ways of enhancing individual and/or community wellbeing. Empirically, our findings offer fresh insights on differences in health-related experiences in a deprived neighbourhood, which in conjunction highlight each one's shortcomings and possibilities as well as tensions and investments.

In terms of health promotion practices and engagement, the differing forms of habitus outlined here illustrate the pitfalls of health messaging which focusses on individual health behaviour, for this often does not take into account local understandings of health or may be at odds with them. Favoured current health promotion programmes tend to be individualistic, focusing on changing individuals'

behaviour, sometimes incorporating new innovations and initiatives, such as self-tracking (Copelton, 2010; Harries & Rettie, 2016; Weedon et al. 2020) and cycling (Nettleton & Green, 2014). As our material demonstrates, however, individualistic interventions are apt to be perceived as alien and unlikely to fit the habitus of many residents, as illuminated by the humour expressed by older adults about doing press-ups and the sense that local people would not want carrots or lentils. As Bourdieu teaches us, conceptions of practices, such as health, are not natural but underpinned by inequality and invested with power, so rather than presume what healthy behaviour ought to be, health promotion programmes may consider starting with local conceptions and practices of wellbeing and supporting those.

In conclusion, Bourdieu's concepts of habitus, field and capital enabled us to make critical sense of the contradictions of health and groups in St Ann's. We suggest medical sociology could make more of the critical aspects of Bourdieu's notion of habitus, which highlights its constraining and enabling contradictions. Not only does it attend to differences, but how those differences are mobilised by different groups, including health promoters, to naturalise their positions in the field and to suppress the legitimacy of less powerful groups' ways of being.

AUTHOR CONTRIBUTION

Tom Scott-Arthur: Conceptualization (equal); Data curation (lead); Formal analysis (equal); Investigation (lead); Methodology (equal); Validation (equal); Writing-original draft (lead); Writing-review & editing (equal). **Brian Brown:** Conceptualization (equal); Formal analysis (supporting); Validation (supporting); Writing-original draft (equal); Writing-review & editing (equal). **Paula M Saukko:** Conceptualization (equal); Data curation (supporting); Formal analysis (equal); Investigation (supporting); Methodology (equal); Supervision (lead); Validation (equal); Writing-original draft (equal); Writing-review & editing (equal).

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