

Physical Culture and the Polarised American Metropolis

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Race is the modality in which class is lived. (Hall et al., 1979: 394)

OVERVIEW

- » *Contextualising the contemporary city*
- » *The (ill) health of the urban United States*
- » *Suburban soccer and embodied privilege*

Our aim within this chapter is to illustrate how painfully explicit, and all too predictable, patterns of socio-spatial ordering and arrangement within the contemporary American metropolis are tied to distinct provisions, expectations and experiences of physical health, fitness and activity. In doing so we engage the city as a complex and contradictory space, fragmented by pervasive, and indeed intersecting, class and racial divisions. Such socio-spatial cleavages are neither natural nor inevitable; they are historically entrenched within, and bounded by, particular power struggles and associated political and economic trajectories. Soja (2000) described American cities as an archipelago of fortified enclosures that share little (socially, culturally and economically) in common with adjacent neighbourhoods: the material contrast between such divergent private worlds helping to constitute effective social and psychic barriers that allow for the unquestionably tense – but in many

respects, surprisingly insouciant – coexistence of such disparate communities. Hence, both voluntarily and involuntarily, individuals, and indeed entire communities, become barricaded ‘in visible and not-so-visible urban islands, overseen by restructured forms of public power and private authority’ (Soja, 2000: 299). Thus, we focus on cities as highly differentiated and complex spaces (Merrifield, 2000; Walks, 2001) which incorporate markedly different physical cultural experiences (Ingham, 1997) for those differentially located, and equally complex, (sub)urban populations.

Following an overview of the race- and class-based polarisation of the contemporary American metropolis, we examine the (ill) health of the urban United States addressing how, within the context of particular governmental regimes, those marginalised by class and race are subject to astounding levels of disease, restricted health care provision, and negligible access to health and well-being resources. From this juncture, we turn to the antithesis of urban health and physical disinvestment: the suburban cultures of sporting privilege within which suburban middle-class bodies deploy sport as an agent of social distinction and differentiation. Finally, in our concluding comments, we problematise the material and symbolic return to the city: the new patterns of urban regeneration in select parcels of the North American downtown that serve to marginalise further those not included in the dominant economic and political processes restructuring the city.

CONTEXTUALISING THE CONTEMPORARY CITY

While the archetypal North American city has long been marked by a distinct social morphology defined in, and through, interconnected class and racial relations (see Riess, 1991), this process of metropolitan polarisation intensified in the period immediately following the end of the Second World War. It was at this juncture that ‘decentralization of population from the cities’ (Savage and Warde, 1994: 76) – the suburbanisation of North America – experienced its most startling growth. Earlier phases in the history of North American suburbanisation were engineered in order to accentuate very definite class and race divisions; however, the sheer scale of post-war suburbanisation wrought the most profound influence on differentiating the collective experiences of class and race in (sub)urban North America. There are, of course, numerous intersecting reasons for the post-war reformation of American metropolitan space. First, the massive out migration (colloquially referred to as ‘white flight’) of mainly middle-income white inhabitants from the urban cores of midwest and north-eastern cities, combined with large-scale immigration of predominantly poor African Americans from the rural south into the evacuated urban centres, conclusively established residential racial segregation as the defining characteristic of the late twentieth century (McKay, 1977). This pattern of racial segregation was reinforced through ill-conceived and implemented public housing

policies, and the race-based discriminatory practices within the private housing industry (Wit, 1993). Further fracturing of the post-war American city was the criminal disinvestment and therefore collapse of the urban low-wage labour market, in favour of service-oriented suburban employment centres (Jacobs, 1992). In addition, over the last 20 years, and in the face of crippling post-industrial poverty, the American populace has had to contend with the massive retrenchment of social welfare sensibilities and programmes wrought by the emergence of a neo-liberal hegemony that has come to frame all aspects of American life (Giroux, 2005; Neisser and Schramm, 1994).

As Grossberg (2005) indicated, urban poverty, and the widespread hopelessness and alienation it produces, is the result of targeted political and economic initiatives, not some cultural inevitability or social pathology. Following an unprecedented period of consumer prosperity and confidence during the 1950s and into the 1960s, the political and economic troubles of the late 1960s and early 1970s were, somewhat prematurely, construed as evidence of deep-rooted problems in the US socio-political order. Thus, from the 1970s onwards, and increasingly with the onset of the Reagan Revolution, a *perfect storm* (or more appropriately, the *perfect nightmare*) of reactionary and regressive political (the denial of continued race-based inequality, justifying the programmatic disassembling of the social welfare system), economic (widespread corporate and civic disinvestment in the American city's traditional industrial cores) and legal (aggressive and egregious policing tactics and judicial targeting) trajectories conspired to exacerbate the social injustices and inequalities that had historically plagued the urban African American populace. Exploding the welfare consensus instantiated through New Deal and Great Society reforms, the US government has shifted away from its role as an economic and social 'safety net' keying on stabilising national productivity, and ensuring the provision of societal needs manifest in welfare, education and health care services (Clarke, 1991). Instead, and in the name of cutting taxes and dismantling 'big government', successive administrations in the latter decades of the twentieth century have reformulated the role of government within the United States. This involved the aggressive diminution of state influence over major industries, public services and social welfare, in favour of an approach centred on enhancing capital accumulation by bolstering the scope and 'logics' of the free market (Brenner and Theodore, 2002; Peck, 2003; Peck and Tickell, 2002; Sheller and Urry, 2003). While the doses vary, the basic prescription for this new 'neo-liberal' governance is the same: purge the system of obstacles to the functioning of free markets; celebrate the virtues of individualism (recast social problems as individual problems, such as drug use, obesity, inadequate health insurance) and competitiveness; foster economic self-sufficiency; abolish or weaken social programmes; include those marginalised (often by this shift in the role of government) or the poor into the labour market, on the market's terms (such as through the workfare scheme); and criminalise the homeless and the urban poor (subject this population to curfew orders, increased surveillance, or 'zero-tolerance' policing) (Giroux, 2005; Peck, 2003; Rose, 1999, 2000).

This ideology of neo-liberalism has found its material expression in an all-out attack on democratic values and on the very notion of the public sphere, particularly, if by no means exclusively, within the city. As Giroux (2005) points out, the discourse of neo-liberalism devalues the collective or public good (as was manifest in, for example, welfare and health care provision) in favour of a wider rationale for a handful of private interests to control as much of social life as possible in order to maximise their personal profit: public services such as health care, child care, public assistance, education and transportation are no different and are subject to the rules of the market (Giroux, 2005). With specific regard to health, a diversity of traditionally public issues and concerns have thus become incorporated into the reach of the private sector: disease prevention, health promotion, 'latch-key' children, personal and public health, juvenile curfews, medical services, day care, nutrition, substance abuse prevention, mental health and family counselling, teen pregnancy, services for the homeless, family and community revitalisation, family abuse, arts and cultural awareness, education, recreation, career structures, improvement of infrastructures and economic revitalisation (Pitter and Andrews, 1997). In this sense, the existing neo-liberalism produces, legitimates and exacerbates the existence of persistent poverty, the absence of employment opportunities, inadequate health care, substandard housing and education: an extant racial apartheid created by ever-increasing 'problems of social dislocation in the inner city' (Wilson, 1987: 22), leading to growing inequalities between the rich and the poor (Giroux, 2005: 46). Grossberg (2005), for example, talking of children within the United States, paints a grim picture: the wealthiest nation in the world, it seems, is 'willing to allow between one-fifth and two-fifths of its kids to live in or close to the abysmal conditions of poverty, many with no shelter and no access to medical care' (62).

The cumulative result of this concerted post-war neglect has been most visibly and catastrophically manifest in polarised patterns and experiences of post-industrial suburban socio-economic growth and urban socio-economic decline (Andrews et al., 2003; Kleinburg, 1995; Wacquant, 1993, 1994; Wacquant and Wilson, 1989). As a result of these socio-economic and political processes the contemporary American city evolved into two starkly contrasting spaces: the predominantly white and smugly affluent distending 'technoburbs' (Lemann, 1989) and the largely black (and increasingly Hispanic) 'hyperghettos' crippled by the ravages of federal and corporate disinvestment (Wacquant, 1994). As such, and pointing to the intersections of class and race, the bulk of the population living in the low-density, relatively affluent, suburban peripheries of the nation's 320 metropolitan areas is white – 79 per cent of non-Hispanic whites lived outside metropolitan areas while 52 per cent of all Blacks lived in a central city within a metropolitan area in 2002 (US Census Bureau, 2003) – the nation's inner urban environments having become the site of highly concentrated black and Hispanic poverty (Jacobs, 1992).

By 2001, the US Census Bureau (2003) reported that 12 per cent of the US population lived in poverty; this rate, however, differs by race: 23 per cent of blacks and 8 per cent of

non-Hispanic whites live at or below the poverty line. Further, as Squires and Kubrin (2005) proposes, these figures are spatialised: the dominant features of metropolitan development in the post-war years in North America are suburban sprawl, concentrated poverty and segregation (if not hypersegregation). This (hyper)segregation is manifest in increased and concentrated poverty. Within the city poverty grew between 1970 and 1995 from below 13 per cent to 20 per cent, while, between 1970 and 1990, the number of census tracts in which at least 40 per cent of the population was poor increased from under 1,500 to more than 3,400 and the number of people living in those tracts grew from 4.1 million to more than 8 million. (Squires and Kubrin, 2005; US Department of Housing and Urban Development, 1997). The urban centres of North American cities are thus often places of poverty and despair: low-wage work, insecurity, poor living conditions and dejected isolation for the many at the bottom of the social ladder daily sucked into them. These are often polluted spaces that are tiring, overwhelming, confusing and alienating (Amin, 2006). They are places of ill health that 'hum with the fear and anxiety linked to crime, helplessness and the close juxtaposition of strangers. They symbolize the isolation of people trapped in ghettos, segregated areas and distant dormitories, and they express the frustration and ill-temper of those locked into long hours of work or travel' (Amin, 2006: 1011).

Within this context, unsurprisingly, Squires and Kubrin (2005) identified that racial segregation persists as a dominant feature of metropolitan areas. Cities in the United States are disproportionately non-white with over 52 per cent of blacks and 21 per cent of whites residing in central-city neighbourhoods, while suburbs are disproportionately white where 57 per cent of whites but just 36 per cent of blacks reside (McKinnon, 2003; Squires and Kubrin, 2005). Racism and racial inequality are far from a thing of the past and, in terms of concentrated poverty and racial segregation, are the fruits of previous waves of urban policy and planning – *pace* the racially skewed death toll of Hurricane Katrina, particularly with regard to the loss of life in New Orleans (Gibson, 2006; see also Denzin, 2006; Molotch, 2006) – that are particularly pronounced within the city as an 'actually existing spaces of neoliberalism' (Brenner and Theodore, 2002). Indeed, in 2003, 30–34 per cent of Hispanic and black children were poor compared with 10–13 per cent of Asian and non-Hispanic white children, figures that are predicted to rise in the foreseeable future due to record levels of immigration (US Department of Health & Human Services, Center for Disease Control & Prevention, 2005). It seems that the internal, domestic war against the poor, youth, women and the elderly, especially those further marginalised by class and colour (Giroux, 2003a, 2003b, 2005), continues unabated within the contemporary neo-liberal city – the intersections between race, poverty and urban youth becoming fixed and undisputed as a 'problem' that government or other socio-political apparatus needs to 'look into' or 'resolve' (Zylinska, 2005). Indeed, these historically rooted patterns are not just statistical or demographic curiosities, they are spatial and racial inequalities directly associated with access to virtually all products and services associated with the 'good life' (Squires and Kubrin, 2005). While there are

multiple manifestations of inequality – such as high levels of racial discrimination in the housing market, the fear of crime, increased surveillance, the violent crime victimisation rate (35.1 per 1,000 in urban areas, 25.8 in suburban areas, figures that are higher for black residents), home-ownership rates, job opportunities, access to retail and commercial businesses, family life (Squires and Kubrin, 2005; US Department of Justice, 2001) – it is the institutionalised patterns of health inequality with which we are most interested within this current chapter.

THE (ILL) HEALTH OF THE URBAN UNITED STATES

As Giroux (2005) has pointed out, while the United States ranks 1st in military technology, military exports, defence expenditures and the number of millionaires and billionaires, it ranks 18th among advanced industrial nations in the gap between rich and poor children, 12th in the percentage of children in poverty, 17th in efforts to lift children out of poverty, and 23rd in infant mortality (Giroux, 2005: 87). Thus, in the richest democracy in the world, and in figures marked by race: 12.2 million children live below the poverty line, more than 16 million are at the low end of the income scale, and 9.2 million, nearly 90 per cent of which belong to working families, lack health insurance (Giroux, 2005). These figures, however, become even more horrific when considering the concentrated poverty and racial segregation within the inner city (Frazier et al., 2003; Massey, 2001; Massey and Denton, 1993; Sampson et al., 2002; Squires and Kubrin, 2005). In 2000, for example, the poverty rate for African Americans was 22 per cent, double that of the entire nation, while the poverty rate for black children was 29.4 per cent compared with 8.4 for white children (Street, 2001, in Giroux, 2005).

It appears that health disparities may constitute the most concrete disadvantages associated with the spatial and racial divide in urban areas (Squires and Kubrin, 2005), given poverty causes poor health by its connection with inadequate nutrition, substandard housing, exposure to environmental hazards, unhealthy lifestyles and decreased access to and use of health care services (US Department of Health & Human Services, Center for Disease Control & Prevention, 2005) (see also Box 12.1). Even more perturbing, these disparities manifest themselves quite early in life. The black infant mortality rate in 1995 was 14.3 per 1,000 live births compared with 6.3 for whites and Hispanics and 5.3 for Asians. Further, and perhaps an indicator of the shift of the role of government away from social provision, the ratio of black to white infant mortality increased from 1.6 to 2.4 between 1950 and the 1990s (Kingston and Nickens, 2001, in Squires and Kubrin, 2005). The spatial inequalities inherent within the inner city clearly contribute to the long-established disparities in health and wellness of those populations disadvantaged by class, race and social location. For example, access to clean air and water, exposure to lead paint, stress,

obesity, smoking habits, diet, social isolation, availability of public spaces (such as parks and recreation facilities), proximity to hospitals and other medical treatment facilities, and availability of health insurance are all determined by spatial location (Bullard, 1996; Dreier et al., 2001; Kingston and Nickens, 2001; Klinenberg, 2002; Squires and Kubrin, 2005: 52). For example, while the hospital admission rate for asthma in the state of New York is 1.8 per 1,000, it is three times higher in the Mott Haven area of the South Bronx (Dreier et al., 2001; Squires and Kubrin, 2005).

The magnitude of the crisis is exacerbated by evidence that in some cities, such as the District of Columbia, the child poverty rate is as high as 45 per cent (Giroux, 2005). Indeed, and as a telling exemplar, within the Washington, DC area, the affluent and predominantly white suburb of Bethesda, Maryland, has one paediatrician for every 400 children, while the poor and predominantly black neighbourhoods in the District's south-east side have one paediatrician for every 3,700 children (Squires, 2005). These figures are not just a localised occurrence. According to Eberhardt et al. (2001), overall mortality was one-third higher for black Americans than for white Americans. In 2003 age-adjusted death rates for the black population exceeded those for the white population by 43 per cent for stroke, 31 per cent for heart disease, 23 per cent for cancer, and almost 750 per cent for HIV disease (US Department of Health & Human Services, Center for Disease Control & Prevention, 2005: 11). Further, preliminary age-adjusted death rates for the black population exceeded those for the white population by 38 per cent for stroke, 28 per cent for heart disease, 27 per cent for cancer, and more than 700 per cent for HIV disease (Eberhardt et al., 2001: 6). These horrific imbalances are also manifest in the leading cause of death: young black males aged 15–24 years old are most likely to die through homicide, which is also the second leading cause for young Hispanic males. Indeed, this homicide rate for young black males in 1999 was 17 times the rate for young non-Hispanic white males, and the rate for young Hispanic males was 7 times the rate for young non-Hispanic white males (Eberhardt et al., 2001: 6). The US Department of Health and Human Services, Office of Minority Health's (OMH's) own figures do not reveal any more of a progressive picture. The OMH reported in 2001 that African American men were 1.5 times as likely to have new cases of lung and prostate cancer, 1.8 times as likely to have new cases of stomach cancer, had lower 5-year cancer survival rates for lung, prostate and pancreatic cancer, compared with non-Hispanic white men. African American women were 20 per cent less likely to have been diagnosed with breast cancer; however, they were 30 per cent more likely to die from breast cancer, compared with non-Hispanic white women, they were 2.6 times as likely to have been diagnosed with stomach cancer, and they were 2.3 times as likely to die from stomach cancer, compared with non-Hispanic white women (OMH, 2006). These figures are even more astonishing for diabetes and heart disease with African American adults 2.4 times as likely to be diabetic than non-Hispanic whites and 20 per cent more likely to suffer from heart disease. Further, most astoundingly, and a clear indicator of health as a spatialised and

racialised condition within the contemporary United States, while African Americans make up 13 per cent of the total US population, they accounted for 50 per cent of HIV/AIDS cases in 2003.

Box 12.1 Spatialised and racialised health-based inequities in Baltimore

While cautious not to map the experiences of one particular city with those of the remainder of the nation (see e.g. Massey, 1997, 2000), we would like to offer a very brief sketch of one particular city – Baltimore. Indeed, Harvey (2001) suggests that Baltimore is emblematic of the political and economic conditions that have moulded cities within our present moment, thus we offer this exemplar as telling with regard to the spatialised and racialised health-based inequities of the distinct geographic morphology of urban life. While a small or select portion of the city has been subject to intense regeneration and capital investment, – especially apparent in the Inner Harbor ‘tourist bubble’, 24 per cent of the city’s residents live in poverty (compared with 14% nationally) as Baltimore’s per capita income level fell to 57 per cent of Maryland’s average (Johns Hopkins Institute for Policy Studies, 2000), life expectancies are 14 years under national averages, teen pregnancy was the highest among the nation’s 50 largest cities in 1999, and 34 per cent of children under 18 in the city live below the poverty level (nationally, this figure is 10 per cent) (Hagerty and Dunham, 2005; Harvey, 2000; Johns Hopkins Institute for Policy Studies, 2000; Siegel and Smith, 2001; Silk and Andrews, 2006; US Census Bureau, 2004). Homicide rates in the city average around 300 per year (around seven times higher than the national rate, six times higher than New York City, and three times higher than Los Angeles) in the last decade – the majority of homicides are endemic to drug- and gang-related violence (Dao, 2005). Furthermore, large parcels of the city are characterised by block after block of vacant row houses, the city has led the nation in violent crime, juvenile homicide, heroin, cocaine and syphilis rates, and a higher percentage of the city’s population tested positive for heroin than in any other US city, with some 59,000 addicts in a city of 675,000, nearly 1 in 10 of the population (Cannon, 1999). Put simply, although there has been a recent stabilisation in murder rates and violent crime, Baltimore is, as with many cities whose civic administration operates less in the interests of citizens and more in the interests of bolstering the ‘logics’ of the marketplace (see e.g. Sheller and Urry, 2003), the ‘home of the comfortable and the prison of the choice-less’ (Johns Hopkins Institute for Policy Studies, 2000: 48).

The relationships between community infrastructure and health have a long and detailed history (see e.g. Dalgard and Tambs, 1997; Halpern, 1995; Sampson et al., 1999; Witten et al., 2003). With regard to leisure-time physical activity, not surprisingly, lack of

infrastructure and poorer (in economic terms) school districts mean that those living below or near poverty are less likely to have regular leisure-time physical activity and more likely to be inactive. Indeed, in 2003 about one-half of adults who were poor or near poor were inactive in leisure time compared with about one-third of adults living in families with income more than twice the poverty level (US Department of Health & Human Services, Center for Disease Control & Prevention, 2005: 40). Yet, the pathways said to overcome such concentrated inequalities – enhanced opportunities for physical activity associated with access and satisfaction with parks and recreational facilities (Sharp et al., 1999), the direct health effect of close proximity to amenities such as health services and public transport (Dalgard and Tambs, 1997; Taylor et al., 1997), the opportunities community amenities provide for social connections (Warin et al., 2000; Witten et al., 2003) – seem to be those very social programmes discarded by power blocs centred on securing the logics of the marketplace. The provision of public amenities such as parks, recreational facilities and social and cultural services – venues that provide opportunities for health-promoting activity, well-being, as well as informal meeting places, outside home and work, where social relationships can be formed and maintained (Oldenburg, 1997; Warin et al., 2000; Witten et al., 2003) – are those venues subject either to ‘development’ or increased surveillance (see e.g. Flusty, 2001; Rose, 2000). Within such spaces of catastrophic social, psychological and physical ill health, the potential for organised sporting activities to be used as a fulcrum for improving general public wellness has been overlooked. Instead, and as woefully underfunded urban public school systems struggle to provide even the most basic physical education programming, representative sport teams and interschool competition, sport has become an important facet of the politically reactionary ‘social problems industry’ (Hartmann and Depro, 2006; Pitter and Andrews, 1997). Under such auspices, recreation-based sport initiatives (such as the vanguard Midnight Basketball League) have become agents of social surveillance and control designed to ameliorate elevated crime and delinquency rates, impoverished urban populations thus being pathologised as problems in need of redress, rather than as woefully underprivileged and underserved swathes of humanity deserving of significant social, economic and indeed health-related programmatic intervention.

SUBURBAN SOCCER AND EMBODIED PRIVILEGE

Within this section of the chapter, we focus upon the prevalence and significance of soccer within the contemporary American suburb as a means of illustrating the contrasting position, and indeed influence, of physical culture within a socio-spatial context considerably different from the urban dystopia previously described. Thus, our aim is to demonstrate how, whereas the unhealthy nature of contemporary urban spaces has become one of the ‘afflictions of inequality’ (Wilkinson, 1996), the contrasting health-oriented sensibilities

and orientations (such as seemingly obligatory youth soccer participation) associated with suburban American culture have become the expected and unacknowledged *corollaries of privilege*, as manifest in very different health provisions, practices and outcomes. Despite their overbearing cultural, economic and political presence (the suburban American populace grew from 41 million or 27 per cent of the total population in 1950 to 76 million or 37 per cent in 1970: by the 1990s suburbanites became the absolute majority of the national populace: see Kleinberg, 1995; Lemann, 1989; Thomas, 1998), American suburbs are by no means homogeneous bastions of upper middle-class affluence (Zwick and Andrews, 1999). We nonetheless focus on the experience and vision of the American suburb that dominates popular perception: those affluent, largely white, metropolitan peripheries and populations dominated by aesthetically driven cultures of lifestyle consumption (Andrews, 1999). Out of this fundamentally competitive socio-spatial context, the American suburban soccer phenomenon was to emerge.

Whilst not envisioned as part of the suburban American dream (see Jackson, 1985), soccer, like the detached family home, the reliance on the automobile, the shopping mall, and a preoccupation with material consumption, has become an emblematic constituent of suburban American reality:

What has happened is that soccer was viewed by the general populous (*sic*) as ethnic, urban and very blue collar. What we find, however, is that while there is still a base of ethnic and urban supporters, the reality is that soccer today is mom and dad, two kids, two lawn chairs, Saturday afternoon with the family dog, watching the kids play, \$40,000 income, mini van. (Hank Steinbrecher, Executive Director and General Secretary of the United States Soccer Federation, quoted in Pesky, 1993: 31)

Thus, in recent decades, soccer's ethnically differentiated, hyphenated-American identity (see Hayes-Bautista and Rodriguez, 1994; Malone, 1994) has comfortably coexisted with the game's emergence as perhaps *the* sporting practice and symbol of the *fin-de-millennium* suburban United States, the two populations combining to form 'America's silent sporting revolution' (Anon., 1996: 27) mobilized by the 45 million 'soccer Americans' who either played or watched the game on a regular basis (Steinbrecher, 1996).

Soccer does not possess any innate, essential, qualities that can explain its seeming affinity with the status-driven suburban middle-class habitus. However, more than the simple act of 'playing the game', the entire *soccer field* has been incorporated into the complex universe of 'practices and consumptions' (Bourdieu, 1990) which structure and constitute the suburban cultural system. As heretofore 'noncommodifiable phenomena' (Gephart, 1996: 33) youth soccer has, in a Bourdieuan sense, been discursively constructed as a highly exclusive asset in the field of cultural production, whose scarcity makes it a prized activity in the cultural marketplace and puts those with access to it in a position of cultural privilege. Access to economic capital is probably the single most critical determinant of participation in suburban youth soccer (Andrews, 1999).

Not that formal barriers are erected to preclude participation in competitive soccer programmes, yet the significant financial outlay demanded by participation effectively precludes many less economically secure middle-class families (Andrews et al., 2003). That individual players are able to apportion considerable amounts of their time to soccer also speaks to more than their evident commitment to the game: it also illustrates the extent to which their lives encompass an 'absence of necessity' (Bourdieu, 1984, 1986) that is pointedly missing from the lives of children from less privileged populations. Unlike many US adolescents, the offspring of the affluent suburban middle class certainly did not face pressures to enter the part-time labour force in order to augment their family's income. Rather, their parents' financial stability afforded them a wholly unfettered out-of-school time, without which they simply could not have been a member of the soccer team. As with other trappings of their existence, the privilege of 'spare time' often passes as unrecognised, its being viewed as a taken-for-granted condition of being a teenager, rather than an expression of membership of a dominant class (Shilling, 1993).

Part of soccer's ability to appeal to contemporary suburban values lies in its obtuse relationship with more established elements of American sporting culture. Specifically, both American football and basketball did not rest easily with the superficially progressive mores of the maturing suburban hegemony of the United States. The exaggerated hypermasculinity and female marginalisation celebrated by American football became increasing incongruous with a new generation of post-Civil-Rights parents, many of whom strove for a semblance of gender equality in their children's lives, if not their own. Within this climate of increased gender awareness and activity in the realm of sport – and emerging as it was in the shadow of American football's physical and symbolic chauvinism – soccer assumed the mantle of the gender-inclusive American sport *par excellence*. Interestingly, the same rationale that made soccer a suitable physical activity for girls – its perceived encouragement of non-aggressive behaviour, sociability and the all important *fun* – similarly made it attractive to parents seeking an alternative to American football for their sons. According to Wagg, 'soccer' appeals to liberal and/or Democratic families concerned to promote equal opportunities but deterred by the aggressive masculinity embodied within American football (1995: 182). As Hornung noted, soccer is 'a sport preferred by middle- and upper-middle class parents who want to protect their kids from the savagery of American football' (Hornung, 1994: 39). Soccer was thus popularised because it appeared to offer the *right* type of aerobic and corporeal benefits for boys and girls (Bondy, 1992; Pesky, 1993), as dictated by the health and aesthetic norms of the suburban middle-class habitus.

Soccer has also been cast as the appropriate activity for the *normal* suburban athlete, whose *innate* intelligence was counterpoised, even *in absentia*, by the *natural* athletic ability of the black urbanite. According to a 1977 article in *US News & World Report*, 'Another possible reason for the growth of soccer in some suburbs - one that the

game's proponents do not discuss publicly, but a few say privately – is that some white youths and their parents want a sport not as dominated by blacks as football and basketball' (1977: 100). Over the last three decades a racially charged 'national fantasy' (Berlant, 1991) has enveloped basketball. This centred upon the popular fears and fascinations associated with the perceived natural physicality of the urban African American athlete, who, were it not for sport, would unerringly be involving his body in more deviant, promiscuous and irresponsible pursuits (see Cole, 1996; Cole and Andrews, 1996; McCarthy et al., 1996; Reeves and Campbell, 1994). Unquestionably, the racial signifiers contained within popular basketball (and to a lesser extent American football) discourse have, in opposition, influenced soccer's symbolic location within the contemporary popular imaginary. In spatial (suburban/urban), racial (white/black) and corporal (cerebral/physical) senses, soccer became the antithesis of basketball. There also appears to be a widespread assumption that the standard of US soccer is hampered by the *type* of athlete (i.e. white/suburban/cerebral) who is presently dominating the game, and that soccer in the United States would undoubtedly improve if the *right* populations (i.e. black/urban/physical) were encouraged to take up the sport. Accordingly, a *Chicago Sun-Times* columnist noted, 'soccer will never take off in America until the talent that still resides within our cities is fully tapped and discovered ... Somewhere in the Robert Taylor Homes are a handful of Peles' (Hornung, 1994: 39).

The particular class location of soccer in the United States engenders a specific health-oriented relation to the body, which is itself related to the suburban middle-class habitus – the system of dispositions, tastes and preferences – which forms the basis of the suburban middle-class lifestyle (see Bourdieu, 1978, 1980, 1984, 1990). The economic stability proffered by membership of the relatively privileged middle class allows for the development of relationships with the body based upon sport's ability to further the interrelated health and aesthetic dimensions of physical existence. Thus, bodies are invested in, through health/fitness-inducing predilections, practices and programmes, for future life benefits, and contemporaneous social approval. For, within the American suburban context, the bodies of the middle classes and indeed those of their children are markers of upward social mobility, status and achievement that are self-actualised through involvement in the right healthy lifestyle practices, leading to the assemblage of the appropriately formed healthy bodies (Howell, 1991). Soccer provides the suburban middle class with an opportunity for distancing itself from the instrumental relation to the body exemplified by the pragmatic habitus of the black urban working class. Soccer is implicitly performed as a symbolic site for reaffirming the ascendant position of the suburban middle-class lifestyle; involvement in the soccer ritual effectively sustains the normalised suburban community, thereby advancing notions of the moral and cultural superiority of (white) suburban practices, institutions and individuals in relation to their (black) urban counterparts. Soccer is part of a middle-class lifestyle 'that separates those who live in the suburbs from urban others. Those who are different ... perceived as

dangerous' (Dumm, 1993: 189). Youth soccer participation has thus become an important part of a normalised culture that marks a fetishised suburban affluence and productivity as the antithesis of a pathologised urban deprivation and indolence.

In many respects, suburban soccer culture represents the sporting version of the gated residential community: an artificial space and population protected by exorbitant property values from the perils and unease created by the proximity of social undesirables and economic subordinates. Thus, soccer is ascribed an exclusivity, or rarefied symbolic value, through which the ever status-conscious suburban middle class is able to nonchalantly 'distinguish itself from the less fortunate' (Ehrenreich, 1989: 39). Moreover, the economics of suburban soccer participation effectively denies the urban and suburban poor, the working class, and even many of the lower middle class from access to the game in its bourgeois incarnation. This class division is explicitly racialised, since socio-spatial apartheid in the United States has resulted in the nation's affluent suburbs – and thereby soccer as a field of suburban cultural production – continuing to be the domain of the white middle class (see Jackson, 1985; McCarthy et al., 1996). As Hersh noted, 'soccer in the U.S. is essentially a white, middle-class, suburban sport, just the opposite of the game's demographics in most of the world' (1990: 1).

CONCLUSION

Within this social autopsy of health and physical culture within the North American urban landscape, we addressed how the urban poor – those increasingly categorised as degenerate or unproductive – have become subject to elevated levels of ill health and disease, continued restricted access to health care, well-being resources and to physical culture. We contrasted these horrific lived experiences, the afflictions of inequality (Wilkinson, 1996), with their suburban corollary, the contrasting health-oriented sensibilities and orientations of the American suburb. Unlike the very real and sadly tangible ill health and poverty of the American inner city, we suggested normalised suburban existence is manifest through soccer as a racially coded, embodied performance of the cultural values and ideals espoused by the suburban middle class. Characterised by the *right* interrelated health, corporeal and aesthetic norms for suburban boys and girls, soccer is experienced and advanced as a compelling popular euphemism for spatial, class and racial superiority. In this way, the spatialised and racialised inequities of urban life become mapped onto the material and symbolic constitution of health; differently put, and somewhat rearticulating the quote with which we opened this chapter, health becomes the modality through which race, and by extension class, is lived.

This contention is only strengthened when one considers that in our contemporary moment there has been a perceptible economic and emotional (r)eturn to North America's urban landscapes. That is, select parcels of the downtown cores of numerous US cities have become, are in the process of becoming, or aspire to be, spectacular consumptive environments predicated on capital leisure spaces: urban governments have sought to (re)capitalise upon the economic landscapes of their cities (through shopping malls, themed restaurants, bars, theme parks, mega-complexes for professional sport franchises, gentrified housing, conference complexes and waterfront pleasure domes) (Brenner and Theodore, 2002; Gottdiener, 2000; MacLeod, 2002; MacLeod et al., 2003; Silk and Andrews, 2006; Waitt, 1999; Wilcox and Andrews, 2003). These 'tourist bubbles' (Judd, 1999) are the paragons of urban regeneration and form part of the processes of reclaiming the city as a middle-class space for a newly gentrified, domiciled, tourist class (Florida, 2002). Fully supporting the market logics of urban entrepreneurialism, health or, more accurately, a pervasive *healthy lifestyle* discourse provides a symbolic accoutrement to the reimaged cityscape. As distinct and unimaginable from the sketch we proffered earlier of the decay of the urban environment, the urban core is recast through physical culture. Indeed, these spaces are evaluated and ranked on these very criteria. *Men's Fitness* magazine, for example, which annually evaluates US cities (using such criteria as: the number of fitness facilities, such as gyms, for the new urban residents; diet patterns; reactions to public health 'emergencies' such as obesity; the role of civic legislation and leadership in creating fitness and health education directives, including requiring developers to build open spaces and trails, and in enacting fitness-promotion initiatives (Lucia, 2006)) recently ranked Baltimore as the 'fittest city in America' (Silk and Andrews, 2006). Baltimore achieved this place of honour for apparently having 'one of the healthiest diets around' with 'half the average number of junk-food places per capita of all the cities in our survey', for a 'citizenry who has taken to exercise', for 'excellent air quality', for 'top-notch health-care', and for the efforts of Mayor Martin O'Malley to make 'his populace more active' (Lucia, 2006).

Within such delusional rhetoric, the city becomes represented as a healthy, safe and sanitised urban space that could not be further differentiated from the experiences, lifestyles, health care and access of those within the fortified enclosures on the urban fringes of the phantasmagorical – to borrow from Benjamin (2002) – zones of commercial investment and revitalisation within remodelled, spectacular US cityscapes. Rather, the 'healthy body politic' is mapped onto the inner city, and along with those in the sub-urb becomes the legitimate public populace. The *right* corporatised, healthy, aesthetic thus becomes the *body proper* (Zylinska, 2004) that fulfils the 'obligations' of participatory democratic citizenship (in this sense through the *right* rates and acts of fitness consumption), and thereby further marks the (ill) health of the corpus, those constitutive socially, morally and economically pathologised *outsiders*, who exist outside of the 'legitimate' North American urban morphology.

CHAPTER SUMMARY

Within the contemporary American context a history of discriminatory housing policies and the more recent neo-liberal policy agenda have combined to create socio-spatial disparities that demarcate two distinct American social worlds, one white and one black. This bifurcated world incorporates frightening discrepancies in infrastructure that contribute to declining health and wellness among the black population of the United States. Equally, the recent surge of soccer within the suburban American context is further manifestation of the distance between poor blacks and middle-class whites, specifically in terms of the relationship between space, culture, economics and health. Recent urban regeneration has borne 'healthy' tourist bubbles which legitimize the lifestyles enjoyed by those productive urbanites, while further pathologizing those who exist outside (both physically and symbolically) the 'legitimate' North American metropolis.

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