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ASKE JUUL LASSEN

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Keeping disease at arm's length – how older Danish people distance disease through active ageing

ASKE JUUL LASSEN*

ABSTRACT
Many older people live with a range of chronic diseases. However, these diseases do not necessarily impede an active lifestyle. In this article the author analyses the relation between the active ageing discourse and the way older people at two Danish activity centres handle disease. How does active ageing change everyday life with chronic disease, and how do older people combine an active life with a range of chronic diseases? The participants in the study use activities to keep their diseases at arm's length, and this distancing of disease at the same time enables them to engage in social and physical activities at the activity centre. In this way, keeping disease at arm's length is analysed as an ambiguous health strategy. The article shows the importance of looking into how active ageing is practised, as active ageing seems to work well in the everyday life of the older people by not giving emphasis to disease. The article is based on ethnographic fieldwork and uses vignettes of four participants to show how they each keep diseases at arm's length.

KEY WORDS – active ageing, everyday life, chronic disease, ethnography, health strategy, Denmark, activity centres.

Introduction

As longevity rates increase amongst the European population, a greater proportion of people are living longer with chronic conditions. Thus, because of the rising incidence of chronic diseases, the ways in which people live everyday life with disease have come under scrutiny (*e.g.* Ådahl 2012; Clarke and Bennett 2013; Danholt and Langstrup 2012; Williams 2000). In this article, I describe how older Danish people aged 58–92 at two activity centres in the Copenhagen area keep diseases at arm's length.[1]

The older people in this study deal with their different diseases in various ways, but they do not engage in their diseases, adapt their everyday lives

* Department of Ethnology and Centre for Healthy Ageing, University of Copenhagen, Denmark.

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to them or pay much attention to the body's signals. They do not assume individual responsibility for their health and disease, as they are expected to in a general individualised health discourse (Maynard 2006; Rose 2007; Wheatley 2005). These older people instead keep a distance from their diseases in order to continue everyday life. However, this distance is not absolute: they cannot erase their conditions or act completely nonchalantly in relation to them. The disease is constantly there, at arm's length, and this inattention demands a certain distancing work. I argue that they are able to obtain this distance by engaging in different forms of activity.

The activities of the older people are inscribed into the concept of active ageing. Active ageing is a policy tool developed in the World Health Organization (WHO 1998) and the European Union (European Commission 1999), wherein old age is rearticulated from a period of passivity to one of activity and participation (Walker 2002). The older people are encouraged and expected to stay active, flexible and independent through physical, mental and social activities, as well as a longer work life (Brooke *et al.* 2013; European Commission 2012; WHO 2002). Although the concept of active ageing is predominantly unnoticed by my informants at the activity centres, the discourse of active ageing is very present in their everyday lives. The way they talk about activity, and indeed the very fact that they attend an activity centre, is an indication of an activity ideal amongst these older people. This is believed to be good for their quality of life, health and functional capacity as well as for the national economy (MandagMorgen 2010; Sundhedsstyrelsen 2008).

The aim of this article is to bring attention to how some older people cope with their diseases through distance and activity. How does active ageing change everyday life with chronic disease, and how do older people combine an active life with a range of chronic diseases? Through my empirical findings I demonstrate how activities form part of a health strategy in which they distance their diseases. This distance consequently facilitates a higher activity level and enables the older people to lead the active lives they are expected and encouraged to lead (for an outline of these expectations, *see* Alftberg and Lundin 2012; Boudiny and Mortelmans 2011; Clarke and Warren 2007; Ranzijn 2010; Rudman 2006; Tulle and Dorrer 2011; Venn and Arber 2010; Williams, Higgs and Katz 2012). In this way, activity and disease at arm's length are mutually enabling. Integrating the benefits of disease at arm's length into future international health-promotion and active ageing programmes might prove to be beneficial to older people's health and quality of life.

In their article about limb-girdle muscular-dystrophy patient Gino, sociologists Michel Callon and Vololona Rabeharisoa (2004) present an alternative way of relating to biology, disease and genetics. Gino refuses

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to identify with disease categories and biology. His refusal is not just a rejection of the implications of a certain condition, but a more general denial of how humanity and morality are depicted in contemporary biomedicine, and how this biomedicine has become an integral part of everyday life. Gino does not relate to his disease, and he will not allow himself or his children to undergo genetic and health testing. He knows he has the condition but, as there is no cure for it, he will not enter the domain of biomedical morality and humanity.

Gino exemplifies how disease is practised differently in everyday life than in policy documents and medical consultations. There has been an ongoing dispute within the fields of medical sociology and anthropology about the medical colonisation of the life-world; this has been termed 'medicalisation' (Zola 1972) and later 'biomedicalisation'. In cultural gerontology, this approach has been adapted to the ageing process, with the claim that old age itself has been biomedicalised (Estes and Binney 1989). Sociologist Susan Pickard (2013) argues that there is a new political anatomy of the old body, wherein the old body is assessed by the clinical gaze through the same standard as the adult body, thereby rendering the old declining body to be pathological and not 'just ageing'. Although I agree that a biomedical rationale has certain implications for how old age and everyday life are formed, 'biomedicalisation' does not take into account the agency of older people, and the way the older people themselves see their bodies as distinct from adult bodies. They do not think that they are ageing pathologically when they have multiple chronic diseases, but regard this as part of being old. In this article, the relationship between health guidelines, bio-medicine, older people's subjectivity and practise is depicted as an entanglement in which categories of disease and health are negotiated.

People do not always see their health as bad when they have painful or serious conditions, but pragmatically 'keep going' through good and bad days, as health service researchers Richardson, Grime and Ong (2013) have argued in the case of osteoarthritis. In the same way, the metaphor of an 'arm's length' does not suggest that they do not relate to their conditions at all; they distance disease, but only to a certain degree. Disease is always within reach. In this way, an 'arm's length' is ambiguously just as much a part of the body as it is a distance.

Phenomenologist Tony Fry has described how television is dealt with at arm's length – how that which is almost always remote is brought near through television. For the older people, activity seems to contain some of the same qualities as television, *i.e.* it 'bridges distance without making material connection' (Fry and Adams 1993:14). Thus, it is a tool that can make an older person relate to his/her body without sensing the materiality

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of the diseases contained therein. They focus on wellness rather than illness by engaging in activities.

In the following, I use empirical vignettes to demonstrate how older people keep disease at arm's length. It may seem like a form of resistance against the health discourse, but it also ambiguously enables active ageing. Before I delve further into that, allow me to present my fieldwork design and some methodological problems.

Fieldwork and methods

The article is based on fieldwork conducted at two activity centres in the Copenhagen area in January and February 2011 as well as April and May 2012 and is part of a PhD study on the concept and practice of active ageing. The members of the activity centres are retirees or early retirees.[2] At the time of my study, the participants at the centres were between 58 and 92 years of age. I did participant observations at the activity centres for four months wherein I studied a range of activities: Pilates, ping pong, IT classes, bingo, card and dice games, darts, billiards and metal-smiths' workshops. During the four months I interviewed 17 of the members. The two centres combined have more than 1,200 members, and the 17 interviewees represent the frequent participants of the above-mentioned activities. Thus, the findings do not represent an average of the users, but are based on a sample of some of the more active users.[3]

The selection criteria for these 17 interviewees were that they were living independently (all), frequently participated in the activities at the centre (at least twice a week), represented both genders (eight female, nine male) and were self-assessed as an 'active older person' (all). Subsequently, what is signified by 'an active older person' became a topic of inquiry during the interviews. The interviewees emphasised different aspects – such as being physically, socially and/or mentally active, proactive, entrepreneurial or independent – but the most common denominator for being an active older person was the urge to continue everyday life despite advancing age, and to participate in shaping one's own everyday life.

The interviews were semi-structured, and all but three were conducted in the interviewees' homes. In those three cases, the interviewees preferred to hold the interviews at the activity centre because of ill spouses or problems with the maintenance of their homes. Each interview lasted between one and four hours, covering such topics as physical, mental and social activities, the use and meaning of the activity centre, everyday life and routines, health and illness, the use and understanding of technology, as well as a brief life history. Only a few of these topics are addressed in this article,

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but the other topics were significant to the interviews as a whole: they were part of the narrative developed through the interview.

Six of the 17 interviewees were followed around in their everyday lives whilst picking up their grandchildren, buying groceries, winter swimming,[4] attending or arranging dinners with friends and family, *etc.*, using the technique of shadowing (Czarniawska 2007). This technique was used to examine the types of activity my interviewees engage in outside of the activity centre. Furthermore, this technique provided insights into how these older people handle their diseases in different settings and situations in their everyday lives.

The interviews and some of the participant observations and shadowing were recorded. When recording was not possible due to practical constraints (*e.g.* when playing billiards or cycling to the grocery store), I took notes extensively. The material was transcribed and then condensed into key themes and findings. It was during this process that the distanced role of disease in everyday life became apparent. Through the help of my supervisors I then explored how this topic had previously been described and the idea of disease at arm's length formed. A first draft of this article was then distributed to my research group as well as presented at a PhD course. The idea of disease at arm's length was then probed with the interviewees and other members of the activity centre in the second round of fieldwork (April and May 2012), to include the interviewees in the analysis. Their feedback elaborated the idea of disease at arm's length, as they described how different activities enabled the distance, and that the distance varied from situation to situation. Their feedback was then included in the next round of analysis after the second round of fieldwork. In this way the fieldwork and the analysis has been an iterative process conducted in a dialogue with the older people in the study.

I conducted the fieldwork as part of my PhD dissertation, which focuses more broadly on the concept and practise of active ageing. Thus, this article is the result of a broader study of active ageing, as well as the result of many hours of guidance from my PhD supervisors, who have helped me elaborate the idea of disease at arm's length and have pointed to some of the literature that I discuss throughout the article. As part of a study of active ageing, this fieldwork was not designed specifically to study disease, but because active ageing is related to concerns about health and disease, these themes were part of my study. The empirical findings might have been different if I had met participants through patient organisations, or if I had focused specifically on managing everyday life with disease. My approach to the interviews and participant observations centred on activity, and in the first round of fieldwork disease was often not mentioned until late in the interviews. These situations inspired the idea of 'disease at arm's length'.

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I could interview older people for several hours about many aspects of their everyday lives, with no mention of disease until I specifically asked about it.

When I did, it turned out that many of these informants – who often displayed no outward signs of disease, and were able to describe their days and activities without referring to disease at all – had several chronic and life-threatening conditions. Diseases that I would expect to have a huge influence on their activities, daily chores, thoughts and life situations – such as diabetes, arthritis, cancer and cardiovascular disease – simply did not factor into their stories.

The interviews would have been different if I had started by asking about disease. In this way the knowledge generated during interviews is situated; it is not a total description that encapsulates how interviewees always relate to their diseases. There are probably other situations where disease plays a major role – medical consultations, moments of pain, adjustments to their medical regimens, *etc.* – but the situations of playing billiards, the conversations at the activity centres or buying groceries show another part of everyday life with disease. As Clarke and Bennett argue, older people who suffer from chronic conditions might feel a need to present themselves in a positive light, in order to not fall into ageist stereotypical categories as 'grumpy and bad tempered' (2013: 357). In everyday life situations of these participants – at home, in the activity centre, at social gatherings, in their community, with their families – disease seems to be held at arm's length.

In the following I present four vignettes from my fieldwork. While I do not claim that these four vignettes represent how all the active older persons at the activity centres distance disease, they are examples of how disease is handled by many of the interviewees. These four interviewees are chosen because their accounts can show how disease is kept at arm's length in different ways. Different practices, diseases and situations call for different ways of handling disease, but these vignettes all tell the story of the need to distance disease in order to continue everyday life in high age despite a range of chronic diseases.

Empirical findings: four vignettes

Valter: 'What can you do?' – the ambiguous task of continuing life after diagnosis

Valter is 73 years of age. He is divorced and lives alone near the activity centre, where he plays a very active role as its manager and a member of the board. Aside from his daughter and ex-wife, whom he continues to see frequently, his social life entirely revolves around the activity centre.

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He suffered a thrombosis in 2008, but survived without any severe, permanent damage. He has not made any major lifestyle changes as a result of the event, apart from taking medication and trying to refrain from eating beef: 'I'm old. These things happen. I just take one day at a time'. He has the beginning stages of chronic obstructive pulmonary disease (COPD), which he handles in the same way:

> Why should I bother about a disease that develops over years if I might not be here tomorrow? Don't get me wrong, I'm not happy about having COPD. But what can you do? Lay down and die? (Valter, in an interview)[5]

This quote does not mean that Valter is unconcerned about being active. His role at the activity centre enables him to keep fit and stay active. For him, activity is not so much physical activity, in which he has never been particularly interested, as it is mental activity. He plays Sudoku every morning and card games on the computer every evening to stay mentally fit. He also handles all of the accounting for the activity centre on a daily and annual basis. His physical activity is also related to his tasks at the activity centre, as he walks to do a lot of the food shopping and to buy prizes for the bingo games. He regards this as exercise, but does not appreciate it. He talks a lot about keeping mentally fit, but does not like all the health and exercise advice to which he feels subjected. In this way, he simultaneously internalises and criticises the active ageing discourse. Many of my informants seem to embody this ambiguity: they talk about the activity regime as a suppressing power, even whilst they employ different strategies to stay active. In some ways, it seems as though their level of activity (especially physical exercise) is what defines how healthy they are perceived to be. The members of the activity centre see Valter as being very active and thus very healthy. As Laz (2003) has argued, respondents often describe themselves as being in good health despite their conditions, as long as they lead active lives. The subjective experience of good health seems to be based on a person's efforts in relation to exercise, participation and engagement in life.

Valter is engaging in a form of 'busy ethic' (Ekerdt 1986) in which he feels obliged to continue his busy and active life from before retirement, partially so that he will not decline too fast. This is a form of health strategy wherein he engages in activities and chores to stay fit – mentally as well as physically and socially – whilst trying not to think about his diseases. He succeeds in this distancing and achieves a sense of having a superficial body with no inner, deep abnormalities, but he dreads the day when he will have to give up his position as the activity centre's manager – which he has decided to do in the coming year, due to his condition. Will leaving his position at the activity centre – and the correlated sudden drop in daily chores and activities – impede Valter from his distancing of disease?

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His activities create direction and purpose, and he dreads the emptiness he foresees in his future. But the COPD demands that he stops his activities – in turn, this will lead to more time to think about COPD and his declining condition. Thus, Valter senses the presence of his declining body, but he tries to keep it at arm's length through a high level of participation and social activity at the centre. Decline is embodied within an arm's length and is not something completely outside of him. He is not what Featherstone (1995) calls a 'post-body', altering the experience of embodiment through virtual reality and an altering of the body's infrastructure; instead, Valter is a situated, embodied, ageing subject who sees decline at the end of his arm; that is, at the end of the activity he must soon stop, due to the condition that he is trying to keep at a distance. Activity helps Valter create distance, whilst distancing the disease enables his active lifestyle. Disease at arm's length and activity go hand in hand.

Daisy: staying active to avoid loneliness and distance disease

Daisy is 79 years of age, and she has been a widow for the past 25 years. Her husband died after five years of illness following a stroke, during which he was dependent on her for help. The heavy lifting and hard work – also from her job cleaning offices – has caused a lot of back problems and arthritis. During the time of her husband's illness and after his death, Daisy also regularly suffered from severe depression. She still seems depressed and lives a solitary life, but is nevertheless very active at the activity centre. She dreads the weekends when the activity centre is closed because she misses the company. 'The centre is half my life', she says, with equal amounts of affection for the centre and sadness about her situation.

Daisy engages in myriad activities at the centre: card games, dice games, darts and party planning. In addition, she volunteers at DaneAge,[6] where she leads a needlework group and exercises with a community calisthenics class. According to Daisy, the activities help her create a sense of purpose. When she sits in front of the television at home, she often feels depressed. In addition to arthritis and back pain, she also has type 2 diabetes and received an artificial wrist after a fall two years ago. Of her many physical conditions, it is the wrist that gives her the most trouble; it bothers her when cooking and cleaning. As Katz and Marshall (2004) have argued, normality commonly refers to functionality. When Daisy can no longer cook or clean properly, it is her normality that is at stake, as she is no longer able to perform her everyday chores. She takes medication to manage her other conditions, and she exercises to keep her blood sugar stable, but the problem with her wrist is different – it impedes her functional capacity.

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Being diagnosed with type 2 diabetes did not change the expectations she had about how long she can live, especially because medical and technological developments in the field of diabetes have changed what it means to be diagnosed. If she can no longer control her blood sugar through diet and exercise, she can always start taking insulin. If that does not work, different insulin regimes can be tried as well as insulin pumps, gastric bypass, *etc.* As long as she remains active and does not sit in front of the television too much, Daisy manages to keep diabetes at arm's length. Her activities are a way to avoid contemplating her conditions too much and a way to physically control her conditions. As long as she feels like she is doing her best to stay fit, she does not have to face the potential severity of her conditions. She also takes medication to combat high blood pressure, but it does not work as the doctor had hoped:

> My doctor struggles a bit with my blood pressure, but I don't really think it's worth worrying about . . . I'm old – it's a part of it. (Daisy, in an interview)

Laz (2003: 517) argues that corporeal 'facts' never speak for themselves but are experienced and interpreted. In Laz's article, one of her informants – Catherine – has been told by her doctor that she has arthritis, but she feels no complications, just as Daisy does not experience her high blood pressure. When the doctor confronts Daisy about a condition with which she has no experience, she senses what Tulle (2008: 64) calls situated embodiment. In other situations her body prevents her from cleaning, is a trigger for depression or is a way to get out the door and participate in calisthenics and social activities. But Daisy does not sense the inner workings of her body. In this sense she is disembodied whilst simultaneously being subjected to a medical regime that embodies her. She externalises and disembodies her conditions by making it the doctor's problem, not her own – at the same time, she uses her body in physical activities that help her distance the disease. In this case, keeping disease at arm's length and active ageing seem interdependent. Daisy engages in physical activities to keep her diseases at arm's length, and keeping her diseases at arm's length enables her to lead an active life.

Karl: having a good time as a way to keep disease at arm's length

Karl is 78 years of age. He is married and used to do everything with his wife. However, his wife has suffered from depression for the last couple of years, and Karl has spent an increasing amount of time at the activity centre. A couple of times a month, he convinces his wife to accompany him to the centre, but he mostly goes alone to play billiards with his friends. He tries to help his wife, but feels inadequate in handling her depression. When talking about disease, he primarily refers to his wife's depression. He only starts

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to hesitantly explain his own medical conditions when he is directly asked. He has always had what he calls an aversion to doctors: 'Where I come from, you just don't go to the doctor.' Karl grew up in a working-class family and takes great pride in his background. He is a former machinist and metal-smith, and stresses how important it is that the group at the centre is comprised of 'equals', referring to their shared working-class background. He waited until he was age 60 to have a health examination, as he had always felt fine. However, the doctor did not agree with Karl's assessment of his own health:

> I wasn't sick, but then you go to the doctor and he says, 'Oh, but you are sick.' What the hell are you to make of it? And then they fill you up with all that stuff [drugs]. (Karl, in an interview)

The doctor urged Karl to change his lifestyle – to eat more healthfully and to exercise – but Karl could not find the motivation. He explains that he felt it was already too late, and he decided to not let his doctor dictate how he was going to live. He continued his life as usual and thinks he is doing fine almost 20 years later. In this situation, Karl's doctor prodded him to become an active and health-focused subject and to act accordingly. Instead, by showing no desire to assume such subjectivity, Karl reacts like Callon and Rabeharisoa's Gino when faced with disease: 'I'm not the "I" that you want me to be' (2004: 24) – meaning 'I will continue to live life the way I have always done'. For Karl, keeping disease at arm's length is a direct defiance of the doctor's orders, and a refusal of what Kontos (1999) terms the 'biological imprisonment of the elderly'. Karl will not be reduced to the biological portrait his doctor has painted; thus, he continues to live his life in spite of the attempted biological imprisonment.

Although Karl says that he is doing fine now, he seems to be struggling with some physical conditions. In recent years, he has undergone two heart-bypass surgeries and a heart-valve surgery – 'but other than that, I'm fine'. He jokingly assesses his current condition by saying: 'They should have put a zipper in my chest for easier access.' He seems happy about the life he has lived, and does not regret his way of living. He acknowledges that he might have made a mistake in not changing his diet 20 years ago, but he is very satisfied with the 20 years he has had – in spite of his doctor's claim that he was sick. After the heart operations, he was offered rehabilitation, but he thought the rehabilitation centre's atmosphere was too dull and sad, and he decided it was too long a trip (approximately five kilometres) just to be depressed about all the diseases there. He would rather spend time at the activity centre where it feels cosy, and play billiards with his friends there. His doctor seemed pretty upset about Karl's decision to not attend rehabilitation, but Karl dismissed this by saying that it was the doctor's

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job to worry: 'My health is my doctor's concern', he says, echoing how Daisy distanced her disease through externalisation and disembodiment.

Karl keeps his disease at arm's length by using the activity centre in a manner somewhat similar to Daisy. They both go to the centre to enjoy life, instead of sitting at home and contemplating their diseases; it is an escape from their homes. For Daisy, it is because of her disease, loneliness and depression; and for Karl, it is because of his disease, but also due to his wife's need to rest and his feeling of inadequacy towards her depression. Karl and Daisy both use the centre to have a good time, be part of a community, feel that they lead active lives and keep their diseases at arm's length. Karl's health strategy involves having a good time through activities and not worrying about his health, which he perceives as his doctor's job. He keeps his diseases at arm's length to such an extent that it seems as though there is almost no material connection between them – that the distance is not one within him that can be bridged, but something that is external and disembodied.

Andrea: 'I am not ill and decrepit' – fighting disease through activity and distance

As diseases progress, keeping disease at arm's length can turn into a struggle for survival rather than a health strategy. This is the case with Andrea, who is 75 years of age. She is a widow who lost her husband eight years ago. His death was a huge shock to her, and she is still struggling to get over it. Following her husband's death, she needed to move out of their house – not for economic reasons, but because she could not handle his absence in the house. She moved to an apartment, but it did not work out for her; she missed having a garden. When her son suggested moving closer to him and his family, she bought a house of her own at age 74. She sees this move as something that says a lot about her will to return to a normal life after her husband's death, and that it also says a lot about her will to live and not do things the way others expect her to. Her friends tried to talk her out of buying a house – partially because it was far away from them and her old neighbourhood, but mostly because, in her opinion, they expected her to 'become an old lady, succumb to my condition, give up all that hassle of gardening, and lay down and die'. But Andrea was not ready to succumb, and she felt that her gardening work would benefit her activity level and health.

Andrea is very proud of her move, but also experiences a lot of problems tending to the house and garden. When asked about her health, she reluctantly starts to describe her conditions. Andrea suffers from cardio-vascular disease, osteoporosis, gout, and was operated on and treated

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for breast cancer two years ago. After recovery, she had pain in her chest that she chalked up to the surgery. She stopped going to her doctor after the cancer treatment, as it made her feel ill and declining. When she eventually contacted her doctor again about the aggravating chest pains, she was promptly hospitalised and needed to stay there for several weeks to undergo surgery and be monitored. The doctors diagnosed her with a cardiovascular disease, which she now struggles to keep at arm's length. She feels as though she lives artificially because she is only alive due to 'plastic things in my veins' and the medication she takes. She finds the medicine unnatural. She has to take six pills each day, which constantly reminds her of both her own disease as well as the years when her husband was sick and she had to 'feed him pills'. She puts her pills in a wooden box because a regular pill-organising box reminds her of her husband's illness. And the very idea that surgeons have been inside her heart, 'rummaging around in the holy of holies', is hard for her to bear. She is still coping with how to continue life after such a shock.

Her body has become fragile to such a degree that Andrea struggles to keep her diseases at arm's length. Her active daily life is a way for her to fight her diseases on several levels: on a physical level because she is encouraged to exercise to regain her pre-operational fitness; on a mental level because activity allows her to distance her diseases; and on a cultural and social level because the activities enable her to think of herself as an active older person, and they help her be part of the community at the activity centre. Activity is a way for Andrea to cling to a sense of normalcy, and to cling to her experience as a healthy subject despite her conditions. She struggles to keep her conditions at arm's length, but briefly forgets her mortality when she is at the activity centre:

> I don't know what it is. I guess I like the feeling of doing something about my health, not just sitting and pondering it. I sort of forget my heart problems – hmmm, it's weird, because sometimes I have to stop exercising because of my heart, so in that way, of course it's hard to forget it. But maybe it's just because I have people around me at the centre, so I don't feel like an old dying lady when I exercise. (Andrea, in an interview)

Andrea no longer practises a health strategy, but rather a survival technique; she engages in activity to resist the approach of death. She tries to distance, disembody and externalise, but her heart is too closely entangled with medical technology and danger. She can only succeed at distancing via the situated disembodiment that she attains through physically exercising around others. Andrea's sense of embodied danger and keeping disease at arm's length are constantly negotiated through tools and technologies, such as the active ageing discourse, corporeal artificiality, gardening work and pill boxes.

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Discussion

As seen in these four vignettes, older people seem to combine active ageing with the ability to keep disease at arm's length. I regard this to be a health strategy that silences rather than emphasises the pathological body. It is not about being a responsible and attentive patient (Olesen 2010), but about being inattentive through activity. It is about the ongoing shift between situated embodiment and disembodiment (Tulle 2008). These informants are entangled with medicine and biology but have found a position in which social and/or physical activity forms enough agency in and of itself, without all the awareness of disease and mortality.

Practising a good health strategy is often defined as understanding and relating to what in Foucauldian terms could be called 'the deep, inner body' (Foucault [1963] 1973), and thinking in terms of potentiality and risk (Beck [1986] 1999; Frankenberg 1993; Giddens [1990] 2000). Since the late 1800s, this awareness of the body has been cultivated in Europe through processes of subjectification (Mellemgaard 1998) that have recently taken on new forms (Otto 2009). In contrast, keeping disease at arm's length means silencing the body's inner workings. The older people in this study do not relate to the 'deep inner body' nor do they seem concerned with risk.

Williams describes the many conditions and diagnoses that people live with as 'a state of normal crisis', claiming that crisis and disease are often what constitutes the normal. For some, disease is continuous and good health is the exception (Williams 2000), although researchers have questioned whether disease can be a state of normalcy (Larsson and Grassman 2012). As seen in the case of Daisy, she does not question her state of normalcy when she is diagnosed with diabetes or arthritis, but does so when her new wrist impedes her from doing her everyday chores. Daisy does not seem to experience any problems with her various diagnoses; they are normal to her. Her condition becomes present when it impedes her from cleaning, not when her blood sugar and blood pressure is rising.

Previous research on salutogenesis (Antonovsky 1979) argues that people learn to cope and live well with stressors and risk factors despite disease, due to resilience (Richardson, Grime and Ong 2013) or due to a sense of coherence (Ciairano *et al.* 2008). Salutogenesis focuses on why people stay well when faced with disease, as opposed to a pathogenic model, which focuses on the obstacles people face. Although the concept of 'disease at arm's length' has some similarities with the salutogenic approach, it differs in the way it views the role of disease in people's everyday lives. While the salutogenic approach regards disease as a stressor and something that people learn to cope with and overcome, 'disease at arm's length' is based on the ethnographic accounts of older people who have not 'learned'

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to overcome disease; there is not necessarily a stressor to overcome. In this way, disease at arm's length does not assume that disease is necessarily something that older people relate to or cope with. However, as I described earlier, this does not mean that these interviewees always keep their disease at arm's length. But in many situations throughout everyday life disease is not something they handle. It is absent.

The older people with multiple chronic illnesses in this study do not stand out amongst their peers. Multiple chronic illnesses are common for their age group. In this sense it does not require a lot of hard work to fit disease into their social roles, as suggested by research on people in their fifties (Townsend, Wyke and Hunt 2006). Rather, with the concept of active ageing, the older people in this study engage in a health strategy wherein distancing disease through activity fits well with a new type of old age.

The type of old age depicted in active ageing forms a newly emerging type of late-life subjectivity. Older people are encouraged to lead an independent life and be self-caring (WHO 2002). Distancing disease through activity seems compatible with this type of subjectivity. However, paying attention to the body's signals and leading an independent and healthy lifestyle are key components of a general individualised health-care focus that encapsulates an active old age (Katz 2000). From a Foucauldian point of view, this attentiveness and self-care can be seen as a technology of the self (Foucault 1994) in which the self disciplines and controls itself by constantly assessing and relating corporeal sensations to the inner state of the body – and is expected to take action if something 'feels wrong'. But active ageing is ambiguous in this aspect. In older people's everyday lives, the practise of active ageing can be a way to keep disease at arm's length, and not a way to sense possible abnormalities in the body. Karl is independent when he chooses to not follow rehabilitation. But it is a form of independence that does not fit with health-care advice. Independence can also mean negligence and lack of self-care.

To Karl, Daisy and Andrea, it is the doctor's job to know about the inner workings of their bodies, not their own, and Andrea tries to forget how surgeons have operated on her heart. The idea of an inner body that others can know about and operate on troubles her. Thus, there is a difference between how active ageing is thought about at the policy level – *i.e.* as part of a health focus on prevention and sensing the body – and how the older people distance their bodies through activity.

Keeping disease at arm's length can also be regarded as a technology of the self, which uses activities as tools to create distance. This can be a way to manage physical deterioration. However, this technology of the self requires a certain type of self that is simultaneously embodied and disembodied. Embodiment is ambiguous and situated, when Andrea senses her heart

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beating during exercise but also engages in activity to forget her heart problems. Rose and Novas (2000) have argued that the self has become closely connected to the body; it is a somaticised self. When selfhood is increasingly connected to the body, the self becomes an individual engaged in an inherent quest for longevity as well as a realisation of the potentiality in one's own body. This selfhood presents some challenges to the ageing body: if the self is connected to the body and the body declines, then what is happening to the self? With terms like the 'ageless self' (Kaufman 1986) or the 'post-body' (Featherstone 1995), it has been suggested that the self becomes increasingly disembodied with age. In line with Emmanuelle Tulle (2008), I suggest this is not the case, but rather that embodiment is situated; it varies from situation to situation in different spatial and material practices.

Keeping disease at arm's length is a form of situated embodiment in which the disease is both present and absent. When the self faces chronic disease, a certain distancing is required in order to resist being overwhelmed by the disease; the self uses activity to create this distance. Thus, active ageing is not a way of relating to the body's sensations, but a way of keeping the sensations out there – at arm's length. Physical activity is used ambiguously to create distance from the body's sensations.

Health-promotion programmes also emphasise activity, but often attempt to make individuals constantly aware of their bodies; they point to the body as the 'spatial entity' of risk factors and preventive measures (Armstrong 1995; Wheatley 2005). The Chronic Disease Self-management Program is an international project that teaches so-called 'patients' how to be conscious of their bodies' inner workings in order to monitor and control them (Nielsen and Grøn 2012). Health strategies involve a certain awareness and idealisation of the body:

> Idealizing the body and wanting to control it go hand in hand. 'Health' is a moral discourse that incorporates an emphasis on individualism, hard work and material reward that is woven throughout secular culture, seamlessly inhabiting our consciousness. (Maynard 2006:213)

Disease at arm's length can be seen as a rejection of this type of embodiment.

Valter recognises that he has COPD, but knows there is nothing he can actively do to prevent the disease from developing, as he does not smoke and therefore cannot quit. He does not engage in a lot of physical activity to reverse his decline; instead, he acknowledges the condition and tries to make the most out of the activities he enjoys whilst he still can, hoping that these will be sufficient to delay the progression of the disease a bit. This is an example of situated embodiment, not an idealised and controlled body. The body briefly presents itself as a key agent, but then assumes a more inferior position in the majority of Valter's everyday life. He does not engage in

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a range of physical activities in order to impede dependence; instead, he participates in the activities he enjoys and finds meaningful, disregarding both the potential health benefits and risks implied in these activities. In this way, Valter and the other people in this study take an ambiguous stance towards the active ageing discourse.

The older people in this study engage in activities and participate in their local communities, and lead active lives in various ways. But they do not necessarily engage and participate in medically healthy activities or health-focused communities. Perhaps this is one of the reasons that active ageing seems to be a dominant discourse and a powerful rearticulation of old age: it is such a broad concept that older people can appropriate it, and become independent, engaged, participating, self-caring, healthy or active in their own differing ways without embracing all the different aspects that make up active ageing in the WHO and the European Union.

In their paper about Gino, Callon and Rabeharisoa (2004) describe the unawareness of disease as a refusal of a decision-making, autonomous and responsible subjectivity. They suggest a different sociology that can accept other ways of being human than a reductionist view of humanity, and my conceptualisation of 'keeping disease at arm's length' is an attempt to contribute to such a sociology.

Conclusion

In some ways, the vignettes I have described here are simple to interpret. Active, Danish older people do things – engage in certain activities – that they enjoy, and thereby manage to keep their diseases at arm's length. Forgetfulness, inattentiveness, nonchalance, indifference, negligence and irresponsibility can be seen as key components of this reversed health strategy. However, a certain kind of artfulness seems to be involved in some of the examples. The ambiguity of the active ageing discourse is highlighted in the vignettes where older people with severe diseases are still engaged in active ageing. The older people master this ambiguity – but not by expressing a medicalised view of old age, or by using a lot of time and energy to relate to their diseases, being alert to physical changes and monitoring themselves. On the contrary, they master this ambiguity by participating in activities and leading active lives to keep their diseases at arm's length.

Throughout this article, active ageing is positioned as a dominant cultural discourse and practice. However, a certain ambiguity is inherent in this practice. The concept of active ageing is inscribed in a general health discourse that emphasises awareness of the body, but the practice of active ageing seems to distance the body. The practice and concept of active ageing are entangled, but within this entanglement, embodiment is

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situated; awareness of the body and health advice is only momentary. The body briefly appears, but most of the time, active ageing is a way to keep diseases at arm's length and to de-emphasise bodily sensations. I regard this distancing as a health strategy. It is not an unhealthy negligence, but a way to continue an active life despite one's diseases.

Valter, Daisy, Karl and Andrea keep disease at arm's length in their active ageing practice in a less extreme manner than Gino in Callon and Rabeharisoa's work (2004). In this way, active ageing holds an ambiguous and paradoxical position as part of a health regime that focuses on being aware of the body – and being unaware is exactly what these older people strive to do via their physical and social activities. We may question whether this is a healthy practice, but it should be clear that active ageing and keeping disease at arm's length are both entangled together and enable each other.

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NOTES

1 The two activity centres in this article are primarily member-organised and-driven. The members volunteer as activity organisers and, for a small fee, all older people living in the municipality can become members and attend the activities. One of the centres has 110 members with approximately 50 weekly users, and the other has 1,100 members with approximately 200 weekly users.
2 'Early retiree' is a translation of the Danish term *førtidspensionist*. This pension is given to people who have a continuous functional disability of 50 per cent or more – usually, because they have a severe chronic disease.
3 Due to the confidentiality of the interviewees and the other members of the activity centres all names have been changed to pseudonyms. The fieldwork has followed the code of ethics outlined by the American Anthropological Association (2012). All interviewees gave informed consent and the fieldwork was conducted safely.
4 'Winter swimming' is a translation of the Danish term *vinterbadning*. In Denmark, some people swim in the ocean during the winter (in water temperatures around 0 °C), albeit only for very quick dips during the coldest months.

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5 All quotes have been translated from Danish by the author.
6 With more than 600,000 members DaneAge (*ÆldreSagen*) is the largest organisation in Denmark for older people.

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Address for correspondence:
Aske Juul Lassen, Department of Ethnology and
Centre for Healthy Ageing, University of Copenhagen,
Karen Blixensvej 4, 2300 Copenhagen S, Denmark

E-mail: ajlas@hum.ku.dk

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