

Exploring Deprivation, Locality and Health: A qualitative study on St  
Ann's Nottingham

By

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## Abstract

This thesis is an attempt to better understand the inter-relationship between deprivation, locality and health. This study explores the views of different residents in St Ann's, a deprived neighbourhood in Nottingham, to find out how they 'make sense' of their health. The thesis is based on some participant observation in the area but mainly draws on qualitative interviews with diverse residents in St Ann's: (including, in particular, working-class older adults of different ethnicities; some working-class parents with children; middle-class younger adults living in the area; and activists and professionals providing services to the area, such as volunteers running the food bank, the local priest and GPs. As I asked all of my participants questions about their lives and their health, as well as their perceptions of what health was like in St Ann's generally, I realised they did not mention what talk about things that I, or public health professionals, would expect them to i.e. whether they took regular exercise or ate fruits and vegetables. Rather than individual lifestyle 'choices', people mostly talked about places, doing 'rounds' and routines. They also talked about other groups, which allegedly were less healthy than them. Further, different groups of people in the area spoke about health quite differently. It is these broader discussions and concerns, and differences between groups of people, that I make sense of throughout my thesis.

I argue that existing quantitative research on health, deprivation and the physical environment typically focuses on how health varies across different neighbourhoods. Some of these studies examine how factors, such as the proximity of supermarkets or leisure facilities, produce health inequalities. However, while I found residents in St Ann's mentioned the proximity of shops, I also found that health and place had broader meanings to people in terms of gathering together and structuring routines. Additionally, I found that different people had conflicting ideas about health, place and one another. Addressing health therefore needs to take these conflicts into consideration rather than implementing public health policy that mainly articulates the views and habits of the middle-class. I use concepts from Bourdieu (1979), such as 'habitus', 'field' and 'symbolic violence' to make sense of these conflicts, arguing that the reasons why people act as they do is beyond their cognitive and rational understanding. In circumstances such as those in St Ann's, where the working-class residents were most at home in their given

social space – where habitus meshes with field - their apprehension of their social environment is more practical than it is theoretical and more tacit than it is explicit. In other words, I argue that residents in St Ann's are curtailed by their habitus.

Additionally, I argue that there is insufficient previous work which has acknowledged and validated the experiences of residents in deprived neighbourhoods. Residents may articulate deprivation and lack of understanding of what constitutes health, but they also draw attention to important issues that, whilst often mentioned in the literature (e.g. social cohesion and health), have not been sufficiently accounted for, such as the importance of sociability, community activities, amenities and services. Finally, it should be acknowledged that these issues are not equally or similarly important for all residents, so that middle-class residents are unlikely to mix with locals at the community centre for example and that also older and younger residents considered different places important. So, instead of accepting the premise inherent in much public health research that seeks to identify the barriers to change with individuals, there first needs to be a more rigorous examination of the practices and lifestyles of the working-class residents within deprived communities such as St Ann's. We should seek to understand that their current practices are important for their well-being and sense of community. However, and, at the same time, we should seek to identify appropriate approaches that can improve their health that does not only fit the middle-class agenda. A key element of this is to take the various elements of their practical, tacit knowledge more seriously as part of these conditions of possibility. Then, it may be possible to more fruitfully identify how and why such practices are created, and what might be the conditions of possibility for change.

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## Chapter One: Understanding Deprivation, Locality and Health

### An Introduction

This thesis has its origins in my time studying for a Master's degree in Public Health at Nottingham Trent University. I had focussed my dissertation on obesity and deprivation in the developed world and the extent to which a deprived neighbourhood could have an effect on a person's weight (Prentice and Jebb, 1995; Drewnowski, 2004; Booth, Kingston and Poston, 2005; Cummins and Macintyre, 2005). I was aware that obesity levels were much higher in deprived areas and amongst low socioeconomic groups, and so I wanted to find out what 'determinants' in deprived neighbourhoods encouraged individuals to have poor lifestyles. I believed, therefore, once I knew what the causes were, I would be able to design an 'intervention' to solve the problem.

So, my first research idea involved interviewing individuals with a high BMI in a deprived area. I believed the main problem with overweight individuals arose from their individual lifestyle choices. For example, the foods they chose to consume and their lack of physical activity could cause them to become overweight and have a higher level of lifestyle related illnesses. I initially sought to interview individuals with low socioeconomic status in a deprived area and a high BMI to find out how they made sense of their 'obesity' and what they thought accounted for their high body weight. I also knew from reading existing literature (Sarlio-Lahteenkorva, 1998; Aphramor, 2005; Monaghan, 2005; Throsby, 2007; Greener, Douglas and Van Teijlingen, 2010) that different people, such as healthcare providers, community workers and mothers of young children, tended to view and conceptualise obesity differently, and so I thought it would be a good idea to interview different groups.

With this idea in mind, I visited the area of St Ann's in Nottingham as I was aware it was classified as a 'deprived' area and statistically had higher obesity levels in comparison to the rest of the city. I initially thought it would be an appropriate starting point for my study. However, as I discuss further on in this introductory chapter, I soon realised this approach focussing solely on obesity was not practical or feasible. I began to spend some time sitting in the community centre in St Ann's observing the local residents, where I



realised it would not be practical or ethical for me to try and interview only obese residents. Instead, designing a study that focussed on people's perceptions of their health in a deprived neighbourhood would be a more interesting and achievable idea. Additionally, by only focussing on obesity I would also perhaps be missing the 'larger picture' of health and deprivation. I began to realise that adopting ethnographic methods and carrying out a community study in a deprived locality centred around health would be more interesting.

This thesis is therefore an attempt to better understand the inter-relationship of deprivation, locality and health. This study aims to explore the views of different residents in St Ann's, Nottingham, to find out how they 'make sense' of their health. This thesis focusses on a deprived community.

Before I discuss the background to St Ann's further, I first discuss my aims for this thesis.

### Study Aims and Research Questions

After conducting some participant observation in the area and visiting the places where diverse groups of individuals tended to congregate (the community centre, the food bank, the café and so on) I realised that it would not be possible to devise a research project focussed solely on 'obesity' and to only interview these residents. Instead, I realised that creating some research questions that asked residents about health more generally in the neighbourhood would allow for a more 'open' interview and perhaps yield more fruitful and interesting data. I devised the following aims for my thesis:

1. How do individuals in St Ann's make sense of their health and what do they think accounts for their health?
2. What do these individuals think makes people healthy?
3. How do the views of diverse groups of residents (working-class, middle-class and community workers) differ?

The first research question aims to focus on what health means for each participant I interview. The second question focuses on what individuals think makes them healthy. For example, do they believe health is determined only by diet and exercise, or do they make sense of health in other ways? Their health may well relate to living in the neighbourhood. In this case, I will ask what they think accounts for the health and/or ill

health in the neighbourhood. The third research question aims to ascertain whether there are differences and perhaps tensions in the views of different sorts of people in the area.

Later on in this chapter, I also discuss in more detail how these research questions arose.

Before discussing this project any further, however it is pertinent to explain why the area of St Ann's was chosen as a focus.

### The Neighbourhood of St Ann's

St Ann's is an inner-city housing estate approximately 1.7 miles from the Nottingham Town Centre. At the time of the 2011 census, there was a total of 19,316 people living in approximately 9,000 households in the St Ann's boundaries, according to QPMZ Local Statistics (2011). These statistics below highlight the high levels of deprivation that exist within the area as well as overall poorer levels of health:

1. 35.4% of adults in St Ann's smoke, significantly higher than within Nottingham City
2. 54.9% of adults are estimated to be overweight/obese, significantly higher than Nottingham City
3. GCSE Achievement is significantly worse than nationally
4. Life expectancy for males is 73.2 years which is significantly lower than the national.
5. Life expectancy for females is 79.5 years which is significantly lower than the national.
6. St Ann's is ranked as the 163<sup>rd</sup> most deprived out of England's 7,589 wards, and the 2<sup>nd</sup> most deprived in the city.

*[Nottingham City Council, Public Health, Ward Health Profile – St Ann's Ward, 2011.]*

Secondly, with regard to health in St Ann's, the respondents of the 2011 Census were asked to rate their health (UK Census Data, 2011). The percentage of residents in St Ann's rating their health as 'very good' is less than the national average. Also, the percentage of residents in St Ann's rating their health as 'very bad' is more than the

national average, suggesting that the health of the residents of St Ann's is generally worse than the average.

Additionally, the figures show, on the claiming of benefits in St Ann's, that the rate of unemployment in St Ann's is both higher than the average in comparison to the rest of Nottingham, and higher than the national average, suggesting that finding a job in the area is difficult. The rate of claiming any benefit (which includes work benefits) is more than 25% higher in St Ann's than the national average, suggesting that many people are under employed or on a low salary (ibid.). It is clear then from a statistical standpoint then, that St Ann's has high levels of inequality, socioeconomic deprivation and poorer health in comparison to the rest of the city.

Thirdly, St Ann's is a diverse place with people of different ethnicities and ages. Approximately 68% of the population living in St Ann's is White British (OPZM Local Stats UK, op.cit.). Locally its residents have become severely stigmatized with a reputation as a place to avoid allegedly riddled with crime and drugs, single mothers and benefit claimants (Johns, 2002).

Johns (op.cit.), Coates and Silburn (2012) and McKenzie (2012) have written a detailed history of the area. In particular, they highlight what has remained constant and what has changed despite the upheavals to working class life over the last 40 years. McKenzie (ibid.) has argued that residents in St Ann's have a strong sense of belonging to the neighbourhood

As I will discuss in my methods chapter, I began my field work by conducting some participant observation in the area. From walking around in the area, I noticed that the community centre in St Ann's was welcoming, and popular with some of the local residents and having a strong sense of community (also in Johns, op.cit.; Coates and Silburn, op.cit.; and McKenzie, 2012). I thought this would be a useful place to conduct research. Indeed, it turned out to be an effective starting point. In addition to this, St Ann's is quite diverse, with a large Pakistani, Black Caribbean and Indian population as well as White British; and these ethnic groups are not as prevalent in the other deprived areas of Nottingham such as the Meadows area (UK Local Area Statistics, 2013), and so St Ann's was an interesting place to study in this respect as well.

## Interview sample

I interviewed mainly working-class older adults (Over 65) (n=10) for the study. The working-class residents I primarily found in the community centre. I also interviewed three parents with children (n=3), Jamaican and African men and women (n=6) I met these participants either at the local church or the food bank. I also interviewed some working class single men and women (n=3) who spent time in the community centre or the local library. This totalled 23 residents.

Additionally, I interviewed some middle-class residents (n=5) who lived in St Ann's but worked full time usually outside of the area. As I discuss in my chapters, they always identified as not 'being part' of the local area and did their best to avoid associating themselves with the people who lived there at every opportunity. I met the individuals I interviewed here throughout the course of my own life, either at university, in the gym, coffee shops or through my own friends who knew someone who lived in St Ann's.

The third group I interviewed were the community workers (n=4). These were individuals who either volunteered or were employed to work in St Ann's. For example, individuals who ran the food bank, the receptionist in the community centre, the local vicars and community volunteers who ran certain groups and activities (such as Slimming World) in the area.

I asked all participants I interviewed in St Ann's a number of questions about their lives and their health. These questions were about their own health, as well as their perceptions of what health was like in St Ann's generally. When people spoke to me about health, I found that participants tended to talk more about places, routines and other groups of people, rather than their own individual 'lifestyle' choices; additionally, Additionally, different groups of people in the area spoke about health quite differently. It is these broader discussions and concerns, and differences between groups of people, that I aim to make sense of throughout my thesis.

I now turn to reviewing the academic literature that exists on the three themes that emerged from my study: health and place; routines and health; and 'othering' health and deprivation.

## Health and place

It became apparent within minutes of the very first interview I conducted in St Ann's that place was important to residents. However, as I shall discuss, different groups perceived place quite differently.

Extensive research (Ruppel Shell, 2004; Graham, 2009; Wilkinson and Pickett, 2009; Dorling 2011) has established that lower socioeconomic groups living in deprived areas are more likely to have short and long-term health problems such as obesity, but what is less well understood is how deprived individuals perceive their health and how local professionals and policy-makers understand it.

A significant amount of research has demonstrated that a person's life chances and opportunities with regards to health are related to a characteristic geographical pattern in the UK (see for example, Elleway, Macintyre and Kearns, 2001; Bridge, 2002; Cotter, 2002; Lupton and Power, 2004; Dorling, Rigby, Wheeler, Ballas, Thomas, Fahmy, Gordon and Lupton, 2007). Where we are born, live, study and work directly influences our health experiences: the air we breathe, the food we eat, the viruses we are exposed to and the health services we can access (Dorling et al, 2007). The social, built and natural environments affect our health and well-being in ways that are directly relevant to health policy. Spatial location (the geographic context of places and the connectedness between places) plays a major role in shaping environmental risks as well as many other health effects (Elleway et al, 2001). Furthermore, once factors concerning individual characteristics, circumstances (such as one's socioeconomic status) and life choices are taken into account, geographical variations in health outcomes cannot be entirely explained by simply examining the type of individuals living within different localities (ibid.).

Place therefore matters in terms of the positive and negative attributes of localities (Bridge op.cit., Cotter op.cit., Dorling et al op.cit.). As explained by Cotter (ibid.), in deciding where to live, people make decisions based upon (often highly subjective) judgements about the merits of areas that are as much shaped by their view of the place as by their opinion concerning the individuals who live there. The extent to which place, and the complex set of circumstances, processes and interactions that operate within and around the communities, really impacts upon life opportunities is, however, open to

considerable conjecture and debate. Partly, this stems from arguments concerning the type of methodological approach and evidence required to demonstrate that place exerts a significant and independent impact upon lives (see for example, Congdon, Shoulds and Curtis, 1997; Curtis, Southall, Congdon and Dodgeon, 2004; Dibben, Sigala and Macfarlane, 2006).

An important theme in the majority of literature around health therefore is the physical environment (Forsyth, Manintyre and Anderson, 1994; Elleway and Macintyre, 1997; Elleway, Anderson and Macintyre, 1997; Shohaimi, Welch, Bingham, Luben, Day, Wareham and Khaw, 2004; World Health Organisation (WHO) 2015 [online]). Shohaimi et al (2004) argue that there are many factors that combine together that affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and physical environment. To a large extent, factors such as where one lives, the state of the environment and relationships with friends and family all have considerable impacts on health. However, the more commonly considered factors such as access and use of health care services often have less of an impact (WHO, 2015).

Safe water, clean air, healthy workplaces, safe houses, communities and roads are also factors highlighted in literature that all contribute to good health (Elleway and Macintyre op.cit.; WHO op.cit.).

It has been suggested (Donkin, Dowler, Stevenson and Turner, 1999; Morland, Wing, Roux and Poole, 2002; Stafford, Cummins, Elleway, Sacker, Wiggins and Macintyre, 2007), that the price and availability of food may be an important mediating factor in the relationship between neighbourhood environment, diet quality, and health. One recent study in the US found that the presence of supermarkets was associated with lower prevalence of obesity (Morland et al, 2002). Another study by Stafford et al (2007) demonstrated how features such as access to swimming pools and other leisure facilities are associated with lower levels of obesity.

Studies in the US and Canada have found neighbourhood differences in the price and availability of food, with 'healthier' foods generally more expensive, and less readily available in poorer than in wealthier communities (Morland, op.cit.). Donkin et al (1999) in their UK study found that although low socioeconomic individuals in deprived neighbourhoods may have physical access to reasonably priced shops, this does not imply that they will, even then, be able to afford a healthy diet. Additionally, the majority of the

food outlets found by Donkin et al's (ibid.) study were often not where most people would expect to do their main shop, many were off-licences and newsagents. These independent stores tended to charge higher prices than supermarkets. There were few superstores. Findings from two of these studies (ibid. and Morland et al, op.cit.) therefore indicated that whilst reasonably priced shops may be nearby, the cost of a healthy diet for a person in the UK living on income support would be out of reach as requiring more than 50% of their weekly income (Donkin et al, op.cit.)

The above quantitative literature tends to discuss health in terms of how there are specific 'determinants' that exist within the physical environment within deprived areas that can adversely affect an individual's health (such as the availability of shops and so on). However, these studies have not consulted residents to find out the extent to which they think these 'determinants' can impact upon the health of the area or how they perceive places.

#### Qualitative approaches to health and place

While the above studies discuss the associations between health and access to supermarkets, because these studies did not consult the residents to find out how they defined 'health' in the first place, instead health was defined by the researchers. Additionally, the above quantitative studies often discuss shops as simply places to buy healthy foods. However, in my own research, I found that shops cannot be reduced to 'health' food outlets. Shops and the places where residents gather have more meanings than this. For example, in a qualitative study (Cannuscio, Weiss, Fruchtmann, Schroeder, Weiner and Asch, 2009) on visual epidemiology, it was noted from participants that Asian takeout restaurants and corner shops that sold alcohol were not just food outlets. They also reflected substantially more complex neighbourhood social attributes. The shops in this study were described by residents as a source of low-quality food, drug paraphernalia, and alcohol, and as generators of violence (Cannuscio et al, 2009). Cannuscio (ibid.) argued that by simply classifying shops together as 'food outlets' and emphasizing their nutritional role, epidemiologists may misconstrue important pathways through which these establishments can affect health.

Importantly then, a shop can have a 'reputation' which may be based on the type of people who visit it and their activities inside or outside of the building. People can construct their

own meanings and interpretations of a place. As argued by Nettleton (2006) to fully appreciate the experiences of health, or ill health, it is important to examine both the meanings and the interpretations of illness for both sufferers and other people. These meanings and interpretations that people have are shaped by the wider socio-economic and socio-political context. Illness and poor health, therefore, is both inherently individual and social (ibid., 2006).

Other qualitative studies (Saelens, Sallis, Black and Chen, 2003; Summiniski, Poston, Petosa, Stevens and Katzenmoyer, 2005; Burgoyne, Woods, Coleman and Perry, 2008; Day, 2008,) have explored the local determinants of residents engaging in physical activity in deprived neighbourhoods. Day (op.cit.) found that neighbourhood cleanliness, peacefulness, the 'ease' of being able to walk about and social interaction with one another were all dimensions of the local outdoor environment that residents experienced they impacted on their health for better or for worse.

Saelens et al (2003), Summiniski et al (2005) and Burgoyne et al (2008) explored the local determinants of engaging in physical activity in two deprived, Irish city-based neighbourhoods. These studies found a number of themes, such as neighbourhood walkability, neighbourhood density, land use mix, street connectivity and aesthetics and safety: were all aspects that residents identified as being important for their own health and the health of the neighbourhood. Additionally, Saelens et al (op.cit.) found that the concept of 'community contentment' was paramount in determining the amount of physical activity people in a neighbourhood. The quantity of physical activity residents engaged in, and this was related to the degree of contentment/comfort within the 'self' and how the 'self' interacts within the neighbourhood.

Other qualitative studies have looked into residents perspectives of 'good health' and the environment (Woodgate and Skarlato, 2014; Mckenzie 2012). Woodgate and Skarlato's (op.cit.) study into people's perspectives of health and the environment found good health was defined and visualized as 'being outside' in a safe, clean, green and liveable space. Mckenzie's (2012) study found that the importance of connections to people within St Ann's was paramount for their wellbeing and sense of self. Individuals in both of these studies talked about these conditions ('being outside', in a safe, clean, green, and liveable space) contributing to healthy environments and how healthy environments contributed to a strong sense of place.



The qualitative literature above has yielded useful insights on people's perspectives of their health within the physical environment. However, the qualitative studies have tended to focus solely on low socioeconomic groups living in deprived areas. They have not compared different groups living in a deprived area to see how they differ. This is therefore an aspect that I explore within my own thesis. My contribution then, is to analyse what certain places and spaces mean to different groups of people and how they can impact upon their health as well as the health of the area. Additionally, if different groups have differing needs and views, it will be interesting to see if this creates any tensions or conflicts between them.

### Routines and health

Another theme that emerged from my interviews and observations was the importance of 'doing rounds' or routines, which some residents of St Ann's related to their health.

To make sense of these 'practices' that were carried out in St Ann's I drew from the work of Bourdieu.

Bourdieu's concept of habitus encompasses the implicit practices and routines that structure the logic of everyday life (Bourdieu, 1984). It refers to the physical embodiment of cultural capital, to the deeply ingrained habits, skills, and dispositions that we possess due to our life experiences. Bourdieu (ibid.) often uses sports metaphors when talking about the habitus, often referring to it as a 'feel for the game'. For example, a skilled baseball player 'just knows' when to swing their bat without consciously thinking about it. Habitus can help explain why food and eating are much more than a process of bodily nourishment: they are an elaborate performance of gender, social class and identity. Bourdieu (1979) used the term 'dispositions' to describe the ways in which individuals conceive of and view the world from their social position. Dispositions are constructed by a variety of social, cultural and material resources and experiences; they dispose individuals and groups towards particular attitudes, morals and expectations.

With respect to routines and practices, Bourdieu's (1979) work on logic of practice emphasizes the importance of the body and practices within a social world. He stresses that mechanisms of social domination and reproduction were primarily focused on bodily know-how and competent practices in the social world. Bourdieu (ibid.) opposes Rational

Choice Theory as grounded in a misunderstanding of how social agents operate. Social agents do not constantly calculate according to explicit rational and economic criteria. Rather, social agents operate according to an implicit practical logic.

A practice then, (such as walking to a shop) is theorised as a manifold of socially organised, embodied activities ('sayings and doings') that are 'bundled' with material arrangements and linked into a nexus by understandings ('knowing how to carry out desired actions through basic doings and sayings'), rules ('explicitly formulated directive, remonstration, instruction, or edicts') and teleaffective structures ('ends, projects, tasks, purposes, beliefs, emotions and moods') (Harries and Rettie, 2016, p. 89).

I frequently found that many of my participants had their own social practices which involved routines and chores. Similar to Bourdieu's (1984) work, these practices were underpinned by and displayed the person's gender and social class position and identity.

#### Health and Practices – Qualitative Studies

There is some emergent literature, sometimes drawing on human geography on people's routines and health within neighbourhoods (Richard, Laforest, Sufresne and Sapiniski, 2005; Grant, Edwards, Sveistrup, Andrew and Egan, 2010). Grant et al (2010) found that there were a wide range of issues identified by their respondents which related to the determinants of health and quality of life in their neighbourhood. The most common themes were independence, financial security, social integration, health care services, housing, accessibility of community services and their own decision making power. Some of these findings were echoed by Richard et al (2005) who found that the reasons why older people walked were influenced by overlapping personal meanings including exercise, managing everyday life, contact with nature, social connection, and discovery. For example, older adults (ibid., 2005) placed an importance on having routines that involved seeing other local residents, (such as in community centres), visiting green spaces (such as parks), and specific places, such as the pharmacy or GP surgery. These activities and practices were viewed as being paramount for their wellbeing.

Work on health and practices has often focused on older people and how neighbourhood context influences walking practices (Lockett, Willis and Edwards, 2005; Michael, Green and Farquhar, 2006; Strach, Isaacs and Greenwald, 2007; Day, op.cit.). Safety features that protect from falls and traffic hazards, convenient access to destinations, well-maintained pedestrian infrastructure, neighbourhood attractiveness, and public

transportation have all been identified as important aspects of the neighbourhood walking context by older people. Most of these studies asked older people how the physical environment influences physical activity. However, these studies typically did not ask older adults broader questions surrounding their own health, which may have highlighted aspects outside of the physical environment that can influence health.

There are a number of qualitative studies on older adults, mobility and geography, which draw on practice theory and have pertinence with regards to my research (Wiles 2003; Boneham and Sixsmith 2006; Walker and Hiller, 2007; Delormier, Frohlich and Potvin, 2009). In one of these qualitative studies into the daily geographies of caregivers in a community, Wiles (op.cit.) also found from interviewing older adults that most described their routines in striking detail. They would pinpoint specific times they carried out certain practices such as visiting a shop or taking a walk. They would then explicitly detail, why they took a walk at this time and how this was important to them. For example, some older adults knew the specific times when a certain food item was available in a local shop, such as a bakery and so they tailored their routine to be able to visit the shop at this time. Wiles (ibid) suggests that older adults develop routines because they are in need of structure helping them cope with daily life. Routines are therefore created as a coping strategy.

One qualitative study (Backett-Milburn, Wills, Gregory and Lawton, 2006) argued that behaviours and routines are bounded by distinctions of taste, according to social position. Backett-Milburn et al (ibid.) argue that certain ‘tastes’ and routines usually associated with working-class people (such as visiting local shops, community centres, public houses, cafes and so on) do not usually require significant planning and so can therefore be done on a day-to-day basis.

To sum up, there has been a significant amount of qualitative research conducted within deprived areas and people’s routines, particularly routines of physical activity and accessibility. A large portion of this work has focused on older adults and how the various ‘features’ or ‘living environments’ within their neighbourhood has affected their health. However, an understanding of how the wider residential environment within a neighbourhood affects people’s routines and practices has remained under-researched. My contribution here is to study how these practices relate to other groups who live in deprived areas, such as middle-class people, parents of young children and community

workers. Importantly, the studies above have not compared different groups with one another and how their health-related practices are similar to or different from each other and how these practices relate to one another. This is another aspect that requires investigation in my research.

### 'Othering,' health and deprivation

'Othering' is a process that "services to mark and name those thought to be different from oneself" (Weis 1995, p.17) This is often done in a negative way (downward social comparison) (Fine, 1994; Weis, op.cit.).

When I spoke to people about their health in St Ann's, they would often compare their health to 'other' residents in the area. However, I found that there were varying 'othering' practices in that area, in that, 'othering' was conducted differently by different types of people in St Ann's. There is a significant amount of literature that has discussed the concept of othering which I will now discuss while highlighting its relevance to my thesis and where further research is required.

Qualitative literature on othering (Fine, op.cit.; Weis, op.cit.; Johnson, Bottorff, Browne, Grewal, Hilton and Clarke, 2004; Grove and Zwi, 2006) tends to argue that othering is essentially a form of marginalisation. Othering is therefore a process through which people construct their own identities in reference to others. By talking about individuals or groups as 'other', one magnifies and enforces projections of apparent difference from oneself (Grove and Zwi, op.cit.). According to Johnson et al (2004), othering' defines and secures a person's own identity by distancing and stigmatising an(other). Its purpose is to reinforce notions of a person's own 'normality', and to set up the difference of others as a point of deviance. The person or the group being 'othered' experiences this as a process of marginalisation, disempowerment and social exclusion (Fine, op.cit.). This effectively creates a separation between 'us' and 'them'. Othering practices can, albeit sometimes unintentionally, serve to reinforce and produce positions of domination and subordination; this is referred to as downward social comparison (ibid.).

Additionally, it is frequently argued (Krieger and Sidney, 1996; Krieger, 1999; Johnson et al, op.cit.) that persons who are treated as other often experience decreased opportunities and exclusion (Krieger, op.cit.). Additionally, social experiences such as

discrimination and othering have been associated with population health consequences such as shorter life expectancy, higher infant mortality, and hypertension (Krieger, op.cit.; Krieger and Sidney; op.cit.). According to Krieger and Sidney (ibid.), individual health effects have also been observed including depression and stress responses. Othering can also affect health by creating access barriers. Those who have had negative experiences in the health system and those who feel unwelcome are less likely to re-enter the health system and seek appropriate health care (Johnson et al, op.cit.).

Although there are theoretical and conceptual treatments of othering and social comparison in literature such as those discussed above (Fine, op.cit.; Weis, op.cit.; Sidney, op.cit.; Krieger and Sydney, op.cit.; Krieger, op. cit.; Johnson et al, op.cit.; Grove and Zwi, op.cit.) the research has rarely considered othering practices in relation to place and deprived neighbourhoods, particularly using qualitative methods. In addition to this, othering practices across social groups within a deprived locality were not explored in any of these studies.

Furthermore, many of these studies tend to approach othering and downward social comparison from micro or psychological perspective. These studies (Johnson et al, op.cit.; Grove and Zwi, op.cit.) looked at small-scale interactions between individuals, such as group conversations or group dynamics, rather than discussing the larger scale processes inherent in macro level sociology.

For these reasons, I have used Bourdieu (1979) to provide much of the theoretical backbone for my chapter on othering, in particular, Bourdieu's (1979) concept of symbolic violence, defined as the ideas and values of the middle-class, who impose them (often through subconscious means) onto a dominated social group.

### Qualitative approaches to othering

A recent qualitative study used Bourdieu to investigate how culinary taste practices contributed to the formation of middle class identity in a working-class area (Cappellini, Parsons and Harman, 2015).) This study found that the middle-class participants tended to rely on a set of approved, but also 'ready-made' set of products and procedures (i.e. local farm products and stores and cooking techniques) that were legitimised as and aligned to middle class tastes. The local shops or restaurants were not seen as decent and legitimate cosmopolitan choices. This is because the middle-class groups saw these

places as being connected with the working-class culture in the area. Indeed, these views held by the middle-class participants can be seen as a form of symbolic violence.

Additionally, the middle-class participants in this study (Cappellini, Parsons and Harman 2015) seemed to make a conscious effort to operate outside of the local area where they could gain their resources in a 'safe' and 'user friendly' manner. This was important for developing a secure middle class culinary taste despite living in a working class area. This approach allowed their sense of being middle class to remain largely intact. Additionally, the middle-class participants in this study viewed the prospect of engaging in the local area more as 'risky', as it could result in developing the 'wrong' taste.

This is a pertinent finding, as it shows that the middle-class people living in a deprived area tended not to associate themselves with certain places and shops in the local area as these places did not fit with their middle class 'tastes'. Instead, they viewed these places as being associated with the working-class culture in the area. Unfortunately, this study did not interview the working-class residents within this area to see if and how their views might differ. Additionally, it would be interesting to see if the working-class residents were aware that the middle-class residents 'othered' their lifestyles in this way.

Another qualitative research into othering and health (Bowes 1993, Johnson et al 2004), has explored the interactions between health care providers and South Asian immigrant women and the othering practices between them. Johnson et al's (op.cit.) study found that older adults were othered as there were frequent uses of othering in terms of how the health care providers discussed the South Asian patients. In particular, terms used to distinguish 'they', from 'us' and 'white' from 'brown' were markers that signalled othering discourses. Othering language also appeared in descriptions of situations that health care professionals found 'difficult'. For example, frustrated with some patients' noncompliance with routine and ostensibly simple medical advice, healthcare providers often drew on cultural characteristics and other generalisations to explain this behaviour. The alienating and marginalising effects of these practices were evident in the South Asian women's discussions of their health care experiences (Johnson et al, op.cit.).

To sum up this section, there are theoretical and conceptual discussions of othering and social comparison. There are also some quantitative studies that have used these concepts to explain issues such as marginalisation and identity. However, they have tended to

approach othering and downward social comparison from a psychological, rather than social perspective. For this reason, my contribution in my thesis involves using Bourdieu (1979) to provide much of the theoretical framing for my chapter on ‘othering’, in particular, Bourdieu’s (ibid.) concept of symbolic violence, which I discuss in the chapter itself. Finally, some qualitative studies have shown how specific groups within deprived neighbourhoods (such as middle-class individuals) ‘other’ residents and places, which do not fit with their middle class ‘tastes’. However, my contribution involves exploring how various groups compare and contrast their health and practices with each other, to see if they sometimes make themselves look ‘better’, or whether they criticise others or empathise with those who are both worse off than them and misunderstood.

### Structure of Thesis

This chapter has focused on how my reading has helped me to develop an initial understanding of deprivation, locality and health. Chapter 2 will discuss my methods. This includes how I conducted the research, recruited participants for the interviews, observed the neighbourhood and analysed my data.

The third chapter is my first empirical chapter titled ‘How health was discussed’. The main purpose of this chapter is to show how health was talked about in St Ann’s and what people said when asked about it. This chapter is therefore a descriptive chapter, fleshing out the themes that emerged from my research and how these frame my thesis. The first part of the chapter uses some pertinent sociological work (Crawford, 1984) to set down a theoretical framework. I then go to discussing the three themes that emerged from my interviews: ‘Meanings’, ‘Practices’ and ‘Othering.’

The fourth chapter (Meanings of places) focuses on the meanings of several important places in St Ann’s. It shows how people in St Ann’s explain and conceptualise the different places within it. Firstly, this chapter discusses the current research into health and the physical environment. Secondly, I discuss how ‘place’ for the individuals in St Ann’s had a diverse and broader meanings for different people.

In the fifth chapter (Practices), I discuss another important theme that emerged from the interviews and observations. This was the importance of ‘doing rounds’ or routines, which some residents of St Ann’s related to their health. I discuss how these routines were often associated with activities, such as visiting the community centre, the food bank, betting shop and the church. I also discuss how these practices were different for the different groups I interviewed in St Ann’s. Certain routines were often highlighted as being important for one’s health. I argue that these different class, age and gender positions ‘play out’ differently in terms of routines and health reflecting the power of Bourdeusian ‘habitus’. I also relate these routines to existing qualitative literature on social practices and health.

The sixth and final empirical chapter (Othering) starts by defining ‘othering’. This was another theme that emerged from my interviews. When I spoke to people about their health in St Ann’s, they would often compare their health to ‘other’ residents in the area. However, I discuss how I found that there were varying othering practices in the area, in that, ‘othering’ was conducted differently by different types of people in St Ann’s. I discuss how, in order to understand health in St Ann’s, there was an importance to analyse this practice of othering to discover how it has been used by residents in making self-evaluations about their health.

With regard to a person’s social status and their social comparisons, I discuss ‘symbolic violence’ (Bourdieu, 1979) and how this relates to my findings in this chapter. This is particularly with regard to how ‘symbolic violence’ is perpetuated within society, especially in the sense of how a person’s class position allows them to dominate others.

I then discuss and analyse my findings in three separate sections. The first section, ‘Everyone knows St Ann’s is bad’ discusses how the neighborhood was viewed negatively by outsiders. The second section, ‘Classic othering: They eat ‘bad’ foods’ discusses how most of the groups I interviewed in St Ann’s (the middle-class, the community workers, the working class and a few GPs) saw themselves as ‘better’ in health and behaviour than the majority of others. In the final section, ‘some try to understand others’, I discuss how some of the GPs working in the area viewed the health behaviours of the St Ann’s residents, as well as discussing the working-class residents and community volunteers who thought that the middle class ‘helpers’ who came into the area were ‘out of touch’ with the residents’ culture.



Finally, in the conclusions I reflect on what my thesis contributes to existing literature and what the ‘take home’ message might be in relation to health in deprived neighbourhoods.

## Chapter 2: Research Methods

This chapter describes the steps that were undertaken to address my research questions. I discuss briefly the very beginning stages of my research, where I explain my initial ideas on what I wanted to find out and how and why these changed. Following on from this, there is a discussion on why I chose the participant observation (PO) that I conducted in St Ann's. I explain how I used PO to gain familiarity with the area and how this steered my research questions. Thirdly, I discuss my sampling which includes a discussion on how I decided who I wanted to interview, the purposive and theoretical sampling. I also detail how I found these different groups of people. The final part of this chapter discusses interpretivism, hermeneutics and iterative inductive research and how they relate to my research. Finally, I explain how I used thematic analysis to analyse my data and identify my themes.

### Research Process

In Chapter 1, within the introduction to my thesis, I explained that my MA dissertation had focused on obesity in the developed world, and so my initial plan was to complete a PhD 'in obesity', and that I was still interested in continuing this focus for my PhD. I knew from my Masters work that obesity levels were generally higher in areas of deprivation. Therefore, my initial PhD research proposal involved a case study of a low socio economic status locality somewhere in Nottingham. I wanted to interview people with a high BMI and interrogate them about their lifestyle.

However, I began to realise relatively quickly that finding these obese people to interview would not be possible for various ethical and practical reasons. Moreover, Over time, I started to realise that a qualitative PhD focussed purely on 'obesity' would was perhaps not feasible or desirable given some of my interests. By only focussing on obesity I was perhaps be missing miss the 'bigger picture' which was centred around my interest in health and deprivation more broadly. Before re-thinking my research questions about and what I wanted to find out, it was suggested that I should think about what which deprived area in Nottingham I would like to conduct my study. in. If I

could find out about the area (by doing PO) and what (if any) prior research had been done there, this might stimulate my interest in terms of asking achievable research questions.

So, as I mentioned in my introduction chapter, I therefore devised the following research questions for my thesis:

4. How do individuals in St Ann's make sense of their health and what do they think accounts for their health?
5. What do these individuals think makes people healthy?
6. How do the views of diverse groups of residents (working-class, middle-class and community workers) differ?

These questions sought to found out what health means for each participant I interview. Additionally, I am interested in what individuals think makes them healthy. If it appears that their health relates to living in the neighbourhood, I will ask what they think accounts for the health and/or ill health in the neighbourhood. Finally, I am keen to ascertain whether there are differences and perhaps tensions between the views of different sorts of people in the area surrounding health.

### Participant Observation

For my research, I used several ethnographic methods, because I was studying a locality and so I found a number of ethnographic methods that were helpful. Ethnography can be defined as the systematic study of people and cultures (Hammersley, 2007). It is designed to explore cultural phenomena where the researcher observes society from the point of view of the subject of the study (Hammersley, 2007). According to Hammersley (2007), Ethnography therefore draws on a family of methods, involving direct and sustained contact with human agents, within the context of their daily lives (and cultures), watching what happens, listening to what is said, and asking questions (ibid.).

Participant observation is the main method of ethnography and involves taking part as a member of a community while making first mental, and then written, theoretically

informed observations (O'Reilly, 2009). Ethnographic research is driven by a methodology (or theory about research) which dictates that researchers learn about the lives of the people they are interested in through first-hand experience in their daily lives (Birks, 2015). The aim of participant observation is to gain a close and intimate familiarity with a given group of individuals (such as a religious, occupational, sub cultural group or, in my own case, a community) and their practices through an intensive involvement with people in their cultural environment. This is usually done over an extended period of time (Atkinson and Hammersley, 1994).

The two key elements of participant observation are therefore participating and observing (O'Reilly, op.cit.). In practice, once one has gained access to a group or setting, the aim is to understand things from the 'native's' point of view and to blend into the setting so as to disturb as little as possible (ibid.). Making sense of the world that one has entered involves understanding what works in practice and in everyday experience. Atkinson and Hammersley (op.cit.) view the social world as the outcome of interaction between the various actors in a setting. This implies a practical and grounded methodology that is placed in everyday settings.

With regard to my own research, I found that both participating in and observing a setting or group can be difficult to achieve in practice. A participant is a member of a group, joining in activities, sharing experiences and emotions, contributing to debates, and taking part in the very interactions on which social life is built (Birks, op.cit.). An observer is an outsider (as I was), watching and listening. Observers do not always fully take part and they are rarely fully-fledged members of a community. I decided to deliberately walk through the area whenever I could. I live in Mapperley Park, which is situated next to St Ann's and so it was easy for me to walk through St Ann's on my way home from the city centre. I would also regularly go jogging and cycling through the area on the way to my gym, which was situated on the outskirts of the city centre.

During these early days of passing through the area, it is accurate to say that I held some prejudices regarding the groups who I thought lived there. I was convinced I would be able to spot them walking around. It was clear then, that although I wasn't sure what I was going to find out from conducting research in St Ann's, I held a negative bias towards the people who lived there. I also felt somewhat awkward about the whole experience. Having come from a middle-class background and having always lived in a middle-class

area I had never any reason or need to venture into such places as St Ann's. I felt as though I was truly an outsider. This is a common issue that has been discussed by other researchers (Kitzinger 1990, Green and Thorogood 2009). According to Green and Thorogood (*ibid.*) this scenario is especially made more difficult when the researcher's own personal attributes – gender, age, religion, and ethnicity – affect access.

For example, personally as a researcher, I was not born in St Ann's and have never lived in a deprived area or experienced social disadvantage. In addition to this, as a large, tall male who can look intimidating, I was concerned as to how these personal attributes would affect my chances of being accepted into the community as an 'outsider' and allowed to conduct my research without facing hostility. Referring back to the Kitzinger's (1990) study into intravenous drug users, the researcher faced a similar problem in that he felt uncomfortable entering into high crime areas and 'dangerous drug fuelled environments'. In fact, Kitzinger (1990) reported some individuals 'fleeing' when he approached as they were convinced he was an undercover policeman, due to his personal attributes.

This, however, does not mean that the researcher has to be similar to the research participants (Berg, 2004). As Berg (*ibid.*) and Creswell (2012) argue, 'difference' in qualitative research can be a resource, enabling the researcher to ask naïve questions that an insider would never consider. Participant observation for me therefore, was more a means of access and gaining familiarity than a method of data collection in itself. Indeed, there will always be some places and groups to which some people will never be able to gain access (Creswell, *op.cit.*). However, this does not mean abandoning one's research interests, yet it does mean that the setting or topic needs to be negotiated carefully, particularly if it is a sensitive one. Indeed, an individual's health and their body is a personal subject and so this negotiation of my approach is discussed further on.

Beginning with my first forays into the field, there is one early experience that I remember well. During one jogging trip through the area on the way to the gym, I remember running down the pavement past a couple of young teenagers. One of them was on a bike and the other one was walking. As I came to pass the one that was walking, he turned to me, stretched out his arm handing me a cigarette and said 'Here you go'. For a long time, I could not figure out why someone would offer a cigarette to a person who was exercising. As I thought about it, it felt a little bit like a scene from the 1996 film 'Mars Attacks!'

where aliens land on earth and a random pedestrian offers the alien a bag of chips. It seemed to me that my practice of ‘running’ in St Ann’s was so ‘alien’ to some of the residents there that their way of dealing with it was to offer me something they knew and enjoyed (the cigarette). Or, perhaps they could not understand why I decided to go jogging and, as form of their own irony, offered me a cigarette. This first early experience was one of the triggers that led me to rethink my approach to understanding health in St Ann’s.

The following week I began taking particular trips to the area, which involved walking through St Ann’s and taking photographs. Taking photos can be useful for participant observation as they can be taken home and copied into field notes to act as a prominent visual reminder of what was observed and learnt about a particular setting from that day (O’Reilly, op.cit.). I would take photos of various streets, sidewalks, buildings and roads within the neighbourhood then add them to a collection of field notes I had been writing whenever I visited the area. Fieldnotes are the written record of the observations, jottings, full notes, intellectual ideas, and emotional reflections that are created during the fieldwork process (ibid.). I found these notes incredibly useful in terms of remembering everything that I had observed during participant observation. By reading through them, not only could I remind myself what I’d seen, but also as time went by I found myself coming to different opinions about what specific observations meant. It is common for interpretations to change as one moves through the research process (Atkinson and Hammersley, op.cit.).

On reflection, I learned much from these early visits into the area. I was very surprised at how deserted the area was. I was expecting to see many obese people walking around holding bags of chips. I thought I would see huge queues of people outside the fast food outlets in the area. I expected I would see large gangs of youths on every street corner wearing hoodies and dealing drugs to those who walked past. I thought I’d hear police sirens wailing every five minutes since statistically the area had high crime rates.



What I found however, was very much the opposite of all of this. Not only was the area deserted, but quiet. I did not witness any gangs hanging around on street corners, or the so called 'obese people' walking the streets. I could not find any takeaways that were open and so there were no people in St Ann's queuing up to get their regular intake of 'junk food', such as greasy kebabs. Neither did I see nor hear any police cars. Instead, there were very few people walking about the streets or sidewalks. The photos I took showed this and the deserted nature of the area. Being 'deprived', I expected the area to



look ‘run down’ and unliveable. However, it did not appear as ‘run down’ as I expected - at least not to my eyes.

I would write about the above (my perceptions on the area) in my field notes. It became clear to me when reading through how my perceptions in the area and the people who lived there began to change the more time I spent visiting it. When I began speaking to some of the residents in the area, my perceptions changed again. Initially, given I expected the residents to be unhealthy chip eaters, I had assumed that their deviance from a healthy lifestyle meant that they were idle and refused to exercise. I assumed they would all be unemployed and have large Sky TV dishes outside of all their homes.

I was concerned with involving myself with these people, as I assumed they would not want to speak to me because I was an outsider and not ‘one of them’. I had therefore guessed that they would be unpleasant to speak to. This preconceived idea of mine, however, found itself being turned on its head when my first contact with a St Ann’s resident. He started a conversation with me when I was taking some photos of the area near to the community centre. The resident asked what I was doing. He seemed a little unnerved and suspicious of me at first, but as soon as I started talking his facial expression changed. I explained that I was doing some research on health in the area and that I was a student at Loughborough University, I wasn’t from around here, but was interested in finding out about the place and the people who lived there. This response seemed to surprise the resident. I was informed later on in my field work by a community worker that well-dressed outsiders in St Ann’s are usually viewed by residents as either being ‘the police’ or ‘from the council’, which tends to raise suspicions. I remember being well dressed at the time, and so this might help explain why the resident seemed a little unnerved by me.

Most surprisingly, this first resident I spoke to was not obese. He was an older adult who was out walking his dog. I wondered to myself whether he probably walked his dog through this route every day and so he’d easily notice if anything or anyone was ‘out of place’; for example, me being there. Once I told the resident what I was doing there, he seemed interested and began telling me about his upbringing in the area. He spoke about this in vivid detail, who he lived with, what school he went to, when he left school and where he worked. I found this to be interesting to listen to, as it was clear to me that his life was very much ingrained with living in the area, and that an area was so much more



than simply bricks and mortar. I therefore needed some research questions that were based around people's views about their neighbourhood or place. I was aware that there was a significant body of quantitative research (discussed earlier in my literature review), that has shown that where a person lives has a significant impact upon their health. Therefore, it would be a missed opportunity if I were to ask a diverse section of people in St Ann's about their health but ignore the neighbourhood.

A decision that I had already made at this stage was to be an overt researcher in St Ann's. Overt research can be defined as openly explaining the research to the participants, its purpose, who it is for, and what will happen to the findings and thus being 'open' (Alasuutari, 1995). However, as participant observation formed an important part of my interviews and research, it is often undertaken openly (open at the point of gaining access). An importance to undertake in gaining access (discussed later) therefore, involved explaining my research overtly and then settling into a quieter semi-overt role whilst I conducted my interviews. This resulted in my interviewees knowing what I was doing but not always having it in the forefront of their minds, encouraging them to 'act naturally' in interviews (ibid.).

Following on from this, an example I gave earlier, during my participant observation stage where I was walking around and taking photos, a couple of people would occasionally ask me what I was doing. I would always tell them that I was doing some research for Loughborough University. Funnily enough, this was at the stage where I did not know exactly what I wanted to find out in the area or what specific questions I was asking. However, as soon as I started meeting people I did begin to create some research aims, which started to guide me, even though I did not have an information leaflet to give them. This explanation always seemed to suffice, which surprised me, as I thought people would be so wary of outsiders that they would ask me more questions.

I slowly developed more confidence to speak to St Ann's residents more frequently. After locating the community centre that was situated in the 'Chase' area, I found that there were a number of residents who were easy to speak to (such as the older adults). I saw how ingrained the St Ann's residents were within their community centre, and felt I should conduct a study in the area that took into account the 'places' within it and whether the residents perceived such places to be related to their health.

In conclusion, I needed new research questions to complement my new research aims, aims that would form the basis of my PhD. These new research questions I discussed earlier in my first chapter.

## Sampling

During these early stages of participant observation, I became interested in large numbers of older adults who hung around in the community centre. The community centre was situated in the Neighbourhood Chase area in St Ann's where there was also the food bank, the church and a small corner shop as well as a few other local shops that were occasionally open. Across the road from the Chase was the Valley Centre, which had two GP surgeries inside as well as the local library. I mentioned earlier on that the local area seemed deserted when walking through the streets. However, at certain times of the day, such as lunch time and mid-morning, the Neighbourhood Chase area would be buzzing with people.

I already had the contact details of a middle-class person who lived in St Ann's. I met her on a qualitative interviewing course I did earlier in the year at Oxford University. When I explained to her that I was thinking of doing some qualitative research in St Ann's she informed me that she currently lived there and would be happy for me to interview her when I was ready. She was my first interview. Around the same time, I joined up to one of the gyms that was situated on the outskirts of St Ann's. Geographically, it was listed on Google Maps as being in the 'City Centre', however, importantly, there were some middle-class St Ann's residents who trained there as the membership was not cheap. I would often chat to gym members during training sessions and I met a few of my interviewees this way. We would start talking about what we did for a living and I would explain that I was a student doing some research on health in St Ann's. If they lived there, they would say so and I would always ask if I could interview them. I conducted a few interviews with the middle-class residents this way.

After interviewing some of these middle-class residents, I thought I needed to speak to some people who identified with the area and who were genuinely working class or 'deprived' I realised I needed to find someone who could introduce me to a few residents

(a gatekeeper). During my participation observation stage (shortly after I had been walking around the neighbourhood and taking photos), I had already started meeting and speaking to a GP who worked at one of the GP Practices in the area (St Ann's Valley Centre). Although he was busy, he always made time for me when I wished to come and visit him. During one visit, he took me on a tour of the local surgery and then to the community centre. This was one of many visits to the St Ann's community centre. I was immediately surprised by his relationship with the local residents. During my walk through the area with him, he said hello to everyone we walked past. It was clear he was well known in the area despite not living there and being a doctor (which can sometimes be viewed as an intimidating position). He seemed well liked and accepted by the St Ann's residents. I found this a little reassuring as it demonstrates that even though he was an outsider, he had done 'something' to be accepted into the area. There was no hostility.

It became clear that there were different types of residents in the area and not just the working-class group. I thought speaking to other groups (such as the middle-class group) would yield some interesting findings, as their social-class and socioeconomic status may provide some different data. Similarly, the community workers who worked in the area did often not live there, yet I thought they would offer another perspective on health. I should therefore include this group. At the same time, I realised I only had a certain amount of time to carry out my field work and so it was impossible to speak to everyone. I discuss this further in my 'limitations' section. However, what I was able to do was to interview some of (but not all) these specific groups until I felt I had reached 'saturation' (discussed later).

The GP gave me the contact details to a community worker employed by the Renewal Trust who worked in St Ann's. I emailed her explaining I wanted to do some research in the area and she agreed to be my gatekeeper. I was not entirely sure of my research questions yet, although I mentioned earlier I had left the idea of focusing only obesity and wanted to research something that focussed around place/neighbourhood. The community worker offered to introduce me to some of the older adults who regularly visited the community centre during the day to drink tea and eat cake.

Not only were there elderly people who visited the community centre, but also residents who were white British and working-class. There was also a large black community. Jamaican men seemed to visit certain places at certain times, such as the community

centre and the church. The older adults would also visit the community centre but usually on a daily basis. They would hang around together in groups chatting. There was also a large Eastern European community, although these people rarely seemed to engage with the local area and so I did not get to interview many of these individuals. There were also middle-class people who lived in the area, although I rarely saw these people walking around or visiting certain places in the area. However, I mentioned earlier my first lot of interviews were with middle-class people but I had to recruit these through other means. I explain how I found this group of individuals below. Finally, there were the community workers who worked there (such as my gatekeeper). These were individuals who worked in the area (such as employed positions at the community centre or curate at the local church) but often did not live there. Also, unpaid volunteers who ran various activities such as the food bank, Slimming World or the scouts group for the children. The unpaid volunteers were usually residents themselves.

The diversity across all of these groups became interesting to me. This diversity was in direct contrast to what I thought I'd find (stereotypical obese working-class white people eating chips). However, I was not sure at this stage who I would be able to interview.

So, as mentioned in my research aims and questions, I became interested in how health was understood and talked about in different ways in St Ann's. This idea of health in the locality seemed broader and would perhaps yield more interesting data. The implication for my research questions was that I needed to come up with a set of questions that would explore the contrasting views between different people in St Ann's around health. I wondered if different people would conceptualise their health very differently from one another and what interrelationships would be identified with the neighbourhood as a place. From previous reading, I was sure that health has often been understood very differently depending on who you talk to. The newly designed study therefore aimed to make use of the diversity in St Ann's. Specifically, I included the following groups in an effort to represent this diversity: middle class participants, older adults, community workers, parents of young children and three groups representing different ethnicities.

The topic guide I used for my interviews (see appendix) was used with all residents I interviewed. After interviewing some middle-class people, the older adults were the next group that I approached. I mentioned earlier that many older adults used to visit the community centre every day. However, I was at first a little nervous about approaching

them and so my gatekeeper introduced me to one (Clive) member of this community. I was surprised at how easy the conversation felt. I was concerned that I would not have anything in common with this group of people and so all I would be able to talk about would be my topic guide. However, I could immediately relate to some of the topics he talked about. I realised that even in places that were most different from my own background, it was still possible to find likeness with people.

It is now important to discuss how I found the other groups for my research, how I approached them, what they often said and how I felt about it. This is pertinent because it relates to my findings from my research and how I perceived them. With regard to the second group of people (the older adults), I mentioned earlier that I had the most anxiety about approaching this group. Older adults have often been viewed as coming from a 'different social generation', where there were significant cultural and social differences to today's world (Mckenzie, 2012). I found myself going into St Ann's with some pre conceived ideas about this group. I thought that they would be difficult to communicate with and not want to speak to me because I was a young man from a completely different social and cultural generation.

What I found, however, was the complete opposite. I used to sit for a few hours in the community centre in the area drinking copious cups of tea and coffee waiting for someone to walk in and sit down. I mentioned in my sampling that the older adults frequently used the community centre for this purpose. They would pass by and sit down by the window for an hour or so eating a slice of cake and drinking tea. It was in this moment that I would make my move and go over and speak to them. I conducted some group interviews with older adults also. To conduct a group interview, I would find out where I could find large groups of older adults sitting around, then turn up and join them for a few hours. For example, I always asked at the end of an interview with a participant if they knew anyone else in the area who I could speak to. One lady mentioned that a group of older adults used to sit out all day in the communal area building by their terraced flats. She notified this group that I'd be turning up one afternoon as I wished to speak to them. When I arrived, I walked in their living room to find seven older adults chatting to one another, sitting around drinking cans of cider and watching a film (*Brokeback Mountain*, 2005). They welcomed me in with open arms, offered me tea and cake, and I gained some of the most fascinating data from this group interview.

Before carrying out my field work, I first thought that the best way to get someone to agree to be interviewed is to take the same approach as if you wanted to date them. For example, if I saw someone I liked in my world of dating, I would walk over, introduce myself and pay them a cheesy compliment such as praising them on how beautiful they looked. I would then ask if I could wine and dine them. Therefore, for a qualitative research interview, all I needed to do was change the part about asking them out for dinner, to asking them whether I could speak to them for a bit.

However, having subsequently read a number of texts about qualitative research and interviewing (Seale, 2011; Flick 2014), I could not find the above approach suggested anywhere and so I decided to drastically change my method. Having walked over to them I would ask: “Excuse me, may I ask if you live in St Ann’s?” – The answer was always “Yes”. I’d tell them my name, I’d tell them I was a PhD student doing some research about health and whether I could ask them some straightforward questions about themselves and where they lived. Most importantly, I would tell them that I wasn’t from ‘around here’, I was from a different place that I thought was no ‘better’ or ‘worse’ than theirs. I would deliberately express some naivety about the area and about them, while explaining I was not there to judge or enforce, but to learn from them and see them as the ‘experts’ about themselves and where they lived. The older adults met my approach with praise. I never found myself being told to go away. If they did not have time to speak to me then, they would give me their contact details so that I could arrange to interview them at a later date. I learned that when it came to these older adults it was in fact myself who had never wanted to speak to them – there was never disdain from them towards me.

When it came to interviewing the community workers in the area, I found this process far more easy-going and straightforward. They spent most of their time in the area and so they were approachable. For example, the manager of the community centre had her office upstairs and so I approached the receptionist explaining what I was doing. The receptionist approached her and then the manager agreed to be interviewed. I later interviewed the receptionist too. I mentioned earlier that the food bank was situated in the Neighbourhood Chase area opposite the community centre and so I approached the woman who ran it. I explained my research to her also and after offering her a donation of food she agreed to be interviewed. The other community workers in the area were approached in much the same way. I would find out where they worked, either from other residents (so snowballing) or my gatekeeper and then approach them. On a personal level,

along with the community workers who lived in the area I felt I had most in common with this group. They often identified themselves as being ‘middle-class’, but had an interest in the area often because of the diverse range of people who lived there or the strong personal relationships that they had.

I knew that just interviewing the older adults and community workers was not sufficient for my research aims. So, I decided to interview another group that might be accessible. Some parents with young children did use the community centre and I sometimes saw them walking around the area on school runs and so I was confident this group of people was living in the area. The parents with children were a little harder to find, however. Some of them often used or passed through the community centre, or were involved in the community by other means such as through the local church, library, GP surgery or food bank. I would often conduct my interviews at one of these locations or at their homes if I was invited. I also visited the local parent and toddler group as well as the St Ann’s Scouts club and found some parents through here. Four of these parents were single parents (at the time of the interview) and were mums. The remaining fifth parent was a father who was married. In a similar sense to interviewing the older adults, I always found the parents welcoming in their demeanour towards me. However, I could always sense that they had wariness to outsiders before I approached them. Even if I dressed differently before going into St Ann’s, or tried to behave differently within myself, they knew I was not one of them and I never felt fully integrated into the area. I discuss this theme further in a later chapter and how I found it to relate to health.

Three of the groups interviewed for my research were purposive samples in that they were selected based on the knowledge of the population and the purpose of the study (Charmaz, 2006). As mentioned earlier, with regards to interviewing the residents, I purposively sampled different ethnic groups. Indeed, it is fairly common in qualitative sampling research to ensure that sampling includes the criteria of gender, age and ethnicity (ibid.). Having said this, I was careful not to interview individuals under the age of 18, because interviewing children opens up a number of new ethical issues (Irwin and Johnson, 2005). More importantly, health and place among children in a deprived locality could be a PhD in itself and so I was confident it was for the best to exclude young adults and children from my sample. In addition to this, this group was not easily accessible as they rarely used the community centre or other local facilities that I frequented.

Purposive samples are the most commonly used form of nonprobabilistic sampling, and their size typically relies on the concept of 'saturation' (Charmaz, op.cit.). I continued interviewing until 'saturation' was reached (the point at which no new information or themes are observed). One group I felt I got to know very well was the older adults. It can be noted from my interview list that I spoke to a good number of these. I found myself hearing the same sorts of things from them in later interviews and so I'm confident I reached a point of saturation. With regard to the community workers, who ran the various groups and buildings in St Ann's (such as the church, the community centre and the food bank), they began to give similar data after a handful of interviews. I also demonstrate in my chapters where I discuss the middle-class residents that they started to say similar things and create specific themes after a handful of interviews. The working-class St Ann's residents, however, were a trickier bunch to reach saturation with because of their diversity so I felt I never reached this point. For example, there were many people of different ethnicities and I was not able to speak to all of these. Different ethnicities tended to create different data, perhaps because of various cultural differences.

As I mentioned earlier, I did not interview young people (those under 18) for my research. I also interviewed very few young working-class men. McKenzie (2012) has conducted an insider ethnography on teenagers living in the area and so this group has already been included in previous research. She noted how difficult this group was to access, even for insiders and those (such as McKenzie) who had grown up in the area. I therefore chose to focus my sampling on other groups. Therefore, my sampling was always purposive, not representative of all groups in St Ann's.

Effectively therefore, I snowballed out from various strategic starting points (discussed later) and then built on my sample as I developed my theoretical arguments.

My method of theoretical sampling falls under grounded theory, so sampling was not undertaken once and for all at the beginning of my research, but was ongoing and continuous as ideas developed and theories emerged (Alasuutari, op.cit.). Theoretical sampling involves seeking and collecting important data to elaborate, build on and refine categories in the emerging theories (ibid.). I initially found it is impossible to know what categories would be important or what would emerge from my research. However, as data was collected from my interviews, theoretical explanations were developed and it became important to collect more data in order to refine and elaborate the developing or



constructed theory (Charmaz, op.cit.). Theoretical sampling is therefore iterative, it moves between data collection and analysis, collecting data to ensure that the developing categories (or clusters of ideas) are fully robust (Oktay, 2012).

Additionally, in all interviews I conducted I tended to ask all interviewees the same questions from my topic guide; however, with certain groups such as the community workers I tended to remove the more personal questions regarding what they ate and their own family background. Often, this was not relevant as they only worked in the local area and did not live there. With some questions, however, such as those surrounding the local GPs, I often asked the community workers what they thought about the local GP services in the area or for their thoughts on the adequacy of local services available to residents more broadly. Also, at the beginning of an interview with community workers, I always asked what their role within the area was as I found that this helped to contextualise the interview.

## Interviews

I will now turn to discussing my interviews in St Ann's, which includes a discussion of interview methods and practices I used throughout my interview process.

Broadly speaking, qualitative research is about exploring, uncovering, and making explicit the detailed interactive and structural fabric of the social settings that social researchers suspect to be sociologically interesting (Ezzy, 2002). This is a reflexive process where we often find ourselves assuming, to begin with, a naïve, almost childlike perspective, as we gather information from everything we encounter to build a stock of detailed knowledge, accounts, events, and so on, as a means of enhancing our own understanding of the setting and presenting this to others (Braun and Clarke, 2013).

In the case of my own research, there was no particular 'moment' where I consciously decided to go from participant observation to conducting interviews. For example, even after I started interviewing the older adults, I was still conducting some participant observation on other groups in the area (such as the parents and community workers). Usually, once I had started speaking to a particular group and built some sort of rapport, I would ask to interview them.

Qualitative semi-structured interviews aligned well with my central research question which was to explore the contrasting views between different individuals and different groups in St Ann's around health. I wanted to find out whether different people conceptualised their health differently from one another and what the interrelationships were with the neighbourhood. As previously identified, my literature review helped me to understand that health has often been understood very differently depending on who you talk to. I therefore needed a more 'open' interview setting as opposed to a structured interview which is more intensive and has a rigorous set of questions which does not allow one to divert (Ezzy, op.cit.). The purpose of an interview is to find out what is on a person's mind (Braun and Clarke, op.cit.). Interviews are conducted to find out from the individual those things that cannot be directly observed. I therefore aimed for the respondent's own perspective to emerge, to explore the ways in which people living together in the community share both common and differing understandings around health, to gain insight into particular experiences, to find out motives behind decisions, to get a view of informal procedures, consider apparent contradictions between attitudes and behaviour, and allow respondents time to provide their answers. Semi-structured interviews with both the residents and community workers allowed for new ideas to be brought up during the interview as a result of what each interviewee said (Ezzy, op.cit.).

The open-ended approach is clear from my topic guide. It can be noted from this guide that the first topic I covered revolved around their background. This included questions around where they lived and their family background. Secondly, I moved on to asking them what it was like to live in St Ann's and their daily routines. The third part of my topic guide was around health in St Ann's, so I would ask them about their thoughts about health broadly and what they thought health was like in the area. The final part of the interview was around their thoughts on the UK government's current 'five a day' programme as well as their thoughts on the quality of the local GP services in the area.

I also continued the semi-structured style in the various group interviews. In a group interview, a group of people are asked about their perceptions, opinions, beliefs, and attitudes towards a topic (Braun and Clarke, op.cit.). Questions are therefore asked in an interactive group setting where participants are free to talk with other group members (ibid.). I would still use my topic guide for these interviews; however, I would alter my questioning slightly so that I could create a group discussion around the specific questions and themes I wanted to find out about. Some questions would remain the same. For

example, my question “What do you think people’s health is like in St Ann’s?” This did not need to be altered for a focus group. Normally, I would ask this and one of my participants would start talking. Other members would then start to chip in and a group discussion on people’s health in St Ann’s would begin. On some occasions, one person in the group would answer the question and then stop talking. If there was a gap with no one speaking, I would turn to the other members in the focus group and say “So what does everyone else think about that then?” This would encourage other people to talk and answer the question.

In group interviews, I would tend not to ask so many of the contextual ‘about them’ questions listed at the beginning of my topic guide. It would have taken too long to individually go round every member in the group and repetitively ask them all of these individual questions. Instead, I would ask the group briefly about themselves and then directly cut to all of the questions about St Ann’s as an area and health in St Ann’s.

The majority of interviews tended to last for an hour. Group interviews would sometimes last for two hours. An exception was the first group interview with the older adults. I remember being with this group for an entire afternoon. Fortunately, I had an idea that this focus group would take many hours, and so I had prepared for this.

I prepared an information leaflet that I gave to all of my participants. This explained who I was, what research I was doing and why. It also addressed questions around confidentiality and anonymity. As a necessary pre-requisite for research, research participants should have full knowledge of the purpose and consequences of taking part in the research study (Ezzy, op.cit.). I always ensured my interviewees had this before I started interviewing them. Respondents also gave their consent with regard to the interview being recorded. I would save the voice recording on my iPhone and upload it to my laptop later when it came to transcribing it.

Throughout this thesis, all names are referred to by a pseudonym and all interview and focus group participants have been given pseudonyms to help protect their identities. The majority of names have been altered in a way that seeks to reflect the original names and associations with ethnic and social class backgrounds. For example, Charlotte may have been changed to Harriett and Adam to David.

## Ethics

According to Brewer (2000), in overt qualitative research, research participants should be given as much information as possible in order to ensure their informed consent to our intrusion to their lives. Taking this further, rather than passive ‘informants’ or ‘subjects’, research participants can be encouraged to take an active part in the research process, empowered where possible to contribute, direct, redirect, and guide the research in ways that ensure their own perspective is given due weight (ibid.). In the case of my own research, I explained to everyone I interviewed what I was doing and gave them an information leaflet. I usually described what I was doing as ‘bottom up’ in the sense that I told them it was their opinions and perceptions on their life that I was interested in. Residents often quite liked it when I said this, with some residents saying they felt exasperated at the usual ‘top down’ approach (being told what to do as it was ‘for the best’) carried out in the area by local government and other professionals.

## Interpretivism

I would describe my research as interpretivist. In this section, I explain the interpretivist approach and how it relates to my research. According to Seale (op.cit.) interpretivism is an approach to social science that opposes the positivism of natural science. Interpretivism therefore, refers to epistemologies, or theories about how we can gain knowledge of the world, which loosely rely on interpreting or understanding the meanings that humans attach to their actions. Interpretivism (ibid.) views individuals as actors in the social world rather than focusing on the way they are acted upon by social structures and external factors. According to Flick (2006), Weber, in an early critique of positivism believed that in order to understand human societies, we must begin with the individual actor, with the meanings attached to individual actions, with what was intended when choices were made, possible reactions reviewed, and an eventual action selected. Bryman (2015) identifies Weber’s point, that people do not always simply respond to external stimuli but often think and then choose how to react. So, in other words, they tend to attach meaning to what they do. The task for the sociologist is to try to understand, or interpret what individuals intend when they do certain things. However,

according to Bryman (*ibid.*), Weber also believed (following Kant) that it was impossible to gain objective knowledge of the world simply by using the senses. The sociologist has to make sense of, or interpret, what is observed, and inevitably he or she does this by drawing on his or her own cultural values. This does not mean being subjective and allowing values to affect the work, but rather being sensitive to cultural values and the relevance of meaning for action.

With regard to my own research, I did not always have this interpretivist approach. At the beginning of my research, I discussed earlier how I was only concerned with the positivist-influenced number of ‘chip eating people’ in St Ann’s. The interpretivist outlook was therefore a response to realising that this approach was not the right way forward in St Ann’s as it simply was not practical nor realistic. It was also irrelevant if I wanted to understand people’s interpretations around health. Specifically, I wanted to know whether there was an inter-relationship between deprivation, locality and health by exploring the views of different types of people. I wanted to look at the processes that lead to the behaviours that have already been identified in previous epidemiological studies. This bottom-up approach then involves interpretivism, since I view the individuals in St Ann’s as actors within their social world rather than focusing on the way they are acted upon by social structures and external factors. Of course, as discussed in later chapters, there were themes from interviews where different individuals would talk about other social structures and external factors (so not necessarily just talking about themselves). However, this was still their own interpretation of these factors and the meanings that they assigned to them. For example, in chapter 4, I argue that interviewees created their own meanings around certain places (such as the food bank, the community centre) and that these were all related to their health. Similarly, in chapter 5, I talk about the importance of routines to many of the residents in the area and what these meant to them. This links in with Weber, who argued that people tend to attach meaning to what they do and it is up to the sociologist to make sense of and interpret this.

A further thread in the fabric of interpretivism that relates to my own research is a hermeneutic understanding of the social world. For qualitative research, this can be translated as the interpretation of cultures (Pink, 2012). Historically, hermeneutics has its roots in the interpretation of biblical texts and hence critiques all notions of objective knowledge in favour of understanding through a merging of horizons with the producers of knowledge in order to begin to think like them (Bryman, *op.cit.*). This knowledge can

then be translated for other systems of meaning, such as social science, by a sort of double interpretation (ibid.). Knowledge production here then, is seen as a historical process of moving between parts and wholes, cultures and individuals, history and texts. Hermeneutics then, according to Pink (op.cit.) is the interpretation and understanding of social events through analysis of their meanings for the human participants in the events. It is an attempt to understand groups within the context of their (and our) wider cultures. The central principle of hermeneutics is that it is only possible to know the meaning of an act or statement within the context of the discourse or world view from which it originates (ibid.). According to Bryman (op.cit.), context is critical to comprehension; an action or event that carries substantial weight to one person or culture may be viewed as meaningless or entirely different by another.

An example of this in my own research is when I argue in chapter 4 that visiting a corner shop in St Ann's meant a place of convenience to the older adults, whereas for the middle-class residents in the area it was seen as a seedy and unpleasant place only to be visited if one was in dire need. People in St Ann's all lived within their own contexts and cultures. Therefore, in order to understand their actions and the meanings behind their behaviours, I write a little in later chapters about their backgrounds and the cultures they were involved in. I do this in some detail when I discuss the older adults, as I interviewed more in this group than any other. As argued by Saukko (2003), understanding lived experience and the meanings and actions behind behaviours can demand a hermeneutic approach that aims to understand lived realities. Similarly, as argued by Crawford (1984), health, like illness, is a concept grounded in these experiences and concerns of everyday life. While there is not the same urgency to explain health as there is to account for serious illness, thoughts about health easily evoke reflections about the quality of physical, emotional, and social existence (ibid.).

### Iterative inductive research

In deductive research, a hypothesis is derived from existing theory and the empirical world is then explored, and data are collected, in order to test the hypothesis (O'Reilly, 2005). In an inductive approach, however, this is where the researcher begins with as few preconceptions as possible, allowing theory to emerge from the data (ibid.).

At the beginning of my research, when I was purely interested in obesity, I had a deductive mind-set. In deductive research, a hypothesis is derived from existing theory, and the empirical world is then explored, and data are collected, in order to test the truth or falsify the hypothesis (Willis and Trondman, 2000). In this instance, in my own mind I had a hypothesis that revolved around “I want to see if there are many obese people in St Ann’s then ask them why they are so unhealthy”. However, it was when I began to conduct my participant observation in the area that my perceptions quickly changed.

According to Willis and Trondman (op.cit.), in an inductive approach, the researcher begins with as open a mind and as few preconceptions as possible, allowing theory to emerge from the data. Qualitative researchers often explicitly reject a deductive approach, arguing that the social world is too complex and messy for patterns, laws, and regularities to make any sense. Furthermore, they have reasoned, when data is collected with theories in mind that have already been formed into a working hypothesis, the focus of the research is restricted and perceptions distorted (ibid.). According to Bryman (op.cit.) with an inductive approach, theories are devised to explain what is seen rather than the other way around. This can be seen as ‘starting with a blank sheet’. Qualitative researchers often believe that if they begin their work with theories to test they will end up only seeing things through that specific lens, or focus. They will not learn as much about the group of phenomenon as if they began with a more open mind (ibid.). Additionally, researchers are less likely to be looking for patterns and regularities and more likely to be interested in the messier, complex worlds they participate in and observe.

However, as I found with my own research, it is naïve to think that a researcher can be entirely inductive. This is impossible to achieve. Everyone starts their research with some ideas about what they are interested in, and everyone leaves some people or some focus, or some group out of the picture. For example, even when I had created my new research questions and begun my first batch of interviews, I still had some preconceptions about what I was going to find. Part of me still expected to find an obese St Ann’s resident who would tell me everything I thought I wanted to hear. For myself, there was never a point where I was researching ‘from a blank sheet’.

In the end, I accepted that to an extent I had some preconceptions, some goals and theories, and practical limitations to my work. However, as time went on I tried to minimise the effect of these and even work with them as advantages. Bryman (op.cit.)

recommends keeping as open mind as possible to be able to see the complex nature of the world around the researcher and not to close the mind that would otherwise surprise them. Concepts and theories from other studies are also drawn upon as they become useful. This in itself involves a constant to a fro (an iteration), of participating, observing, writing, reflecting, reading, thinking, talking, listening, participating, in a circular rather than a linear way. This is therefore both iterative and inductive (ibid.).

## Analysis

Throughout my interviews, I kept a field diary, and so the first stage in my analysis was to review the notes I had made. I started noting down any ideas about possible emerging themes. I prepared a brief summary of the main points that emerged from my interviews and noted any particular issues in the form of ‘headers’ for future analysis. This process started very early on. Even during my early days of participant observation (prior to having my research questions) I began writing these notes.

A thematic analysis of all interview data allowed me to identify meaningful categories or themes from my data (Flick, op.cit.). Thematic analysis is the most common form of analysis in qualitative research (ibid.). It emphasizes pinpointing, examining and recording patterns (or ‘themes’) within data. According to Flick (ibid.), themes are patterns across data sets that are important to the description of a phenomenon and are associated to the specific research question. These themes then became the categories for analysis. Interestingly, thematic analysis is also related to phenomenology in that it focuses on the human experience subjectively (Silverman, 2011). This approach emphasises the participants’ perceptions, feelings and experiences as the paramount object of the study (ibid.).

As I mentioned earlier, I recorded all interviews I conducted so that I could view the text and data afterwards whenever needed. I did not need to transcribe all of the interviews, however. From analysing these interviews, I asked myself whether a number of reoccurring themes could be abstracted about what is being said. Indeed, qualitative researchers are frequently interested not just in what individuals say but also in the way they say it (Creswell, op.cit.). I would summarise my own analysis into the following steps:



- 1. I listened to all the interview transcripts and made notes of all the responses that related to my research questions
- 2. Broad headings relating to the research questions were created on large sheets of paper and sub-headings were added to include more specific detailing, and to help avoid the danger of over-generalising. Illustrative quotations from participants were added under the relevant headings. However, the majority of quotations and further notes were put into various word documents. I refer to this as my memoing.
- 3. I wrote up my field notes under the identified headings and sub-headings, with some commentary to provide a 'story' of the research findings – essentially, who said what - and asked my supervisors to comment. By now, I was aware I had some pertinent themes and findings that would likely form the basis of my arguments for my entire thesis.
- 4. Since I now had my themes, I could divide them into chapters. However, I needed to re-examine my interviews when writing my chapters. This involved identifying additional themes as appropriate and making decisions about the weighting; e.g., common and rare perceptions, outliers that were significant in some way (e.g., refuting or supporting the literature).
- 5. Chapters were revised and altered as I received feedback from my supervisors. How I thought about my data and themes often changed as I decided some findings would be better suited for different chapters.

So, the purpose of this approach was to accurately illuminate the key themes from my interview data and begin to order them into chapters. Next, in my first empirical chapter, I discuss how these themes began to emerge from my interview questions and how these were formed into chapters.

### Chapter 3: How health was discussed in St Ann's

In my interviews with people in St Ann's, I asked them a number of questions about themselves, their neighbourhood, their health as well as health in the context of the neighbourhood. The purpose of this approach was to find out about the context of their lives and the broader neighbourhood. Additionally, I sought to find out how they made sense of their own health and what they thought made people healthy.

In this mainly descriptive chapter, I show how my different themes arose from my interview questions. I firstly discuss how health was spoken about in St Ann's when I asked residents about their access to local shops and facilities (Meanings of Places). Secondly, I discuss my questions that were not directly related to health. Importantly, the themes of 'othering' and 'practices' emerged from these contextual questions (not to do with 'health') regarding what it was like to live in St Ann's and people's daily routines. I compare how different people in St Ann's responded to all these questions paying attention to the way in which health was discussed. I also discuss how my participants 'shifted' my research from what I perceived was health to other issues that they considered pertinent to health. These themes form the basis of my subsequent empirical chapters.

Questions on access to local shops in the area involved me asking residents how they felt about what was available in the local area. In responding to these questions, the working-class residents placed an emphasis on how a 'shop' extended beyond the simple 'a place to buy food' into other meanings. Places were not simply somewhere to 'visit' for the working-class residents. They were places to gather at, to walk to that have a pertinence for the wellbeing of the community as a whole. When shops or markets are closed down in the area, working-class residents felt hurt by this. These places created a lively community and enabled residents to interact with one another. Middle-class residents on the other hand did not highlight this. They viewed most places in St Ann's in a negative light. I was surprised to find how this group would 'go out of their way' to avoid the local shops in the area and in some cases, drive a considerable distance to reach their local supermarket.

Questions on daily routines in St Ann's involved me asking residents what a typical day was for them. The older adults placed an emphasis on being able 'to do what they want', such as take a walk to the shops and eat foods that one would not normally associate with health such as 'fish and chips'. Older adults also made comparisons between themselves and 'other' residents, who were not able to eat three meals a day and were housebound. Unable to feed or dress themselves and looked after by a local nurse, these residents were viewed as 'poorly'. From my interviews with community workers on the other hand, I argue that they placed an emphasis on the way their daily routines were helping the St Ann's residents. Being able to care for people who were sick or vulnerable as opposed to themselves was important to them. Conversely, the middle-class residents discussed their daily routines with emphasis on themselves, their own lives and careers. By discussing their exercise routines in interviews, and how visiting certain places daily (such as a gym), they discussed how this enhanced their bodies.

Thirdly, in the section 'question on health and exercise' I would ask residents about their views on health and exercise in general. I explain how the responses changed when I began to ask certain groups about exercise in St Ann's. I was expecting that they would respond detailing their exercise routines, or explain why they did not exercise. However, the reply of laughter I received when asking older adults about health and exercise contrasted with the detailed exercise routines I received from the middle-class groups. Contrasting again, I argue that the working-class residents brought up the topic and importance of place and the people within their physical environment when I asked them about health and exercise.

Fourthly, when asking residents questions about health, I expected my respondents to talk about health from the public health perspective of 'eating five a day' and taking regular exercise. The middle-class residents of St Ann's did, indeed, discuss health in these terms, placing an emphasis on the importance of exercising regularly and eating certain foods. In other instances, health was talked about by the majority of all residents in terms of 'illness' and the existence of high levels of lifestyle related diseases in the area. For example, residents highlighted overall poorer levels of health in the area due to an aging population and higher indices of smoking and alcohol consumption. However, in the majority of interviews with participants, health was discussed from a dimension that I did

not expect. For example, health was often discussed as being ‘poor’ in the area, however many residents, such as the older adults laughed and made jokes about gyms when I asked them traditional questions regarding health and exercise.

In the fifth and final part, I asked all respondents a ‘Question on health in St Ann’s: Similar or different to others’? After asking residents about people’s health in St Ann’s, and their personal views on health and exercise, I would ask whether they thought their health was similar or different to other residents in the area. There were polemics in responses here too. I argue that the middle-class residents thought their health was ‘better’ than the working-class residents because they thought they ate ‘better’ than them, exercised regularly and avoided carbohydrates. The older adults also thought that some residents had ‘worse’ health than them, however I argue that they felt ‘sorry’ for these residents as they were not able to visit the shops for example. The older adults would support those who were more housebound. Conversely, the working-class residents were very critical of one another. They often viewed their health as ‘better’ than the other residents in the area; however, they highlighted that this was due to some residents being ‘fat’ and ‘lazy’ and so not deserving of sympathy.

To make sense of these responses, firstly, I use some pertinent sociological work (Crawford, 1984) to set down a theoretical framework. Crawford’s (ibid.) work argues that health is a concept that is grounded in people’s experiences and concerns of their everyday life. Talking about health then, is a way people give expression to their culture’s notions of wellbeing or quality of life. I relate this to my own work.

A significant finding from my own research (that flows through every chapter) centres around how health was grounded in people’s experiences and concerns of their everyday life. According to Crawford (ibid) health, like illness, is grounded within this. Additionally, different people had contrasting understandings of health. While there is not the same urgency to explain health as there is to account for serious illness, thoughts about health easily evoke reflections about the quality of physical, emotional, and social existence. Crawford (ibid.) argues that, like illness, health is a category of experience that reveals tacit assumptions about individual and social reality. Drawing on this concept, one could say that for people in St Ann’s, talking about their own health was a way to give expression to their culture’s notions of wellbeing or quality of life. Health is

therefore a 'key word', a generative concept, a value attached to or suggestive of other cardinal values.

To further illustrate what this means it is useful to discuss Crawford's (1984) original study, in which he interviewed sixty adults in the Chicago metropolitan area about their health. He introduced himself to respondents by saying he was writing a book on how people think about health. He did not aim to speak to specific demographic characteristics since he was not interested in one particular group or in comparing the views of two or more groups. Two-thirds of those interviewed were white, middle class, under forty, and female. This is a pertinent point, since in my own research I have been interested in comparing the views of different groups of people. However, Crawford's work is still interesting and relevant, since he sought to find out people's understandings about health.

In Crawford's (1984) interviews, an unmistakable theme ran throughout. Health was discussed in terms of self-control and a set of related concepts that include self-discipline, self-denial, and will power. When people talked about threats to health, explanations for health, or prescriptions for maintaining and improving health, one or more of these related values frame the discussion and set the moral tone. Crawford shows that since the mid 1970's in the United States and the UK, the boundaries of what is popularly considered essential health behaviour, or minimally responsible health behaviour, have been expanding (Crawford, op.cit.). The new health consciousness has ushered in an era of rising expectations fixed on improving or protecting the body. As I discussed in my methods chapter, I held a similar outlook on the people who lived in St Ann's prior to starting my research. I believed that the people in St Ann's were not following the necessary 'essential health behaviours' in order to stay healthy which is why the area, statistically, fared poorly in terms of health. I believed that there were certain expectations everyone needed to follow to be healthy such as regular exercise and eating five a day. I believed that people therefore needed empowering with discipline, to enable them to refrain from eating too many chips and to get them to visit the gym regularly. Once they did what was expected of them, they would become healthy.

Crawford (1984) found that the changing standards about smoking, diet, and exercise made some of his respondents feel unhealthy by the mere violation of one or more of these taboos or the failure to do something active for one's health. To be healthy is almost equivalent to pursuing health through adopting the appropriate disciplined activities or

controls. The means to health acquire the quality of an end in themselves. However, my findings were rather different in this regard, as I go on to explain.

For Crawford (op.cit.), health was also viewed as a ‘release’. Interestingly, ‘release’ is very much the opposite of ‘self-control’ or discipline. The ‘release’ theme suggested pleasure-seeking rather than ascetic self-denials, the satisfaction of desire instead of the repression of desire. In these interviews, there existed a language of well-being, contentment, and enjoyment. There was a resistance to changing lifestyle, a defiance of health promotion models or an attempt not to worry about the multiple threats to personal well-being. Health is not rejected as a value, but it is often repudiated as a goal to be achieved through instrumental actions. In this theme, health is understood more as an outcome of the enjoyment of life and the positive state of mind derived from such enjoyment. Health was seen as ‘feeling good’, as distinct from following the rules of the health medical authorities.

So, Crawford’s (1984) study sheds important light on how wide - ranging beliefs surrounding health are. These beliefs are underpinned by an individual’s identity, their emotional and social wellbeing as well as their personal morals.

### [How do you feel about what’s available in the local area?](#)

During all of my interviews, I would ask all of my respondents about specific places in St Ann’s. These included questions about the access to local shops in the area, and whether they thought there were sufficient ‘food outlets’ to provide residents with a variety of healthy food choices. Initially, I expected my interviewees to say that there were not enough local shops, and that health in St Ann’s suffered because some residents (such as the older adults) were unable to access the healthier foods and so instead visited the corner shops that only sold cigarettes and alcohol alongside some ‘unhealthy’ frozen foods. Indeed, while some residents did highlight the lack of leisure facilities and proximity of local supermarkets as a problem, I actually found that places in St Ann’s had a diverse and broader meaning to different groups of people.

Caroline was a 45-year-old working class resident with a 16 year old daughter who had lived in St Ann’s for over ten years. I met her while I was in the St Ann’s library. When I asked her about what was available in St Ann’s, she said the following:

*Tom: ‘... How do you feel about what’s available in the local area do you think there’s enough shops?’*

*Caroline: ‘I think it’s limited... We’ve just got the Haram foods but to be fair it’s just too far to go to Haram foods for me... What we do is go the one in Broadmarsh [City centre]... there’s an Asda on sort of Radford way but again that is quite a limited one... shops around here there’s virtually nothing... [corner shops] it all tends to be the same thing that they’ll sell you’ll get some pizza, some chips, some peas... We do have Oceana [outskirts of St Ann’s] but the trouble is... a lot of their products they sell are in mass bulk... so you can’t always...want to go and buy a box of two thousand poppadum’s for example!’*

While many residents like Caroline highlighted the lack of large shops in the local area, a number of residents highlighted how the importance of a shop extended beyond the simple ‘a place to buy food’. This triggered a shift from thinking about ‘places’ as simply somewhere to visit, buy what one needs and then leave, to issues around the significance and meanings of places for the wellbeing of the community. For example, Alec, a 52-year-old working-class male who had lived in St Ann’s for over twenty years:

*Tom: ‘...In terms of the local area...quite a few people have said that they don’t shop in the local area and I wondered why that was...’?*

*Alec : ‘Yeah the shops were dear, the corner shops... I think you need decent shops around you build this community when I first came here the market area on a Tuesday was massive it stretched right across the chase now you have a fruit and veg store... it just seems shame... [it used to be] a buzzing market place... you need more bringing back to this area cause’ that is going to make the area back what it was in the centre of St Ann’s. And most people kind of meet here and that... I think that needs to come back and probably will when the building of shops has finished’*

The above example is interesting as Alec highlights how a shop is somewhere to ‘meet’ and can make the community ‘buzzing’. Alec firstly highlights that corner shops are expensive, but then places an importance on shops being able to ‘build’ the community. He reminisces about a period when he first came to St Ann’s and

there was a large market the filled the entire Chase area in St Ann's. This encouraged people to go out and gather here in the open market and created a lively community.

Interestingly, there has been recent debate and interest around the state of the white-working class in the UK in terms of how residents in deprived communities relate to their neighbourhoods. In McKenzie's (2015) book 'Getting by', she asks if the white working class in the UK are slowly becoming invisible. She highlights the way in which some white working-class communities in St Ann's felt overlooked by the government due to the closure of the local services in the area, such as shops and markets. This results in this section of the community feeling ignored and marginalised, as their local places and resources are taken away from them.

Gough et al (2005) have put forward an interesting argument regarding the closure of local places. Despite the local value systems being utilised by residents in poor neighbourhoods to create a sense of community and identity, social capital, networks and relationships are being undervalued and diminished in poor neighbourhoods through "*a capitalist logic to locally supplied services*" (p. 118). What Gough et al (2005) describe here is the closure over the last 20 years of many local services within poor neighbourhoods, such as St Ann's. Retailers have been forced out of poor neighbourhoods through profit-rate targets and have concentrated their business in wealthier neighbourhoods. In addition, local banks and post offices have increasingly closed offices in poor neighbourhoods.

The last local bank in St Ann's was closed in early 2000's. The small independent shops in the area have focused much more on selling alcohol, cigarettes and lottery tickets, rather than food or newspapers, in order to increase profits. At the same time, local public houses are closing at an alarming rate, leaving little social space for residents to meet up.

This is where the social exclusion discourse (discussed by Gough et al, 2005) might be beneficial, showing how social capital is being undervalued and destroyed through the actions of the market rather than the actions of the residents in deprived neighbourhoods such as St Ann's.

While the working-class residents tended to place on emphasis on how the various places in St Ann's had an importance that extended beyond them as 'food outlets',



the middle-class residents I interviewed in St Ann's did not say this. In my interview with Jonathan who I met during my time studying at Nottingham Trent university, he said the following when I asked him about the available shops in the local area:

*Tom: ‘..Do you shop like more in the local area because Aldi is kind of the border area...’?*

*Jonathan: ‘...Two shops down the road on the high street Carlton Road are just... if I need milk or eggs or something like that I’ll just nip down there just for convenience...’*

*Tom: ‘But you wouldn’t go in there very often for a big shop...?’*

*Jonathan: ‘Oh no there’s not enough it’s mainly like frozen food or pop and crisps or stuff like that... and it’s too expensive to do it as well I suppose’*

In the above interview, Jonathan explains that he doesn’t shop in the local area due to a lack of availability of the food he buys as well as it being too expensive. Importantly, Jonathan does not mention that it is unfortunate that there is not enough shops in the area, or that the community has suffered because residents do not have anywhere to gather to or walk to (such as a local market). This was common during interviews with middle-class residents: local shops and places were always viewed in a negative light. In later chapters (Meanings and Othering) I discuss this further, explaining the middle-class residents tended to avoid going into the area of St Ann’s whenever possible as they found the local shops seedy. Instead, they would make a conscious effort to shop further afield such as in the city centre. They saw little value in the local shops in St Ann’s, often viewing them as detrimental to the local area.

In chapter 4, I discuss further how different places had different meanings for different groups of people. Shops were not the only places discussed in interviews. Parks, walkways, bars, the community centre, the Church, the food bank, gyms and various other ‘clubs’ were also highlighted in various interviews and these will be discussed in this chapter.

To sum up this section, while many residents in St Ann’s highlighted the lack of available shops in the local area, there were a number of instances where residents highlighted how the importance of a shop extended beyond the simple ‘a place to buy food’ into other

meanings. Places then, are not simply somewhere to ‘visit’ for the working-class residents. They are places to gather at, to walk to that have a pertinence for the wellbeing and social inclusion of the community as a whole. When shops or markets are closed down in the area, working-class residents felt hurt by this. These places created a lively community and enabled residents to interact with one another. Middle-class residents on the other hand did not highlight this. They viewed most places in St Ann’s in a negative light. I was surprised to find how this group would ‘go out of their way’ to avoid the local shops in the area and in some cases, drive a considerable distance to reach their local supermarket.

### What is a typical day for you?

During all of my interviews, I would first ask all respondents specific contextual questions; for example, about their backgrounds, their families and their day to day routines. Initially, I sought to ask these questions so that I could gain some rapport with each respondent and find out about their social context. However, I soon realised that some of my most interesting data was arising from these questions. This data would form the basis for two of my empirical chapters (Practices and ‘Othering’). Interestingly, health was not explicitly mentioned by respondents in answering these questions but was instead often talked about as ‘practices’ or/and ‘othering’. Additionally, responses to these questions varied depending on who I interviewed. As an example, I will now discuss how three different groups people responded to these questions about their daily routines.

In the example below, I interviewed a group of older adults who lived in terraced council accommodation in St Ann’s. They told me they spent the majority of their days sitting out in the communal area together drinking cans of Carling (a type of lager), watching films and talking to one another. When I asked them about a typical day, they said the following:

*Tom: “... So, what would a typical day be for you then... what’s your...?”*

*Sylvia: “Well we have fish and chips on a Friday”*

*Clyde: “Oh on a Friday sorry”*

*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’’*

*Sylvia: ‘‘Their own thing’’*

*Clyde: ‘‘It depends what they want. I mean I think most people, most people eat fairly well*

*Sylvia: ‘‘No they do’’*

*Clyde: ‘‘You’ve got one or two who don’t but...’’*

*Tom: ‘‘Who aren’t eating well?’’*

*Phil: ‘‘Who don’t eat or... but they’re normally looked after by somebody else like’’*

*Sylvia: ‘‘They’re poorly’’*

*Clyde: ‘‘I mean they make sure they get something to eat kind of’’*

*Tom: ‘‘Cause’ some people can’t eat three meals a day for whatever reason?’’*

*Clyde: ‘‘No, no’’*

*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’*

*Clyde: ‘‘Yeah, he needs to be looked after doesn’t he, yeah’’*

In the above example, I did not expect them to respond telling me what ‘unhealthy’ foods they ate (fish and chips), especially as they knew I was doing some research on health in St Ann’s. Therefore, this first response was surprising. However, later on in the above transcript, the group places an emphasis on the importance of being able to ‘do what they want’ as a group, as well as drawing comparisons with the ‘other’ residents nearby who are not able to eat and are looked after by ‘somebody else’. Sylvia views these ‘other’

residents as ‘poorly’, having to rely on people to feed them their three meals a day. Therefore, a straightforward question to this group of older adults about their daily routines yielded responses placing an emphasis on having the ability to eat three meals a day and not be cared for and dressed by nurses. Residents who were not well enough to do this were viewed as ‘poorly’.

While older adults comparing their own health with ‘others’ in St Ann’s was a common occurrence in the area, being able to ‘get about’ was also seen as important for their health and wellbeing. In another interview with an older adult, when I asked Mary about a typical day for her she said the following:

*Tom: “So, what would be a typical day for you then usually”?*

*Mary: “ Mary: “Well I get up at about half seven, eight... except this morning... and then get Reece’s [that cat] food done, make a cup of tea sit down drink my cup of tea have a couple of biscuit. And then normally I’ll get up and go and get dressed. And then I’ll go up to McDonalds and get a breakfast... I used to go to that one in town... oh God... Yes the one opposite the bank but then I got into an argument there... well I didn’t get barred or anything... [After she’s been to McDonalds]... I normally go and get bits of shopping and come home and take me tablets and go back to bed for two hours” (Mary, 76).*

In the above example, Mary identifies some of the things that she associates as being important for her (visiting McDonalds, the betting shop and eating biscuits for example). Interestingly, these activities are not what one would normally associate as being ‘healthy’ activities. However, for older adults like Mary, these activities and ‘rounds’ are important for their wellbeing. In my chapter ‘Practices’ I analyse this further.

When asked about their daily routines, the community workers gave a very different response in comparison to the older adults in St Ann’s. Instead of being concerned with being able to do ‘rounds’ and being ‘out and about’, or ensuring that they ate three meals a day and comparing themselves to ‘others’ who could not, the community workers rarely discussed their own health. Instead they focussed on their own routines and how they could help the St Ann’s residents they spent their time with. In the below, Julie, the St Ann’s vicar said the following when I asked her about her routine:

*Tom: ... What would be a kind of typical day for you living in the area?...*

*Julie: Erm, so we always pray at 9. This morning it was at half past eight for half an hour so... Sometimes chat to parents bringing their children to school or engage with parents, you know between half eight and nine. And then if I'm working in the area I'm either based here at the house, or in the church. Or I'm out and about with you know going to visit people so I'll do that if it's in walking distance. I'll walk but er most of my time I'm in other parts of the city (unclear) ... So I either ... walk into town for meetings and that sort of thing. Or I'll drive to things I'm involved with. So a typical day is quite hard to describe apart from that point in the morning which is where we start erm yeah''*

In the above, Julie discusses the importance of her role in the area in caring for other people as opposed to herself. As I discuss in later chapters, the community workers rarely discussed their own health even when asked directly about it. Being 'engaged' with the community is important to Julie, as well as visiting people who need her help. Conversely, the middle-class residents placed an emphasis on themselves and their own lives when asked about their daily routines. When discussing their daily routines, middle-class residents tended to view their bodies in more of an aesthetic, cultural manner. Their routines involved visiting certain places (such as the gym) to enhance their bodies. They made a point about wanting to 'look good' and 'be slim'.

For example, I met Sam while we were training in a gym, which was located on the border of St Ann's. It is immediately noticeable from the tone of the interview that Sam had an outlook that was different from the other St Ann's residents discussed previously in this chapter. Having been to university and now looking for full-time employment as well as his interest in fitness he was planning his life ahead. This highlights a significant difference then from the older adults and community workers. When I asked Sam about his daily routine he said the following:

*Tom: "So tell me about your typical day living here"?*

*Sam: "...I'm up about quarter to eight. I'm lucky to be able to have breakfast at school so I eat when I get there. I get half an hour for lunch so living so*

*close I just come back here and just cook what I want for lunch. I finish at four so it's eight till four. And it depends on what days, like Tuesdays when I finish I can come straight home and do what I want. Mondays er I used to coach Monday evenings but now I'll be doing (unclear) work so finish school, go and do two hours of (unclear) work and then go to the gym and come home relax and go to bed. Erm, Tuesdays I've got a four day contract at the school so I have Wednesdays off so normally I either... one of my friends I grew up with at school we tend to go out and have a couple of beers on a Tuesday night, which is quite nice. Erm Wednesdays I used to be coaching whereas now I'm looking for more work on a Wednesday, but it used to be coaching it only changed round last week and I had a job interview. And then I dunno about this Wednesday. And then Thursdays the same. I've got rugby training Wednesdays as well, Wednesdays and Thursdays and then weekends it just depends on what's going on really...' (Sam, 24)*

In the above interview, not only were the practices carried out by Sam very different to the older adults (going to a gym, coming home to cook, going to work) but most of these practices were situated outside of St Ann's. Also, the activities that he is engaged with are officially 'organised', such as rugby coaching, rather than informal walking in the area or visiting people. The routines of the middle-class residents also involved practices that they did to consciously advance themselves and their health. They would sign up to an institution such as a gym or a rugby coaching club to be able to increase their skill at a specific sport or achieve a fitness goal.

To sum up this section, I detailed how an interview question asking about daily routines gave varying responses depending on who I was interviewing. The older adults placed an emphasis on being able 'to do what they want', such as walk to the shops and eat foods such as 'fish and chips' which would often be deemed as 'unhealthy'. Older adults also made comparisons between themselves and 'other' residents nearby who were not able to eat regularly and were housebound. Unable to feed or dress themselves and looked after by a local nurse, these residents were viewed as 'poorly'. Community workers on the other hand placed an emphasis on the way in which their routines were helping the St Ann's residents they spent their time with. Being able to care for people who were sick or vulnerable as opposed to themselves was seen as important. Conversely, the middle-

class residents discussed their daily routines with emphasis on themselves, their own lives and careers. They would discuss their exercise routines in interviews, and how visiting certain places (such as a gym) was enhancing their bodies.

### What are your views on health and exercise?

Interestingly, further responses that I did not expect arose when I began to ask certain groups in St Ann's about exercise. I asked all of my participants a number of questions about this. I thought they would respond stating that they either did exercise and saw value in it, or respond saying that they didn't but felt that they 'should' exercise.

For the older adults, the reply of laughter I received when asking older adults about health and exercise was quite common and surprising for me. The overwhelming finding from nearly all interviews is that topics related to the UK government's recommendation of eating five a day, or exercising for thirty minutes five times a week they felt was completely irrelevant to them. When I would ask the elderly about exercise, they would usually make a joke before answering the question. The below excerpt is from a focus group I conducted:

*Tom: ... "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 other person] can just about walk to that door! (laughs) And he just uses it now for fun, he could get up and run around it he can. (laughs). But no, we're not very good but you get by.' (Vincent, 85)*

In the above, Vincent is clearly 'not the sort' to exercise. The idea of exercising to him is so bizarre he finds the thought humorous.

In one qualitative study by Nettleton and Green (2014) the interviewer asked a group of South Asian Muslim women living in London why they did not cycle more often when going about their day to day business. Asking whether people considered cycling to work

was met by the frequent assumption that the question was a joke. Clearly, respondents were obviously ‘not the sort’ to cycle. The absurdity of the question is derived from the way in which it articulates the implicit – so what goes without saying – and is recognised through the humour it generates:

*‘Shila: “So, if you're using the bicycle, what about the children? How are you going to bring them to school? You have to ride the bicycle, and where are the kids? [All laugh] Where do you put them? So, that's not a good idea!”’*

*Deepa: “And another thing is that, because everyone lives in a flat, and there's not enough space, so where would you put your bike?”’*

*Anjali: “And it's not useful for us because we, if we wear a jilbab, how are we going to ride a bike?” “ (Nettleton and Green, 2014. p. 242).*

In the case of my own research, asking the elderly if they do typical exercise (join a gym, go for jog and the like) was completely absurd to them. As one of them mentioned in the above, most of the elderly participants in this focus group I conducted could just about walk to the door at the end of the room. Most of them (n=5) therefore went about their day to day business on electric scooters. However, this act of being able to go out on their scooter and having the physical ability to leave the house every day was seen as important. This theme of ‘dailyness’ and routines will be covered later (chapter 5).

Sometimes I did receive a considered response to my question after the laughter had died down. Or, some older adults would answer the question without humour and begin talking about walking in the area and their routines. They would usually talk about this in terms of specific routines they carried out daily. This was a significant theme among older adults that came out in the majority of interviews with them. I discuss this in chapter 5. However, this theme is important to mention here because it is about their health being immediately placed in the context of their daily routines. When I asked Stan (77) about health in the area he said the following:

*Tom: “I mentioned you know my research was about health in the area. So I mean kind of eating, exercise, diet things like that. Do you have any thoughts on these, what do you think about?...”*



*Stan: Well I walk about fifty mile a week... I do yes I know I do. Because people tell me they tell you do you know Pat yes, do you know who his dog is who goes down there they so oh I was out with him... I go down there up Glasshouse Street, across where them lights are on the lift then under the subway and back through the thingy...' (Stan, 77)*

For Stan, being healthy meant being able to walk his dog at 5am every morning along a specific route. Other older adults tended to talk about being able to get up in the morning, leave the house, go to the local shops, put a bet on, use your bus pass and have the ability to potter about. For the older adults, exercise in St Ann's was often about 'doing rounds' the same way every day. This sometimes included McDonalds, as in the example of Karen, quoted below. In the following below example, I was surprised to find that health for Karen meant being able to carry out tasks that one would not normally associate with health. it. I met Karen while I opened the door for her to leave the community centre one afternoon on her mobility scooter:

*Tom: "I mentioned you know my research was about health in St Ann's. So, I mean kind of eating, exercise, diet things like that. Do you have any thoughts on these generally Mary?"*

*Karen: "Well I get up at about 8 or 9... except this morning there was builders banging and rattling next door. I wanted to hit them over the head with my stick. I make food for the cat, sit down with me cup of tea and have some biscuits. I eat Cornflakes, but I only like them soggy, so I leave them in milk for about half an hour... if they're still crunchy I never eat them. And on Fridays I have Coco Pops. And then I get up and I'll go to McDonalds or KFC for breakfast. Then I come home and put my pyjamas back on and have a nap. Diabetic you see, I get tired easily... and I always fall asleep when I wear my pyjamas."*

Therefore these examples show that the sorts of things one would not normally associate with health (visiting McDonalds, the betting shop and eating biscuits and Coco Pops for example) have in this instance become part of wellness for these older adults. I analyse why in later chapters. Indeed, the things that I did personally associate with health, such

as regular exercise discussed by the middle-class residents, were often seen as an inapplicable alien concept by some older adults.

When it came to asking the middle-class residents who lived in St Ann's about their own health and exercise, this group never laughed at the absurdity of the question or attempted to explain why exercise was not applicable to them. This group turned out to be significantly different in comparison to the working-class older adults. I expected that they would talk about wanting to eat 'five a day' and take good care of their health, however this was often not the case with this group either. For example, when asked about health in St Ann's, body image was a theme often discussed by the middle-class residents. Interestingly, in the interviews I conducted with the working – class residents, it was not mentioned by them. Middle-class residents frequently started talking about how it was important for them to have a specific kind of body, particularly a thin or toned one. The men also said this, but with more of a focus on being 'physically fit' and feeling the need to 'look good':

*Tom: "...as you know my research is about health in the area, so let me ask you broadly first, erm when I say that I'm talking about weight, exercise diet, can you just tell me broadly your thoughts on these...things basically, these topics?*

*Chevorne:... Erm, so weight, I think well I mean myself personally like I know objectively that I'm fine for my weight. But I'm always like constantly oh lose a bit more weight just a little bit more and it has nothing to do whatsoever with my health I couldn't really, I don't care much about my health it's more just looks like that...*

*Tom: The aesthetic side of yeah...*

*Chevorne: Exactly, I just want to look thinner I don't you know, my arteries could be clogged up on the inside, I'm like yeah as long as I look thin I'm like yeah that's the important thing...erm...' (Chevorne, 25)*

In this excerpt, Chevorne started talking about her desire to keep thin, admitting it did not necessarily or primarily have to do with health but to look a certain way. As such, others have found that people frequently talk about being slimmer and looking good when

talking about health, often relating this to the idealisation of thinness in the media (for example, Tiggemann, 2002; Paxton, Schutz, Wertheim and Muir, 1999). However, what is interesting here is that this interest in the body image and being thin was not common among the more working class residents in St Ann's. Chevorne is explaining that she is not concerned about health in the typical sense (eating five a day and getting plenty of exercise) but she is concerned with wanting to be thin and this was typical of To sum up, the middle-class group in St Ann's. talked about health and exercise in relation to body image and being 'slim'. They were Middle-class residents like Chevorne were rarely concerned about being 'healthy' or eating five a day. Instead, they wanted their bodies to be aesthetically attractive and 'in shape'.

The same questions about health and exercise I asked to the working-class residents in St Ann's met with different responses.

The working-class residents frequently brought up the topic of place and the people within their local place in interviews. For example, Rachael was a working-class resident who had lived in the area for over twenty years in total. She had during that twenty years briefly moved away from the area due to personal circumstances, but said she came back is she felt that this "was where her home was". She was one of the people who ran the children's scouts group in the area and so she made a point about being "hands on" in St Ann's every day with the people. Rachael began to talk about the importance of the local park when I asked her about health:

*Tom: "I mentioned my research was about health in St Ann's and when I say health I'm thinking first maybe the typical things associated with... so weight, exercise, diet, mental health and I just wondered if you had any thought about those things in the area really?"*

*Rachael. ... "Any views on [health]... I mean they do play in the park scheme at the minute where er they do send workers down on a Thursday evening to our local park... Unfortunately, it's only for a very short period of time... there are quite a few parents that will only allow their children to go and play in the park at that time. Since once a week, other than that they're not so keen to send their kids across because they'll have their footballs pinched or various other things... I mean they're very good at putting up a lot of no*

*ball signs up but not so good at er... enforcing them... And as for healthy eating, I mean we are quite limited. I know we're on the edge of town, but I mean you get the market here and it does have a couple of stalls. It would be nice to see that encouraged to grow, you know having more choice on fruit and veg cause' the stalls we do actually have in St Ann's there's not much on that front it's mainly sweet shops or you know takeaways (laughs)...'*  
 (Rachael, 44)

So, in contrast to the interviews with the middle-class residents, when asked about health Rachael does not talk about herself or the body or a particular diet. Neither does she laugh at the absurdity of the question. Having spaces such as a park where their children could go and play was clearly important. Rachael talks about these parks and stalls for vegetables and there mainly being shops with sweets for children. In other words, for Rachael, it's the place that needs to be healthy rather than personal behaviour.

Rachael and other young working-class parents were reluctant to send their children to the park as they would have their footballs stolen from them by the 'big boys' often highlighted this story again when I asked them specifically about exercise. These parents in their responses, however, were not talking about exercise as such, but used terms such as 'letting off steam' and 'some play time' after school.

As an interesting note, when I would start talking about health and place with the working-class residents, it was common for the interview to go off on a slightly different tangent. For example, when the parents would discuss the football incidents in interviews, they seemed aggravated and annoyed by the whole saga. However, there were some other forms of anti-social behaviour that took place in St Ann's on the subject of safety that parents usually took in a very light-hearted manner. I give examples of this in later chapters.

However, it is important to acknowledge the significance that life stage may have had in shaping how the middle-class and working-class individuals responded to my questions about their health concerns and choices. For example, the majority of the middle-class residents I interviewed were young and between the ages of 20 and 35. While I did interview some working-class residents in this age range, the majority of my interviewees were over the age of 35. As a result of these ages, many of the middle-class residents

were just starting out their careers and so they were often in education or aspiring towards a particular profession. The majority of the working-class residents, as a result of being a little older, were either already working or more ‘settled’ in their lives. Life stages of these two groups may therefore have shaped how they responded to the questions about their health concerns and choices.

### What do you think health is like in St Ann’s?

As well as asking residents about places in St Ann’s and their daily routines and exercise, I would also ask them about health in St Ann’s. This question also yielded some unexpected responses.

Margaret was a middle-aged single woman who regularly visited the community centre (usually on a daily basis) to have a chat with anyone who was there. She told me that she spent most of her time during the day either “at the bingo hall” or “somewhere on the St Ann’s chase area”. When I asked her about health in St Ann’s, she said that health was poor in the area:

*Tom: “What do you think people's health is like in the area generally then?*

*Margret: “Er.... (laughs)... I know we've got a high amount of smokers (laughs)... We've definitely got a high amount of smokers... (coughs) high amount of drinkers... there are some good active people, but I would say there are definitely two different kinds of people on the estate when it comes to this...and there's an awful lot of them that will rather go and buy a scratch card than pay a pound on their child doing an activity when they can see that they could just kick them out of the back door and go to the park. You know, we get a lot of that so and then they don't go to the park they just you know end up going and finding somebody and start smoking...” (laughs) (Margret 54).*

The above was a common theme in interviews some residents. I mentioned earlier that in most interviews with residents, health was (at first) talked about very generally with

regards to what they thought health was like in the area. Although health was seen as poor, this was seen to be due to the high incidences of smoking and drinking in the area as well as an aging population (such as the above example).

Interestingly, the theme of health being poor in the area ran across all of the groups that I interviewed. In the below example, Vicki who was the vicar at the local St Ann's church said the following when I asked her about health in St Ann's:

*Tom: "What do you think generally people's health is like in St Ann's?"*

*Vicki: Aha, well I don't know if I would know that particularly. Ah, the community that I deal with is an ageing community. Erm and I think... what do I think how could I comment on health and what I compare it to?... I suppose as a generalisation I would say that there are so... I wouldn't know what this area, well I know what the statistics say...So, er and but I suppose what I come across is mental health, erm a lot of cancer and an aging population who become more and more housebound... I also am aware of a lot of isolation amongst the elderly, erm and you know mental health I think there's an awful lot of issues around.*

Vicki highlights the problem of an aging population in St Ann's, high levels of cancer and 'isolation' among certain groups. She is also aware that statistically, St Ann's is shown to be a deprived area.

Middle-class residents in St Ann's also mentioned this and viewed health in St Ann's in a negative light. For example, Chevorne was a 25 year old female PhD student at the University of Nottingham had lived in St Ann's for approximately three years. When I asked her about health in St Ann's, she said the following:

*Tom: "So, so what's kind of people's health like in St Ann's...when you see it?"*

*Chevorne: "Erm, I dunno' erm, I have this perception of erm health not being that great but I couldn't tell you why... (laughs) I feel like that.... Erm, maybe I just guess because I know that St Ann's is has got this reputation for being a deprived area that I kind of think that therefore the residents will erm you know eat cheaper and you know less healthy food erm probably not*

*have as much money and time to go to the gym erm also I did when I was, when I first kind of moved here and I was looking for a GP practice I went to the one that's in St Ann's and there was a load of people like, I know you'd expect it in a GP like coughing and not looking too great...*

*Tom. Yeah not looking too fresh.*

*Chevorne. Yeah I kind of sat there thinking like oh please don't let me pick something up... (laughs) just...and I actually decided to join a different practice after that...' (Chevorne, 25)*

This response is an interesting one as it brings in the 'othering' theme from my research (discussed in chapter 6). However, essentially, Chevorne views some of the St Ann's residents as being 'sick'. She even left a GP practice in the area because she did not like the 'sick' people who were there. This begins to show the differences that the middle-class residents had with regards to their relationship to place.

Dean was a 24 year old man who I met in my local gym. He was currently a student and was living in the area temporarily:

*Tom: 'Two questions I also want to ask you about the area...erm you know in St Ann's we spoke about other people earlier but what do you think people's health is like in St Ann's from what you've seen in general?'*

*Dean: 'People tend to, two extremes I think, a lot of people seem really, I wouldn't say underweight but seem quite skinny or slim or maybe not as well-nourished as maybe possible or obese kind of people. I haven't really looked but there's these things that I've noticed ... Are the skinny looking gaunt lads or the fat women...Which is what I've noticed.*

So, Dean views some residents in St Ann's as appearing 'skinny', 'underweight' and 'malnourished'. Additionally, he notices that an extreme exists in the area with 'fat women' alongside the 'gaunt' looking lads.

To sum up, questions about people's health in St Ann's in the responses from all groups highlighted the overall poor levels of health in the area. This was perceived to be caused by an aging population (older adults becoming housebound), higher indices of smoking and alcohol consumption as well lifestyle 'choices'. Moreover, the middle-class residents tended to be more critical of the working-class groups. This highlights the 'othering' theme from my research which will be discussed in chapter 6.

### Do you think your health is similar or different to others in St Ann's?

After asking residents about people's health in St Ann's, and their personal views on health and exercise, I would ask whether they thought their health was similar or different to other residents in the area. I found this to be a good question, as it allows the respondent to first answer whether they think health is 'good' or 'bad' in the area (without introducing a bias in the question). I would then ask why they thought this was the case. It is important to note, however, that when asking residents what they thought other people's health was like, this is a leading question in itself because it encourages the respondent to answer the question in a particular way. In this instance, talking about 'other' people in St Ann's. I decided to do this deliberately because I was interested in how people in St Ann's perceived one another, since, as argued by Mead (2015), people's social identities are created through ongoing social interaction with other people and subsequent self-reflection about who we think we are according to these social exchanges. In other words, how people perceive themselves and their own health is largely dependent on other people and their interactions with them. I therefore felt it was pertinent to ask my respondents to compare themselves with others.

Similar to the above responses on people's views on health in St Ann's and their own health, I found that the responses on comparing their health to others were diverse depending on who I was interviewing.

All residents seemed to think that their health was different to others in St Ann's. The middle-class group in particular made a persuasive argument as to why this was so for



them. This group I will now discuss and then compare them to the others. Kat was a 30 year old female who I met at Nottingham Trent University. She worked in the IT department and had chosen to live in St Ann's as she found the accommodation cheap and was saving for a deposit to buy a house elsewhere in the city:

Tom: *"...Do you think your health is similar or different to others in St Ann's?"*

Kat. *"I think it's different... I think erm I think because I am quite conscious of my diet, not for my health like I said but just because I try to stay thin. Erm so I try and erm like make sure I eat like the five fruit and veg a day and don't have too many carbs like pasta and things. Like that and drink plenty of water and exercise so in a roundabout way I probably am healthier. (laughs) Because of those things erm which I yeah perceive myself to be healthier than the rest..."*

Tom. *"So do you think other people in the area might not all be taking those steps... for their health..."*

Kat. *Erm yeah yeah... And I just thought of another thing why they might not be as healthy... because there's erm a lot of the people who live around here are cab drivers and obviously cab drivers have erm shift work, and there's a load of research on shift work and how bad that is for your health so that's another..."*

Tom. *Yes, yeah no that is interesting because I did see you know quite a few parked up cabs as I came in..."*

Kat. *Yeah"* (Kat, 26)

The above excerpt, brings in the theme of 'othering' that is discussed in chapter 4. However, importantly, Kat argues that she is healthy because she eats five a day and avoids carbohydrates. She states that other St Ann's residents do not usually take these steps and that those with sedentary jobs (such as taxi drivers) are made unhealthy.

In another interview with a middle-class person (Dean, 24) living in St Ann's, when asked to compare his health to others, Dean argues that he is healthier than other residents:

*Tom. So do you think your health is similar or different to other people in the area?*

*Dean. Again it could be, I could think I'm really healthy myself. But there's a lot of other people that might be of a similar thing to me. I'd say maybe I'm a little bit more healthy in what I eat because I've always kind of eaten or, then again I don't know because I don't tend to socialize too much in this area. so I don't know what everyone eats or doesn't eat but...But er, yeah I'd probably say yeah a little bit more...' (Dean, 24)*

So, like Kat, Dean views his health is better than the other residents in St Ann's due to the way he eats, which is probably 'better' than the rest of the residents in the neighbourhood.

The older adults also sometimes thought that different residents had 'worse' health. They would talk about this in some detail. Particularly, they would highlight how these residents were not able to visit the shops, for example. In one group interview with five older adults who lived in council accommodation, they discussed the other residents in the building who were housebound:

*Tom: "So, can you tell me if you think your health is similar or different to others in St Ann's"?*

*"I don't know, same really... Though well, Terasa's... just gone in a home because she couldn't cope she got Alzheimer's. And that you know, she was falling all the time so she had to go in a home... so ... me and Carol are a friend of hers we went up to see her yesterday. And she's doing alright but she's getting looked after there's somebody there 24/7... yeah which is what she needs. She couldn't cope on her own... you know... and if anyone (unclear), if anybody wants any shopping done you know yeah I mean we look after each other. But other places aren't like that some don't even talk to each other you know" (Lydia, 77)*

This comparison the older adults are making to the ‘other’ members of the community who are not able to ‘cope’ as well has been discussed in other research (Suls, Marco and Tobin, 1991; Wood, Taylor and Lichtman, 1985). These researchers found that the majority of the older adults perceived their own health to be better than their same-age peers. Since it is logically impossible for most people to be ‘better’ than the average person, the question is what accounts for this positive bias? According to Suls et al (op.cit.), one explanation is that seniors selectively compare with other older adults who are in worse health to bolster down their evaluations. This process, known as “downward comparison” has been documented in other settings when people feel threats to self-esteem (Wood et al., op.cit.). This will be discussed in more detail in chapter 4 (Othering). Given the changes of aging, the older adults may engage in careful selection of their comparison groups in order to maintain a positive view of their health.

Certainly, I found this within my own research with the above question with older adults often comparing themselves with other elderly individuals who lived within the same building, or nearby. They would explain (as the transcript above) that these other people had specific illnesses or disabilities which rendered them unable to participate in daily chores and routines (such as shopping). They would then highlight how ‘lucky’ they were that they didn’t have specific illnesses that prevented them from living their daily lives.

So, in the above example, the older adults discussed health as the importance of being able to do something ordinary such as go to a shop. In Walker and Hiller’s (2007) study of twenty older adults in South Australia to find out women’s perceptions of health in their neighbourhood and their accounts of every-day activities, they found that a trusting relationship with neighbours underpinned older women’s sense of satisfaction with, and feeling of security within their neighbourhood. I found something similar in my research with older adults, as they often highlighted the importance of having good relationships with one another. Factors such as living in close proximity to services and existing social networks were also seen as important to them.

Walker and Hiller (op.cit.) found that older adults were able to draw on both existing social networks and neighbours to sustain their independence and social connection within the community. They also found that women were conscious of social disconnection in their neighbourhoods, and to the way that traffic noise and pollution detracted from their neighbourhood environment. These findings indicate that, for older

women living alone, trusting and reciprocal relationships with neighbours are likely to form an important part of their broader social support network and should be recognised in relation to the process of maintaining the health of older women living the community.

Relating this to my own research, older adults rarely talked about things such as ‘pollution’ or ‘traffic noise’. Instead, they would talk about the importance of having their garden tidy and how their discontent was due to Nottingham City Council cuts: they no longer had a gardener. This was of importance to their wellbeing. All of the older adults in this group interview; however, were well aware of other members of the community who were not able. These ‘other’ members were often immobile and not able to get up, take walks and garden. They were reliant on others to ensure that their basic needs were met.

The working-class residents responded quite differently when I asked them to compare their health to the other residents in the area. I expected this group to be supportive of one another and have a strong sense of community. However, as I discuss in later chapters this was not always the case. Instead, they were often critical and harsh about one another. Margaret was a 54 year old parent who I met in the food bank in St Ann’s:

*Tom: ‘Do you think your health is similar or different to other residents in St Ann’s then?’*

*Margret: ‘Well, we do what we can most of us with what we have. But some people to be honest it is just laziness. I mean they just don’t move anywhere most of the time and I try and walk when I can and move about but I just see people on their bums. Mobility scooters is one thing, ever seen a slim person in one? No, just fat ones using them. It’s hardly a coincidence.’*

To sum up, the working class residents responded to this question differently to the older adults. They did not ‘feel sorry’ for residents who were not as healthy as them, or go and visit them if they were unwell. Instead, they would criticise residents who they felt were ‘lazy’ and not making an effort to be as healthy as them. The middle-class residents on the other hand were often not as harsh towards the working-class

residents, but did highlight how their lifestyles (such as their diets) were healthier than the other residents in St Ann's.

## Conclusion

To conclude, this chapter has illustrated the way in which my respondents responded to my interview questions and how this shifted my focus from what I 'thought' was health to my themes of Places, Practices and Othering. With some similarities to Crawford (1984), it was clear in St Ann's that health for residents in St Ann's was a concept that was grounded in their everyday experiences and concerns of their everyday life. The various ways health was discussed gave expression to their culture's notions of wellbeing or quality of life. In Crawford's (ibid.) study however, he only studied one large group of people and so there is an importance to explore how diverse groups differently express health. In subsequent chapters I will delve into my themes in more detail comparing how different groups of people discussed health.

When asked about health, most people in my interviews started off by saying they were healthy. I discuss in later chapters that this is a common theme in other qualitative research into health (Crawford, 1984; Crawford, 2006; Crossley, 2002; De la Rau and Coulson, 2003). According to Crawford (2006), this reflects in part a strong moral imperative attached to health and to the normality of health. This response also reflects that by medical standards most of these people would be considered healthy. Health clearly resembled a status, socially recognized and admired and therefore important for our identities. (Crawford, 2006). Most often, however, people (Crossley 2002) described their health as variable rather than fixed. (Crossley, 2002).

Although there were examples from my own research where certain residents (such as the middle-class group), discussed their health in terms of their identity and being important for their sport or activities, the majority of the other residents I interviewed, such as the working-class and older adults, did not discuss health in this way. Rather, I discussed in this chapter how their health was grounded in local places, their routines and practices as well as 'others'.

Health then, in other words, is a state of being that is understood to shift with experience. It is a matter of degree and it is dynamic. Nor is health viewed as simply a physical matter.

While in Crawford's (1984) work, many people discussed health in the prevailing medical idiom, most use terms and notions that extended beyond the confines of definition and explanation offered by the bio-medical sciences. Perceptions and beliefs about the physical experienced suggested by the word health are frequently vehicles for explaining social and emotional experience, just as emotional and social life provide explanations for the life of the body (Crawford, 1984).

Certainly, from my own research, emotional and social well-being find their confirmation in the body. People's bodies 'make sense' in terms of their social and emotional occurrences.

## Chapter 4: The Meanings of Places in St Ann's

One of the first themes that arose from my interviews and observations was the importance of particular places in St Ann's that residents discussed in some detail. In this chapter, I will discuss meanings of these places in St Ann's and how different groups in the area spoke about them. I begin with a brief overview summarising the significant amount of quantitative literature on the topic of the built environment and health to set the context. Following on from this, I will discuss my own research on this topic and discuss other qualitative literature within this where relevant. The main purpose of this chapter is to show how people in St Ann's explain and conceptualise different places within it.

This chapter is divided up into the following groups: the older adults, the working-class residents and the middle-class residents. This chapter will argue that research on health and physical environment typically focuses on the proximity of supermarkets or leisure facilities. However, while residents mentioned this, I also found that health and place have diverse and broader meanings to different people. Local shops for example, are more than 'food outlets', they are places to gather, places to walk to and signify the community or danger (depending on the group). Similarly, the community centre was seen by some as a place of companionship and community cohesion, whereas others thought it was detrimental to the area and should be taken down. Parks and walkways were viewed favourably by older adults, who walked their dogs through them daily. Parents, however, viewed them as hostile places and were reluctant to allow their children out to play. The GP surgery, while seen to have great importance to people's daily lives, was viewed as an exasperating place where it was difficult to receive care.

I argue that predicting health behaviour and supporting behaviour change is neither obvious nor common sense. It requires careful, thoughtful science, that arises from a deep understanding of the nature of what motivates people and their social and economic pressure that act upon them. If we understand these, we are better able to support them to change. Secondly, health behaviour cannot be reduced down to things that individuals do and think as if they were isolated from others and the places they inhabit. The relations between individuals and places is the starting point and conceptualises things like shared practices that exists above and beyond why individuals do it. We must consider the

elements identified by the residents in St Ann's that they feel are important, the meanings and the consequences. Then we might be able to empower and motivate individuals to generate their own solutions to their problems.

### Understanding health and place

An understanding of place is fundamental to the concept of liveability and health. People live in places, move within and between places, and often depend on the movement of goods to and from places for their wellbeing (Morris, 2003). According to Morris (*ibid.*), the individual characteristics of places are vital in determining quality of life. The internal structure of places and differences between places also matters greatly in terms of socioeconomic inequality. However, it is often difficult to measure what matters about places because their nature depends on both physical and social characteristics. Places not only have a location, territorial domain, and natural environment, but also are social constructs, shaped by human behaviour and interactions.

The physical characteristics within places that can impact upon health are often discussed in many quantitative studies (Parsons, 1992; Ulrich 1992; Kahn, 1997; Gullone, 2000; Morris, 2003). Ulrich and Parsons (1992) for example, believed that the villa gardens of the ancient Egyptian nobility and the Persian walled gardens of Mesopotamia indicated the great lengths to which the earliest urban peoples attempted to maintain direct contact with nature. Most quantitative studies (Kahn, *op.cit.*; Gullone, *op.cit.*; Morris, *op.cit.*) argue for the importance of residents maintaining visual contact with nature as being beneficial to the emotional and physiological health of the neighbourhood residents. For example, Gullone (*op.cit.*), discusses certain landscape features and how they are aesthetically pleasing for residents. This allows residents to create an affinity with them which impacts positively on their health. For example, bodies of water, plants and animals, higher areas, trees with low trunks, green spaces, parks and walkways can all be positive features within the physical environment.

Quantitative literature is useful in this respect, as it does demonstrate that there are certain aspects within the physical environment that can be 'positive' for residents and their health (Cox, 2002; Boulware, 2003). Fresh air, attractive scenery, access to green spaces can have a wide range of social, economic and environmental health benefits for residents (Cox, *op.cit.*). Additionally, natural open spaces and well-designed greenspaces for



example, provide a locus for recreation, social interaction, and community action, are a source of employment and natural resources. Such places are highlighted as having a positive influence on health and well-being for residents in neighbourhoods (Boulware, *op.cit.*).

However, this quantitative literature into environmental health has tended to focus on the 'hazardous' nature of specific 'environmental exposures'. There is also a wealth of research (see for example, Cox, 2002; DEFRA, 2003; Frumkin, 2000) that details the vast number of ways in which exposure to the natural environment can have a negative effect on human health. For example, exposure to pollution from cars, allergies such as asthma and hay fever, respiratory disease and pesticide exposure and the like (Frumkin, *op.cit.*). These studies argue that when hazards to health in the physical environment interact with individual risk factors they can contribute to cancer, cardiovascular diseases, respiratory disorders allergies, neurological and motor disorders and accidental injuries. These risks are likely to be even more serious for older adults than for the rest of the population.

Although these quantitative studies are useful in terms of identifying the positive and negative attributes of the physical environment that can impact upon health, one must avoid the temptation to think of a neighbourhood only as a location or place or territory that simply has positive or negative 'attributes' that can impact upon the health of the residents. A place is distinguished by its people, markets, governments, and institutions, as much as it is by its physical landscape and natural resources, transportation systems (including streets and roads, buildings and boundaries. Like liveability and sustainability, place is an ensemble concept (Elleway et al, 1997).

Additionally, the above quantitative studies do not seek to find out residents' interpretations of these 'determinants' that exist within neighbourhoods. Qualitative methods, such as my own (in-depth individual and group interviews, direct observation, and participant observation) go beyond simple statistical observations and can complement quantitative findings and provide unique contributions to our understanding of the influence place has upon health.

Qualitative studies into health and place have tended to focus on the meanings and interpretations residents have on specific places within their neighbourhood (see for example, Pinder, Kessel, Giren and Grundy, 2009; Brewster, 2014; Milton, Pliakas, Hawkesworth, Nanchahal, Grundy, Amuzu, Casas and Lock, 2015). For example, in one

qualitative study exploring the extent to which certain places in a neighbourhood facilitated or hindered physical activity (Pinder et al, 2009), facilities that supported children's play in a deprived area such as playgrounds and trees for climbing were seen as important by parents. Specifically, parents wanted play equipment that was age-appropriate and mentally and physically stimulating for their children. Constructed and natural walking routes (such as parks) were seen as important in another qualitative study for older adults who would walk through them daily (Brewster, *op.cit.*)

In other qualitative studies (Toma, Hamer and Shankar, 2015; Hanson, Guell and Jones, 2016; Lin, Witten, Oliver, Carroll, Asiasiga, Badland and Parker, 2017;), graffiti and vandalism were often seen unfavourably by residents in the sense that they considered it unsightly and tended to avoid going to areas within the neighbourhood where it was present (Guell and Jones, *op.cit.*). The presence of trees, bushes, gardens, grass, flowers, natural settings, and air quality on the other hand were often mentioned by residents as attributes within their neighbourhood that would encourage them to go outdoors. In a number of qualitative studies (*ibid.*; Lin et al, *op.cit.*), safety concerns were often mentioned by residents: drug users and loitering teenagers were often a concern for parents with children. This resulted in parents feeling reluctant to allow their children to go out and play. Parents felt exasperated by this, as they recognised 'being outdoors' had various health benefits for their children.

However, not all qualitative studies have simply discussed residents' perceptions of specific 'places' or spaces within their neighbourhoods. Social environments and resident interconnectedness are often highlighted in qualitative studies as being positive (Atkinson and Kintrea 2004; Crawford, Bennetts, Hackworth, Green, Graesser, Cooklin, Matthews, Strazdins, Zubrick, Esposito and Nicholson, 2017). For example, one study (Crawford et al, *op.cit.*) identified the importance of organised festivals and celebrations in the local park as bringing together people from divergent backgrounds, thereby encouraging people to interact and create a strong sense of community. Opportunities for residents to socialise in a supportive social environment appears to be important for older adults, who often live alone and place an importance on being able to socialise outside of their homes (Atkinson and Kintrea, *op.cit.*).

Qualitative studies are therefore fruitful, as they provide some ideas as to how residents within neighbourhoods can perceive the places and spaces that surround them. However,

the above studies have tended to focus on specific places within neighbourhoods, such as parks and green spaces for walking, or what specific places they think are ‘negative’ for the health of the area. They have not asked residents generally about their health and day to day life living in the area. A more open-ended approach such as this I believe allows for a far more comprehensive understanding of how residents perceive where they live and how where they live can affect their health. Additionally, the above qualitative studies have tended to only interview low socioeconomic groups within deprived areas. They have not sought to interview a more diverse array of residents to see how they differ.

### Meanings of local shops and places - The Older Adults

I interviewed more older adults for my research than any other group. Within the first interview with this group, I soon realised older adults tended to place an importance on certain places they visited regularly such as the community centre, local shops, the church, the GP surgery and the betting shop. Older adults such as Stan, said they often struggled to make trips to the nearest shops, which were often situated outside of St Ann’s:

*Tom: ...’’Like you said ...having the GP and the shops that’s what’s really important to you isn’t it?*

*Stan: Oh yeah...with anybody who’s old it’s important because some people get round a lot better than others. And it is, you see these people in these walking frames you know, they are in their homes because they probably can’t get far, you know but that’s how they get about.’’ (Stan, 78)*

In the above example, Stan discusses how when you are ‘old’ shops are important as they allow people to get ‘around’ in the neighbourhood. This finding was echoed by a number of older adults I interviewed, who explained that although they were often physically unable to walk great distances, it was important for them to be able to ‘get about’ in the neighbourhood.

Aubrey was another older adult who discussed certain places in St Ann’s. I met Aubrey while I was sitting in the community centre one afternoon. I overheard him talking to another St Ann’s resident regarding how he was unhappy at the recent closure of many

of the local shops within the area. I thought he would be interesting to speak to. In my interview with Aubrey, he pointed out that there weren't enough of the 'right kind' of shops in the area:

*Tom: "Yeah, so do you think there's enough variety of food available in the local area, do you think you can get what you need"?*

*Aubrey: "There's not enough shops near for like people who've got wheelchairs. They are bringing one or two more in so it's getting a bit better but before all you've got was Vic Centre... had to go to Vic centre" (Aubrey, 77)*

In the above, Aubrey discusses how there are not enough local shops in St Ann's for individuals who use wheelchairs. Instead, residents who use wheelchairs are having to travel into Nottingham City Centre ('Vic Centre'). Having to travel to reach local shops has been highlighted in other qualitative studies (see for example, Liese, Weis, Pluto, Smith, and Lawson, 2007; Sharkey and Horel, 2008) Liese et al (op.cit.) found that residents in deprived areas who live further from larger supermarkets and access to convenience stores typically have to pay more for healthy foods. A significant number of participants in a qualitative study (Sharkey and Horel, op.cit.) reported driving a considerable distance to grocery shops for at least some of the time.) The study found that frequency of shopping at larger stores with a better selection and lower-priced healthy foods may affect how often fruits and vegetables are eaten.

Although these above two qualitative studies are useful additions to my own findings regarding the importance of local shops for older adults, they have tended to only focus on residents' perceptions of access to local shops and how this can encourage or 'hinder' fruit and vegetable consumption. While I recognise access and proximity to nearby shops has been highlighted in my own research, as well as others as important to older adults, I argue that this should not be viewed as the primary 'determinant' of health within a neighbourhood. There are other places and spaces that have pertinent meanings for health.

For example, during one group interview with older adults, they highlighted the importance of having their own home:

*Tom: ‘‘So, you said having somewhere to call home is important to you now did I hear that right?’’*

*Sylvia: ‘‘[Yes]... Teresa’s... like just gone in a home because she couldn’t cope. She’s got Alzheimer’s she was falling ill all the time so she had to go in a home... she didn’t even know what day it was... now she’s not in her own place and she knows she can’t go back... You’ve only got to fall off that once and you wouldn’t fall again you know... your flats gone.’’*

In the above, Sylvia discusses other older adults nearby who have lost their home and how she feels sorry for them. I discuss this theme further in my chapter ‘Othering’. Importantly, Sylvia fears not being able to have her own home. She recognises how ‘easy’ it is for older adults to lose their own home and end up in a care home. This is viewed as an undesirable place to be.

Interestingly, the above quote illustrates how Sylvia’s life is influenced by her habitus. As I discuss later in this chapter, according to Bourdieu (1979), habitus mediates between individuals, places (such as a home), what individuals do, and how they perceive such places with regards to health. Habitus therefore makes an individual ‘habit’ places that are ‘normal’ and comfortable to them. For Sylvia, being in her home is what feels normal for her and so she places importance on owning it. Sylvia felt most ‘at home’ within this given space in St Ann’s. It was part of her daily life.

Additionally, for older adults to have a place where they could sit together and watch a film was seen as important for their own wellbeing. In the group interview I did above, the older adults had a communal area on the ground floor of their flats where the four of them would sit together all day drinking Carling and watching films. When I arrived to interview them, this is where we sat:

*Tom: ‘‘[Their communal space]... this is very important for you to have then isn’t it’’?*

*John: ‘‘Yeah, but we’re lucky because of lot of them haven’t got it... we watch a film... we’ve seen all the films we watch a film every afternoon... that’s two or three hours a day you know.’’ (John, 82)*

In the above, John feels that having a place where he can sit with his friends is significant for him. Places then, are not simply destinations where residents can arrive to and then leave, but they can be a home, are a place of companionship and community cohesion for older adults. Places such as these ‘‘Keep people together’’ as John (82) mentioned in my group interview with him and his friends.

The notion of ‘belonging’ to an area, the places within it and being involved in activities with one another has been highlighted in other qualitative community studies (Kelly and Paterson, 2006; Wills, Backett-Milburn, Gregory and Lawton, 2008; Greener, Douglas, and Van Teijlingen, 2010; McKenzie, 2012). Belonging to a particular estate, has practical elements to it, and therefore residents in all of these studies invested into this notion of ‘belonging’. For the St Ann’s residents who had lived in the area for more than 10 years, they explained that apart from town (city centre) they had little or no contact with other areas within the city or even wider, and their social life is firmly located within the neighbourhood. Most of the residents in the above studies all had family, friends and a close social network within the estate they lived in, and therefore what happened and how one could operate within their neighbourhood was essential to the quality of life they had. Residents in a number of studies (Wills et al, 2008; Greener et al, 2010; McKenzie, 2012) spoke about the importance of ‘fitting in’, and ‘being known’ in their neighbourhood. Residents spoke about rarely leaving the estate and enjoyed the benefits of being there, despite acknowledging that it was known as a bad place to live.

Additionally, when certain places and spaces in St Ann’s were ‘taken away’ from older adults, they felt upset by this. In the following interview with Mary, I asked her about health and exercise:

*Tom: ‘... There’s also this government thing about having thirty minutes of exercise three times a week... what do you think about that’?’*

*Mary: ‘It’s non applicable to me really... I’m going out as much as I can go out when I can’t I can’t... I come here sit watching the telly if it’s a nice day I go out. I say right, we’ll get the tools out and go out there... do the gardening. Just potter around... I hold the hose for him [her friend who she gardens with] ... the council are no good are they. You see everything’s stopped, we used to have gardeners but they’ve stopped them because the*

*council have cut down and so many things. We don't have half the things we used to now. We have to do it ourselves. You know, people who had to do community service we used to have a gang of them... we don't now... the gardens used to look lovely.'* (Mary, 77)

Mary reveals that a garden can be a vital place for older adults, as it provides them with a pleasant area to enjoy and encourages them to go outdoors. This was echoed in other interviews with older adults:

*'Tom: "So... having certain places you say is important for you in St Ann's"?'*

*Edith: "Well I have a potter around and whatever... but they've had many cut backs over the council... I tell you something it's getting worse and worse... soon shit will be costing you for breathing... and these old people are living far too long you know! They ought not to live past 60, they ought to put us up against the wall and shoot us all!"' (Edith, 69)*

As shops and places close in St Ann's, and as local gardens are no longer maintained for older adults, it is clear this is having an upsetting effect for this group of residents. Edith explains how the cutbacks by the local council are resulting in some of her feelings of helplessness. She feels as though these closures of places means no one cares for older adults anymore.

Other studies (Johns, 2002; Wacquant, 2009; Skeggs and Loveday, 2012), discussing the relationship older adults have with their neighbourhood have also resonated with some of these findings. For the aging population, where they live is an important site of social interaction and a fundamental part of their identity: a place of family and friendship networks and connections to their wider friends (Skeggs and Loveday, op.cit.). In St Ann's for example, many of these are community-based networks and relationships (such as John who watched films with his local friends). Community therefore plays a fundamental role in their sense of belonging, identity and local well-being. Interestingly, the UK Citizenship Survey (April 2010-March 2011) showed that 76% of people felt they belonged strongly to the neighbourhood they lived in. Research on social capital and well-being (Johns, suggests that everyday interactions with friends, family and

neighbours play a crucial role in sustaining a sense of community but can be extremely fragile. Wacquant (op.cit.) has shown that even subtle changes at the local level (such as the closure of a local shop or disappearance of a green space or garden), can have a significant impact on community spirit and community well-being. In St Ann's, it became clear from my interview responses with the older adults that the closure of their local services and places was having a detrimental impact on their wellbeing.

Older adults then, tended to view specific places and activities in St Ann's as pertinent. Returning to Bourdieu (1979), he used the term 'dispositions' to describe the ways in which individuals (such as the older adults in St Ann's) conceive of and view the world and the places within it from their social position. As I discuss later, dispositions are constructed by a variety of cultural, social and material resources. They dispose individuals towards particular attitudes and behaviours. This results in a 'sense making' understanding of their world, which provides a foundation for the individuals own perceptions on the places around them. In St Ann's then, due to the older adults social position, their local services and places were of paramount importance to their overall wellbeing.

In another example, Clive was an older adult who owned a dog. He would walk his dog several miles at 5am every morning:

*Tom: "What's it like to live round here generally? You said you don't get much trouble, there's not much trouble but there is a bit of a drug problem"?*

*"Not where I am I think it's because I've got a dog... Because like a dog he's got sixth sense if he hears anything in the night he's up and out his basket. Yeah, if there's anyone around like when I take him out it's pitch black in the mornings. But I can walk through that estate, to the community centre, I'll come through that estate, I can't see note but he can. He stops and his tabs are up and he knows there's somebody around or what but I don't know"*  
(Clive, 78).

In the above example, Clive feels that his dog gives him some protection and enables him to feel as though he can walk through the estate with ease. As I discuss later on, this finding is in contrast with the middle-class residents, who often feared the reputation that existed in the area and were concerned for their own safety when they went out.



To conclude this section, the older adults placed a significant importance on certain places that they visited such as the community centre and the local shops. Although some of these shops are at quite a distance often situated outside the immediate area, older adults enjoyed being able to ‘get about’ in the area and not become housebound. Therefore, while other qualitative literature has highlighted the importance of local shops, there are other spaces within a neighbourhood that have importance for older adults’ mobility. I argue then, places are not simply destinations where residents can arrive to and then leave. They can be a home, where there exists community companionship and cohesion. Therefore, when places are ‘taken away’ from older adults, this upsets them. Due to recent government cut backs in the area, some local services for older adults (such as a gardener) have been taken away which results in unkempt gardens. A garden can be a vital place for older adults then, as it provides them with a pleasant area to enjoy and encourages them to go outdoors. Additionally, older adults were not fazed by the reputation of St Ann’s. Instead, they would walk their dogs proudly through the area daily.

### Meanings of local shops and places – The working-class residents

The community centre was often viewed in a positive light in St Ann’s. For many residents, it was a place of companionship and togetherness. There is a café inside as well as an information desk. Upstairs, there is an advice centre which offers services such as debt advice. Some community workers and working-class residents, however, thought that places like the community centre were there for those who were in need. Those in ‘need’ desperately needed advice, some company, tea and cakes but these benefits would not make any positive long-term changes in St Ann’s. They would not solve the deep structural issues at the heart within of the area.

While the older adults tended to talk about the importance of having certain places and spaces in St Ann’s and having one another, not all residents felt the same way. Some of the working-class residents, for example, felt negatively about the community centre. Simon was a 31-year-old male who had lived in St Ann’s for over ten years:

*Tom: “... Quite a few people have mentioned the community centre in the area as being...”*

*Simon: “ ‘Burn it... the community centre, the food bank is not effective and the quicker they burn it down the better...The system is corrupt, and the money being put into St Ann’s is not being properly spent. Some employed members are dishonestly taking money out of the pot’ ” (Simon, 31)*

In the above example, Simon is very critical of the value the community centre has for the area. He argues that the resources being put into the area are not being properly managed. This theme was only present in interviews with three working-class residents. While many residents spoke positively about the importance of specific places in the area, there were examples such as the above where residents gave answers that I did not expect. This demonstrates that place has diverse and broader meanings to different people.

What asking the working-class residents about their neighbourhood, I frequently found that residents rarely cared about the high crime rate that existed within the area; for example, in one group interview with 3 working-residents (Dan 44, Pat 62, Darren 59):

*Tom: “... So, in general then living here...”*

*Dan: “It’s good”*

*Pat: “It’s good”*

*Darren: “ I never complain, it’s good. Yeah...”*

*Tom: “Because it’s got quite a bad reputation St Ann’s hasn’t it”?*

*Pat: “It does have. It’s called Gun City at one time that’s what my lad used to call it. You’re not going to live in gun city are you dad! But it’s not that bad.*

*Darren: “But half the stuff you hear is a load of cobblers”*

*Dan: “You’ve got to live here to find out. Now it’s not so bad. But you’re going to get [drugs] wherever you go, and you’re going to have good places and bad places wherever you live... it doesn’t bother me”*

*Darren: “There’s never going to be any perfect place to live no... in general everywhere isn’t it. It’s not that bad”*

In the above, these residents do not seem concerned or adversely affected by the high crime rates they are aware of in St Ann's. This is a surprising finding, as previous research in St Ann's (Mckenzie, 2012) found that many residents were concerned about issues such as drug-dealing that existed within the area. Additionally, previous qualitative research that I discussed at the start of this chapter (Saelens et al, 2003; Burgoyne et al, 2008; Summiniski et al, 2005), highlighted that issues around neighbourhood safety were a key 'determinant' in preventing residents from wanting to leave their homes and exercise. However, in my own research, in interviews with working-class residents, they regularly felt that issues such as drug-dealing did not bother them. In my interview with Josh (44) for example, he said the following:

*Tom: "You mentioned earlier St Ann's as a place gets bad press... and I think you mentioned drug-dealing in the area earlier in the interview..."*

*Josh: "No, it doesn't bother me [drug dealing]. But you see, half the time they don't want to upset them you know what I mean... they're mostly alright it's the old'ens that are nice, I mean I know a lot of old black people and they're down to earth. You get some of these young'ens... oh about fifteen or sixteen I mean what are they standing on street corners for?... That's it! You see you get runners and all this... people think we're daft but..."*

The above example is interesting, as it demonstrates that what maybe associated as being 'negative' about a place (presence of drug-dealing) by some people, is not necessarily felt by other residents. Indeed, in the qualitative literature discussed at the start of the chapter, I highlighted in some of these studies the presence of drug dealing was seen in a negative light within the neighbourhood by residents. In the case of Josh, he is aware that drug-dealing exists within the neighbourhood and even describes the more mature drug-dealers as 'nice'. Additionally, he identifies them as being 'black' but adds they're 'down to earth'.

Locally, due to a reputation regarding drug-dealing as mentioned above and other crime issues, St Ann's has become a severely stigmatized area with a reputation as a place to avoid, supposedly full of crime and drugs, single mums and benefit claimants (Mckenzie, 2012). In recent years, the area has been linked through the moral panic of media representation, as an area ridden with crime, drugs, gangs and guns, following the high-profile murders of several teenagers on the estate. As Mckenzie (ibid.) found, like so

many estates and poor neighbourhoods in the UK, there have also been many incidents of stabbings, and shootings linked to gang involvement and drug dealing. McKenzie (ibid.) has noted from her research that getting a taxi to pick you up from your home address in St Ann's, or getting a pizza delivered, are not services that are taken for granted. There is a grudging acceptance by the local residents of the restrictions of living in St Ann's, often because of the way the estate has been planned and built, but also because there is an acceptance that there will always be crime in the neighbourhood (ibid.)

I found, however, that in many cases the working-class residents I interviewed found the stigma regarding the high crime rates in the area as an amusing topic. In fact, with some forms of antisocial behaviour in St Ann's, the working-class residents discussed it with humour. In my interview with Vicki, she said the following:

*Tom: [While discussing crime]''... And they all know the streetscape so they can escape and whatever''?*

*Vicki: '‘Yeah, often you'd actually get one of the policeman knock and your door and say is it okay if we nip through your house to get out of... (laugh). So you were constantly letting the police run through the bottom of your house, as well to try and catch up with the people that had already gone... '‘(Vicki, 36)*

In the above, Vicki seems to feel completely unaffected by the high rates of crime that exist in the area. She even makes a joke regarding it. This theme contrasts with the middle-class group, and the previous research conducted in the area, that was frequently fearful of the high levels of crime and antisocial behaviour that existed in the area. Indeed, the middle-class residents I interviewed would not have found this amusing.

Returning to Bourdieu (1979), a 'field' is a setting in which agents and their social positions are located. For example, the neighbourhood of St Ann's could be a field. The argument here is that high-crime rates in the area have become commonplace over a long-standing time period. They have become ingrained in St Ann's culture and 'ways of life'. The majority of the working-class residents knew from living in the area that crime would always be present and so part of their 'field'. Certain crimes had therefore become normalised for them. While one could argue that it may not be rational to laugh at the fact

there exists high levels of crime in your neighbourhood, Bourdieu (1979) would argue that social agents (residents) do not constantly calculate according to explicit and rational criteria. Rather, social agents operate according to an implicit practical logic heavily based on their habitus. Habitus is also internalised, and for the individual there becomes an understanding of a 'common-sense' world. So, what happens both around people and indeed to people becomes as if it is 'natural'. Here then, it makes sense for the working-class residents who have lived in the area for a long time and wish to remain there, to normalise and 'laugh off' the issue of crime. The middle-class residents, due to their social position disliked living in the area and wished to move as soon as they could. They therefore saw the high crime rates as an issue for them.

However, there were some forms of antisocial behaviour that existed in St Ann's that were not dealt with by humour, and gave the working-class residents cause for concern; for example, the safety of their children. In my interview with Rachael, she said the following:

*Tom: "Yes, I've heard a lot of parents say they don't let their kids play on the park..."?*

*Rachael: 'I mean we've got to a point with our lads we don't let them take a football cause' if they take a football they will come home thirty minutes later it's been taken it's been popped. And it is every single time you know they go to the park with a football it gets pinched.'* (Rachael, 44)

While a stolen or destroyed football may seem like a trivial issue, for some residents in St Ann's the wellbeing of their children on the park was seen as paramount. Many parents were reluctant to let their children leave the house without supervision. Phil, for example, said the following when discussing the area:

*"Well, I was mugged and attacked by black people seven years ago and er... you know but I know there's as many white people. I've been mugged and attacked by white people as well (laughs.) But I worry... I worry about my kids. You have to don't you".* (Phil, 34)

With similarities to Rachael then, Phil expresses concerns with regards to the safety of his children in the area although he laughs when discussing his own safety.

The working-class residents then, were aware of the high crime rates in the area, with some residents making a joke about this, and some genuinely concerned for safety. Additionally, the working-class residents, along with the older adults tended to have strong associations with the neighbourhood. However, as mentioned above, these associations were not always positive. There used to be a co-op in St Ann's which was situated in the Neighbourhood Chase region. This was once known as the heart of the area (Mckenzie, 2012). Indeed, there was not only a co-op on the Neighbourhood Chase, but at one time there was also a dry cleaners, a SureStart centre, a thriving market, a post office as well as other useful local facilities and shops for residents to use and visit (Mckenzie, 2012). However, in Mckenzie's (ibid.) ethnography, she noted that the closure of such places had had a devastating effect on the local community, with residents losing their sense of belonging and community cohesion. Additionally, many residents relied on such places (such as the SureStart) for help and support.

During my own time in St Ann's, I did witness some new shops being built which the majority of residents seemed pleased about. However, there were still local shops and places that were continually being closed down. One resident remarked in my interview with him: *'...So I always go there [The Chase] but every time I go something's closed down'* (Phil, 58).

While discussing various places in St Ann's with the working-class residents, they often mentioned the aesthetic appeal of the area, or 'how it looked'. In five interviews conducted, participants mentioned this. The working-class residents acknowledged that the area did not appear 'very attractive' and that this was not 'good for people'. For example, in my interview with Anna, she said the following when I asked her about living in St Ann's:

*Tom: 'So, what is it like to live in St Ann's then'?*

*Anna: 'I'd like to see them sort things a bit quicker. There was a car months and months ago a car hit one of my neighbour's walls. It's knocked all the wall out of joint they've put er a bit of metal rail around it and it's pretty much been left in that state now for over, probably over six months. You know, and you know it's not nice for the people that live there the walls all collapsing in. Luckily the kids have left it alone, but you know it's not great it's right on*

*the corner of the car park. And it's almost like these railings have gone up and they've completely forgotten about it so... it tends to bring a lot more pride as well. I'd say I think some of the kids could do with a boost of that at times...'' (Anna, 28)*

In the above example, Anna explains that the way a place 'looks' has an effect on the pride residents feel living in the area. If walls are left in disrepair for example, this is unpleasant to 'look' at. Importantly then, places can affect how residents feel regarding living there.

Returning to Bourdieu's (1979) concept of habitus, habitus includes particular actions or practices that are enabled by, or are dependent on, particular physical surroundings (natural or artefactual). Habitus is therefore dependent on this environment. It may be distorted (through disrepair in the neighbourhood), transformed or destroyed if the surroundings change or disappear. In other words, the aesthetic appearance of the neighbourhood can be part of the habitus for that individual. If it falls into disrepair, is poorly maintained or damaged, the individual (Anna) notices this.

With some similarities to the quantitative and qualitative literature on place, the working-class residents were sometimes keen on having 'green spaces' for their health. The community workers in St Ann's also seemed keen on the importance of 'green spaces' for people and their health. One resident remarked that other areas in Nottingham had play areas, sand-pits and swimming-pools, which were popular with residents. In my interview with Julie, she said the following about places:

*Tom: "So, how do you think the council could improve St Ann's"*

*Julie: "...Mm, is it to do with the built environment? Er possibly but I'm a great believer in trees and green things. And I recognise I need to get out of the city for my own well-being, so er that's me projecting what I need for... For me and I'm really grateful that I've got trees and the school playing field along here that just makes a real difference... I think one of the biggest factors in peoples wellbeing is the quality of relationships that you have erm so the question for me if you've got good networks and friendships then I think that's really important in terms of mental health."* (Julie, 46)

In the above, Julie expresses the importance of having quality of personal relationships in the area. This is a pertinent point when attempting to understand place. It should not be simply valued for having ‘healthy’ spaces: additionally, the social networks and friendships that exist there are important, too.

My argument here, following Bourdieu (1979) is that the working-class residents, in order to be a person of value, and a valued person, they used the local value system in the area that was available to them. This also made sense to them and it worked. The wider and universal system outside of the area (enjoyed by the middle-class residents), where education can be exchanged in the open market for economic capital, prestige and status, does not apply for the working-class residents in the area. So, the people who live in St Ann’s invest in what does work for them, through what is available, and worth investing in. Education, training and even employment do not always ‘pay off’ within the area; while wages are being driven down in real terms, and higher education is at risk, and often feared. The universal system that Bourdieu (1984) terms ‘the symbolic economy’ moves further away from the poorest people. Therefore, having personal relationships and companionship become extremely important for the working-class residents.

While the importance of the community and personal relationships was highlighted in interviews with working-class residents, in every interview I conducted in St Ann’s I would always ask my participants what the local GP surgery was like in the area. Many interviewees had some long-term health problems which required regular GP visits or visits to the pharmacy to pick up a repeat prescription.

This place, the GP Surgery, was therefore of particular importance to the people of St Ann’s. The Valley Centre in St Ann’s is a relatively new building which holds the library (with an information desk), the pharmacy, and two GP surgeries. Both GP surgeries are directly next to one another. The main surgery (Wellspring), which has several thousand patients registered seemed to be the surgery the majority of residents in St Ann’s were registered to. The surgery has around seven doctors working there. I had assumed therefore, it would be easy to get an appointment. However, in almost every interview I conducted with residents and community workers in St Ann’s, there was a negative perception of this surgery. Residents complained regarding the difficulty of getting an appointment due to the recent change in the appointment booking system. I understood that there was a ‘turn up and wait on the day’ policy at the surgery, or having to phone



up at 8.30am to see if an appointment could be made that day. However, this was often unsuccessful as there were many residents phoning up at 8.30am, and so it was often difficult to get through to the receptionist to make an appointment. In my interview with Keith, he said the following when I asked him about the local GP surgery himself and his family used:

*Tom: ‘‘So, tell me about your experience of the GP surgery in St Ann’s? I think you mentioned it earlier...?’’*

*Keith: ‘‘Well, we’ve had bad experiences with both sides of the GPs there... Dr. Will Johnson prescribed pig insulin to my wife when she was pregnant...pig insulin to fatten up a pig...And er she nearly injected it. And she could have died and my wife so we moved of his books...And then we had issues with that doctors where it’s a phone in scheme first come first served... And when my wife was crawling the walls in December cause’ she’d got some internal rash and she was in agony, and all I wanted was one doctor to phone me up through the day... And they wouldn’t... and if they had we’d have found out that it was the nurse that had seen her... And had prescribed her antibiotics that had caused the infection. (laughs)... Their level of care is just shocking say they’ve got a fancy building...So we moved off their books to Carlton road family medical centre. And we found out their level of care is a lot better. My wife who’s diabetic and needs to be tested and examined every three months not once a year as they did there...’’ (Keith, 40)*

In the above example, we learn from Keith that he has been involved with two GP surgeries in St Ann’s. In both cases, Keith he has had negative experiences involving an incorrect prescription and long waiting times.

Issues surrounding the lack of access to local health services, such as a GP, have also been highlighted in other studies conducted in deprived neighbourhoods (Forrest and Kearns, 2001; Beckett and Dixon, 2006). In one study (Forrest and Kearns, op.cit.), residents reported having to wait to see a doctor in the local health centre for a minimum of two hours every appointment because of the incredible lack of resources. There were patients from all over the globe who struggled to speak English and struggled with the NHS system. The authors (ibid.) recall the story of a Jamaican man who would enter the

GP surgery and sing a round of 'old Jamaican Ska' songs to entertain the patients as they wait. He would receive a round of applause, and leave, always to return the next day.

While I never witnessed any singing during my time in the GP surgery in St Ann's, I heard the stories of many residents such as Keith who had become exasperated and disenfranchised with the quality of care received. At the time, the surgery had recently received funding cuts by the Conservative and Liberal Democrat government, and so the surgery had changed its appointment system with the aim of becoming more 'efficient'. Clearly, this resulted in an already struggling GP surgery having to deal with a daily queue of patients telephoning at 8.30am attempting to make a same day appointment. What exists here then, in St Ann's, and within some communities across the UK, where the poorest individuals live, are hardships caused by the consequences of structural inequality. A political system that does not engage with those who have the least power, and disenfranchisement relating to the notion of fairness regarding their families and their communities. However, there is also humour, love and care for their families, and within the wider community, a strong sense of identity and place. There is also the belief that their strength and pride belongs in their local community, out of which it was born.

The working-class residents also discussed shopping in some detail in my interviews with them. With some similarities to the qualitative literature into health and place, they did often discuss access to nearby supermarkets. However, they frequently discussed the issue of being unable to 'buy in bulk'. This issue was not discussed in other qualitative literature. Danielle was a working-class resident who had lived in St Ann's for five years. While discussing the availability of shops in St Ann's, she said the following:

*Tom: "You mentioned it wasn't also easy to go shopping then"?*

*Danielle: "If you do a big shop, then you know there's more bargains you can get as in two for ones. And having that big shop, but it's also you've got to have the money to do a big shop, so it's almost feels like erm... It's what my friend said to me the other day I can buy a bus pass for three months in advance and that will save me £100. But I haven't got the money to buy that bus pass for three months, so the less money you've got the more money you pay for stuff and the more money you've got the cheaper stuff is...It's the same with the heating around here the heating is on a pre-paid... it's enviro-energy*

*and you can't change the heating if you're in a council house in this area. So you're paying... you have to put money on that card and it works out as more money than if you had a direct debit. So the poorer you are the more money everything seems to be. So with the shopping and yeah... so the less money you've got the more expensive things are" (Danielle, 28)*

In the above example, Danielle explains that food costs less when purchased in 'bulk'. While such purchases would be cheaper overall for residents, some residents in St Ann's are not financially able to make the larger investment, which results in the purchasing of smaller quantities. The cost of living is therefore higher. This suggests then, as opposed to thinking of access to nearby shops as the 'determinant' for health in deprived areas, we should also take into account an individual's economic circumstances as this is what can limit or curtail them from purchasing certain foods.

To conclude this section, for the working-class residents, the community centre was often viewed in a positive light as important for them. This place signified companionship and togetherness. However, this was sometimes controversial, with some residents feeling that the community centre should be taken down. Furthermore, while the working-class residents were aware of the high crime rate in the area, they amused themselves in interviews telling stories of the police catching criminals in their back garden. Therefore, while 'drug-dealing' may be seen as a 'negative' attribute of a place, for some residents this is not necessarily the case. At the same time, however, some views of antisocial behaviour in the area were a cause for concern for working-class residents who were parents. Working-class residents also acknowledged the importance of the area looking 'pleasant'. However, this extended beyond the simple appearance of a place. Rather, it instilled a sense of pride for the residents which was pertinent for their wellbeing. While green spaces were acknowledged as being important for residents, the quality of personal relationships between residents was seen as more important. Furthermore, the GP surgery in the area was viewed as an exasperating place where it was difficult to make appointments and receive quality care.

### Meanings of Shops and local places – the Middle-class residents

In contrast to the older adults and some of the working-class residents, the current corner shops in the area were rarely seen favourably by the middle-class residents. They were

seen as expensive and not stocking much food and only useful for selling alcohol and cigarettes and a few ‘soggy cucumbers.’ In my interview with Chevorne, a 25-year-old PhD student who lived in the area, she said the following:

*Tom: “So why is it that you probably wouldn’t go to those corner shops that you mentioned for your shopping more often?”*

*“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) ... so I try and top up my gas card as little as possible and stay away from there. 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. Then there’s Tesco then there’s another Tesco there’s loads in the city centre. But going this way I can’t think of any supermarkets I could be wrong because I don’t really go in to St Ann’s all that much” (Chevorne, 25)*

In the above, Chevorne explains that she consciously tries to avoid certain places in St Ann’s as she considers them seedy and unpleasant places to visit. For older adults, an underpass for example can be seen as a pleasant walking route they may walk through daily with their dog or while doing their ‘rounds’, for the middle-class groups it is a place to avoid. The ‘hoodies hangin’ round’ that did not seem to faze or deter the working-class residents, are for the middle-classes groups places to avoid and signify danger. Additionally, the corner shops that were seen by the older adults as useful places to visit, place a bet, see their friends and encourage them to leave the house, were viewed by the middle-class as dubious places to avoid at all costs.

*Tom: “So, is there anything you think the council could do to improve the area?”*

*“... 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 like we could... 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 bowling or something like that'' (Dean, 24)*

In the above example, Dean is typical of the middle-class group who were often highly critical of various places within St Ann's. Additionally, in the majority of interviews with this group, they expressed how unhappy they were living in St Ann's. When I asked why this was the case, they would sometimes talk about other people not being very friendly:

*'... Try and say hello to people in the street but it doesn't always...come off...you get a weird look sometimes for saying good morning...'' (Dean, 24).*

However, in the majority of cases, the middle-classes avoided going into St Ann's due to the lack of facilities. They therefore had no need to. Additionally, the middle-class residents frequently expressed that they had little in common with the St Ann's residents and so did not wish to socialise with them.

To conclude this section, in stark contrast to the older adults and working-class residents, the area was rarely seen favourably by this group of middle-class residents. They described seedy and unpleasant places. Whereas the older adults would enjoy taking a walk through the area, to visit certain places, the middle-class group thought St Ann's area as a whole was a place to avoid. Additionally, the middle-class residents viewed the residents in St Ann's in a negative light, explaining they had little in common with them so did not associate with them.

## Conclusion

To conclude, existing empirical research into place and health has investigated how social inequalities in health can be created and maintained within the physical environment (see for example, Parsons, 1992; Ulrich, 1993; Kahn, 1997; Gullone, 2000; Morris, 2003). There is also a considerable amount of literature that shows the various regional variations in health (Parsons, op.cit.; Morris, op.cit.). Yet, on the other hand, there is less detail about the significance and meaning of such variations. I argue that advancing our understanding of how places relate to health requires moving beyond these existing conceptualisations of 'place' in empirical research. This is necessary in order to fully comprehend the complex relationships and meanings that exist between people and

places. Recognising that individuals can become socially embedded within places and spaces, is crucial in order to further understand the importance of place in the generation of health inequalities.

This chapter has demonstrated the diverse array of views and perceptions that exist about different places in St Ann's. Arising from the themes in this chapter, it is plausible to suggest that in seeking to understand a community, it is important to draw from the residents who live within that community. The community members are an essential source of information about neighbourhoods, and subjective views and perspectives should be elicited with and from a cross section of interest groups within neighbourhoods, such as the older adults, community workers and the middle-class residents.

I argued that corner shops, and certain spaces and places within a neighbourhood are not just elements of the physical environment. They also reflect substantially more complex neighbourhood social attributes that are given different assessments depending on the group. For some residents, such as the older adults, they were described as useful places to take a walk to and visit during their daily routines and sometimes meet friends. These places for this group therefore represent community cohesion, mobility, and individual purpose. However, sometimes the same places were seen as dangerous, seedy and should be taken down, as voiced by other residents. Therefore, by simply classifying places as 'outlets', or 'buildings' that have services, we can misconstrue the important pathways through which these establishments and places within the neighbourhood affect health. Depending on the outcome of interest (for example, the occurrence of poor health), straightforward counting of food outlets – a standard objective measure – leads to misclassification, potentially obscuring the relationships examined.

There is therefore a need to gather these understandings of how place influences health and place them into empirical analysis. First, we need to recognise that there is a mutually reinforcing and reciprocal relationship between people and place. Having this view prompts us to analyse the processes and interactions that occur between people and the social and physical resources within their environment. Secondly, we need to recognise that 'context' and 'place' varies depending on the individual and their social position. Charting an individual's personal geography through multiple 'places' that they visit and why they are important to that individual will give us an improved understanding as to

which environments are most salient for health in terms of location, but also how an individual's social characteristics mediate this relationship.

Indeed, within St Ann's place was not viewed as a 'separate' entity from the daily lives of residents. Rather, place underpinned the majority of conversations where I asked residents about their daily lives, their health and perceptions of the local neighbourhood. Secondly, residents' perceptions of places varied, with an individual's personal characteristics such as their habitus and social position mediating this relationship.

Additionally, we need to focus less on 'context' in the geographical sense (the local environment) and more on the context of social space and the meanings individuals attribute to it. Bourdieu (1999) explored how people saw themselves in one of his last books, 'The Weight of the World'. There, Bourdieu contrasts material poverty ('la grande misere') with the positional suffering' that leads to 'all kinds of ordinary suffering ('la petite misere)'. We need to continue to represent, to understand, and to address this positional suffering, using whatever tools we have at our disposal, be these explanations of the voices of living in deprived geographical settings and social spaces. Most intriguingly, given my own findings, there is the need to examine more fully the health and lived experiences of people located in similar regions of social space.

Bourdieu's (1979) view on the role of physical space, and its relation to habitus, is often difficult to discern. This is in part because nowhere in his oeuvre does he treat the subject in detail. What can be said however, is that according to Bourdieu (ibid.), social space translates into physical space but that this translation is often blurred. Social space appears as the distribution in physical space of different kinds of goods and services, of individual agents and physically situated groups. These groups are endowed with greater (the middle-class residents) or fewer possibilities (the working-class residents) for appropriating those goods, with the distribution of these possibilities dependent in part, on their respective locations and social position.

Bourdieu's (1979) concept of habitus, includes particular actions or practices that are enabled by, or are dependent on, particular physical surroundings (natural or artefactual). Habitus is dependent on this environment, and may be distorted, transformed or destroyed if the surroundings change or disappear. For example, it is clear from this chapter that the individual experience of place and health in St Ann's was structured by their gender, age, ethnicity, social class and other social factors. Different individuals within the area were

differentially and multiply positioned in relation to these aspects of social structure. Bourdieu (1979) used the term ‘dispositions’ to describe the ways in which individuals conceive of and view the world and the places within it from their social position. Dispositions are constructed by a variety of social, cultural, and material resources and experiences which dispose individuals and groups towards particular attitudes, morals and expectations. The result is a class rationality or logic – a sense making framework – that provides a foundation for an individual’s own perceptions and views on the places around them.

So, according to Bourdieu (1979) the habitus mediates between individuals, places, what individuals do, and how they perceive such places with regards to health. Habitus therefore makes the individual ‘habit’ places that are ‘normal’ to them, and sometimes this can perpetuate health inequalities as individual’s do ‘unhealthy’ behaviours out of their habitus. For example, visiting McDonalds and drinking Carling are, in the first instance, not ‘positive actions for a person’s health.

The working-class residents felt most ‘at home’ within their given social space in St Ann’s. The places they visited in the area were ‘part’ of their daily lives. In other words, their habitus meshed with field and their apprehension of their social environment was more practical than it was theoretical and more tacit than it was explicit. The working-class residents acted within their own social traditions, expectations, classifications and so on appearing to be so natural and self-evident that their arbitrariness is misrecognised.

However, and at the same time, these practices of some of the working-class residents from deprived neighbourhoods are classed as ‘sick’ and ‘unpalatable’ by others, such as the middle-class residents. There exists a lack of understanding of how these practices may contribute to their health. For example, the corner shop may be a place to go to in terms of daily mobility and routines for the older adults. Additionally, the social relationships reaped from drinking the Carling and being around others may not be the most salubrious activity to do, but it offers the older adults a sense of belonging, sociability, and company. It follows that, the communal spaces, the trips to McDonalds and the corner shops have other functions than simply being ‘unhealthy’ and being affordable or not.

Therefore, according to Bourdieu (1979), it makes sense for the middle-class groups in this chapter to distinguish themselves by preferring to see their body as an aesthetic,



cultural form, and see the places they visit and attribute meaning to as a matter of good taste and style. This is the distinction in the form of what Bourdieu (1979) calls ‘cultural capital’, that allows one social group (the middle-class residents) to have and exhibit its prestige over another. This group therefore attributed the ‘working-class places’ in the area, such as the corner shops and communal areas as seedy, distasteful and unpleasant places to visit that were best avoided. So, while individuals can make choices in their lives, they are limited by structuring principles, or habitus. Individuals can no more ‘step outside’ the boundaries of their classed habitus than an ‘outsider’ can choose to step in to a completely different world in terms of taking up its associated ‘alien’ practices and habits.

Ultimately, the neighbourhood in St Ann’s is a dynamic concept and means different things to different people according to their social position. These meanings were bound by their habitus and residents visited places that were in line with it. Consequently, there is a need to look beyond people’s accounts of place, and examine the interface between context, circumstance and meaning in order to decipher informants’ implicit assumptions, which may be hinted at or left unsaid. Grasping their practical knowledge is what underpins their actions.

## Chapter 5: 'Doing the Rounds', Health and Practices

Another theme that emerged from the interviews and observations was the importance of 'doing rounds' or routines, which some residents of St Ann's related to their health. These routines were often associated with activities, such as visiting the community centre, the food bank, betting shop and the church. Residents would talk about visiting certain places and people every day and doing the same chores.

These practices were different for the different groups in St Ann's. For example, the older adults would associate their health and wellbeing with routines, such as dog-walking and being in the company of others. This draws attention to the fact that routines such as congregating in the community centre, eating and walking in the surrounding parks, are important for residents, particularly for older adults who were often more space-bound. Middle-class residents, on the other hand, adhered to more individualistic routines for improving their health. This was in contrast with the other groups I interviewed. The self-centredness of the middle-class residents came to the fore, as they rejected belonging to the community and did not contribute to its well-being. Their daily routines reflected this. The community workers and parents, however, had routines that were geared towards helping others. For some participants in this group, this was health-related. For example, they would discuss activities such as taking children to swim. However, some of their daily practices simply involved regular volunteering activities and school runs. When asked directly about their own health, they would say little in interviews. It appeared that they were likely to neglect their own needs and health and wished to take care of others. The community workers and parents were either community or/and family orientated with their routines.

I argue that these different class, age and gender positions 'play out' differently in terms of routines and health reflecting the power of Bourdeusian 'habitus'. I also relate these routines to existing qualitative literature on social practices and health. Work on health and practices (Day, op.cit.; Lockett et al, 2005; Michael et al, 2006, Strach et al, 2007) has often focused on older people and how neighbourhood context influences specific social practices such as walking. However, many of these studies focussed on the physical environment and did not consider the broader social context of older adults' everyday

lives. Many times studies on routines also did not contrast the experiences of several routines to highlight their class, gender etc. based underpinnings (apart from Harries and Rettie, 2016).

Further, the majority of traditional public health literature tends to view health based on a behavioural model, which aims to alter the psychological characteristics of individuals such as their knowledge and attitudes to enable them to live a ‘healthier’ lifestyle. However, such approach implies a separation of people from their environment and social context. Drawing on Bourdieu and practice theory, I argue then, that rather than taking a public health perspective that seeks to identify the barriers that ‘prevent’ people from living healthy lifestyles, there needs to be a rigorous exploration into the diverse array of social practices carried out by residents in deprived areas. While there were only a handful of groups interviewed for my own thesis, my data shows the varied and differing social practices carried out by residents bound by their habitus. We need to take the various elements of people’s practical and day-to-day routines more seriously. Then, it may be possible to identify more fruitfully how and why such practices are created and what the conditions are for them to change when analysing health.

### Practice Theory and Health

In my introductory chapter, I explained that in order to make sense of the practices of my participants for my research, I drew on the work of Bourdieu. The concept of habitus begins from both an experiential and sociological conundrum. Essentially, people often feel as though they are free agents, yet base everyday decisions on assumptions about the predictable character, behaviour and attitudes of others (Bourdieu, 1994). Sociologically, social practices are characterised by regularities. For example, working-class children tend to get working-class jobs, middle-class readers tend to enjoy middle-brow literature, and so forth – yet there are no explicit rules dictating such practices. These both raise fundamental questions which habitus is intended to resolve. As Bourdieu (1994) states: *‘All of my thinking started from this point: how can behaviour be regulated without being the product of obedience to rules?’* (p. 65).

In other words, Bourdieu (1994) asks how social structure and individual agency can be reconciled, and how the outer social, and inner self help to shape each other.

To explore how habitus addresses these questions, I will first carry out a brief excursion into this theory. Formally, Bourdieu (1994) defines habitus as a property of social agents (whether individuals, groups or institutions) that comprises a ‘‘structured and structuring structure’’ (p. 170). It is “structured” by one’s past and present circumstances, such as family upbringing, and educational experiences. It is structuring in that one’s habitus helps to shape one’s present and future practices. It is a structure in that it is systematically ordered, rather than random or unpatterned. This structure comprises a system of dispositions which generate perceptions, appreciations and practices. The term ‘disposition’ is, for Bourdieu (1994), crucial for bringing together these ideas of structure and tendency.

These dispositions or tendencies are durable in that they last over time, and transposable in being capable of becoming active within a wide variety of theatres of social action (Bourdieu, 1994). The habitus is thus both structured by conditions of existence and generates practices, beliefs, perceptions, feelings and so forth in accordance with its own structure. The habitus, however, does not act alone. Bourdieu (1994) is not suggesting that we are pre-programmed automatons acting out the implications of our upbringings. Rather, practices are the result of what he calls ‘an obscure and double relation’, or ‘an unconscious relationship’ between habitus and field. Bourdieu summarises (1994) this relation using the following equation:

$$[(\text{habitus})(\text{capital})] + \text{field} = \text{practice}.$$

This equation can be unpacked as follows: practice results from relations between one’s dispositions (habitus) and one’s position in a field (capital), within the current state of play of that social arena (field). This concise formulation highlights something of crucial significance for understanding Bourdieu’s approach: the interlocking nature of his three main ‘thinking tools’ (habitus, field and capital). Practices are thus not simply the result of one’s habitus, but rather of relations between one’s habitus and one’s current circumstances. Bourdieu (1994) describes this relation as the meeting of two evolving logics or histories. In other words, the physical and social space we occupy (such as residents in St Ann’s) are (like the habitus) structured, and it is the relation between these two structures that gives rise to practices.

To sum up this point, a society is a multidimensional space consisting of a number of spaces or fields. Within a neighbourhood, these might be various institutions, social

groups, such as communal areas and the like. When entering a field, the individual has with him/her a habitus. Habitus is a kind of bundle of resources. It is therefore a capital of different 'types'. These include economic (financial resources), social (one's networks) and cultural (knowing cultural norms so how to behave and what to do in various social contexts).

As an individual enters a particular space or field, all these forms of capital are transformed into symbolic capital. Symbolic capital can be explained as a capital having a particular meaning in a particular field. So, knowing an 'important' individual can give an individual a certain amount of social capital, for example. Following on from this, there is the 'doxa'. 'Doxa' can be defined as a set of rules in a particular field (Bourdieu, 1994). It therefore defines what is thinkable and 'sayable' within a given social space.

In addition, I frequently found that many of my participants had their own social practices which involved routines and chores. Similar to Bourdieu's (1984) work, these practices were underpinned by and displayed the person's gender and social class position and identity.

Research (Lawton, 1980; Glass and Balfour, 2003) on health and environment has tended to argue that the ability for older people to function in their living environments and have a good level of health is an outcome of the dynamic between the competencies of the individual and the demands of the specific environment. As Glass and Balfour (op.cit.), note, the environment may challenge competence but may also 'buoy' it. These insights have been often applied with a focus on designing suitable housing environments for older people, paying less attention to the wider environment. Such work has also concentrated on physical function, paying less attention to other ways in which physical surroundings, which may include built and natural elements, may stress or support the older individual. Glass and Balfour (ibid.) have argued that most recent work has tended to focus on home and care-giving environments. Therefore, understanding of the wider residential environment and its contribution to older people's health and well-being remains an under explored area.

Surveys of older people's general satisfaction with their residential neighbourhood have tended to conclude that physical features and/or appearance, and social dynamics, are important influences (for example, Scharf, Phillipson, Smith and Kingston, 2002). Friends and neighbours have been found to be among the most valued assets, with good

social bonds increasing residential and neighbourhood satisfaction, whilst problems crossing roads and walking on pavements, or a poor general overall appearance can be strongly felt negatives (Scharf et al, 2002). Connecting this with routines and social practice, there has been some interest in neighbourhoods and older people's functional health and/or mobility (Balfour and Kaplan, 2002). Balfour and Kaplan (*ibid.*) found that multiple problem neighbourhoods were associated with decreased physical function over 1 year, with the strongest single predictors being noise, poor lighting, heavy traffic, and poor public transport. Such features seem likely to diminish the amount of exercise taken. Other quantitative and qualitative studies (Patterson and Chapman, 2004; Michael et al 2006) have linked higher levels of walking within the availability and proximity of services such as shops and leisure facilities – provided the services are of sufficient quality, and with the availability of attractive, pedestrian-friendly walking routes. Other factors (Patterson and Chapman, *op.cit.*) have drawn attention to features of urban design that affect older people and their walking. These include seat availability and design, steps and access routes, lighting, street layout and signage.

There are a number of qualitative studies on the elderly, mobility and geography, which draw on practice theory and have pertinence with regards to my research (Wiles, 2003, Boneham and Sixsmith, *op.cit.*; Walker and Hillier, *op.cit.*; Delormier et al, *op.cit.*). In a qualitative study by Wiles (*op.cit.*), the author found that older adults regularly discussed their daily routines in interview questions regarding their neighbourhood. These routines were discussed in outstanding detail in many instances. Older adults would often discuss specific times they carried out their daily rounds, such as when they visited friends, their local church, took their medications and so on. Older adults also had their own 'practical knowledge' with regards to certain local shops and places. For example, some residents knew the specific times when certain food items were available at their local market, or when certain friends would also be visiting the same places as them. The older adults would then tailor their routines to be able to visit these places at these specific times. Wiles (*ibid.*) also suggests that older adults often develop daily routines as a means to 'cope' with day to day life, as well as provide a 'purpose' and some 'structure to their days.

Other qualitative studies (Backett-Milturn et al, 2006; Nettleton, 2006) have argued that an individual's behaviour and their routines are bounded by distinctions of taste, according to social position. There therefore exists, certain 'tastes' and routines that are

often associated with working-class groups. For example, visiting the local community centre, public house, café and so on do not usually require significant planning or pre-thought and so they can therefore be lived on a day to day basis.

This relationship between habitus and practice theory has been discussed in other qualitative studies. One qualitative study by Nettleton and Green (2014) illustrated how two different groups of people (South Asian Muslim woman living in London and fell runners in the English Lake District) had diversely different practices. The interviewer asked a group of South Asian Muslim women living in London why they did not cycle more often when going about their day to day business. As a practice, cycling is also both embodied and embedded social action, articulated within particular social and material environments from which it derives meaning. In one interview Nettleton and Green (ibid.) asked a group of Muslim women whether they had ever considered cycling to work. Asking such a question was often met with the assumption that it was a 'joke'. Clearly, these respondents were 'not the sort' to cycle. This is an example one type of practical, tacit knowledge and the ways in which the dispositions of a particular group exclude a particular practice as 'unthinkable'. The absurdity of the question is derived from the way in which it articulates the implicit – so what goes without saying – and is recognised through the humour it generates.

Another qualitative study (Harries and Rettie, 2016) into the elderly, place and health, found that practices (such as shopping and walking) were being formed as health practices for some residents. For example, participants in this study often made a point about deliberately visiting the shops in order to get more exercise. Others, though not talking explicitly about health, frequently drew on a health discourse (for example, e.g. when they talked of being 'active'). Being active was not always explicitly highlighted by residents as being part of health. Instead, being active was interwoven with carrying out rounds, visiting the community centre and seeing friends.

With regards to the routines and practices of older adults within neighbourhoods, 'motilities' is a term frequently discussed in some of these studies (Urry, 2007; Green, 2009; Nettleton and Green, op.cit.). These studies highlight the importance for older adults to remain 'mobile' despite their age or disabilities that they may have. Being able to take a daily walk for example has also been discussed by Urry (op.cit.) who argues that

the time spent traveling is not necessarily unproductive and wasted dead time that people always wish to minimise:

*‘Movement often involves an embodied experience of the material and sociable modes of dwelling-in-motion, places of and for activities in their own right, to climb a mountain, to do a good walk, to take a nice train journey. There are activities conducted at the destination: activities conducted while traveling including the ‘anti-activity’ of relaxing, thinking, shifting gears; and the pleasures of travelling itself, including the sensation of speed, of movement through and exposure to the environment, the beauty of a route and so on.’ (Urry, op.cit.. p.11)*

In other words, there is more to walking than simply doing it as a required to complete a chore. A social practice such as walking has varying meanings for each individual who decides to take a walk. Additionally, when taking a walk it allows time for that person to think and feel the sensation of movement (ibid.).

To summarise this literature, there has been a significant amount of qualitative research done into deprived areas and people’s routines, particularly routines of physical activity and accessibility. However, a large portion of this work has focused on older adults and how the various ‘features’ or ‘living environments’ within their neighbourhood has affected their health. Findings from these studies are quite similar to my own. However, an understanding of how the wider residential environment within a neighbourhood affects people’s routines and practices has remained under researched. These practices have also usually not been studied in relation to other groups, who live in deprived areas such as middle-class residents, parents of young children and community workers or activists.

In the three sections below, I discuss the findings from the three different groups of people I interviewed for my research. The first section discusses the older adults, who were the working class in St Ann’s. This is followed by a discussion of the young middle-class residents and, finally, the parents and community organisers.



### 'Doing the rounds': The older adults

During my field work, I found that older adults often framed their answers to questions about health by relating it to their daily lives and routines. This was particularly the case in interviews with older adults who often spoke about 'doing rounds' and 'chores' in the area.

The case of a 77 year old man, Clive illustrates a routine. Clive had lived in St Ann's for most of his life. He was the caretaker in the community centre, which meant he visited every day. This was where I first started speaking to him. At the beginning of the interview with Clive, I assumed he was retired due to his age. This suggestion did not go down well with him, and he immediately remarked he worked as the caretaker at the community centre. When younger, he had worked as a bricklayer, and he explained that he was one of the people who had built the community centre, the church "brick by brick", and a number of other buildings in the area.

To find out what daily life was like living in St Ann's, I would ask early on in the interview what a typical day was like for them. This question was asked in order to obtain some contextual information, and I was also interested to see whether any topics surrounding health would come up without my mentioning health itself. In many interviews with older adults, the way they answered the question about a typical day, and the way they answered a question about their health, were quite similar. For example, Clive explained that a typical day for him involved walking his dog along a specific route and visiting the community centre. When I asked Clive about health later on in the interview, he highlighted this routine again in a similar way, but also detailed what food he ate and gave more of an emphasis on walking. Clive could only frame his answer for both questions (a typical day and what health was like) by relating it to his routine practices:

Tom: *"So living here then, what's a typical day for you?"*

Clive: *" Well I take me dog out about half past four in the morning... Cause' I've got a dog... Rocky....No I wake up at... I wake up at quarter to four..."*

*then I take the dog out, a good walk. I go down there up Burton Street, across where them lights are on the lift then under the subway and back through the thingy... Then I come to work here upstairs for about what an hour an hour and an hour before they come in...because someone will come in about 8 o'clock', cause' it's flexy time now they can come in at ten o'clock then will work till six you know what I mean it's like flexible hours what it is now''.*  
(Clive, 77)

For Clive, his daily practices always involved walking his dog at specific times and visiting the community centre to get his meal and open and close it. This practice was also a social occasion. In the community centre he was surrounded people he knew and could socialise with them. Later in the interview, when I asked Clive about health in St Ann's, he talked about being able to '*walk about fifty mile a week*'. This practice was always done with his dog.

As I discuss later on in this chapter, these routines outlined by the older adults were certain socially conditioned practices. Bourdieu (1977) refers to 'practical functions' which are the daily rhythms of everyday life. The body is central to this, and practices are not wholly consciously organised. This brings to the fore the role of the body and habits. So, for Clive, his practices which involved walking the dog had their own internal logic derived from his individual past experience of reality and the constraints of his habitus.

When I was discussing health in St Ann's with another older adult, Pat, who was also 77 years old, his routine meant that he was able to get his meals cheaply at the community centre since it served food daily:

Tom: '*So what do you tend to eat... do you tend to cook?*

Pat: *I do Saturday and Sunday, but I have a good dinner here... It's only £2.50... Yeah, so I, what did I have for breakfast this morning? Oh I had two sausages sandwiches and then, I had two apples, two oranges. Then I'll have my dinner here, then perhaps a sandwich at night you see or take my dinner home when I've finished upstairs cause' you haven't got to light a gas stove you haven't got to wash pots you haven't got to do nothing''*

Although Pat said he had a stove and was able to cook, he was reluctant to do so as he had to wash “‘pots n’ pans” which was unnecessary since he could get most of his meals at a good price at the community centre. However, the primary reason the older adults visited the community centre was for company. For example, Ethel (68), liked to visit the community centre every Tuesday and Thursday as there was a lunch buffet she could go to where she met some of her friends. People’s eating routines were formed in relation to not only places (the community centre) but also to other people. Many people, such as Clive, Ethel and Pat, visited the community centre to eat together with other people. The café would serve a variety of hot and cold food. I noticed that lunch time was usually busiest, with older adults coming in and out of the community centre every few minutes. They would order some food and cups of tea from the café area and then sit down together in a group chatting. Eating therefore did not involve an isolated ‘choice’ but it was a choice conditioned by the context in which it occurs. For example, Clive wants to see his friends regularly, and so he has routines that help him through the day to be able to do this.

Ethel was of Jamaican origin and had recently retired but often helped out in the community. When I asked Ethel about a typical day for her, she spoke about the places and practices that were important to her:

*Tom: “What’s a typical day for you at the moment then if there is a typical day for you during the week?”*

*Ethel: “Now I’m not working I’ve got a typical day of hospital appointments... doctor’s appointments. I do on a Monday we go to the museum to do work, I liaise with club members if they are not well we try and visit them, find out what their needs are, how can we help. But my day now is mainly spent with community really.. interests... because I can’t manage the housework how I used. 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...” (Ethel 68)*

Ethel’s response is interesting as she discusses the importance of helping others, and how she finds the practice of gardening ‘therapeutic’. This environmental aspect of health that she identifies as being important to her wellbeing has been discussed in other qualitative research into older people and place (Day, op.cit.; Lockett et al, 2005; Michael et al,

op.cit.; Strach et al, op.cit., Isaacs and Greenwald, 2007). Similarly, as with the other interviews quoted in this section, Ethel discusses the importance of being able to liaise with other people in the area and socialise.

Everyday routines were not always described in such detail by older adults but they still involved other people and set places. For example, Sylvia gave the following summary of her days:

*‘‘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’’ (Sylvia, 77).*

Margaret, another older adult, who I met in the community centre summarised some of her week days as the following:

*‘‘Well I have a friend who comes to see me on Tuesdays and Sundays... and we have a natter and a moan and play on my computer... well I play on it he’s got something better to do’’ (Margaret, 74)*

In the interview with Margaret, she spoke about the importance of having a friend come and visit her on certain days in the week and why this was important to her. The quotation from Sylvia was from a group interview I conducted with three other older adult participants who lived in council accommodation. This group of older adults were discussed in chapter 1. However, they also spoke about routine as being able to get up and walk about daily, visit shops, watch films together and drink lager. Being able to have these routines was vital to them. They were also aware of other members of the community who did not have this routine:

Aubrey (76): *‘‘It depends what they want... I mean I think most people, most people eat fairly well... you’ve got one or two who don’t... but they’re normally looked after by somebody else like...’’*

Sylvia: *‘‘They’re poorly’’*

Aubrey: *‘‘I mean they [the nurses] make sure they get something to eat kind of...’’*

Tom: *‘‘Cause’ some people can’t eat three meals a day for whatever reason?’’*

Aubrey: *‘‘No, no’’*

Sylvia: ‘‘...As well. Cause’ I just saw a carer I guess there’s nurses that come round and...’’

Aubrey: ‘‘Yeah she’s come to see Frank who’s got (unclear)... they come and dress ‘em’’

Sylvia: ‘‘Yeah he needs to be looked after doesn’t he, yeah.’’

Routine to these older adults therefore, extends further than simply carrying out a sequence of acts repeatedly day after day. Being able to carry out a routine meant being able to get up every day and take a walk, visit the shops, meet up with friends and so on. There was an importance of staying mobile within the community, and the participants were aware that this was not possible for those residents who had become home-bound or bed-bound.

As I discuss later in this chapter, due to the limitations of the older adults’ habitus (Bourdieu, 1979), the older adults did not tend to carry out social practices that were not in line with their current social environment. Taking a walk and visiting friends for example, were activities in line with their habitus, and so they made an effort to have routines which involved these.

### Doing the rounds – The working-class residents

Being able to walk when carrying out daily practices was not only highlighted in interviews with older adults. Stellah was a 46-year-old woman of African Caribbean origin, who had lived in St Ann’s for seven years. Stellah is an example of a resident who appears to be in between two of my groups (the older adults and the middle-class residents) I met Stellah during my time at Nottingham University. Although she was completing a Masters at the time of the interview, she told me that she still considered herself to be working-class:

*Tom: So I mentioned that my research is about health in St Ann’s particularly, so by that I mean kind of weight, exercise, diets. Do you have any thoughts on these generally when I mentioned them? What do they mean to you?*

*Stellah. Well, that one I think it depends with the... what you call wellbeing... like now we have started this Insanity workout thing which you download from YouTube. So every morning six o'clock... myself and my girls because my husband cycles to work he works in Pizza factory, so I think he's got very good... But like myself, I wasn't doing anything in terms of exercise. Of course I walked from St Ann's to uni and back home unless if I'm going to (unclear), then I catch a bus but coming into town I walk even if I'm coming to do some shopping I make sure that I walk... But still I feel it's not sufficient. So, now we've gone into this business of ... six o'clock we get up myself and my younger daughter who's in year twelve and we do exercises for thirty minutes and those old friends of ours [the older adults] will be just watching us because we do it like on a balcony so they can watch us... But they're also very active because there is sort of a garden area where there are flowers a lawn... they always work together... no they don't do [exercise] but they are doing gardeny exercise for them... it's an exercise for them isn't it...*

Stellah talks about several routines in this example – cycling, walking, and gardening. These form an important part of her own health. She speaks explicitly about the routines as health due to her ambiguous class position: i.e. the working-class residents did not relate their walking to health so explicitly. She also spoke about her husband's daily cycling habits and how this was a 'very good' form of exercise for him, even though she highlights that she does not feel that walking alone is a sufficient form of exercise for her or her teenage daughters.

To sum up these two sections, routines were important to older adults. Some of these routines could be considered to be classically related to health, for example walking. However, others were not so, such as drinking lager together with friends (the older adults) and visiting the community centre. A pertinent issue arose that centred on being able to be in the company of others and also being able to do these rounds as opposed to those who were bed-bound and could no longer do them.

There have been some similar observations in other qualitative research on elderly and place, which I discussed earlier in my literature review, such as the importance of having parks and green spaces for people to walk in, and having the companionship of local residents. However, some of the activities carried out by older adults in my own research

were very different to these. Usually, activities such as drinking lager together would not be considered ‘healthy’ and would certainly be discouraged in traditional health promotion messages. However, as I discuss in my analysis section, by understanding practice theory it can be argued that what people ‘do’ in their daily lives has an underlying rationale within their broader life context and habitus. So, drinking lager with neighbours might have a significant positive effect on well-being in terms of providing friendship and social interaction.

### Young middle-class residents and gym-use

When I interviewed young middle-class residents who were living in the area, their routines were quite different. Middle-class residents tended to view their bodies in more of an aesthetic, cultural manner. Their routines involved visiting certain places (such as the gym) to enhance their bodies. They made a point about wanting to ‘look good’ and ‘be slim’.

The middle-class residents were not doing rounds in the same way as the other St Ann’s residents. 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 into the city centre.

I met Sam while we were training in a gym, which was located on the border of St Ann’s. It is immediately noticeable from the tone of the interview that Sam had an outlook that was different from the other St Ann’s residents discussed previously in this chapter. Having been to university and now looking for full-time employment (as well as his interest in fitness) he was planning his life ahead. This highlights a significant difference then from the working-class residents.

When I asked Sam about his daily routine he said the following:

Tom: *‘So tell me about your typical day living here’?*

Sam: *‘Well, I’m up about 7.30am and I have a good breakfast. If it’s a weekend my girlfriend lives in Leicester so I... she either comes here for the weekend or I’ll travel down to see her. Erm, my family, my mum and my brother live in Rugby which is about fifty minutes away an hour so sometimes go and see them or if I’m staying in Nottingham we’ve got our first rugby*

*game next week so that plays throughout the Summer. So that will be every day, 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 so that will be Saturday from now on and Sundays... erm yeah chilling out... I mean exercise is quite big we train two nights a week and gym three, four times a week. Playing rugby on Saturdays and then bowling. We do quite a lot of bowling to be honest... mainly pub sports (laughs)... I suppose... or yeah doing things with my girlfriend (laughs). We go to the cinema quite a bit... we go to the shows at the ice arena quite a bit, Nottingham is really good for that. In the week, well it's work at the minute... earning money and all that shit'' (Sam, 24)*

In the above interview, not only were the practices carried out by Sam very different to the working-class residents (going to a gym, cooking a substantial breakfast, going to work and earning money, going to 'shows' in Nottingham and the like) but most of these practices were situated outside of St Ann's. Also, the activities that he is engaged with are officially 'organised', such as rugby coaching, rather than informal walking in the area. The routines of the middle-class residents also involved practices that they did to consciously advance themselves and their health. They would sign up to an institution such as a gym or a rugby coaching club to be able to increase their skill at a specific sport or achieve a fitness goal.

According to Bourdieu (1979), due to his social position, Sam had the means to follow certain social practices that were very different to the older adults and working-class residents. His higher levels of cultural and economic capital (prestige and status), meant that he was able to carry out certain activities that would be seen as unachievable (due to the constraints of their habitus) for the older adults and working-class residents.

Lauren, a PhD student at Nottingham University was another middle-class woman living in St Ann's, and her daily routine involved the following:

Tom: *''Okay, so what would be your typical day then, so kind of let's pick a weekday as that's generally where...''*



Lauren: ‘...I’m quite OCD-ish so I’m like...quite organised (laughs) ...I’m an early riser as well so I get up at 5 every morning...have some breakfast and watch some TV of course just to get myself awake and get ready and then drive into Uni which is Sutton Bonington... It’s kind of near Loughborough..... where all the life science-ey students are...I drive down there that takes about half an hour... then I work there are because I know that I’m useless from about two o’clock onwards. I really try and just focus and not really take breaks or anything like that so I kind of work for like seven hours straight then...come home do some housework erm watch some TV. If it’s a Thursday I have a ritual where I go to the cinema on Thursdays (laughs), so I’ll go and see a film... Yeah maybe read a little bit and then go to bed, I’m a bit of an old woman (laughs)...I’ve always been an early riser, I think it’s since doing the PhD this is the first time where I, it’s like I can do this on my schedule, I don’t have to be at a lecture I don’t have to be at the office at nine, I work when I’m most productive and I know that I’m really great in the mornings and then after lunch... I just suddenly go downhill’ (Lauren, 28).

Lauren’s packed routine involved getting up early, watching TV, driving to university, working, and coming home to do housework. Similar to Sam, there is not much crossover in the content of this routine in comparison to the older working-class residents, who liked living in the area and spent their time doing rounds in the area. Lauren’s routine had a focus on ensuring she was able to get to University as soon as possible to ensure she was productive with her working day. When describing her routine, she used words such as ‘focus’, being ‘OCD-ish’, ‘not taking breaks’, ‘schedule’ and being ‘productive’. Her routine was officially organised so that she could be productive when studying at work. She had an awareness of when she was most productive in the day and when it was best for her to work. However, she does not engage in any ‘exercise’, which illustrates that not all middle-class residents were necessarily focussed on fitness in their self-advancement.

Summing up this section, the middle-class residents tended to view their bodies in more of an aesthetic, cultural manner and so their routines and practices involved visiting certain places (such as a gym or sports club) to produce this. The middle-class residents

were not carrying out rounds in the same way as the other St Ann's residents. In addition to their practices being situated outside of St Ann's, their activities were officially 'organised' such as coaching people in sport. This is in contrast to the working-class residents I interviewed, who did not sign up to institutions such as a gym or club. The routines of the middle-class residents were also conducted to advance themselves and their membership to a gym or coaching club enabled them to increase their skill at a specific sport or achieve a fitness goal. Moreover, the routines of the middle-class residents were often focussed on allowing them to be 'productive' in their day, which was also a key difference.

### Parents, activists and 'caring'

During my field work, I frequently interviewed some community workers in the area. Most of these community workers however, were volunteers and few of them were in paid positions. For example, the paid positions included the employed community organisers, the manager at the community centre, staff at the community centre and two of the local vicars who were well known people in the St Ann's area. Most of the volunteers worked in the area had community roles such as running the local scouts group, or the slimming group of women. They often had children.

The community workers very rarely discussed their own health, instead focussing on discussing the health of the St Ann's residents they spent their time with. They would speak to me about their role in the area, as opposed to themselves. Even when asked directly about their own health, they tended to talk about other people in St Ann's, such as their own children, other people's children, their family members and other residents who lived in the area. In my interviews with this group, there were few examples where they would talk in detail about their own health.

Young parents living in St Ann's had routines that were, again, different to these other groups. Their routines revolved around services they provided for other members of the family, such as taking children swimming and to the local Scouts club. Keith was a parent who was involved in the running of the community centre. He also carried out other community tasks such as locking and opening the St Ann's church and running the local scouts club for children. He even considered himself as a 'community organiser'. Keith

was a full-time carer for his wife, who was disabled, as well as caring for his four children. At the beginning of the interview he told me that one of his children was trans-gender and currently going through his transition to become female. Keith was a volunteer in the St Ann's community having worked with SureStart and running his own father's support group. He always carried a large bunch of keys around with him, for the various buildings he looked after in the St Ann's Chase area. The following illustrates his routine:

*Tom: "So what's like a typical day for you could you tell me like, or does it vary how do you like an average day what would you do.."*

*Keith: "Right well I wake up at 6 if it's a school day...because my son goes into er a breakfast school (unclear) school so I can get him in er about er twenty to eight and then I've got the day to do things for me wife if she wants any shopping or sometimes I have a few volunteer commitments in the day and then like my daughters have gone to school and when they come back we have some dinner and depending on what night it is the Monday night I have cubs so run the cub group, Tuesday night er me son has swimming so got swimming er Wednesday night sometimes it's meetings I have different meetings we have the Holding Hands community meetings and er then other CO meetings, Church Warden meetings most I have different meetings that kind of rotate on a Wednesday night, Thursday night er we have beavers and scouts and explorers which are different er... 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."* (Keith, 40)

Keith's routines involved helping out in the community. For example, he said that forming his own father support group was important as he'd previously been involved in SureStart but was involved in a clash of ideas. Keith took children swimming and participated in parenting groups, which can be seen as advancing the physical and mental health of his children and others in the community. Keith rarely spoke about his own health in my interview. When I did ask Keith about his own health, he immediately began talking about other people (his family):

*Tom: ... "So I mentioned my research is about health in St Ann's. So when I say health, I'm thinking maybe the typical things such as weight, exercise*

*diet...I just wondered whether you had any thoughts on those things very broadly really? ... What do you think of when I mention those things do you think they're important do they kind of what do they kind of mean to you I suppose?"*

*Keith: "Yeah... we have to be very careful I suppose with our diets because... I've got he wife who's diabetic... so we have to be careful on those lines and also I've got... my youngest daughter has got a spice allergy... So anything with spice and that even includes cheese and onion crisps ... Even certain sweets have paprika in them which is a (unclear) ... and that will make her ill so we have to be very careful ... Or It's diarrhoea within two hours." (laughs)*

*Tom: "Okay. You don't want that when you're on the train or something..."*

*Keith: (laughs) "No... It's quite a thing." (Keith, 40)*

In this example, despite explicitly asking Keith what health meant to him, he immediately begins discussing his wife who is diabetic as well as his youngest daughter who suffers from a spice allergy. He saw himself as servicing the health of others, and so did not discuss his own health.

This quotes above illustrate how the community organisers (who had a higher level of cultural capital) resulted in their practices reflecting this (Bourdieu, 1979). Their higher level of cultural capital (such as education) meant that they were able to carry out certain activities that would be seen as unachievable for the working-class residents. For example, volunteering in the community centre and caring for one another. Keith was involved in community meetings and organisations.

Parents with children usually spoke about the routines of their children or other members of their families rather than their own, even when asked directly about health. Mark was a community organiser who was often involved in running certain groups and projects in the community centre. He had lived in St Ann's for over twenty years. When I asked him about his daily routine, he talked about his young lad:

*Tom: "...I see. So tell me about a typical day for you then... what..."*

*Mark: 'Typical day is the same for us we're down here every day... we get up in the morning ... we get up at about 7 in the morning get lads [their son] breakfast you know walk him down to school, drop him off at school at quarter to nine then we come in here... that's part of the school so parents can take their kids to the school then they... they won't let him out of school without us being there... he's getting older now but I wouldn't let him come to school on his own... when he goes to school no way I'll always go... to know that he's safe.'* (Mark, 58)

Mark's routine needed to be carried out by either himself or his wife, due to safety issues they had regarding the local area and his son being led astray by some local youths. Taking care of others (his child) was therefore an important part of his day.

Rachael was also a community organiser who worked with Keith in helping to run the community centre and the St Ann's Scouts group:

*Rachael: 'When it comes to them being back at school obviously this one [points at daughter] has to get up crack of dawn she has to travel two estates to get to her school... She's crossing Wilford so she'll travel from here she'll nip through the Meadows and then you'll cross Wilford jump over the sort of Lidl back there so er... Yeah a lot of kids seem to travel quite a distance to get to the schools there are schools that are local but unfortunately they only hold so many kids and erm... and they're not always the most desirable schools either I mean you hear bad things about some schools'* (Rachel, 41)

Rachael discussed the routine of her daughter going to school. This was a common theme with the community organisers who were parents. They would also talk about the routines of other local residents. The middle-class residents, however, did not do this in interviews with me. They would only talk about themselves and their own lives and practices.

While the community organisers (such as Rachael) did have a higher level, or a different kind of cultural capital (Bourdieu, 1979) in comparison to the working-class residents, they still had restrictions to their habitus which meant they did not

have the means to follow the well-known health advice of eating five a day and joining a gym. Instead, they focused on the routines of others and caring for them.

When I asked Rachael about her own health, she talked in detail in chapter 4 about the importance of children being able to play safely on the local park. Further on in my interview with Rachael, however, she said the following:

*Tom: ‘I mentioned my research was about health in St Ann's. When I say health, I'm thinking first maybe the typical things associated with... so weight, exercise, diet, mental health and I just wondered if you had any thought about those things ... really’*

*Rachel: ‘... As for healthy eating, we don't have much but I know we are near to town. We don't have much supermarket choice except in the city centre... There's the Tesco's and Aldi, and Erronds has thrived since it opened because it's closer to St Ann's than other supermarkets. People haven't got to trapes into town and... I think that has helped a lot especially with the elderly and the disabled... and it's just a lot easier for them to get to a nice shop. I think with them building an Asda on Carlton road as well that will be good... so there's more shops nearer for us... You don't have to go into the city centre which sometimes cant' be easy for us all...I get involved in a lot of groups is they do very little advertisement about that on this actual estate but an awful lot over in other areas such as Sneinton they... are their target market and they don't bring... they don't come to the activities in this estate... They will go to the festivals in the others and it's a shame that really they don't engage more with the estate... They're actually based on you know I'd like to see projects like that being encouraged... engaged more with the estates that they've started on...’*

Similar to Keith, Rachel does not talk explicitly about her own health. She begins discussing how there is a lack of healthy foods available within the local area, meaning it is difficult for some residents to access it. However, she does not talk about how well she can personally access these foods. Instead, she talks about there being a lack of availability of food stalls generally. For Rachel then, she viewed health as other residents

in the area being able to access nearby shops, as well as having a strong sense of community where there existed local projects where residents could gather together.

The ordinariness of routines was not just a daily ritual for residents in St Ann's but also formed part of their involvement in the community. Vincent was another volunteer in the St Ann's community who helped out. I met him in the food bank as he was delivering a food parcel for those in need:

*'...and then weekends, depends sometimes there's community commitments, scout commitments sometimes I do a bit of down time from which I'm... if possible same with Sunday I'm church warden there's me and David we do it on a week on week off proposal where we if we're on warden duty we have to be here at ten and shut up when everyone's gone. Can be sometimes one o'clock and then we have to be here for six o'clock for the evening service and again you can be here till about eight thirty to shut up again after that, so that's you get your Sunday dinner and everything else in between if you're on duty...'* (Vincent, 52)

Vincent did a significant amount of volunteering within the St Ann's community and so his daily routine (even at weekends) involved carrying out specific rounds and chores within the area. Indeed, many of the community workings in the area relied on volunteers.

To sum up, community activists were geared towards helping others. Sometimes this helping was related to health. For example, taking children swimming or organising activities such as Father's groups and so on. However, some of it was simply carrying out school runs (Mark and Rachael), or carrying out chores in the local community such as in the local church (Vincent). In interviews with these participants, when I did ask them about their own health they would normally talk very briefly about residents not being healthy in the area due to their age or prevalence of high smoking and drinking rates among the younger population. I found this to be relatively unsurprising data. However, what appears more significant is that these participants tended to forget about their own health and talk more about taking care of others. These community activists therefore seemed community oriented or orientated towards others (their and other people's children). Perhaps they had little time for their own health due to their other

priorities. Importantly then, different social positions play out differently in terms of routines and health for residents.

## Discussion

Frohlich et al (2001) argues one's health is largely determined by what people do, or their 'daily doings', so who they come into contact with, where they visit, how they travel, and the environment that they are within. This is my starting point. I discuss in this section, using practice theory and habitus, how, in a deprived neighbourhood that the different groups I interviewed had different practices.

For example, older adults such as Clive and Pat appear to be advancing their health through routines, for example, by walking and being in the company of others. This draws attention to the fact that routines such as congregating in the community centre, eating and walking in the surrounding parks is important for the health and wellbeing of the residents. This was particularly the case for older adults who were often more space-bound. They also acknowledged that the appearance of their immediate local area was important. This included the communal garden, where they would go out and take a daily walk, with some older adults highlighting that being able to do the garden had a positive impact on their health and wellbeing. It would seem that the areas where they performed their social practices (such as walking and visiting friends) needed to have an attractive appearance. Some of these findings were highlighted in other qualitative studies into the elderly, place and health I discussed earlier (Day, *op.cit.*; Lockett et al, 2005; Michael et al, 2006; Strach et al, 2007). Further, local shops and places to visit were important for practices such as walking.

These routines in St Ann's discussed by the elderly were certain socially conditioned practices. For example, Bourdieu (1977) refers to 'practical functions' which are the daily rhythms of everyday life in which the body is central. Schatzki (2001) describes this practical understanding as 'the bodily realised know-how out of which human activity proceeds'. This bodily realised know-how, or embodiment, requires habitual action or performances (such as routines and chores), which, along with bodies, are of central interest in health research. Schatzki (*ibid.*) draws extensively on Bourdieu's (1977) theory of social practices. He summarises three main contributions from Bourdieu of value to health research. First, Bourdieu argues that practices move and are located in time and space (Schatzki, *op.cit.*). So, in the case of my interview with Clive, his practices such as



walking the dog and visiting certain places were always carried out throughout the day at certain times. Importantly, Clive's practices were always carried out within a specific place, and he insisted he never needed to leave the St Ann's area. Secondly, practices are not wholly consciously organised, bringing to the fore the role of body and habits (*ibid.*). Thirdly, practices have their own internal logic derived from an individual's past experience of reality and the constraints of habitus (*ibid.*, 2001). These three features of practices share similarities with Giddens' theory of structuration in that they position bodies, experiences and regular performance as central to the creation of social order and health (Delormier et al, *op.cit.*).

The activities carried out by the older adults in St Ann's were often mixed. For example, drinking lager together and putting on a bet at the corner shop. This highlights the contradictory nature of habitus. These residents were carrying out these activities unconsciously. There is an importance then, to not simply celebrate and recognise the practices these residents have as being significant, but to also understand their underlying rationale in their broader life context.

Due to the restrictions of their habitus (Bourdieu, 1979), the older adults in St Ann's did not tend to carry out social practices that were not in line with their current social environment. They did not have the means to follow the well-known public health advice of eating five a day and joining a gym because that lifestyle was perceived as unachievable and unrealistic for them. This was highlighted in another qualitative study (Backett-Milburn et al, 2006), who found that there were certain 'tastes' and routines usually associated with working-class people such as visiting a local shop or a café.

Conversely, the middle-class residents in St Ann's who I interviewed, did have these means, and so their daily practices were very different to the elderly. The middle-class residents adhered to the individualistic agenda of improving their own health. They had a far more self-centred approach in that they rejected the community and did not contribute, or wish to contribute to its well-being. Their practices were based on improving themselves as individuals and their own health. However, it is important to note that not all of the middle-class residents engaged in activities that could be considered healthy. For example, Lauren and Sam had routines that involved working and studying hard, and so there is an importance not to generalise that the middle-class residents were always focused on health and fitness.

The community organisers were an interesting group to interview, primarily because the majority of them were also working-class St Ann's residents who lived in the area. I argue, however, that they have a higher cultural capital (Bourdieu, 1979) in comparison to the working-class residents. This often enabled them to exhibit their prestige over them. The community organisers worked in the area and were always involved in running activities for other residents such as the food bank or local church. Some of the community workers did recognize the importance of practices for the residents. For example, they recognised that older adults enjoyed walking in the area and visiting certain places and that this more than likely had an impact on their health. However, in chapter 4, I argued that that they tended to view having access to green spaces and parks was more important for health (as argued by most academic literature on this topic) and that the local area lacked this. This point, however, was rarely mentioned by the working-class residents.

The community organisers who had a higher level of cultural capital resulted in their practices being reflected in this. Their higher level of cultural capital (such as education) meant that they were able to carry out certain activities that would be seen as unachievable (because of the constraints of their habitus) for the working class residents. In the case of the above interviews, Keith mentioned in his routine that he was able to volunteer in the community and run the local Scouts group of children. He was able to involve himself and be interested in local community meetings at the community centre and the church.

The community organisers, however, still had restrictions to their habitus which meant they did not have the means to follow the well-known public health advice of eating five a day and joining a gym. They recognized that this was unachievable for them and recognized it was completely unachievable for the 'other' residents in the area. I recall an anecdote told by an interviewee who ran the local food bank where she detailed a time when an 'outsider' came into the food bank and offered a 5 kilogram bag of carrots as a donation. She insisted that now she had these carrots all of the 'poor people' in the area would be able to eat properly.

Indeed, during my own interviews with both working-class and middle-class residents in St Ann's, there were rare occurrences where people would attempt to overly rationalise their social practices to me. For example, if I were to ask why they visited the community

centre, or why they visited a certain shop, they would only explain in their reply what that place or space ‘gave’ them. I discuss this in chapter 4, but, importantly, each practice carried out by a resident always had a purpose and was important to them.

With reference to questions surrounding physical activity, asking the elderly if they did typical exercise (join a gym, go for jog and the like) was completely absurd to them. As one of them mentioned in the above section, most of the elderly participants in this focus group I conducted could just about walk to the door at the end of the room. Most of them therefore went about their day to day business on electric scooters. However, this act of being able to go out on their scooter and having the physical ability to leave the house every day was seen as important.

It is very tempting, at first, when reading about some of the practices of the working-class residents, the middle-class residents, or the community workers in St. Ann’s, to label or translate ‘healthy’ or ‘unhealthy’ behaviour as ‘healthy’ and ‘unhealthy’ social practices. However, it is unhelpful to do so (Delormier et al, op.cit.). Some behaviours currently labelled unhealthy, such as drinking alcohol or smoking a cigarette, do not necessarily qualify as practices in their own right. Instead, they would be considered smaller actions within more substantial and socially recognised practices such as taking a tea break, seeing a live band or celebrating a friend’s birthday (ibid.). Such binary classifications also perpetuate existing, but unhelpful ideas, of what is good and bad in health; which are often overly simplistic and ignore the complexity and diversity experienced in everyday life (Schatzki, 2001). In fact, ‘healthy’ and ‘unhealthy’ could instead be conceptualised as meanings within a practice. For example, practices labelled risky or potentially unhealthy may be simply unavoidable, such as working at a desk. In essence, most practices could be said to have both good and bad health outcomes and it is the sum total of participation in a particular set of practices that will result in the observed health outcomes of individual people or groups (ibid.).

I argue then, rather than taking public health research that seeks to identify the barriers that ‘prevent’ people from living healthy lifestyles, there needs to be a rigorous exploration into the diverse array of social practices carried out by residents in deprived areas. While there were only a handful of groups interviewed for my own thesis, my data shows the varied and differing social practices carried out by residents bound by their habitus. We need to take the various elements of people’s practical and day-to-day

routines more seriously. Then, it may be possible to more fruitfully identify how and how such practices are created and what the conditions are for them to change. We should therefore seek to examine the collective unspoken knowledge or practical reasoning that make certain practices more or less likely.

Theories on social practice then, tend to descend to individual humans and move away from looking for linear or causal relationships for what people do, explaining them by attitudes, behaviours or choices (Reckwitz, 2002). When studying people, the unit of analysis becomes the practice, rather than the person as an individual performer (ibid.). Applying social practice theory to health research means health and wellbeing are outcomes of participating in a set of social practices (such as routines and chores), rather than the result of individual behaviours and/or external structural factors.

There are many practices that can make up a daily routine I discussed in my own research. Social practices can be described as being composed of three key elements (Reckwitz, op.cit.). These are meanings, materials and skills. To take the social practice of taking a walk, meanings covers ideas about what it means to walk, why, where, when, what do wear and use, and with whom. Materials refers to clothing, devices, tracks and paths/roads and lights. Skills refers to knowing how to walk and managing the walk (ibid.).

A practice, or a behaviour such as taking a walk, has a visible aspect to it, such as seeing someone taking a walk. However, there are elements that make up this social practice which are ‘submerged below the water line’ and cannot be noticed at first glance (Holeman and Borgstrom, 2016). In the case of walking in St Ann’s, these elements could be the socially shared tastes and meanings that the individual has. This is known in practice theory as the differentiation of practice as a performance (the observable behaviour), and practice as an entity (what is hidden beneath).

In addition to this, social practices interact with other practices to form bundles and complexes (Holeman and Borgstrom, op.cit.). In St Ann’s, for both the working-class residents and the middle-class residents, practices were rarely performed in isolation from one another. A practice such as taking a walk usually involved visiting a specific place, shop, or person which are different practices in themselves.

I mentioned in my literature review that there are a number of qualitative studies on the elderly, mobility and geography which analyse practice theory and have pertinence with regards to my findings from my own research (Wiles op.cit.; Boneham and Sixsmith,

op.cit; Walker and Hillier, op.cit.; Delormier et al, op.cit.) These studies would often highlight older adults who could describe their daily routines in striking detail (Wiles, op.cit.), such as pinpointing specific times they carried out certain practices. Wiles (ibid.) suggests that older adults develop routines because they are in need of structure to help them cope with daily life. Routines are therefore created as a coping strategy. In my own research, I did not have many instances where older adults said they went about their daily chores as a means of coping with their lives. Certainly, there were instances where they expressed some exasperation with daily life. For example, some older adults said it was hard to live off a pension and keep their homes running. However, I do not agree with older adults knowingly creating 'coping strategies'. This is not a language they used in my own interviews. It would seem overly simplistic to assert that these routines were only created as a means of coping with day-to-day life in the area.

## Chapter 6: Othering

Another theme that emerged from my interviews and observations was that of ‘othering’. Othering is a process that ‘services to mark and name those thought to be different from oneself’ (Weis, op.cit., p.17). This is often done in a negative form (downward social comparison) (Fine, op.cit.; Weis, op.cit.).

When I spoke to people about their health in St Ann’s, they would often compare their health to ‘other’ residents in the area. However, I found that there were varying othering practices in the area, in that, ‘othering’ was conducted differently by different types of people in St Ann’s. This was usually conducted in a negative way. I realised that in order to understand health in St Ann’s, there was an importance to analyse this practice of othering to discover how it has been used by residents in making self-evaluations about their health. This chapter will argue that when interviewed, different groups in St Ann’s effectively ‘othered’ others in various ways. I argue, in certain instances, when individuals make these distinctions between one another this is a form of symbolic violence, which perpetuates inequalities at the local level.

This chapter begins with a brief discussion defining ‘othering’ and ‘social comparison’, in particular, ‘downward social comparison’. This includes a discussion on why individuals make and rely on social comparisons. I argue, however, many of these studies tend to view othering and downward social comparison theory from the micro level, or a health psychologist perspective. These studies (Johnson et al, op.cit.; Grove and Zwi, op.cit.) have tended to look at small-scale interactions between individuals, such as group conversations or group dynamics rather than discussing the larger scale processes inherent in macro level sociology with regards to ‘othering’ and ‘social comparisons’. For these reasons, I have used work from Bourdieu (1979) as the theoretical backbone to this chapter, in particular Bourdieu’s (ibid.) concept of symbolic violence, defined as the ideas and values of the upper classes who impose them (often through subconscious means) onto a dominated social group. This macro approach has allowed me to analyse my findings on a more structural level, as well as an interpretivist one.

With regard to a person’s social status and their social comparisons, I discuss ‘symbolic violence’ (Bourdieu, 1979) and how this relates to my findings in this chapter. This is

particularly with regard to how ‘symbolic violence’ is perpetuated within society, especially in the sense of how a person’s class position allows them to dominate others.

I then discuss and analyse my findings in three separate sections. The first section, ‘Everyone knows St Ann’s is bad’ discusses how the neighborhood was viewed negatively by outsiders. All of the participants I interviewed for my research mentioned this. The working-class residents viewed these outsiders negatively and were conscious that people looked down upon them. All groups, but particularly the working class residents were aware of the negative social comparisons other people made on the area and the damaging effect this was having. I discuss and analyse this. Negative perceptions of St Ann’s are relevant to othering, as they create prejudiced and negative views surrounding the St Ann’s residents, which reinforces their isolation and feelings of separateness from those outside of the area.

The second section, ‘Classic othering: They eat ‘bad’ foods’ argues that most of the groups I interviewed in St Ann’s (the middle-class, the community workers, the working class and a few GPs) saw themselves as ‘better’ in health and behaviour than the majority of others. The middle-class individuals seemed to do this the most, pinpointing how the working-class residents were ‘unhealthy’ because they did not visit the same ‘upmarket’ shops or cafes as them. I argue that this is a form of ‘symbolic violence’. The middle-class group only mentioned St Ann’s with regards to making a conscious effort to leave the immediate area when they could. The two other groups (the working-class residents and the community workers) also carried this out but quite differently. This was a surprising finding, as previous research (Mckenzie, 2012) has frequently shown St Ann’s is a close-knit community with a strong sense of community companionship among the working-class residents. I frequently found this was not the case, however.

In the third section, ‘Some try to understand others’, I discuss how some of the GPs working in the area did view the health behaviours of the St Ann’s residents in a negative light, but attempted to be understanding towards them. The GPs would often be sympathetic in their responses, pinpointing that living in poverty and being on a low income limited people’s ability to live a healthy lifestyle.

In the final section, 'Us and them', I discuss the working-class residents and community volunteers thought the middle class 'helpers' who came into the area were 'out of touch' with the residents' culture.

### Othering and Social Comparison

In seeking to understand 'othering' and how it relates to my research in this chapter, there is firstly an importance to understand how certain practices in health and lifestyle can marginalise particular groups of people (Weis 1995, Johnson et al 2004, Grove and Zwi 2006, Fine 1994). I now go on to discuss this.

One form of this marginalisation can be referred to as 'othering' (Weis, op.cit.). Othering not only "serves to mark and name those thought to be different from oneself" (ibid., p.17) but is also a process through which people construct their own identities **in** with reference to others.

Literature discussing othering (Johnson et al, op.cit.; Grove and Zwi, op.cit.), has tended to argue that individual's other others as a way of magnifying and enforcing their differences from themselves. It therefore reinforces a person's own identity, by distancing themselves from the other. This person, or the group being 'othered' experiences a process of marginalisation and social exclusion effectively creating separation between these groups. Secondly, a number of authors (Fine, op.cit.; Weis, op.cit.) discuss othering as primarily being a form of 'downward social comparison'. Therefore, to understand the process of 'othering' and how it relates to my work, it is useful to firstly discuss social comparison theory.

According to Fiske (2011), social comparisons form the foundations of self-knowledge, and can satisfy the basic human need to feel competent by letting people know whether their opinions are correct and what their abilities allow them to do. Social comparison theory (Buunk and Gibbons, 1997; Suls, 2003) has had a sizable impact on research on health and health behaviours. Individuals use the attitudes, beliefs, and behaviours of others as benchmarks for evaluating their own attitudes, beliefs, and behaviours, and usually shift their own to match those of the group (Suls, 2003). Furthermore, norms about health behaviours are acquired via social comparison processes, for instance,



through the use of alcohol and cigarettes, seeking health care and counselling, adherence to treatment regimes, and to attend to diet (Fiske, *op.cit.*).

In the case of status hierarchies, social comparisons of status positions can have different effects (Prag, Mills and Wittek, 2014). Perceiving oneself to be 'healthier' and 'better' than others is beneficial for self-esteem, positive affect, and it reduces anxiety (*ibid.*). Negative results of comparisons diminish self-esteem, produce negative affect, and can cause stress (Buunk and Gibbons, *op.cit.*). According to Marmot (2004), in the case of an individual of low socioeconomic status for example, a person with little income, income comparisons will most likely lead to stress. In the case of income inequality, people living in areas with high, rather than low, income inequality are more concerned about how they compare with others (status anxiety) and feel deprived, marginalised, and angry as a result (relative deprivation). Threats to one's social esteem, value, and status have been shown to be salient for creating stress (*ibid.*).

Whereas early research (Mussweiler, 2003) assumed that social comparisons largely depend on situational factors and not on personality, recent research, however, shows that individuals vary in their tendency to engage in social comparisons (Frieswijk, Buunk, Steverink and Slaets, 2007). Social comparisons can be functional in many situations. For instance, (Frieswijk et al, *op.cit.*) found that when a group of older adults conducted frequent social comparisons with others this serviced an adaptive function that enhanced their subjective well-being. In this instance, social comparisons provided the elderly with information from others that allowed them to make adjusted assessments of their own situation. For example, there was a tendency for older adults to engage in social comparison, or Social Comparison Orientation (SCO), which enabled them to meet certain common demands involving their day-to-day health problems. Since many of these health issues were irreversible and due to old age, older adults had to rely more strongly on cognitive processes to maintain a certain level of subjective well-being than the other older adults they compared themselves to who lived nearby.

Social comparison was therefore beneficial for older adults as it allowed them to exert more control over their lives. This was because, under these circumstances, the social comparisons older adults engaged in gave them a level of hope and inspiration in their lives (Frieswijk et al, *op.cit.*).

There are some additional studies that have looked at the effects of downward social comparison on an individual's health (Kondo Kondo, Kawachi, Subramanian, Takeda and Yamagata, 2008; Pham-Kanter, 2009). These papers argue that individuals tend to care about others' health status for reasons of altruism or sympathy. Secondly, other's health status may matter for individuals as a benchmark to assess their own state of health. The empirical literature on subjective wellbeing (Kondo et al, op.cit.) has tended to focus mainly on income and other economic variables, such as unemployment, as a term of comparison between individuals.

Although there are theoretical and conceptual treatments of othering and social comparison in literature such as that discussed above (Johnson et al, op.cit., Krieger, op.cit.; Krieger and Sidney, op.cit.; Fine, op.cit.; Weis, op.cit.) research rarely has considered othering practices in relation to place and deprived neighbourhoods, particularly using qualitative methods.

In addition to this, many of these studies tend to approach othering and downward social comparison from micro or psychological perspective. These studies (Johnson et al, op.cit., Grove and Zwi, op.cit.) looked at small-scale interactions between individuals, such as group conversations or group dynamics rather than discussing the larger scale processes inherent in macro level sociology. For these reasons, I have used Bourdieu (1979) to provide much of the theoretical backbone to this chapter, in particular, Bourdieu's (ibid.) concept of symbolic violence, defined as the ideas and values of the middle-class, who impose them (often through subconscious means) onto a dominated social group.

### Othering and Distinction

In seeking to understand how individuals of different social classes make distinctions between one another, Bourdieu (1979) is a pertinent theorist here. He sought to trace a very definite ongoing relationship between class and status. Rather than status or consumption divisions replacing class inequality, he argues (1984) that tastes for a whole range of cultural objects and practices – for example, pastimes, music, art, food – can be seen clearly as being structured by social class. The general thrust of Bourdieu's argument is that social class groups consciously and unconsciously attempt to distinguish themselves from lower social classes through the appropriation and consumption of distinctive forms of culture.

This has a particular relevance for my own research in St Ann's, since, as I will argue, the different social classes I interviewed in St Ann's (such as the middle-class groups and the working-class) frequently distinguished themselves from one another by their appropriation and consumption of distinctive forms of culture.

Just as different people possess different levels of income and wealth – what Bourdieu (1984) calls economic capital – they also possess different levels of cultural capital. The latter is acquired over the course of an individual's lifetime through formal education and informal learning and it manifests itself as the ability to appreciate particular kinds of cultural objects and practices. For example, thinking of the cultural capital required to order wine in a restaurant, itself a generally esteemed or 'legitimate' form of consumption. In order to appreciate wine fully, one must have an acquired knowledge of wine-producing countries, regions, grapes and estates. One must also have a knowledge of different vintages and an awareness of the suitability of different types of wines for accompanying different kinds of foods. Liking the taste of wine is not enough. That gets valued as culture, however, is always being challenged and contested. For Bourdieu (1984), class positions tend to be reproduced through the family as parents pass on their levels of economic capital and cultural.

With reference to my research in St Ann's, it was a frequent occurrence for the middle-class groups to view their own lifestyles and cultural practices as 'legitimate' by comparing them to the 'illegitimate' practices of the other working-class residents. However, as I shall discuss in the relevant sections, different groups in St Ann's made these distinctions in different ways.

One way of understanding how these contemporary social hierarchies and social inequalities are maintained, as well as the suffering they cause is Bourdieu's (1979) concept of symbolic violence. According to Bourdieu (*ibid.*) social inequalities are maintained less by physical force than by forms of symbolic domination. He refers to the results of such domination as symbolic violence. His (*ibid.*) notion of symbolic violence follows on, and is a consequence of, his understanding of language. He sees language as, "an instrument of power and action" as much as communication. Language itself is a form of domination. While symbolic domination may be seen to have played a part in all social formation, Bourdieu (*ibid.*) argues that it is becoming more and more significant in contemporary, advanced capitalist societies.

Bourdieu (1979) sees symbolic capital (e.g., prestige, honour, attention) as a crucial source of power. Symbolic capital is a kind of capital that is accrued through socially taught classificatory schemes. When a holder of symbolic capital uses their power this confers against an agent who holds less, and seeks thereby to alter their actions, they exercise symbolic violence.

According to Bourdieu (1984), symbolic violence then, is fundamentally the imposition of categories of thought and perception upon dominated social agents who then take the social order to be just. It is the incorporation of unconscious structures that tend to perpetuate the structures of action of the dominant. The dominated then take their position to be 'right'. Symbolic violence is in some senses much more powerful than physical violence in that it is embedded in the very modes of action and structures of cognition of individuals, and imposes the spectre of legitimacy of the social order.

Social class therefore, can act as a hierarchical mode of distinction which, rather than being limited to economic structures, is reproduced also through every day, largely un-reflected upon cultural practices, including consumption practices. Following this approach, class operates relationally and contingently in our everyday practices since feelings of inferiority and superiority and the markings of taste constitute a psychic economy of social class. This economy is often concerned with the tensions between middle class and working-class identities where class can be produced in a dynamic between classes with each class being the 'other's'. Further on in this chapter, I analyse my own examples of this where both the working-class and middle-class groups in St Ann's tended to other one another.

Previous research carried out in St Ann's (Mckenzie, 2012) often discussed two pertinent themes related to my own research. These are on the negative stigma attached to the area by outsiders, and the strong sense of community and belonging to the neighbourhood felt by many residents. Mckenzie (ibid), found that some residents felt that the neighbourhood 'belonged' to them. For example, older adults discussed 'being part of the neighbourhood' and belonging to it. Often, residents said that other than venturing into the city centre, they had little or no contact with other areas of Nottingham or even wider, and their social life was firmly located within the neighbourhood. Most of the residents therefore had social life located within close proximity to their home, and how they could operate within St Ann's was essential to the quality of life they had.

Mckenzie (2012) also noted that the neighbourhood had been subject to a number of harsh social realities: unemployment and low pay, and the lack of decent housing and good education. Locally, it had become severely stigmatised with a reputation as a place to avoid, supposedly full of crime and drugs, single mums and benefit claimants. Residents in this study had an acute understanding of how they were known and ‘looked down on’ in Nottingham more widely and society generally because they lived on a council estate. Participants in this study never denied where they thought they were positioned, often saying ‘at the bottom’, or ‘lower class’. Residents also complained about how St Ann’s was stigmatised and how this affected simple things in their daily lives. Getting a taxi to pick you up from your home address, or take you home to St Ann’s after a night out, or having a pizza delivered to your home were not services that were taken for granted if you lived in the neighbourhood (ibid.).

To sum up this section, I defined othering and discussed how othering practices in health and lifestyle can marginalise particular groups of people. Othering defines and secures a person’s own identity by distancing and stigmatising another. Its purpose then, is to reinforce notions of a person’s own ‘normality’, and to set up the difference of others as a point of deviance. The person or the group being othered experiences this as a process of marginalisation, disempowerment, and social exclusion. Othering practices can therefore serve to reinforce and produce positions of domination and subordination.

I also discussed symbolic violence (Bourdieu 1979), being the imposition of categories of thought and perception upon dominated social agents who take the social order to be just. It is the incorporation of unconscious structures that tend to perpetuate the structures of the dominant. The dominated (or those who have been ‘othered’) then take their position to be ‘right’. Symbolic violence is therefore embedded in the very modes of action and structures of cognition of individuals, and imposes the spectre of legitimacy of the social order.

Symbolic violence is pertinent to St Ann’s, since, as I shall argue, there are a number of examples where the imposing of one group over another is prevalent. This does not only take place between the middle-class people imposing their categories of thought onto the dominated working-classes, but also instances of the working-classes dominating one another through different means.

### 'Everyone knows St Ann's is bad'

A common theme across all my interviews was how the neighbourhood was 'othered by outsiders'. All residents, but particularly the working-class residents were very aware of the negative social comparisons other people made on the area. In an interview with John (57), a working-class resident, we discussed how the area had a reputation:

*“ It's all a historical thing... it's always been poor... in terms of the development of the city, so it's not just a recent thing. You know, this is a stigma that's been on this area for like two centuries, so it's not going to go away very quickly... yeah it's news stories... ” (John, 57)*

John was aware that people thought negatively of St Ann's. He felt this some of this negativity came from the media. This negativity regarding the area created by the media was also discussed in several other interviews. For example, Nicky (44) worked in the St Ann's church and said the following:

*“ They [residents] feel that St Ann's gets a bad press... people have a long history with St Ann's and have lived here for a very long time and there is a significant... they have a number of significant relationships here and they like living here because it's very convenient for the centre of town ” (Nicky, 44)*

Nicki also noted that there was a strong sense of community that existed in the area where residents had formed several strong relationships with one another. Interestingly, this theme that centred on the strong sense of community in the area was echoed across all of the groups I interviewed, especially the community volunteers. In another interview with Joyce (55) who ran the food bank in the area, regardless of the negative press coverage, she said the following when we discussed the strong sense of community in the area:

*“ ... I am really impressed with the commitment of loyalty and friendship that young people have for one another and the way they are for one another... I feel that there is a real strength in the sorts of relationships that some young people are able to find in this community and I've been impressed by them ” (Joyce, 55)*

Joyce was aware of the sense of community among young people, despite the negative press they had received within the area. Interestingly, habitus (Bourdieu, 1979) can help us to understand how the negative namings and reputation of an area or people can be absorbed into an identity. Habitus can be historical and reference back to the understandings of social positions. It can also adapt; therefore, it is not determining, but generative; it can help us to see how individuals and groups can push against, resist or adapt those negative namings. The working-class in St Ann's have experienced a devaluing of their social positions (as John and Nicky highlighted), but they have found value for themselves within their local culture (Joyce), even though, by engaging within the local culture, it has further devalued their social position outside the estate. They have found an identity within that they valued, even though it may not be understood as a mainstream valued identity.

From my interviews with community volunteers, I also found they highlighted that there was a combination of closeness in parts of the community, but also areas of isolation and segregation, particularly between different ethnicities and outsiders. Some community volunteers thought this existed because parts of the community 'looked down upon' other parts or people.

The below was conducted with the curate who worked in the St Ann's church:

*"People say things like 'the black people will always sit with the black people and the whites with the whites'... people often feel invisible in a group because they don't know how to interact with others'" (Julie, 44)*

She remarks here that she thought specific groups of people in St Ann's tended to stick together and therefore separated themselves from different groups. The community volunteers frequently mentioned this, sometimes adding that residents in the area rarely initiated conversation with the 'unknown' people who were in the area. Anna (44), a community worker who worked at the receptionist in the community centre said the following:

*... It's the people who don't live in this neighbourhood, they are viewed as 'outsiders' and are not St Ann's like us... they behave, and act, and look different from St Ann's... they are not easily tolerated within the neighbourhood... they won't get spoken to first'" (Anna, 44)*

In the above, Anna explains what being an ‘unknown’ outsider in the area meant. Interestingly, during my period of participant observation in St Ann’s, I recall walking through the area and being asked by two residents what I was ‘selling’. My appearance, perhaps due to my dress and social class, very clearly gave the impression to the St Ann’s residents that I was not one of them, and perhaps a salesman.

When I asked Julie (quoted above) why residents rarely initiated conversation with outsiders, she replied that she thought certain groups “*looked down upon*” other groups because they did not live the same lifestyle as them. These ‘other people’ were seen as different in a negative light. There existed a “*fear for the strange*” in the area.

As I discuss later, the working-class residents and the community workers perceived that some outsiders were identifying themselves in opposition to them. They believed outsiders to be ‘strange’, and so some groups in the area looked down on them. This is a form of symbolic violence (Bourdieu, 1979).

However, in the next third and final section, the perspective changes and the volunteers defend the residents against outsiders for being out of tune with the culture of the place. In this instance, the community volunteers othered the middle class outsiders.

The older adults othered others for some similar, but mainly for different reasons to the working-class residents. The older adults saw themselves as not respected and marginalised in terms of nobody caring for them. There are frequent themes of abandonment. This included poor quality local services, such as the GP surgery. I also found an interesting theme around how the older adults were viewed by others in society, particularly the younger generation and the local GP services:

*Sylvia (77): “These youngsters today - they couldn’t care less about us”*

Sylvia for example, felt that she was not respected by the current generation of people within society and so she preferred to sit in the communal area council housing block with the other local older adults throughout the day. She othered the young people of today in a negative light because she believed that they (the young people) had careless perceptions of the older generation. I mentioned in chapter 4 that the older adults said they were not unhappy doing this. They quite enjoyed only having the company of one another and so this should not be viewed as a ‘sad’ finding.



The older adults primarily enjoyed the company of one another. They tended to other others because they Older adults thought that no one cared about them when they had passed a certain age. This relates to health with regards to the local GP services in the area:

*Tom: ‘Well, I spoke to a guy called Stan at the community centre... older guy...*

*Sylvia: Yeah*

*Tom: And he was saying that the problem is is when you get past a certain age, GPs...*

*Sylvia: No they never...*

*Tom: they don't really care.*

*Sylvia: No they don't no.*

*Clyde (78): they don't.*

*Tom: Nobody cares. And that's a crying shame really.*

*Sylvia: I mean, I got a letter about a month ago oh they said they can't do anything for me. They told him they can't do anything for him, they can't do anything for him, they don't care just keep taking your tablets and we'll let you know and come and fetch you when you've gone, but they can't do anything for you.’*

In the above, these older adults are expressing exasperation at the way in which the elderly are treated when they ‘pass a certain age’. They feel that as they experience poor health, GPs and health professionals do little to help them and so they feel othered in sense that they do not receive proper healthcare.

A similar finding also occurred in other interviews with older adults. Stan (79) said the following:

*Tom: "And what was it [the GP Practice] like before? Was it a good practice?"*

*Stan: "Yeah it was alright, it was alright. But I don't think personally myself they don't do anything to help people, it's only my personal opinion..."*

*Tom: "Right."*

*Stan: "But I mean there's a lot of old people around here I mean you know I think when you get to 65 or 70 they think oh well he's on his way out or she's on her way out..."*

*Tom: "Do they?"*

*Stan: "I mean it's alright putting him in a flat, and shutting the door but that's not the answer. It's like when these district nurses come, they come in the morning to see these people, I mean they only stop for a quarter of an hour they should be stopping for about an hour, they should be there giving them their breakfast, make sure they're bathed and clean clothed and have a little natter and talk to them the time of day you know what I mean, but now it's in and out and job done..."*

*Tom: "Well when I was living at home in Sherwood a few years ago there was an old lady who lived across the road who'd had, she'd had a stroke and she had about five visits a day from carers and they were in and out within five minutes, they'd come in they'd say hello, make a cup of tea, sign the sheet and they'd be gone and then she'd phone us and say oh they've not done this they've not done that because they've had to go and it's because they've had to do fifty visits that day they've not had the time to stay..."*

*Stan: "Yeah"*

*Tom: "And all she wanted was twenty minutes half an hour for someone to come in..."*

*Stan: "That's what it's all about you assure them that you're somebody of respect, you're not a dog, you're a proper human being. If you've been to work*

*all your life and you've paid your taxes and this that and the other you should be allowed''*

The above is an interesting finding. It relates to how the older adults were treated by local healthcare services. With some similarities to the earlier findings for the older adults, Stan feels that the GP services in the area do not do anything to help after the age of 70. Instead, older adults are shut inside their homes and receive poor quality care. It seems therefore, the older adults are othered by how they are treated in terms of their healthcare.

In another interview with an older adult, Mary (76) remarked at how difficult it was surviving:

*Mary: '...I can remember when National Insurance come in, and that was to pay for your healthcare. But now you're still paying that and you've got everything you want you've got the privates... but I mean it's bad, nobody wants to know anyway when you get... and I'm not just saying it because I'm seventy odd it's just... but you see they don't care about you, you know what you mean you see these people talking but like I'm on me own. But you've got to make sure all the bills are paid, you've got to make sure the house is clean, you've got to do everything yourself. And it's like a time machine, your minds high up in the air it's not you know... you know it's up here it's feeding the dog, making sure he's fed properly. If you have a dog you can't just leave him in the house, he wants to go out when I take him out. And I had chicken that was out of date, half for the week and the other half he had with Pedigree chum and his biscuits, because that's the way it's got to be. There's a lot to do, people don't realize. I mean I've got no family, you see others round here, you see they've got two three round where they can say oh you alright mum come on I'll take out out a bit or something. Like that or take you to Aldi in the car... you've got none of that because I've not got a bus pass yet...''*

In the above, for Mary life is difficult because she is by herself. She feels isolated and othered by everyone else because they do not care. She often struggles to maintain a basic standard of living. She also remarks that life is easier for other older adults in the area who have family to care for them.

## Everyone knows St Ann's is 'bad' – Discussion

Two themes that centred around the negative press attached to the area (Joyce and Nicky and John) and the strong sense of community residents felt, can be related to work by Mckenzie (2012). Types of social research which have focused upon specific neighbourhoods and communities often have noted the importance of 'belonging' to both landscape and a group of people.

Mckenzie (2012) looks at what happens when a person belongs to a landscape, to a group which is recognised by its deviance, when a neighbourhood becomes devalued and when its residents are stigmatised, because they have insufficient institutional capital, in the forms of paid employment, transferable work skills and education. Bourdieu (1984) argues that these resources make up the forms of social, economic, cultural and symbolic capital that allow groups, individuals and communities to become valued. Those communities who are denied access to these valuable resources and institutional capital do not simply passively accept their fate, but instead engage in a local system that finds value for themselves and their families in local networks and a shared cultural understanding of how the environment works.

In other words, the working-class groups in St Ann's, due to their social position and restrictions of their habitus, had insufficient forms of capital to allow them to become valued - in the traditional sense of paid employment and education, for example. Instead, residents in St Ann's do not simply accept this as their 'fate', but have engaged in a local system that finds value for themselves. They do this by establishing strong local networks between one another and a shared cultural understanding of how the area works. This can help explain why there is such a strong sense of community that exists within the area.

It is clear from my interviews that some outsiders used St Ann's as a form of dominant social comparison. This is a form of symbolic violence conducted by the outsiders. The residents perceived that the outsiders were identifying themselves in opposition to them. The outsiders, according to the residents, viewed the area as having high crime rates due to the 'sort' of people that lived there and the area being unpleasant place to visit or live. The fact that the outsiders saw their activities as high status, and the working-class activities as 'lower' activities perpetuates the economic inequality.

The older adults appeared to be most hurt or insulted by this. They seemed to be aware that other people are othering them. In turn, this finding can affect how people in St Ann's feel about themselves and can, over time, cause social stress.

Some of my findings from the older adults relate to one qualitative study (Johns, op.cit.), I discussed earlier, exploring the interactions between health care providers and South Asian immigrant women and the othering practices between them. This study found that older adults were othered as there were frequent uses of othering in terms of how the health care providers discussed the South Asian patients. In particular, terms used to distinguish "they", from "us" and "white" from "brown" were markers that signalled othering discourses. Othering language also appeared in descriptions of situations that health care professionals found 'difficult'. For example, frustrated with some patients' noncompliance with routine and ostensibly simple medical advice, healthcare providers often drew on cultural characteristics and other generalisations to explain this behaviour. The alienating and marginalising effects of these practices were evident in the South Asian women's discussions of their health care experiences (ibid.). In the case of my own research, it is therefore possible that the older adults othered the healthcare services because of how they were treated by them. Certainly, in my interviews with this group they alluded that they were treated this way because of their age and deteriorating health.

The older adults othered themselves then, because they felt that they were not properly respected by certain groups in society. Many of them therefore preferred to sit with one another, either in communal areas by their terraced flats or together in the community centre. They made a point about being happy doing this, arguing it was important to them to have one another. They also felt othered by the local health services, arguing that they were not cared for when they had passed a certain age. With regards to healthcare, they felt othered since they viewed the current approach as 'shutting the elderly away' and 'closing the door' on them.

A similar finding here was also highlighted in a qualitative study by Day (op.cit.). This study explored health among a group of older adults specifically looking at how the neighbourhood context influenced walking practices. Work on health and practices has often focused on older people and how neighbourhood context influenced walking practices (ibid.). The quality of the local health services (such as the GP surgery) was a pertinent factor here. However, it was often noted that older adults felt that due to their

age, their local surgery was disinterested in them and so they felt ‘shut out’. Therefore, the older adults in St Ann’s were often marginalised in the area because they felt that nobody (such as the local health services) cared for them due to their age. In turn, this reinforces their feelings of isolation and continues to perpetuate inequalities at the local level.

### Othering and class: They eat bad foods

Most of the individuals I interviewed in St Ann’s saw themselves as ‘better’ in health and behaviour than the majority of others. However, different groups of people did this differently. In this section, I discuss and analyse this finding.

The middle-class people living in St Ann’s frequently looked down upon the working-class residents for their lifestyles. I found that the middle-class residents only discussed themselves in interviews, such as their bodies and exercise routines. In every interview, they all made a point about not involving themselves within the immediate area, and normally worked outside of St Ann’s. In chapter 1, ‘What people said about health’, I showed that the middle-class people living in St Ann’s made a conscious effort to leave the immediate area when carrying out their daily activities. They made a conscious effort to avoid the working-class residents whenever possible viewing them and the places they visited as ‘seedy’ (Chevorne) and ‘unsociable’ (Dean).

For example, when asking the middle-class people about their health, I would ask what they thought health was like in St Ann’s. This is a pertinent question as it allows the respondents to either talk about their own health in the area, or talk about health in the area more generally. Michael, who was a 29-year-old middle-class male living in St Ann’s said the following:

*Tom: I mentioned me research was about health. When I say health, I’m thinking about maybe the typical things we tend to associate with it, so weight, exercise diet and the like. I wondered if you had any thoughts on those terms generally?*

*Michael: I think round here I think a lot of people I come into contact with... for instance I go to Costa all the time... they say oh you’re a bit snobby... a*

*lot of people round here will go oh you know I can't go in there. Whether it's because they can't afford it or they just feel like they don't fit in. They won't go in there. Whereas I do, because I like it. But everyone always looks at the price of stuff, which obviously, they have to you know. I tend not to so much. A friend of ours she goes to Farmfoods and buys frozen chicken and all that stuff but I sort of say, it's not the best food in the world. I always go to the butcher. And they say to me, oh I wouldn't go in there. I love going to the butchers. I don't go all the time. They say oh it's too much hard work... it's too this it's too that. And I say, well that's why you're a size 25!' (Michael, 29)*

Michael identified himself as enjoying taking regular trips to Costa Coffee (an upmarket coffee chain) and his butcher. He is aware that the other St Ann's residents look down upon him as being 'snobby' for visiting such establishments. He compares himself to 'other' residents in the area, and suggests that these residents do not visit these places as they would not 'fit in'.

Indeed, Michael believes that middle-class culture (visiting a butcher and Costa coffee) as legitimate (Bourdieu, 1979). He believes that the other working-class residents in the area dis-identify with his 'middle-classness'. They can never 'do middle-class' correctly, as they do not feel comfortable when they enter the space inhabited by the middle-class.

So, in practice, and in the case of my own research, othering excludes those persons (the working-class residents being the others) who do not fit the norm of that social group, which is a version of the self.

In another interview with a middle-class male living in the area, (Charles, 25), when discussing health in St Ann's, he said the following when discussing other residents:

*"I think, that's why your kids are the size of a house, because you give them crap. I don't do that. I go down to the market every week. Well I didn't get there yesterday... and I always go to the butchers and stuff but I don't know if that's because that's how I was raised or, just because I prefer it because it tastes nice." (Charles, 25)*

Charles others the working-class residents in St Ann's as he believes they are feeding their children badly. Being a father himself, he reiterates he does not do this, and chooses to shop at 'healthier' places.

There are similarities here between Charles and Michael. Both Charles and Michael view their health as being 'better' than the other residents because of the places they visit to purchase their food and drink (such as Costa Coffee and the butcher), meaning their health is 'better'. In addition, they view the other St Ann's residents in a negative light, because they do not visit the same places as them or buy the same foods.

There were also instances where the middle-class residents othered the working-class residents as they were viewed as being 'sick'. The below response is from a middle-class woman who looked down upon the area as it was 'unhealthy'. She said the following when I asked what she thought health was like in the area:

*Tom: "So, so what's kind of people's health like in St Ann's...when you see it?"*

*Anna: "I think people look pretty unhealthy to me. Well, the whole area has a bad reputation everyone knows it. And people know it's deprived so no one is going to be eating quinoa and tofu really are they? (laughs). The residents are deprived so they will buy cheap food which isn't good for them. When I moved here I used to always try and avoid the residents (laughs). Sometimes I worry I might catch something from them! (laughs). (Anna, 32).*

Essentially, Anna views some of the St Ann's residents as being poor. She even believes she could be infected by them due to their poor health. This begins to show the differences that the middle-class residents had with regards to their relationship to place and the people that lived there.

To relate this to Bourdieu's (1984) theory of taste, taste assumes that individual aesthetic preferences reflect individual class positions, which are a complex combination of economic, social and cultural capitals. Taste displays such a combination through two processes: sharing similar preferences and feelings with people belonging to the same class (Anna and Charles for example), but also sharing dislike and distance for the preferences of the lower class (Anna and Michael for example). For Bourdieu (1984), the



sharing of likes and dislikes, such as those that existed between groups in St Ann's constitutes the symbolic dimension of class struggle as taste is unequally and hierarchically distributed. The middle-class individuals in St Ann's shared a similar and non-reflexive taste (displaying the privileges of choice, and prioritising an aesthetic disposition) rather than simply using food to avoid hunger. The middle-class interviewees also shared similar distastes for working-class food considered to be '*frozen chicken*' and from '*Farmfoods*'.

In one other qualitative study (Cappellini et al, 2015) investigating how culinary taste practices contributed to the formation of middle class identity in a working-class area, the study found that the middle-class participants tended to rely on a set of approved, but also 'ready-made' set of products and procedures (i.e. local farm products and stores and cooking techniques) that were legitimised as and aligned to middle class tastes. The local shops or restaurants were not seen as decent and legitimate cosmopolitan choices. This is because the middle-class groups saw these places as being connected with the working-class culture in the area. Indeed, these views the middle-class participants held can be seen as a form of symbolic violence.

Additionally, the middle-class participants in this study (Cappellini et al, op.cit.) seemed to make a conscious effort to operate outside of the local area where they could gain their resources in a 'safe' and 'user friendly' manner. This was important for developing a secure middle class culinary taste despite living in a working-class area. This approach allowed their sense of being middle class largely intact. Additionally, the middle-class participants in this study viewed the prospect of engaging in the local area more as 'risky', as it could result in developing the 'wrong' taste.

To sum up this section, I argued middle-class people othered others in the sense that they often discussed themselves in interviews. They frequently looked down upon the working-class residents for their lifestyles and 'choices'. This is a form of symbolic violence (Bourdieu, 1984). Some middle-class people made a deliberate effort to leave the immediate area when carrying out their daily activities. These findings resonated with another qualitative study I discussed (Cappellini et al, op.cit.) who had some similar findings.

Activities the middle classes alluded to in my research were often health-related practices, such as visiting specific shops or places such as a gym that were important for their wellbeing and physical appearance. Other middle-class residents identified themselves as different to the working-class residents by pinpointing specific places (such as an upmarket coffee shop) that they visited. They thought the working-class residents would not visit such places as they were ‘out of their price range’, or simply that they were ‘not the sort’ to go there. The middle-class groups tended to view the places (such as the supermarkets) which the working-class residents visited in a negative light, as only stocking unhealthier foods.

The community volunteers were another group in St Ann’s who I found tended to distinguish themselves from working-class residents in a dominant way. Some community volunteers argued that the working-class residents made unhealthy choices even when they were not expensive, blaming them for their poor health. However, as I argue further on in this chapter, the community volunteers also defended residents against others from outside of the area.

Although community volunteers identified the ‘closeness’ as well as the ‘segregation’ that existed in parts of St Ann’s, they also did not always view the working-class residents favourably. For example, Maggie (61) who ran the food bank said the following to me:

*“I know you’ve got the same amount of money as I do. But this is what we put on our table, and this is what you put on your table... very different. That certainly doesn’t help with the health... eating crap food it certainly doesn’t help your mental health. ” (Maggie, 61)*

Even though Maggie identifies herself as being in some similar socioeconomic circumstances as the working-class residents (having the same amount of money), she is still critical of the food some residents serve up. She believes this does not help their health, and exacerbates mental health problems within the area.

In another interview with a community volunteer, Jerry (38) worked at the reception in the community centre. When I asked him about health in St Ann’s, he told me the following:

*Tom: 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. God's honest truth. I don't want to walk. It's like, are you taking the piss? You've got a five-grand scooter sat there. And the NHS have paid for that because you're too fat to get off your own arse. My aunts got one! It's because she's just fat and lazy. Well, not everybody but you know rather a lot of them. And they're classed as disabled and they're getting disability benefit. It's just because you're overweight.*

Jerry views some working-class residents in a negative light when discussing their use of mobility scooters, naming them as '*fat and lazy*'. Working at the reception in the community centre, he sees '*so many*' of them every day. During my interview with him, he became angry when discussing this, explaining that the NHS had paid several thousand pounds for each scooter given to these overweight residents who were '*too lazy*' to walk.

The above is interesting as the volunteers 'blame' other residents for being unhealthy.

Some of these findings resonate with Southerton, (2002) and Skeggs (2004) findings, that belonging for individuals in communities is often achieved through establishing boundaries between 'us' and 'them', and by defining a culture of 'them' as lacking since it does not conform to the well-established and normalised behaviour in the area that is deemed 'right' and 'healthy'. This was particularly the case for residents who had higher culture or economic capital than others (the community volunteers in the case of my own research). These residents then look down upon the residents who are lacking and not conforming, thus dominating them and practising symbolic violence.

To conclude this section, some community volunteers were critical of the foods consumed by the working-class residents, even though they identified they were in similar economic circumstances to them. They believed the food 'choices' by the working-class residents exacerbated certain mental health problems in the area. Secondly, some community workers were critical of the levels of exercise some residents undertook,

pinpointing the high use of mobility scooters that existed in the area. They felt that most residents who used such scooters did not need them.

There were also instances where the working-class residents in St Ann's saw themselves as 'better' in health and behaviour than the majority of the other residents. This is an interesting finding, since the majority of previous research in St Ann's (Mckenzie, 2012) has strongly argued that there exists a sense of community and companionship in St Ann's where residents support and befriend one another. There are examples below where I found the opposite.

When I asked this group of people about health in the area, they were often critical of the other local residents.

*Tom: 'What do you think people's health is like in the area generally then?'*

*Debbie. 'Erm, we have lots of smokers and drinkers. It's not good. I mean like with the youths and the gangs it's peer pressure and... one of my wife's great nephews is getting dragged into the gangs and then he's... his other cousins fine and just keeps out the way... It's different issues you see. You see it starts the families. It's how you engage with your children and a lot of them don't engage with their children! A lot of single parents round here, a lot of dads who don't bother. And I know a lot of dads who are bringing up their children because their mothers are suffering from addiction and stuff. So I've seen it on both foots and there's a lot of brokenness. It lies open for a lot of bod role models to manipulate as well as good role models. But it's unhealthy behaviours of the parents you see... that's how the kids learn that's why we have the issues' (Debbie, 54).*

The above was a common theme in interviews with the working-class residents. Whenever I asked a question about health, they often enjoyed having the opportunity to criticise the more 'unhealthy' behaviours of other local residents. In the above, Debbie is critical of the way in which some parents bring up their children. She argues that parents do not create good role models for their children in the area and so there exists a gang problem. Interestingly, there was never an occurrence where a working-class resident would say they thought their health was worse than other residents. Occasionally, they

would say it was the same, but more often than not they felt it was better, since other residents engaged in unhealthy behaviours such as unnecessarily riding electric scooters when visiting the shops or refusing to do basic exercise such as walking.

To conclude this section, the working-class residents enjoyed distinguishing themselves from one another and outsiders when talking about their health. They could easily pinpoint the so called ‘unhealthy’ behaviours of their local residents. This sometimes included parenting and the other residents’ dislike of physical activity.

#### Othering and Class – The eat ‘bad’ foods discussion

The middle-class residents often compared themselves to the working-class residents who they perceived to not be as ‘active’ or as ‘healthy’ as them (Michael, Charles, and Chevorne). This was a form of downward social comparison, and formed a part of the middle-class group’s own self-enhancement in that they were primarily concerned with their own bodies and exercise routines which they perceived as superior and ‘healthier’ in comparison to the other residents.

The middle-class people (Michael, Charles, and Anna, and some of the community workers (Jerry and Maggie), often used their social comparisons to form the foundations of their self-knowledge. For example, Anna perceived herself to be ‘healthier’ than others in the local area which positively affected her. Michael perceived himself as ‘better’ because of the more upmarket shops he visited. It is clear then, with this group that the effects of downward social comparison and othering need to be considered when assessing their health. The middle-class people often used the shops they visited and their ‘healthy’ daily practices (and how they were different from others) as a benchmark to assessing their own health.

It becomes clear then that the views and behaviours of the middle-class people (Charles, Michael and Chevorne), due to their social position were a form of symbolic domination (Bourdieu, 1979). The middle-class people often classed themselves differently in comparison to the working-class residents with regard to their lifestyles and health behaviours. These categorisations helped to make up their world. There was no force needed to maintain this hierarchy, however. It was an effective and efficient form of domination in that the middle-class people needed to exert little energy to maintain their

dominance. They only needed to go about their daily lives as they did, adhering to the rules of the system that provided them with their positions of privilege. As these systems of domination were reproduced, the dominated (working class residents) perceived these systems to be legitimate, and thus thought and acted in their day-to-day lives in their own best interests within the context of the system itself.

The lifestyles of the middle-class group were also led by certain ‘tastes’ (Bourdieu, 1984). Each time a middle-class person made a decision about where to purchase their food, or which gym to join, this was a social choice and not so much a ‘personal quality’. When they made their preferences for a particular kind of habit or practice, they were expressing, however unwittingly, the predispositions of the ‘structured structure’ that is their habitus. The middle-class people looked down on the working-class residents for not making the same ‘choices’ as them, in terms of their health. The middle-class people distinguished themselves as members of a certain class when they reproduced the differences between classes that were marked by their health practices. The working-class residents would rarely join up to the same gym as the middle-class residents. To do so would feel uncomfortable to them. Therefore, in their avoidance of this, the social hierarchy that exists is reproduced and social limits are established for the subordinated (working-class) agent. Social inequality therefore persists. For them, the middle-class people were somehow ‘better’ than the working-class residents because of their ‘healthier’ lifestyles.

In other words, the middle-class activities were seen as ‘high status’ by them. The working-class activities were seen as ‘lower status’. The working-class people could not carry out the same activities as the middle-class groups, because of the restrictions to their habitus. The middle-class people therefore viewed the foods eaten by the working-class groups as ‘less good’. As an example of this, if a working-class person were to visit an expensive restaurant, Costa Coffee, they would likely feel like a ‘fish out of water’. It is these cultural differences which perpetuate inequality.

The working-class people also othered the other working-class people who lived in the area. Debbie, for example, spoke negatively about residents who drank and smoke. She was also critical of parents who she perceived to be feckless and refuse to pick up their children. These were perceived to be ‘unhealthy’ behaviours as these parents disliked walking. This was perhaps conducted as a way of self- enhancement. For example,

perceiving oneself as ‘healthier’ and ‘better’ than the other residents because they walk, take their own children to school and refrain from drinking or smoking.

Even though these working-class residents who refrained from drinking and smoking may have been of a similar social class to the other working-class residents they referred to, this does not mean that Bourdieu’s concept of symbolic violence was not in play. There still existed processes of classification and domination. The working class people categorised themselves as different to the other working class residents, and it is these categorisations that make up and order the world and, hence, constitute and order people within it. With some similarities to the middle-class people, but perhaps to a lesser extent, these working class groups needed to only about their daily lives to reinforce their social positions as different, or ‘better’ in comparison to the other working-class residents they referred to.

### Understanding others

The GPs were a group in St Ann’s who I found often distinguished themselves from the working-class residents, in that they often viewed the residents’ health behaviours in a negative way. However, with the majority of the GPs I interviewed, they did not specifically other residents when discussing them. There were few examples of symbolic violence. The GPs would recognise for example, that many of the health issues in the area were due to the lifestyles people lived. Yet, they would highlight that this was due to many residents living in poverty and therefore being less able to follow health advice. The GP’s did often not view the residents in a negative light, look down upon them, or make distinctions between themselves and their patients. They recognised that residents faced many daily hardships, and so it was not productive to ‘blame’ residents for the lives that they lived.

I suspected that this may be due to the GPs I interviewed in their surgery following certain professional codes of practice, whereby they were careful in their workplace environment not to speak about residents (their patients) in a negative way or make dominant distinctions between themselves and the residents.

For example, in one interview I conducted with Jane outside of her workplace in a restaurant in the city centre, I found she sometimes viewed residents in a negative way

but was very understanding towards them. Jane was a GP who worked in St Ann's for several years. Due to her personal dissatisfaction in this role, she had at the time of my interview, moved to another surgery in the city centre and outside of the St Ann's area. I asked her about the frequent health 'issues' she dealt with as a GP in St Ann's:

*Tom: "So could you tell me what the main health issues were when you were working in the area? If you could list the top few...?"*

*Jane: "Okay, the older population... it would be things that were directly related to lifestyle. So it would be chronic obstructive pulmonary disease, cardiovascular disease, because of basically smoking... We didn't have a huge amount of really obese people... they've got major psychological issues... it was also an attitude to exercise" (Jane, 55)*

In the above, Jane pinpoints cardiovascular diseases being the most common illnesses in the area. She subsequently says that one of the causes inherent here is people's 'attitude' to exercise.

Later in the interview with Jane, I asked her to elaborate on what she meant by an 'attitude' to exercise. She said the following:

*...The tiniest change starts in the home. And they have no power in the home, so how do we expect them to take control of their own lives... A friend of mine ran a psychotherapy group and she said they [the residents in the area who attended the group] started to exert their power by not helping her to clean up their coffee cups and leaving a mess. That was the only place they could do it was in the psychotherapy group. It was such subtle moves. (Jane 55)*

To sum up, Jane views the St Ann's residents as not having any individual 'power' in their homes and so this prevents them from 'taking control' of their own lives and living healthier lifestyles. Instead, residents in the area attempt to exert their power in other social settings. Alternatively, bandying this interpretation could be seen as a form of symbolic violence on behalf of the psychotherapist (Bourdieu, 1979).

According to Bourdieu (1979), due to the working-class residents lacking symbolic capital, in the above example, residents may have been making attempts to find value.



They used the local value system in the area that was available to them. Due to the strength of their personal relationships, they were able to exercise some power within other social settings.

### 'Us' and 'Them'

There were also examples where the community volunteers and working-class residents othered the middle-class 'helpers' who came into the area to drop off food parcels as they thought they were out of touch with the residents' culture.

During the early stages of my fieldwork I remember speaking to a lady who was involved in the running of the food bank. She remarked that there was a genuine frustration in the area created by outsiders who were clearly middle-class coming in and suggesting 'recipe cards' for cooking and eating followed by statements such as 'People simply just don't know how to cook and eat properly.' It was a frequent occurrence in the food bank where outsiders visited dropping off 5kg bags of lentils and carrots believing that this would encourage residents to start making their very own lentil soup. This story was highlighted in one interview with Amanda (28), who was a community volunteer who often visited the food bank to donate food:

*"This one time I was sat there like handing over food to Joyce [ran the food bank] and 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)... anyway, we was speechless. That happens all the time, there's this idea of lentil soup making and all sorts from some people'" (Amanda)*

There seemed to be a cultural misunderstanding prevalent here. Amanda viewed the middle-class person entering the food bank as having a specific view that the 'problems' in the area could be cured if only the residents had at their disposal a large amount of carrots and/or lentil soup. However, she clearly disagrees that a supply of carrots or lentils for the residents in St Ann's would in any way help the area or the people who lived there.

To conclude this section then, the community volunteers identified a combination of closeness in parts of the community as well as areas of segregation and isolation. This was prevalent particularly between different ethnicities. For example, specific groups tended to stick together and therefore separate themselves and other the other groups. With similarities to previous research here (Mckenzie, 2012), community volunteers felt residents rarely initiated conversations with the ‘unknown’ people who came into the area, such as outsiders. This was due to the fact certain groups ‘looked down on them’ because they did not live the same lifestyle as them. The community volunteers also viewed some of the middle-class people who came into the area to ‘help out’ as being out of touch with the residents’ culture.

The working class-residents also othered outsiders. Anyone who lived outside of St Ann’s and was not from there would frequently be othered. For example, they often viewed the ‘middle-class people’ who came into the area to conduct community projects (to get people back into work, for example) as being naïve, and not listening to them. This cultural misunderstanding that the working-class residents attributed to outsiders was explained to me in a number of interviews. One reason why the working-class residents othered others could be related to the various distinctions attached to the people who live there and how they were viewed by outsiders. Keith (47) said the following when I discussed this with him:

*Tom: ... ‘I think values in society generally have changed not just in St Ann’s I think that yeah now value different things...*

*Keith: And I think we do get looked down upon by different groups...*

*Tom. mm*

*Keith. Sad, thing, and we've known it ourselves since scouting compared to other groups we get looked down on as St Ann's.*

*Tom. Really?*

*Keith. And then when one of the parents come to me and said oh I've noticed it. I was like we're trying to keep that away from you... but er you know we're*

*not daft (laughs) and there seems to be that but you know anyone from St Ann's gets...[looked down upon]''*

Keith was a working-class resident in St Ann's who often helped out running the local Scouts club for children. This meant that he spent a significant amount of his time around parents who lived in the area as well as events where the St Ann's scouts group would integrate with different scout groups from other areas within Nottingham. From his experience, he felt that the St Ann's Scouts group was frequently looked down upon and seen as inferior because of where they came from. This had also been noticed by another parent, which suggests it is quite a prevalent issue.

In the above, there is a connection between the negative press, and how the working-class residents othered the outsiders. The residents felt that the negative press in the area largely comes from the prejudiced views of the outsiders which includes the British media:

*Chantelle (42) "...mm yeah yeah. I mean I think there is that big stigma attached to the area which I don't think is true and I think it's been created a lot by the media..."*

*Tom. 'yeah.'*

*Chantelle: "and yes there has been shootings yes there has been stabbings but a lot of these were a while ago and the thing is if they happen anywhere else it doesn't get as much attention."*

*Tom: 'yes.'*

*Chantelle: "You know...there was a couple of serious child murders in Hucknall over the years you know in the news for a while and suddenly they're forgotten."*

This demonstrates that the reasons why the working-class residents othered outsiders extends into media representation in terms of how The area is believed to be unfairly focussed on during news stories. Indeed, news stories can affect people's views and so one argument could be that this prejudice has been created slowly and over time by the British media encouraging outsiders to view the area in a negative light. In another

interview with a working-class resident, the interviewee remarked that there was a “*real fear of the stranger*” for this reason. Residents often remarked that outsiders, and even people from the council had a negative view of them, explaining that outsiders did not listen to the people of St Ann’s and had the view that people just needed to get a job:

*Clive (52):... ‘People who were coming from very posh areas like Wollaton and Plumtree... and giving er and very really and judging us and saying right well they’re going to stop smoking they’re all going to breast feed and dad’s are going to get a job. And they wouldn’t listen to what we’ve got and when we said different opinions there was a lot of conflict’*

The above comment is quite similar to the lentil soup quotation from Amanda (28) I discussed earlier. It seems that a number of residents are very aware that outsiders are not understanding of the culture in St Ann’s and are attempting to press their dominant tastes and habits onto the neighbourhood. While this is not othering in the explicit sense, it is once again a type of symbolic violence.

I would often mention this story of the lentil and carrot soup in interviews with working-class residents when they mentioned the negative views from outsiders. They never seemed surprised by this occurrence. It therefore seemed to me that there is an inherent awareness people have around the negative perceptions from outsiders. The working-class residents always felt insulted by these perceptions, with one interviewee (Rachel, 44) arguing that she had children who were struggling at school. One child was disabled and one had ADHD and so she had no interest or motivation to do activities that involved making the carrot soup as her life priorities where were some distance away from thinking about what to do with lentils and carrots.

To conclude this section, I have argued that othering for the working-class residents has been created because of the understood views and perceptions of the outsiders. These outsiders also include the British media representation of the area and how that can affect people’s views. Negative perceptions of St Ann’s are therefore relevant to othering, because it creates prejudiced and negative views surrounding the St Ann’s residents which reinforces their isolation and feelings of separateness from those outside of the area.

## Conclusion

To conclude, this chapter has discussed how different groups in St Ann's often compared their health to 'other' residents in the area. I found that there were varying othering practices in the area that were carried out by different groups. This was usually conducted in a negative way, and therefore a form of symbolic violence perpetuating inequalities at the local level.

The first section, 'Everyone knows St Ann's is bad' discussed how residents felt outsiders negatively viewed the neighbourhood. All residents were aware of how outsiders looked down upon them. I argued that this is a form of dominant social comparison. The outsiders, according to the residents, viewed the area as having high crime rates due to the 'sort' of people who lived there and the area being an unpleasant place to live. The fact that the outsiders saw their activities as high status, and the working-class activities as 'lower' activities perpetuates economic inequalities. I discussed how the older adults appeared to be most hurt or insulted by this. They seemed to be aware that other people are othering them. In turn, this can constitute to how people in St Ann's feel about themselves and cause social stress.

In the second section, 'Classic othering: They eat 'bad' foods' I argued that most of the groups I interviewed in St Ann's (the middle-class, the community workers and the working class) saw themselves as 'better' in health and behaviour than the majority of others. The middle-class individuals seemed to do this the most, pinpointing how the working-class residents were 'unhealthy' because they did not visit the same 'upmarket' shops as them'. It becomes clear then that the views and behaviours of the middle-class people (Charles, Michael and Cheverne), due to their social position were a form of symbolic domination (Bourdieu, 1979). The middle-class people often classed themselves differently in comparison to the working-class residents with regards to their lifestyles and health behaviours. These categorisations helped to make up their world. There was no force needed to maintain this hierarchy, however. It was an effective and efficient form of domination in that the middle-class people needed to exert little energy to maintain their dominance. They only needed to go about their daily lives as they did, adhering to the rules of the system that provided them with their positions of privilege. As these systems of domination were reproduced, the dominated (working class

residents) perceived these systems to be legitimate, and thus thought and acted in their day to day lives in their own best interests within the context of the system itself.

In the final section 'Us and them' I highlighted that there were areas of 'closeness' in parts of the community, as well as areas of segregation and isolation experienced by some residents. The community workers often highlighted this, explaining that different ethnicities in the area tended to 'stick together'. I argued that residents rarely initiated conversations with 'unknown' people who came into the area, such as outsiders, as they felt they were 'looked down upon'. Middle-class people who came into the area to 'help out' in the food bank were often viewed as being out of touch with the residents' culture.

## Chapter 7: Conclusions

This final chapter brings together the main findings from the analysis of my fieldwork data, relating them to the principal aims of my research. I then contextualise my findings in relation to the current academic literature that exists on the topic and explain how my thesis contributes to it.

The aim of this thesis was to better understand the inter-relationship between deprivation, locality and health. This was achieved by conducting a community study which exploring the views of different groups of residents in St Ann's, Nottingham, to find out how they 'made sense' of their health. This thesis has focussed on a deprived community. My aims were:

1. To explore how individuals in St Ann's make sense of their health and what they think accounts for their health
2. To explore what these individuals think makes people healthy
3. To ascertain how the views of different groups of residents (working class, middle class and community workers) differ.

In order to meet these aims, I conducted qualitative interviews with different groups of people who lived in St Ann's. In my first empirical chapter (How health was discussed in St Ann's), I discussed how the themes from my later empirical chapters (Places, Practices and 'Othering') emerged from my interview questions. This first chapter therefore illustrated how in a deprived community, health was conceptualised differently and this significantly refocused my research. The various groups I interviewed all had different conceptualisations of health in terms of their perceived notions regarding what health 'should' be. When residents discussed health in these interviews, I noticed that specific themes were emerging from my data which formed the basis of my later chapters. The first of these themes was 'Places' and formed my next empirical chapter.

My second empirical chapter (Meanings of Places) argued that current quantitative research on health and the physical environment typically focused on how health varied across different neighbourhoods. Many of these studies have suggested what may account for this, such as the proximity of supermarkets or leisure facilities. However, while I found residents in St Ann's did also mention this, my contribution detailed how health and place had diverse and broader meanings to different people. While other qualitative

literature has analysed how certain places can impact the health of a community, such as local parks and walkways, I found that there were many other characteristics within a community that have their own meanings for residents and their health. Importantly, and not highlighted in previous literature, there were conflicting views on the importance of certain places. The community centre was seen by some as place of companionship and community cohesion, whereas other residents thought it was detrimental to the area and should be taken down. I detailed how for some residents local shops had diversely different meanings. For some residents, local shops and places signified the community (older adults), while for others they were a sign of danger (middle-class residents). The GP surgery was viewed by some as having a great importance to people's daily lives, whereas for many residents it was viewed as an exasperating place where it was difficult to receive care.

When residents discussed places in St Ann's, these discussions were often bound up with descriptions of 'Practices'. However, the importance of 'doing rounds' or 'routines' was mentioned by residents when not discussing local places or their health. In this chapter, I argued that practices in St Ann's were different depending on the group. For example, older adults would associate their health and wellbeing with routines, such as dog-walking and spending time in the company of others, possibly doing 'unhealthy' things, such as sitting and watching television or drinking lager. This draws attention to the fact that routines such as congregating in the community centre or communal areas in the council houses, eating and walking in the surrounding parks, were important for residents, particularly for the older adults, who were often more space-bound. The middle-class residents, on the other hand, adhered to more mainstream and individualistic routines of improving their health. This was in contrast with the other groups I interviewed. The self-centredness of the professionals came to the fore, as they rejected belonging to the community and did not contribute to its well-being. I found that their daily practices reflected this. The community workers and parents, however, had routines that were geared towards helping others. For some participants in this group, this was health-related. So, I argued that these different class, age and gender positions 'played out' differently in terms of routines and health reflecting their different 'habitus'.

Much research on local health routines has focused on older people and how neighbourhood context influences; e.g. activities such as walking. However, my contribution here argues that previous research on practices has tended to focus on the



physical environment and did not consider the wider social context of older adults' everyday lives. Additionally, many times studies on routines did not contrast the experiences of several routines to highlight how their class, gender etc. play out differently. Drawing on Bourdieu and practice theory, I argued that rather than taking a public health perspective that seeks to identify barriers that 'prevent' people from living healthy lifestyles, there needs to be a rigorous exploration into the diverse array of social practices carried out by residents in deprived areas. By taking seriously (and not simply deeming them as 'unhealthy') the various elements of people's practical and day-to-day routines, we may be able to identify how such important practices are created and what the conditions are for them to change when analysing health.

In my final empirical chapter 'Othering', I discussed how residents in St Ann's often compared their health to 'other' residents in the area. Importantly, I found that 'othering' was done differently by different types of people in St Ann's. I realised that in order to understand health in St Ann's, there was an importance to analyse this practice of othering to discover how it was being used by residents in making self-evaluations about their health. I found that current studies on 'othering' and 'social comparison' tended to view 'othering' from a micro level, or health psychologist perspective (Johnson et al, op.cit.; Grove and Zwi, op.cit.). These studies have tended to look at small-scale interactions between individuals, such as group conversations or group dynamics rather than discussing the larger scale processes inherent in macro level Sociology with regards to othering and social comparisons. I used work from Bourdieu's (1979) concept of symbolic violence to illustrate how a person's class position allows them to 'dominate' others.

I explained how the negative perceptions of St Ann's are relevant to othering, as they create prejudiced and negative views surrounding the St Ann's residents, which reinforces their isolation and feelings of separateness from those outside of the area. Additionally, the majority of groups I interviewed in St Ann's saw themselves as 'better' in health and behaviour than the majority of others. The middle-class individuals seemed to do this the most, pinpointing how the working-class residents were 'unhealthy' because they did not visit the same 'upmarket' shops or cafes as them. I argued that this is a form of 'symbolic violence'. This was a surprising finding, as previous research (Mckenzie, 2012) has frequently shown St Ann's is a close-knit community with a strong sense of community companionship among the working-class

residents. I frequently found this was not the case, however. My contribution here, asserts that there is a need to realise different people have conflicting ideas about health and one another. Addressing health therefore needs to take these conflicts into consideration rather than implementing public health policy that can only be adopted by the middle-class group.

It is important to acknowledge regarding all of these chapters that life-stage may have had an impact in terms of how the working-class and middle-class residents responded to my questions regarding their health concerns and choices. Many of the middle-class residents I interviewed were between the ages of 20 and 35, and so they were often starting out in their careers or still in education. The working-class residents, on the other hand, were generally over the age of 35 and so were often already working (either paid employment or volunteering). Our age and life-stage can therefore have an effect on our health concerns and goals.

### [Contribution of this thesis and back to Bourdieu](#)

Quantitative literature into health and place (Macintyre and Elleway, 2003; Meade and Earickson, 2002) has tended to focus on an individuals' locale (where they live) and how this impacts their health. Quantitative studies (Macintyre and Elleway, *op.cit.*; Jones and Moon, 1993) have also looked at how place can 'constitute' a person's health in terms of residents' access to physical resources as well as their social relations.

A considerable body of quantitative research (Elleway and Macintyre 1996, Elleway et al, 1997; Shohaimi et al, *op.cit.*) supports the view that the structure of a neighbourhood, and especially the quality of social relations between residents impacts on health and health inequalities. For example, a review of work on social ties and health (Seeman, 1996) suggested that social integration reduces the risk of mortality and leads to better mental health in deprived areas. However, some quantitative studies (Popay, Williams, Thomas and Gatrell, 1998) also point to negative health outcomes associated with social relationships. For example, Popay et al (*ibid.*) argued that from a behaviourist perspective, many unhealthy lifestyle behaviours such as drinking and

smoking tend to be social activities. Individuals who have strong social bonds with one another can therefore ‘pass on’ and ‘influence’ their lifestyles onto others close to them.

Alongside discussing how there are particular ‘determinants’ that exist within deprived neighbourhoods (such as shops to resources and social cohesion) that can impact on an individual’s health, other quantitative studies (Macintyre, 1997; Marmot, Rose, Shipley and Hamilton, 1978; Kennedy, Kawachi and Prothrow-Stith, 1996) have focused on broader social variables and structures, such as low income, poor housing and unemployment.

Although the quantitative studies help one to understand the extent of health problems within deprived areas, as well as suggest some of the causes, there are a number of critiques to highlight that relate to my own research. Firstly, existing theoretical frameworks (and by implication much empirical quantitative research) fails to capture the complexity of causal explanations in the health inequalities field. In particular, there is inadequate attention paid to the role of social organisations (the relationships between groups of people), and processes in relation to neighbourhood inequalities. Secondly, these social processes and tensions have not been conceptualised within a sociological framework.

Also, some of the quantitative studies (Macintyre, *op.cit.*; Popay et al, *op.cit.*) on health and place have tended to discuss ‘risk factors’ for health within deprived neighbourhoods. Reductionist language such as this effectively reduces places into ‘determinants,’ which ignores the meanings and experiences residents have of these places. Some quantitative studies (Macintyre and Elleway, *op.cit.*) have moved towards incorporating aspects of social relationships in analysing health inequalities. For example, social ties influence health behaviour, in part, because they influence, or ‘control’ our health habits. For example, a spouse may monitor, inhibit, regulate, or facilitate health behaviours in ways that promote a partner’s health. Social ties can instil a sense of responsibility and concern for others that then lead individuals to engage in behaviours that protect the health of others, as well as their own health. So, social ties provide information and create norms that further influence health habits. However, while it is useful to draw on some of these insights, the danger with discussing these social ties, is that it simply adds another possible ‘risk factor’ to the existing set, ignoring the complexity involved.

Qualitative research into health and place (Cannuscio et al, op.cit.; Saelens et al, op.cit.; Burgoyne et al, op.cit.; Day, op.cit.; Summiniski et al, op.cit.) has sought to uncover how ‘places’ can have pertinent meanings and interpretations for low socioeconomic groups living in deprived areas. Several of these studies (Burgoyne et al 2008, Summuniski et al 2005) have analysed residents’ perceptions of their local shops or local places they tend to visit. My research has taken a lead from these studies. However, my perspective on health was broader than this as I sought to ask residents more wide-ranging questions about themselves and their health living in a deprived area. Additionally, the above qualitative studies have tended to only focus on low socioeconomic groups living in deprived areas.

Other qualitative studies (Macintyre, Elleway and Cummins, 2002; Sooman and Macintyre et al 1995) have studied health and place with a focus on ‘experience’ and the perspectives of the people who live in the deprived places being studied. In research by Macintyre et al (1993), this study gave prominence to the importance of people’s everyday ‘experience.’ Sooman and Macintyre (1995) studied residents’ perceptions of their local environment in four socially contrasting neighbourhoods in Glasgow. Six aspects of the areas – local amenities, local problems, area reputation, neighbourliness, fear of crime and general satisfaction were all discussed by respondents in these interviews. These are important insights, which map onto my own findings. However, while these aspects of the local area were discussed by respondents, they were initially suggested as topics of discussion by the researchers in the interviews. So, it is somewhat unclear if these topics would have been raised by the residents in a more open-ended context.

After conducting a few interviews in St Ann’s, I realised the day-to-day life for residents in the area meant different things to individual people who had their own histories and associations with it. So, I found it necessary as my contribution to the literature to develop a more comprehensive conception of both places and health, and individuals in places, that took people’s history and daily lives into account. Additionally, people’s relationships to places and their practices that involved such places were diverse in St Ann’s. This unexpected diversity I found regarding places, practices and othering in St Ann’s has not been highlighted in other studies. In some cases, the diversity in St Ann’s also created tensions.

For some residents in St Ann's, there was one dominant 'place' in which they spent much of their time. For others, paid employment, education and visiting certain institutions that would not usually have been visited by other groups residents came to the fore. As I discuss in relation to Bourdieu (1979), the individual experience of place and health in St Ann's was structured by gender, age, ethnicity, and other social factors. However, individuals were differentially and multiply positioned in relation to these aspects of social structures. Whilst previous quantitative research discussed earlier (Elleway and Macintyre, *op.cit.*; Elleway et al, 1997, Shohaimi et al, *op.cit.*) has considered some of these issues in a spatial and quantitative way, such as mapping people's movement across physical space, and previous qualitative research (Cannuscio et al, *op.cit.*; Day, *op.cit.*; Saelens et al, *op.cit.*; Burgoyne et al, *op.cit.*; Summiniski et al, *op.cit.*) has sought to uncover how specific places can have certain meanings. My own research has explored the meanings different people attach health relates to broader questions about their lives and their neighbourhood.

Additionally, if more attention is paid to the meanings people attach to places and health and how these shape social action, this could place a missing link in our understanding of the causes of inequalities in health. In particular, I argue that the articulation of these meanings could provide invaluable insights into the dynamic relationships between human agency and wider social structures that underpin the inequalities in health.

My primary contribution to the qualitative literature on health and place is to highlight the various 'conflicts' and tensions' that existed between certain groups living in St Ann's. This was a surprising finding, since a previous ethnography carried it in the area (Mckenzie, 2012) found that there existed a strong sense of community in St Ann's. I did indeed find that there existed a strong sense of community among some of the working-class residents. However, at the same time, many of the working-class residents would often criticise one another or different generations (old versus young) in terms of their 'unhealthy' behaviours. Similarly, there were instances when the community workers highlighted the strong sense of community in the area, followed by ironically criticising and 'othering' the various residents they deemed to be living an unhealthy lifestyle.

Importantly, the main tension that arose from my research throughout my chapters existed between the middle-class residents and the working-class residents. This finding has been highlighted, for example, in a qualitative study investigating how culinary taste practices contributed to the formation of a middle-class identity in a working-class area (Cappellini et al, op.cit.). My contribution to the literature in this respect, centres on how the middle-class residents in many aspects of their lives used their social position as a form of symbolic domination (Bourdieu, 1979). I highlighted how the middle-class residents thought themselves different or better to the working-class residents when discussing their health, their daily routines, the local area and their general lifestyles. Importantly, these categorisations helped to make up their world. According to Bourdieu (ibid.), the cultural roles of an individual are more dominant than economic forces in determining how hierarchies of power are situated and reproduced across societies. Status and economic capital are both necessary to maintain dominance in a system, rather than just ownership over the means of production alone. So, as the middle-class residents went about their daily lives, adhering to the rules of the system that provided them with their positions of privilege, these systems of domination were reproduced. The dominated (the working-class residents) perceived these systems to be legitimate, and thus thought and acted in their day-to-day lives in their own best interests within the context of the system itself.

According to Bourdieu (1979) then, people's lifestyles have different 'forms' and stand in a hierarchical relation to one another. These hierarchies can help explain why certain tensions existed between groups in St Ann's. According to Bourdieu (ibid.), lifestyles themselves are socially ranked. The hierarchical 'status' of a lifestyle is a function of its proximity to or distance from the 'legitimate culture'. The latter refers to those elements of culture universally recognised as 'worthy', or in the same way distinguished such as those by the middle-class residents. In St Ann's, the middle-class residents frequently tried to distinguish their culture and lifestyle as 'superior' to the working-class residents for example. As such, the composition of their legitimate culture is permanently in play: it is the object of a perpetual struggle. Thus, for example, when apprehended in relation to the underlying habitus that generated them, the characteristic details of the bourgeois style of eating and the working class style of eating amount to nothing less than "two antagonistic world views... two representations of human excellence" (Bourdieu 1984, p.199)

Understanding ‘legitimation’ then, according to Bourdieu (1984) is key to understanding how some groups of people are valued (the middle-class tastes), and others are devalued (the working-class residents). Value is created through it being made legitimate, and conversely, practices, resources and people can also become illegitimate. Misrecognition is a term used in sociology to understand the classification of the legitimate and the illegitimate, and what Bourdieu (ibid.) calls the function of symbolic violence. This is violence which is exercised upon a social agent with his or her complicity. In other words, people are subjected to forms of violence, which can include being treated as inferior and denied resources (such as the working-class residents in St Ann’s), and they are limited in their social mobility and aspirations. However, sometimes, these people do not perceive it that way. Rather, their situation seems to them to be the ‘natural order of things’.

So, using Bourdieu (1979) here helps to explain how these tensions existed between these two groups. According to Bourdieu (ibid.), a perpetual ‘competition’ exists over the appropriation of the most ‘distinguished’ objects of practices with different individuals. Initially seized upon by those with the greatest economic and/or cultural capital (the middle class residents) – that is, by the dominant class or one of its fractions – such objects or practices diffuse downward through social space over time. However, precisely to the extent they become progressively ‘fashionable’, each earlier group of followers tends to abandon them in favour of new objects and practices that will enable them to re-assert the exclusivity of their taste. In this form of competition, the dominant class invariably takes the leading role as ‘taste maker’. According to Bourdieu (1984) then, the working class, generally incapable of asserting itself in such competitions as a result of both its lack of capital and its opposing disposition, tends to stand aloof from them. This acts to thwart against which the petty middle-class and the dominant class can attempt to affirm their cultural distinction. Indeed, in Bourdieu’s (ibid.) view, the working class’ incapacity to participate in the race claim those forms of culture which legitimacy its members nonetheless acknowledge is so severe they may be said to be “imbued with a sense of their cultural unworthiness” (ibid., p.132).

Additionally, the working-class residents were aware of some of the negative views held by the middle-class groups and I discussed how this came across in interviews. Therefore, these tensions worked both ways. Working-class residents tended to

highlight the extent that they felt ‘misunderstood’ by the outside world, particularly with regards to those who were employed to carry out local initiatives within the area. They viewed these middle-class groups as ‘outsiders’ who were ‘out of touch’ with their way of life.

The tensions that existed between the working-class residents were also interesting and add to my contribution towards the literature. With parents speaking negatively about residents who drank and smoked, or other parents who refused to pick up their children from school, these were perhaps conducted as a way of self-enhancement. Although these working-class residents were of a similar social position to the other working-class residents they referred to, this does not mean that Bourdieu’s concept of symbolic violence was not in play here. Importantly, still existing in St Ann’s was a process of classification and domination. The working-class people categorized themselves as different to the other working class residents, and it is these categorizations that make up and ordered the area.

In St Ann’s then, there were contending versions around health. These categorisations also existed between the community workers and the working-class residents that created some tensions. Different notions existed of what health ‘should’ be in St Ann’s. The community workers however, seemed to have a more detailed understanding of St Ann’s as an area in comparison to the middle-class residents. They involved themselves daily within the area, running groups and visiting residents who were in need. I discussed how in interviews, they were often sympathetic towards the working-class residents, highlighting how inequality and poverty as well as rising unemployment within the area had eventually lead to poor health. Despite this, they often made social comparisons and enacted symbolic violence to form the foundations of their self-knowledge. With similarities to the middle-class residents, they viewed themselves as ‘healthier’ than the working-class residents, they spent their days helping, but also acknowledged this was due to their social class enabling them to live different lifestyles.

In general, police and practice in the UK and many other countries has addressed lifestyle related health issues (such as obesity) with two main areas of focus: encouraging sports participation and, more recently, encouraging active transport, such as cycling and walking (De Nazelle, 2016). However, the policy gains from these



promotion efforts have been modest at best (Duncan and Jones, 1993), reflecting to some extent the limitations in the evidence base underpinning policy approaches and interventions. Much of the expanding research literature on the problem of how to encourage active mobility maps onto two theoretical approaches which I outlined in my literature review. The first of these is the behaviourist perspective, which addresses the existence of individual barriers to undertaking more exercise. Structural approaches focus on the material and social environments that limit opportunities for taking up healthier habits. The literature here has been disappointing on identifying which environments do foster more exercise, with findings being difficult to generalise and taking insufficient account of cultural factors that mediate how far, for instance, access to well-connected streets might impact on the amount of walking or cycling done. A review by the National Institute for Health and Clinical excellence (NICE) (in De Nazelle, *op.cit.*) on interventions to increase physical activity found insufficient evidence to recommend popular individual level interventions, such as exercise referral or organised walking/cycling schemes, and a systematic review found little evidence for population interventions to achieve changes to more active modes of transport.

Additionally, these public health initiatives and interventions to increase physical activity primarily fit with the habitus of the middle-class residents. Symbolic understandings and economic position come together in that they are consumers of the more expensive services (gyms outside of the area). Also it is an understanding that these activities as meaningful that separated the middle-class from the other local St Ann's residents. However, the working-class residents understood health differently to this. Sometimes, the practices they associated with health and well-being, such as drinking lager together or putting on a bet at the corner shop, go against the received wisdom of what constitutes a healthy lifestyle. However, they attributed other meanings to these activities, such as social belonging and being able to socialise in opposition to their peers who were no longer able to do this but were bed-bound, socially isolated and at the mercy of poor, rapidly deteriorating and under-funded home care services. Other practices, which the residents engaged in, such as walking the dog, have been recognised as potentially beneficial from the more recent mainstream public health perspective.

Importantly, it is worth returning to some concepts from Bourdieu (1979) to understand why these practices of the working-class residents (such as drinking Carling) were so different in comparison to the middle-class residents. Firstly, the reasons why people act as they do is likely to be beyond their cognitive and rational understanding. In circumstances such as those in St Ann's, where the working-class residents were most at home in their given social place – where *habitus* meshes with *field* – their apprehension of their social environment is more practical than it is theoretical and more tacit than it is explicit. This practical comprehension implies that how we act is pre-reflective; with social traditions, expectations, classifications and so on appearing to be so natural and self-evident that their arbitrariness is misrecognised. In other words, and to a certain extent then, the working-class residents were curtailed by their *habitus*. Thus, the most profound influences and constraints on our actions remain implicit. Consequently then, sociologists should seek to look beyond informants' accounts and examine the interplay between context, circumstance and practice in order to decipher the informants' implicit assumptions, which may be hinted at or left unsaid. We should therefore attempt to grasp practical knowledge, because practical, rather than cognitive or intellectual reasoning, underpins action.

Having said this, I have argued that there is insufficient previous work that has acknowledged and validated the experiences of these deprived groups. Their experience may articulate deprivation and a lack of understanding of what constitutes health, but they also draw attention to important issues that, whilst often mentioned in the literature (for example, social cohesion and health), have not been sufficiently accounted for, such as the importance of sociability, community activities and amenities. Furthermore, it should be acknowledged that these issues may not be equally or similarly important for all residents, so that middle-class residents are unlikely to mix with the locals at the community centre.

The results from this thesis could be interpreted as demonstrating that the middle-class residents were simply more informed, better educated, better read and therefore, more conversant with healthy lifestyle concerns than the working-class residents. While this may well be true, the corollary of this for public health nutrition is, however, far from simple. Public health nutrition programmes, especially those with an educational component, have to address individuals, groups and communities from a variety of

socio-economic backgrounds. However, I have argued that, on the whole, these programmes primarily fit with the habitus of the middle-class residents. Recently, low-income groups have become something of a target. However, public health education programmes have traditionally been based on an approach where health professionals deliver nutritional factors and concepts to passive individuals. The assumption behind this approach is that education, by virtue of its capacity to enlighten, informs and possibly emancipates those who hold illogical and unfounded knowledge and beliefs. It is based implicitly, and sometimes explicitly, on a belief that the knowledge of the residents (such as the working-class in St Ann's) is inferior and needs correcting.

This thesis then, attempts to draw greater acknowledgement to the importance of engaging with the logic and practices of the working-class residents in neighbourhoods like St Ann's. We should not attempt to hector and harangue this group to try and re-educate them to predetermined standards. Firstly, we should hold a high regard for the resources already existing in a community – be they cultural or material – on which further capacity can be developed. In other words, where there is pre-existing social and cultural knowledge and practices, allow these to form the basis of health programmes.

One approach might be to work with local community organisations, such the Renewal Trust who worked alongside residents in St Ann's. These community organisations will already be engaged with the local residents and have fostered personal relationship with them. This approach is entirely different to 'unknown' public health professionals who simply attempt to 'implement' a health promotion policy on a passive 'target population' in a deprived area. We can not hector residents and start from the premise that they are 'unhealthy' and their so called unhealthy behaviours must be modified. Instead, once a local community organisation has gained the trust and respect of the residents, we can begin asking residents what activities they enjoy doing. In the case of the older adults, they enjoyed walking and carrying out routines. The working-class often enjoyed this too but were also keen on helping one another. Both of these groups placed an importance on community cohesion and togetherness. We must start by finding ways to actively encourage these salubrious activities.

This approach is based, in one way or another, on an acceptance that there resides within individuals, organisations and communities logic and practical reason which is worthy of regard as a useful starting point for participative inquiry. This is not to argue

that the overall poor levels of health in St Ann's must remain unchallenged, especially when it appears to foster habits which do not promote health. It is to argue, instead, that for too long public health initiatives have paid more attention to a universal science-based understanding of food which they attempt to impact to clients and communities without an appreciation of their knowledge and practices, its social origins and the role it plays in structuring worldviews. There needs to be recognition that different forms of knowledge co-exist, and that there is a logic, a rationality and a sense-making basis, and is an important starting point for health improvement.

The significant differences across social groups surrounding health in St Ann's show that current policy needs to be attuned to the ways in which practical or tacit knowledge frames the conditions for the possibility of transformation. This policy should therefore seek to understand the practical or tacit knowledge inherent with all residents, not simply to fit the middle-class ideals and habitus. If we want to further understand how place has a relevance for health, we cannot rely on naïve readings of interview data that merely document articulated theories of 'determinants' within deprived neighbourhoods and residents' perceptions of them. If sociology is to make a contribution to understanding what is useful for public health, in outlining the most productive possibilities of what change might be, we need to move beyond noting that practices and lifestyles in deprived neighbourhoods is contingent and complex, and start building new more theoretical models of where, how, and when change is more or less likely to happen.

Therefore, instead of accepting the premise inherent in much public health research that seeks to identify the barriers to change, there first needs to be a more rigorous examination of the practices and lifestyles of the working-class residents within deprived communities such as St Ann's. We should seek to understand that their current practices (drinking Carling and visiting the community centre) are important for their well-being and sense of community. However, and at the same time, we should seek to identify appropriate approaches that can improve their health which do not only fit the middle-class agenda. A key element of this is to take the various elements of their practical, tacit knowledge more seriously, as part of these conditions of possibility. Then, it may be possible to more fruitfully identify how and why such practices are created, and what might be the conditions of possibility for change. Simply beginning

with questions of behaviour, and taking account of barriers as unproblematic evidence for why people do (or don't) do what they do, risks finding answers that relate only to more rationalised and cognitive theories of practice. It leaves under-examined the collective tacit knowledge or practical reasoning that make certain practices more or less likely.

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## Appendix A – Information leaflet for interview participants

The below leaflet had a slightly different layout for my interview participants. It would be printed off in a landscape format, and fold into a proper leaflet. The below leaflet has been re arranged for the layout of this thesis. However, the content is the same.

### An invitation to take part in a research project about health and lifestyle in St. Ann's Nottingham

#### Who am I and what's my research about?

My name's Tom, and I'm a second year PhD student in Sociology at Loughborough University. The focus of my research is to explore the views of different residents in St. Ann's to find out the ways in which people understand and talk about health and lifestyle. I am hoping to involve as many individuals living in St Ann's as possible from all walks of life. I wish to talk to you about your life and what you think accounts for your lifestyle. It is not my intention to ignore any people or groups in the area of St Ann's and so the more people I can find the more diverse range of viewpoints my research will uncover. I am also interviewing local GPs and some local health professionals to find out how these different people understand health and lifestyle in the area. From this I will be able to analyse these different perspectives.



#### Will you tell anyone what I say? How will my information be kept?

Everything you say will be kept confidential. When the interviews are transcribed (typed up) you will have a different name (unless you choose for us to use your real name). If you would like more information on this please do not hesitate to contact me...

#### How can I get in touch?

You can email me at: [T.scott-Arthur@lboro.ac.uk](mailto:T.scott-Arthur@lboro.ac.uk)

You can also call me: 0789 4662851



You can also view my profile on the Loughborough University Social Sciences website:  
([www.lboro.ac.uk/Scott-Arthur](http://www.lboro.ac.uk/Scott-Arthur))

[Are you being paid by anyone to conduct your research? Who is funding it?](#)

I should like to emphasise that I am not being employed, or paid to conduct this research. In fact, I am paying Loughborough University's postgraduate tuition fees to be able to do it! Therefore, this is all being done within my own time as from my research so far I have identified that there are some policies in the area that are ineffective and ignore local people and their viewpoints.

[Who is supervising your research?](#)

My two PhD supervisors are Dr. Paula Saukko and Professor Karen O'Reilly who are both Sociologists at Loughborough University.



If you wish, you can contact them on the below:

[p.saukko@lboro.ac.uk](mailto:p.saukko@lboro.ac.uk)

[k.oreilly@lboro.ac.uk](mailto:k.oreilly@lboro.ac.uk)

[Do I have to say yes to talking to you?](#)

Not at all. It's your choice whether or not you wish to take part. I would like this to be a positive experience for you and so you can change your mind at any time by telling me.

[Where and when will we meet?](#)

This could be anywhere within the local area where you feel most comfortable. It could be at your house or any other place where you usually spend time. You can choose a good time to meet.

[Who will be there?](#)

Only myself will interview you but if you wish someone else to join such as a friend, that's fine with me.

## Appendix B: Topic Guide

The following topic guide was used for all interviews.

1. Tell me about yourself
  - Where do you live? How long have you lived here for? What was your background before moving here? Why did you choose to live in St Ann's?
  - What is your family background?
  - Work history?
  - Leisure time/hobbies/pastimes?
2. What is it like to live here?
  - Typical day?
  - Typical week? Weekends?
  - Leisure time and friends?
  - How do you think the council could help improve the area?
3. My research is about health in St Ann's e.g. weight, exercise, diet? Do you have any thoughts on these?
  - Where and what do you tend to eat?
  - Do you cook? Eat out?
  - Where do you shop? Local area? If not, why not?
  - How do you feel about what's available in the local area?
  - What do you think people's health is like in St Ann's?
  - Is there anything you think that could be done to improve health in the area?
4. You may know that the government recommends five portions of fruit and veg per day, what do you think about this?
  - The government also recommends 30 minutes of exercise five times per week – what do you think?
  - Do you exercise? How? What facilities?
5. I'm also talking to local GPs about health in the area
  - Do you go to the local GP?
  - What do you think of it?
  - Do they help with any specific issues you have?
6. Finally is there anything else you'd like to add about health in St Ann's or something you would like to ask me?

## Appendix C: Ethical check list

### **Ethics Approvals (Human Participants) Sub-Committee**



### **Ethical Clearance Checklist**

Has the Investigator read the 'Guidance for completion of Ethical Clearance Checklist' before starting this form?	Yes
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#### **Project Details**

1. Project Title: Understanding deprivation, locality and health: Exploring the views of lay people, GPs and local public health professionals in St. Ann's Nottingham

#### **Applicant(s) Details**

2. Name of Applicant 1: Thomas Scott-Arthur	10. Name of Applicant 2: Dr Paula Saukko
3. Status: PGR student	11. Status: Staff
4. School/Department: Social Sciences - Sociology.	12. School/Department: Department of Social Sciences.
5. Programme (if applicable): Sociology PhD	13. Programme (if applicable): .
6. Email address: t.scott-arthur@lboro.ac.uk.	14. Email address: p.saukko@lboro.ac.uk
7a. Contact address: Flat 5, Havelock House, 1 Lucknow Road, Mapperley Park, NG35AY	15a. Contact address: Department of Social Sciences, Brockington Bldg, Loughborough University, Loughborough LE11 3TU
7b. Telephone number: 07894662851	15b. Telephone number: 01509-223357.
8. Supervisor: No	16. Supervisor: Yes
9. Responsible Investigator: Yes	17. Responsible Investigator: No

#### **Participants**

##### **Positions of Authority**

18. Are researchers in a position of direct authority with regard to participants (e.g. academic staff using student participants, sports coaches using his/her athletes in training)?	No
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### Vulnerable groups

19. Will participants be knowingly recruited from one or more of the following vulnerable groups?	
Children under 18 years of age	No
Persons incapable of making an informed decision for themselves	No
Pregnant women	No
Prisoners/Detained persons	No
Other vulnerable group Please specify: Click here to enter text	No
<b>If you have selected No to all of Question 19, please go to Question 23.</b>	
20. Will participants be chaperoned by more than one investigator at all times?	N/A <sup>†</sup>
21. Will at least one investigator of the same sex as the participant(s) be present throughout the investigation?	N/A <sup>†</sup>
22. Will participants be visited at home?	N/A <sup>†</sup>

### Researcher Safety

23. Will the researcher be alone with participants at any time?	Yes
<b>If Yes, please answer the following questions:</b>	
23a. Will the researcher inform anyone else of when they will be alone with participants?	Yes
23b. Has the researcher read the 'guidelines for lone working' and will abide by the recommendations within?	Yes

### Methodology and Procedures

24. Please indicate whether the proposed study:

Involves taking bodily samples (please refer to published guidelines)	No
Involves using samples previously collected with consent for further research	No
Involves procedures which are likely to cause physical, psychological, social or emotional distress to participants	No
Is designed to be challenging physically or psychologically in any way (includes any study involving physical exercise)	No
Exposes participants to risks or distress greater than those encountered in their normal lifestyle	No
Involves collection of body secretions by invasive methods	No
Prescribes intake of compounds additional to daily diet or other dietary manipulation/supplementation	No
Involves pharmaceutical drugs	No
Involves use of radiation	No
Involves use of hazardous materials	No
Assists/alters the process of conception in any way	No
Involves methods of contraception	No

Involves genetic engineering	No
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Involves testing new equipment	No
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**Observation/Recording**

25a. Does the study involve observation and/or recording of participants?	Yes
If Yes:	
25b. Will those being observed and/or recorded be informed that the observation and/or recording will take place?	Yes

**Consent and Deception**

26. Will participants give informed consent freely?	Yes
---	-----

**Informed consent**

27. Will participants be fully informed of the objectives of the study and all details disclosed (preferably at the start of the study but, where this would interfere with the study, at the end)?	Yes
28. Will participants be fully informed of the use of the data collected (including, where applicable, any intellectual property arising from the research)?	Yes

**Deception**

29. For children under the age of 18 or participants who are incapable of making an informed decision for themselves:	
a. Will consent be obtained (either in writing or by some other means)?	Yes
b. Will consent be obtained from parents or other suitable person?	Yes
c. Will they be informed that they have the right to withdraw regardless of parental/guardian consent?	Yes
d. For studies conducted in schools, will approval be gained in advance from the Head-teacher and/or the Director of Education of the appropriate Local Education Authority?	N/A
e. For detained persons, members of the armed forces, employees, students and other persons judged to be under duress, will care be taken over gaining freely informed consent?	N/A
30. Does the study involve deception of participants (i.e. withholding of information or the misleading of participants) which could potentially harm or exploit participants?	No
If Yes:	
31. Is deception an unavoidable part of the study?	Choose an item
32. Will participants be de-briefed and the true object of the research revealed at the earliest stage upon completion of the study?	Choose an item
33. Has consideration been given on the way that participants will react to the withholding of information or deliberate deception?	Choose an item

**Withdrawal**

34. Will participants be informed of their right to withdraw from the investigation at any time and to require their own data to be destroyed?	Yes
--	-----

**Storage of Data and Confidentiality**

35. Will all information on participants be treated as confidential and not identifiable unless agreed otherwise in advance, and subject to the requirements of law?	Yes
36. Will storage of data comply with the Data Protection Act 1998?	Yes
37. Will any video/audio recording of participants be kept in a secure place and not released for any use by third parties?	Yes
38. Will video/audio recordings be destroyed within ten years of the completion of the investigation?	Yes
39. Will full details regarding the storage and disposal of any human tissue samples be communicated to the participants?	N/A
40. Will research involve the sharing of data or confidential information beyond the initial consent given?	No
41. Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?	No

**Incentives**

42. Will incentives be offered to the investigator to conduct the study?	No
43. Will incentives be offered to potential participants as an inducement to participate in the study?	No

**Work Outside of the United Kingdom**

44. Is your research being conducted outside of the United Kingdom?	No
<b>If Yes:</b>	
45. Has a risk assessment been carried out to ensure the safety of the researcher whilst working outside of the United Kingdom?	Choose an item
46. Have you considered the appropriateness of your research in the country you are travelling to?	Choose an item
47. Is there an increased risk to yourself or the participants in your research study?	Choose an item
48. Have you obtained any necessary ethical permission needed in the country you are travelling to?	Choose an item

**Information and Declarations**

Checklist Application Only:
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If you have completed the checklist to the best of your knowledge, and not selected any answers marked with an \* or †, your investigation is deemed to conform with the ethical checkpoints. Please sign the declaration and lodge the completed checklist with your Head of Department/School or his/her nominee.

**Checklist with Additional Information to the Secretary:**

If you have completed the checklist and have only selected answers which require additional information to be submitted with the checklist (indicated by a †), please ensure that all the information is provided in detail below and send this signed checklist to the Secretary of the Sub-Committee.

**Checklist with Generic Protocols Included:**

If you have completed the checklist and you have selected one or more answers in which you wish to use a Generic Protocol (indicated by #), please include the Generic Protocol reference number in the space below, along with a brief summary of how it will be used. Please ensure you are on the list of approved investigators for the Generic Protocol before including it on the checklist. The completed checklist should be lodged with your Head of Department/School or his/her nominee.

**Full Application needed:**

If on completion of the checklist you have selected one or more answers which require the submission of a full proposal (indicated by a \*), please download the relevant form from the Sub-Committee's web page. **A signed copy of this Checklist should accompany the full submission to the Sub-Committee.**

**Space for Information on Generic Proposals and/or Additional Information as requested:**

Click here to enter text.

**For completion by Supervisor**

Please tick the appropriate boxes. The study should not begin until all boxes are ticked.

- ☒ The student has read the University's Code of Practice on investigations involving human participants
- ☒ The topic merits further research
- ☒ The student has the skills to carry out the research or are being trained in the requires skills by the Supervisor
- ☒ The participant information sheet or leaflet is appropriate
- ☒ The procedures for recruitment and obtaining informed consent are appropriate

Comments from supervisor:

[Click here to enter text.](#)

**Signature of Applicant:** [Click here to enter text.](#)

**Signature of Supervisor (if applicable):** [Click here to enter text.](#)

**Signature of Head of School/Department or his/her nominee:** [Click here to enter text.](#)

**Date:** [Click here to enter text.](#)









