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Colonising the future: temporal perceptions and health-relevant behaviours across the adult lifecourse

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Abstract Health promotion is premised upon a proactive approach to health and its management, one that requires a future-orientated outlook, in which the threats of (future) ill-health can be anticipated and thereby mitigated. Despite this, little is known about the extent to which concerns about morbidity and mortality actually feature in people's present and future perceptions of self, and whether such perceptions have any influence upon their present health-relevant behaviours. By drawing upon interviews with 55 people aged 26–81, this article highlights the central role that embodiment plays in the mediation of health promotion messages. The embodied experience of ill-health, it will be shown, is an important, underlying prerequisite for perceiving a future in which (further) ill-health is anticipated. This pivotal finding will be used to illuminate the observation that, when lifestyles are changed to concur with professional recommendations, these changes tend to be reactive in nature.

Keywords: embodiment, risk perceptions, health-relevant behaviours, perceptions of the future, health promotion

Introduction

This article reports some of the findings of a qualitative study conducted in England in 2000 in which semi-structured, in-depth interviews were conducted with 55 participants. In this, a lifecourse approach was employed to explore the ways in which people of different ages, and from different backgrounds, had – or had not – actively thought about, and planned for, their futures. This focus was considered important because, within the supposed 'risk society' of late modernity, increasing onus is being placed upon individuals to take responsibility for all aspects of their present and future lives (Giddens 1991, Beck 1992). One arena in which this cultural shift has

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become apparent is that of health and its management. Whereas historically disease and its causation were understood in fatalistic ways (Brandt 1997), within the contemporary Western context, responsibility for health and its maintenance has been set firmly within the hands of individuals (Lupton 1995, Brandt 1990). Indeed, the past few decades have seen a significant upsurge in health promotion activities sponsored by governmental and other agencies. Health promotion advocates a proactive approach to health, in which individuals are encouraged to adopt and/or maintain a range of 'healthy' lifestyle behaviours in the present in order to lessen their risks of developing various acute and chronic conditions in the future (Blaxter 1990, Department of Health 1999).

One of the most notable achievements of health promotion to date has been the extent to which its messages have been successfully disseminated to the lay population. As Blaxter (1990) has found, most people can competently cite what they (and others) should be doing to lessen their risks of future ill-health. Yet herein lies the paradox: while most age and social groups are well-acquainted with the messages of disease prevention, few people, in practice, enact 'healthy' lifestyles either entirely or in part (Blaxter 1990, Backett and Davison 1995, Dean 1989, Hunt and MacLeod 1987). As Williams suggests, the translation of health promotion messages into actual practice 'remains a fundamental stumbling block for those concerned with the promotion of "positive change" to a "healthier lifestyle" ' (1995: 578).

This article will consider a body of work that has already greatly enhanced our understanding of why health promotion activities have been, in the main, remedial rather than radical in their impact. By drawing upon the findings of the interview study, it will also develop an area of enquiry and explanation that has received surprisingly little attention. In spite of the fact that health promotion – and 'risk management' in general – require a future-orientated outlook, one in which individuals can see themselves as vulnerable to the threats of ill-health and ultimately death (Lupton 1999: 21), few studies have paid explicit attention to the ways in which people, in their daily lives, actually anticipate their futures with regard to these emerging realities. As the findings described in this article suggest, the manner in which people 'imagine' their futures varies according to their position in the adult lifecourse, and, in particular, according to their current health status. While it is common for younger people to perceive a long-term future for themselves in which the potential constraints of morbidity and mortality are often absent, for older people – especially those experiencing poor health – future morbidity, and death, are often viewed as impending certainties. These shifting experiences and perceptions, it will be shown, are highly relevant to whether people are overtly 'health conscious' or not. As this article will further suggest, the presence, or absence, of 'health consciousness', 'morbidity consciousness' and 'death consciousness' often appear to have a direct bearing on people's motivation to adopt behaviours aimed explicitly at lessening their risk of future ill-health. Such observations will be used

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to raise pertinent questions about the likely (future) impact of predictive genetic susceptibility testing for common, adult-onset disorders with a multifactorial aetiology.

Study background, design and methods

The study was commissioned by Age Concern England, to explore the extent to which people from different age, gender and socioeconomic groups had actively thought about future eventualities such as ill-health and death, and whether these perceptions influenced their current health behaviours and planning for their futures[1]. Although there is already some relevant research within this area, only limited insights can be gained from this body of work. For example, while some studies have explored perceptions of risk of susceptibility to future illness (for example, Davison *et al.* 1991, Ponder *et al.* 1996, Glik *et al.* 1999), these have generally only focused on specific conditions such as coronary heart disease, and/or have rarely explored the relationship between risk perceptions and actual health-relevant behaviours (Hunt *et al.* 2001). This situation also applies to the research that has examined variations in death attitudes and anxieties across the lifecourse, without actually exploring their impact on provisioning for the future (for comprehensive overviews of these studies, see Fortner and Neimeyer 1999, Gesser *et al.* 1987).

Thus, as the present study was essentially exploratory, it lent itself well to a qualitative design, one that would enable themes to be identified and tested during the study period, rather than simply assessing those formulated prior to data collection (Britten *et al.* 1995). An interview schedule was designed that allowed perceptions of morbidity and mortality to be identified, and their effects on present health-relevant activities and future planning to be examined. The interviews began by exploring the general state of health of participants' family and friends, thereby creating opportunities for them to share information about the deaths of people who were important to them, and any concerns they might have about the health of others. This was considered an important line of enquiry because some studies have suggested that the experience of death and ill-health within one's circle of significant others may have some influence upon one's own existential awareness (see, for example, Hallowell *et al.* 2001, Tokunaga 1985, Yalmon and Lieberman 1991). The second part of the interviews contained a series of questions about participants' perceptions of their own general state of health in the present and the past, and also if they had any concerns about their future health. This question was further explored by asking if any behaviours had been consciously adopted in the recent or distant past to improve and/or maintain health, and, if they had, what factors had prompted these changes. The interviews then went on to explore experiences and perceptions of later life, and if any proactive plans had been made for

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these events. They concluded with a series of open-ended questions about hopes and expectations, in which participants were invited to talk about their perceptions of self at various points in future time.

A flexible, open-ended approach was achieved by using an emergent study design informed by grounded theory research (Glaser and Strauss 1967). Data collection and analysis occurred concurrently, and systematic efforts were made to check and refine developing categories of data (see Charmaz 1983). The ongoing process of data collection and analysis directed further literature reviews, investigation topics, sample selection, and interview questions. Thus, while some themes were formulated at the study's outset, others emerged during data collection. These emerging themes were explored with respondents in later interviews, and, when necessary, were subjected to further revision. Analysis also continued after data collection, when individual transcripts were repeatedly re-examined and cross-compared using manual, iterative methods. Although some revisions were made to the interview schedule, its core structure remained essentially the same. Hence, it was possible for comparisons to be drawn between different interviews and clusters of interviews, as well as for points of similarity to be identified.

The sample

The study was conducted within tight time constraints[2]. Despite this, it was possible to interview 55 people within the allocated period of five months. Recruitment was achieved through snowballing techniques, in which people were drawn from four distinct geographical localities in England (one rural, three urban). As one of the central aims of the study was to explore possible variations across the adult lifecourse, people of a wide variety of ages were involved in the study. The youngest interviewee was 26 and the oldest 81, with the ages of the others falling more or less evenly on a spectrum between these two extremes. Roughly equal numbers of men and women were interviewed (27 men, 28 women) to allow possible gendered variations to be identified. Likewise, potential class variations were accommodated through the recruitment of people from a wide range of occupational backgrounds. While social class is notoriously difficult to classify, the study followed Blaxter (1990) in using the conventional Registrar General's social class method, which is based on occupation, or previous occupation in the case of the retired, or husband's occupation in the case of married women. The social classes of the participants are as follows: classes I/II (professional, employers and managerial families) ($n = 20$), class III non-manual (IIIN) (other non-manual occupations) ($n = 15$), class III manual (IIIM) (skilled manual occupations and own account tradesmen) ($n = 8$), and classes IV/V (service occupations, semiskilled and unskilled) ($n = 12$). Hence, participants from classes IV/V are slightly under-represented in the final sample. Only one participant came from a minority ethnic background.

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Data collection

The interviews were conducted between February and June 2000, and varied in duration from 15 minutes to two-and-a-half hours. Most participants were interviewed in their own homes, although some chose to be interviewed at their place of work. With their permission, the interviews were tape recorded. All participants completed a form in which they provided information about their age, (former) occupation, education and ethnic status. Field notes were written immediately after the interview had taken place. These were used to record information that had been shared after the tape recorder had been switched off.

All aspects of the research were guided by, and conformed to, current BSA ethical guidelines. For example, confidentiality was assured and maintained throughout the study, and participants' identities have been protected through the use of pseudonyms.

Outline of findings

The interviews evoked a wide variety of responses. Whilst some participants talked extensively about health issues and voiced concerns about future morbidity and mortality, for others, health-related concerns did not seem to feature prominently in their daily thinking and activities, let alone in their perceptions and planning for their futures. While some modest gendered and class variations were identified when the data were analysed, the strongest distinctions emerged when the responses of people from different age groups were compared. Older participants, as a general rule, appeared to be much more 'health conscious' than those of younger ages, and were more likely to perceive the prospect of future ill-health and death as certainties as opposed to possibilities.

At first sight, the findings appeared to resonate with those of other studies which have pointed to the role of increasing age in precipitating thoughts of finitude (for example, Kalish and Reynolds 1977). Such a phenomenon, Kalish and Reynolds suggest, stems from a general 'recognition of the reality that older people are more likely to die than people of any other age' (1977: 212), combined with the fact that older people are much more likely than others to have been exposed to ill-health and death amongst their family and peers (see also Keith 1982, Field 2000, Stillion 1995). 'Commonsense' explanations such as these, however, were thrown into question in this study because important differences occurred between interviews with participants of similar ages. For example, not all older[3] participants appeared to be concerned about their health, let alone with the prospect of death; similarly, some people in the middle-aged groups claimed to be attentive to health issues in ways that distinguished them from many of their

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contemporaries, as well as most younger and some older participants. When the transcripts were re-examined to take account of these variations within particular age groups, it became apparent that it was the experience of embodied ill-health, rather than increasing chronological age per se, that prompted people to perceive themselves as directly vulnerable to the threats of future morbidity and mortality. This general shift in perceptions and experiences with increasing age could thus be accounted for by the fact that, as people grow older, they become more prone to degenerative diseases and multi-morbidity[4]. The over-riding importance of health status over chronological age was amplified in a second, pivotal finding: when participants in all the age groups reported that they had changed their lifestyles with long-term health goals as their motivation, their accounts suggested that these changes (with almost no exceptions) had been reactive rather than proactive.

The following sections have been structured to highlight these key findings. They begin with the perspectives of those participants (predominately in the younger age groups) for whom good health was taken for granted, and conclude with those for whom the experience of embodied ill-health had become central to their daily activities and future perceptions. Gendered and class-based issues are also briefly highlighted in some places. The article ends by providing some reflections upon the implications of the findings for future health promotion activities.

Taking good health for granted: absent bodies, immortal selves

> Up to forty you don't give a bugger. Do you, you know? You don't really think about it at all (Howard, 55, IIIN).

A substantial number of interviewees appeared to take basic good health for granted, an experience that was most common amongst younger participants, but also extended to some in the middle and older age groups for whom no obvious health problems had featured in their lives. Importantly, when these people were asked about their current state of health, and also if they had any concerns about their future health, such lines of questioning often elicited terse and dismissive responses:

> It's not something that plays on my mind; it's not something I think about (Kate, 30, IIIM).

> I wouldn't say really I've given it any thought to be honest (Michael, 38, IIIN).

The failure of health-related questions to strike a responsive chord suggests that, for these participants, health held the status of an experiential absence,

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one displaced from the realms of conscious attention. Indeed, it was often only after they were forced by the interviewer's questioning to qualify comments such as those made above, that participants described 'states of being' from which underlying, long-term health complications were absent:

> I don't think I've ever had a day's sickness in my life (Elizabeth, 42, IIIN).

> Well, I suppose because I've not been particularly ill, I'm not really concerned about it (Lucy, 46, I/II).

As the above responses suggest, for as long as it can be take for granted, health – to borrow an insight from the phenomenologist Leder (1990) – is experienced as 'an absent presence'. As van Hooft similarly suggests: 'Insofar as we are living our lives more or less successfully, our health is not an issue for us, and is not directly experienced as a state of our being' (1997: 27). Importantly, while health retained a background quality for participants, the possibilities of imagining a self in sickness, and in death, also appeared to be absent. When these participants talked about their hopes and expectations for the future, virtually all projected their lives forward in ways characterised by what has been termed an 'unrealistic optimism' (Segal *et al*. 2001, Weinstein 1982). Not only was an extended period of longevity taken for granted in their accounts (many participants, for example, made reference to what they *would* be doing in their 80s); importantly, the ways in which they described their futures precluded any references to ill-health, let alone death. While some talked about their hopes of continuing to work on a part-time or voluntary basis after they had reached retirement age, the majority spoke with great enthusiasm about their plans to travel extensively in later life. In all cases, their comments revealed an implicit assumption that they would retain the corporeal and mental capabilities to pursue these goals, an assumption that finds resonance in broader postmodern discourses of ageing. In these, as Gilleard and Higgs (2000) observe, positive images of ageing, in which later life is perceived as presenting opportunities for leisure activities and personal development, are increasingly jostling for prominence with those in which ageing is seen as involving inevitable deterioration and dependency.

> I want to travel round the world to some remote and amazing continent, that's what I'm contemplating (Catherine, 26, I/II).

> There's another thing I shall do when I'm old, too, is I'll become a connoisseur of fine wine . . . Well, I really would like to have a nice cellar. So when I'm older and have more time, I think I would like to go backwards and forwards to France buying wine . . . [and] . . . I might as well have a pad in New York, so when I'm 80 I can be actually going to the opera and the ballet and things like that (Elizabeth, 42, IIIN).

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Whilst these participants demonstrated a clear capacity to 'look forward', significantly, none of them claimed to have either adopted or changed aspects of their lifestyles with the aim of promoting longevity. This could not be explained by an ignorance of the messages of health promotion: indeed, a general awareness of the current orthodoxies of preventative medicine (*e.g.* don't smoke, don't drink to excess, exercise regularly, adopt a low-fat diet) was frequently alluded to in these interviews. When, however, participants talked about their own health-relevant behaviours, their comments often indicated a perception that health-promotion activities lacked any relevance to themselves. This did not necessarily mean that these participants reported lifestyles that might be characterised as uniformly 'unhealthy': as Blaxter (1990) has similarly observed, patterns of health-relevant behaviours within this group tended to be mixed, consisting of both 'good' and 'bad' components. Nonetheless, when they were encouraged to explore the motives underlying the supposedly 'healthy' components of their lifestyles, it became apparent that long-term health considerations were not of central, if any, salience to them. For example, the high cost of cigarettes, rather than a concern about future health, was a frequently-cited reason for smoking cessation. Physical and other sporting activities were pursued 'more for the pleasure . . . than necessarily because it's keeping me healthy' (John, 42, I/II). Dieting was also commonly reported amongst members of this group, although this was largely a gendered phenomenon. Whilst weight management is known to lessen the risks of developing conditions such as cardio-vascular disease and diabetes, such an agenda did not appear to have influenced these participants' actions. Instead, they articulated their motivations in terms of current discourses centring upon the aesthetics of the body, those in which the appearance of a youthful, slim, outer body has become a culturally revered symbol of a successful social self (Bordo 1993, Shilling 1993). Indeed, this immediate desire to 'look good' rather than to promote longevity was reflected in the smoking behaviours of two women currently on diets. They described how their fears about gaining weight, and of becoming 'ugly and unsexy' (Elizabeth, 42, IIIN), had acted as a significant barrier to stopping smoking, a situation that also finds resonance in Monaghan's (2001) study of male and female body-builders. To achieve their goal of changing 'one's bodily appearance so that it more or less approximated idealised images of health, youth, fitness and beauty' (2001: 337), a significant proportion of Monaghan's informants took physique-enhancing drugs which, like cigarettes, are known to have potentially serious, long-term health damaging effects.

Whilst the dieting and bodybuilding examples can be understood in the context of contemporary Western notions of individualism, as Williams (1998), drawing upon the work of Crawford (1984, 1998), rightly reminds us, the pursuit of a socially sanctioned self in this cultural setting is inherently contradictory. At the same time as ideals of individualism are expressed and played out through regimes of bodily regulation and self-constraint (of which health promotion activities are one component), consumerist society exalts powerful,

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oppositional values such as ' "letting go", indulging one's desires and enjoying the corporeal excesses that follow' (Williams 1998: 442). The latter, Williams suggests, are pleasurable, thus making them important to contemporary wellbeing, a perspective which goes some way to explaining why 'excesses of corporeality', such as heavy drinking, smoking, and/or eating junk food, were also a commonly reported feature of these participants' lifestyles:

> I think the guilt that people associate with not drinking, not smoking, not eating the wrong things, is actually worse in very many cases than actually committing the sins. Because people get so obsessive. And you're probably getting more benefit from getting enjoyment out of life and your friends than you would if you abstained from everything (Catherine, 26, I/II).

> I smoke, I smoke a lot. I've given up a few things, but not for long. It's always in the back of my mind to give up [for financial reasons] but it's either lack of will power or the fact that I really enjoy smoking, so I've not really thought about giving it up properly (Andrew, 32, IIIM).

Williams' work forms part of a broader trend in which studies have attempted to 'bring back culture' (Milburn 1996: 42) into their analyses and, in so doing, have highlighted the ways in which health-relevant behaviours that may seem 'irrational' from the standpoint of health promotion are in fact reasonable, and in some cases, eminently sensible when considered from a lay perspective (Backett and Davison 1992, Frankel *et al*. 1991, Graham 1993). Yet, Williams' article also highlights an additional theme of key analytic import, that of the lived experience of the body. As he points out, the 'healthy body' is the site from which 'corporeal transgressions' and 'excesses' are most likely to occur, because: 'We take our bodies for granted to a far greater degree when healthy than sick' (1998: 451), an observation well supported by the data presented here. However, an important dimension missing from Williams' account is the way in which this 'taken-for-grantedness' of the body can also impact upon future conceptualisations of self. As the data above have vividly highlighted, participants who took the embodied experience of 'good health' for granted did not appear to anticipate (and, by implication, perceive themselves as being vulnerable to) future ill-health and death, a phenomenon which adds a crucial dimension to understanding why they did not regard disease prevention activities as having any immediate salience. Indeed, such a situation became very apparent in the interview with Andrew, the heavy smoker quoted above, who offered the following response when asked if he ever worried about the possible effects of his smoking on his future health:

> I don't think about getting old and any heart attacks and stuff, or being crippled. When you're healthy you don't think about it and don't plan for it or worry.

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The central importance of embodiment to both present and future conceptualisations of self is a key theme that runs through the remainder of this article. Indeed, as the final findings section illustrates, it is one that is thrown into particularly stark relief in cases where the embodied experience of ill-health had become a central feature of participants' lives. For now, however, I will briefly consider the experiences of an intermediary group, for whom subtle, but discernible, shifts had taken place in their attitudes towards their future health, but not in terms of their actual health-relevant behaviours.

The ageing body: health-related intentions, but not actions

> Once you start getting the odd muscle ache you try and start thinking about doing some exercise, but I'm not too serious about it (William, 54, I/II).

For some participants, a point had been reached in the lifecourse at which they claimed to have become aware of some subtle and gradual alterations in their bodies. Whilst some pointed to specific changes in this regard – for example, declining eye-sight, stomach problems and 'the odd muscle ache' – most described a more generalised and periodical awareness of the ageing process, of sometimes being conscious of 'being a bit slower' (Sarah, 42, IIIN); of 'your body telling you that you're not sixteen' (Louise, 31, IV/V) (see also Cunningham-Burley and Backett-Milburn 1998). The age at which this awareness set in varied considerably between different participants. Louise, for example, described how she had started to become mindful of the effects of ageing in her late 20s, an experience she put down to a past in which she had lived on the streets and had been a heavy drug user. The vast majority, however, indicated that it was only in their late 30s, 40s, or sometimes even 50s, that they had become periodically aware of the ageing process. One woman identified the onset of the menopause – with its 'occasional and embarrassing bodily reminders' such as 'hot flushes' – as being a trigger in this regard (Alice, 55, IIIN).

When these participants talked about their hopes and expectations for the future, their conceptualisations revealed both points of similarity to and difference from those described earlier. While many retained a positive and forward-looking outlook (travel plans, for example, continued to feature significantly in these interviews) their perceptions of later life often also indicated a slightly more realistic and pragmatic view of the future:

> I would like to think that I was mentally and physically active to work and also to do the things I wanted – to travel and do things with our house and family (Guitta, 46, I/II).

> I would like to think that I'll still be living here and still liking what I like now: music and ballet and having the odd drink and going out for a meal.

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> No great change really. I'm quite content – unless I get very ill, which I hope I don't (Bryan, 58, IIIN).

> Hopefully I'll have the health to enjoy it [retirement]. I do dread old age *if* I am not going to be able to get around (Sarah, 42, IIIN).

What is salient here is that, while participants did articulate some apprehensions about future morbidity, these concerns were framed as possibilities rather than certainties, as 'ifs' rather than 'whens'. Indeed, participants often went on to describe how, within the context of their daily lives, such thoughts about future ill-health and its effects tended only to be 'fleeting' or 'peripheral', and thus did not impinge significantly on their thinking and planning for their futures. Relatedly, whilst the majority suggested that they had now started to become more attentive to the messages of health promotion – that they had begun to 'think about' doing more to keep themselves healthy – few were able to point to instances in which they had actually made changes to their lifestyles. Whilst many spoke of their intentions to take more exercise, to give up smoking, or to change their diet, they also described how the more 'pressing' and 'immediate' requirements created by work and family responsibilities (Backett 1992, Backett and Davison 1995, Calnan and Williams 1991, Watson 2000), had led to postponement of these activities:

> I plan to do a lot more to keep myself healthy than I do now. But, at the moment, I literally get up in the morning, get in the car to the station, train to London, the bus to the office and I sit in the office and then repeat it round the other way (Penny, 53, I/II).

Clearly, time constraints and other practical factors (for example, not having safe and easily accessible public spaces in which to exercise (Greenhalgh *et al*. 1998, Ross 1993)) can act as barriers to the implementation of (health-relevant) lifestyle changes. Additional (albeit less explicit) barriers are also created by the 'habituated' and 'routinised' nature of most behaviour in everyday life. By drawing upon Bourdieu's concepts of 'habitus' and the 'logic of practice', Williams (1995) highlights the complex ways in which practices and behaviours (including those relevant to health) can become such an 'unthinking' part of daily life (1995: 598), that their existence becomes, to some extent, exterior to individuals to which they supposedly belong. This perspective enhances understandings of why 'unhealthy' behaviours may persist even when people do appear sympathetic to the messages of health promotion.

However, the wholesale currency of explanatory factors such as these was thrown into question in this study by virtue of the fact that some participants reported that they had made conscious – and often successful – attempts to reconfigure their behaviours in line with professional recommendations. Their experiences are now considered.

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(Ill)-health: an omnipotent presence

> It's all your health when you get older, because if you haven't got that, you've got nothing (May, 73, IV/V).

Not all participants took their present and future health for granted; indeed, as the quote above suggests, there were some for whom health-related concerns appeared to have become a predominant feature of their lives. As other studies have similarly found (for example, Calnan and Williams 1991), explicit attention to health issues only appeared to surface after health 'problems' had set in: health became a subject of thematic awareness by virtue of its absence. Importantly, a diagnosis of acute or chronic disease was not always sufficient to bring about a conceptualisation of self as 'ill' (see Radley 1997). The disease also had to become manifest in tangible ways. George (74, I/II), for example, described how, when he was first told that he had type II diabetes following a routine medical check-up, 'I honestly and truthfully was not aware that it was a serious complaint'. It was only after he had started to experience secondary complications that he actually began to see himself as 'sick'. As he suggested:

> I think the emphasis I would make about it [diabetes] as a disease is that if you've got a heart disease, or you've got a liver complaint or your kidneys are all congested, it hits you hard; it doesn't seem to be with diabetics. . . . And it isn't until your eyes go, or partially go, and just recently I've had a lot of electric current in my toes, that you realise that it's very very serious.

Participants thus tended only to become overtly health-conscious after they had experienced episodes of acute and chronic ill-health that had had apparent and long-lasting bodily effects. These included heart attacks (with consequent problems of breathlessness and lethargy), diabetic complications, pleurisy, and painful, crippling arthritis, which limited mobility, and thus impeded an independent lifestyle. In all such cases, a heightened awareness of embodiment, and of bodily betrayal, was indicated by participants, an experience brought about by the constant reminders that their bodies no longer performed in 'unthinking', 'pre-reflexive' ways (see Leder 1990):

> I keep trying to plod along, thinking that I can still do the things I used to do, like gardening and housework, but my body says 'no'. That tells me you're not 50, you're 80-odd sort of a thing (Bill, 81, IV/V).

Not only was the body (and by implication health) rendered thematic by virtue of these experiences of bodily *dys*function (see Leder 1990, Williams 1996), the bodily effects of ill-health also appeared to have brought about a

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reconceptualisation of self as being inherently vulnerable and contingent (Lawton 2000), one which 'involves a recognition of the worlds of pain and suffering, possibly even of death, which are normally only seen as distant possibilities or the plight of others' (Bury 1982: 169). This situation became apparent when participants referred to their own futures. As the following quotes illustrate, a key conceptual shift appeared to have taken place, one in which further morbidity (and sometimes also death) were viewed as certain, impending threats to the self, as 'whens' rather than 'ifs':

> We are anxious about what is going to happen to us. We haven't actually dealt with what will happen to us *when* we are no longer physically capable of caring for ourselves (Frances, 56, I/II).

> We have our holidays now while we can. There *will* come a time when neither or both of us won't want to or won't be able to. It's the same with driving. I've told my oldest son, I said '*when* I get to the stage where you don't think I'm fit to drive, take my car away, because I won't realise how bad I've got' (Arthur, 71, IV/V).

Indeed, it was due to these tangible future concerns, and the constant bodily reminders that triggered them, that many participants claimed that they had begun to 'consciously think and act healthily' (Gordon, 55, I/II). Such conceptualisations often led to active efforts being made to follow the recommendations of health promoters, participants' reported motivations being to 'lengthen that life that diabetes would shorten' (Melissa, 56, IIIM), 'to live as long as possible, keep as fit as possible, to live till I die' (Arthur, 71, IV/V). For example, two participants who had had heart attacks described how they now paid very careful attention to their diet and levels of alcohol consumption. Many, likewise, suggested that they now tried to take regular exercise in order to maintain or improve their future health. As Frances, 56, I/II, who was suffering from arthritis, described:

> I walk at lot, although it's painful if I walk very far. I always push myself because I work on the principle that if you don't use it, you lose it. Generally speaking, I'm very aware of further deterioration, so I make sure I exercise.

Smoking cessation – explicitly for health reasons – was also notable within this group: one man had stopped after he developed a circulation problem in his left leg which had caused him considerable discomfort, another after he had developed pleurisy.

These findings illuminate broader trends identified elsewhere, namely, that the adoption of health promoting behaviours tends to be most prominent amongst those who are already experiencing (embodied) ill-health. As Blaxter has observed, smoking cessation is most likely to occur amongst those

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with poor health (1990: 192). Calnan and Williams, in a related fashion, have found that health-related dietary changes most often take place in response to actual health problems such as heart disease (1991: 522; see also Dean 1989), and various commentators have observed that compliance to diabetes therapies generally increases after the onset of complications (Dietrich 1996, Maclean and Goldman 2000).

Somewhat ironically, however, the very factors that may motivate the adoption of health-promoting behaviours can sometimes also act as significant barriers to the realisation of these aims. Such a situation became evident in the interview with Roger (64, IIIM) who described how the stroke he had experienced two years previously had left him 'so weak' that he had had to take early retirement from his building job. He spent a considerable part of the interview talking about his worries about the future, in particular, of 'having to sell the house to pay for old age care'. Indeed, this was one of the central issues he pointed to in explaining his determination to do everything he now could to preserve 'what remains of my health'. Whilst he had successfully adopted a low-fat diet, his inability to exercise was a source of considerable frustration:

> I get too tired. When I try to walk any distance, I have to sit down. We have a dog and I can just about manage to walk him up the street and down the other side, but then I have to sit down, and I'm shot through for the rest of the day.

Discussion and concluding remarks

In a theoretical contribution to studies of health and lifestyles, Williams (1995) pointed to an urgent need for empirical research that can inform and enhance current analytical understandings of *why* people adopt, maintain and/or change their lifestyles in ways that are relevant to their long-term health. By drawing upon the views of people from a wide variety of age and social groups, this study has provided an array of data that has allowed meaningful comparisons to be drawn between participants who had actively changed their lifestyles with health goals as their motivation, and those for whom health was essentially taken for granted. In so doing, it has highlighted the complex ways in which dominant health and risk discourses are mediated – and often muted by – people's everyday, lived experiences of embodiment (see Watson 2000). Health promotion is premised upon a proactive attitude to health and its management, a 'colonisation of the future' (Giddens 1991) wherein the possibilities of illness and death can be anticipated and thereby mitigated. As the findings described in this article indicate, however, the embodied experience of ill-health is an important, underlying prerequisite for perceiving the future in this way. Indeed, it is one that explains the somewhat ironic observation that, when participants did

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intentionally change their behaviours to concur with professional recommendations, these changes tended to be reactive.

Some reservations might be expressed about these findings by virtue of the study being cross-sectional rather than longitudinal. As Strauss and Howe (1991) suggest, the possibility of cohort effects should be taken seriously in any study that attempts to compare the experiences of members of different generational groups. In this respect, there are potentially valid grounds for arguing that some of the differences observed between older and younger participants could be accounted for by the different cultural/historical contexts into which they were socialised. For example, whereas older people grew up at a time when medical sovereignty was rarely challenged, younger people, as a consequence of being socialised into consumerist society, are more likely to question the knowledge and authority of medical and other professionals (McKinstry 2000). This observation might partly explain why older people are more likely to comply with health-promotion advice than those of younger ages. Some commentators, likewise, have pointed to the role of shared historical experiences – such as living through one or both World Wars – to explain the general propensity of older people to talk more openly and pragmatically about ill-health and death than members of junior generations (Field 2000, Stillion 1995).

There is, however, good reason to think that cohort effects did not have a substantial impact on the study's central findings, because there was a substantial overlap in the responses of participants from different age/generational groups. As has been illustrated, participants' current state of embodiment appears to be the central experience that united or distinguished them from one another. Indeed, in line with other studies (for example, Kastenbaum *et al*. 1981), this article has highlighted the importance of analysing people's perspectives across the lifecourse through a theoretical lens in which functional age takes precedence over chronological age.

In highlighting these issues, this article has sought to enhance current understandings of why health-promotional activities have been, in the main, remedial in their impact. The findings, however, can also be used to raise pertinent questions about the effects of developments in health-promotion activities in the future. Advancements in the new genetics bring with them the likelihood that it will soon be possible to provide widespread, predictive genetic susceptibility testing for a whole range of common, adult-onset disorders with a multi-factorial aetiology, such as heart disease, type II diabetes and Alzheimer's disease. Whilst the knowledge that these diseases have a hereditary component is already well established within lay and medical circles (Davison *et al*. 1989, Hunt *et al*. 2000, 2001, Ponder *et al*. 1996), the introduction of predictive genetic testing (PGT) offers the potential for genetic risk information to be provided to greater numbers of people than can be achieved through a knowledge of their family histories alone (Marteau and Lerman 2001). Consequently, the geneticisation of medicine has been viewed with considerable enthusiasm by some commentators (for

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example, Summers 1993), and it is likely that professional efforts targeted towards primary prevention through lifestyle changes will become even more intensive in the future (Davison 1996).

This article's findings can be used to contribute to the small body of work (for example, Marteau and Lerman 2001) that has begun to question the potential of the risk information provided by PGT actually to facilitate proactive, health-beneficial lifestyle changes. As Davison has observed, predictive genetic testing for late onset, multi-factorial disorders can only provide 'possible rather than defined futures', futures that involve ' "ifs" rather than "whens" ' (1996: 318). Importantly, as has been shown here, the prospect of ill-health often needs to be perceived in more concrete and absolute terms – as a 'when' rather than an 'if' – before people are actually motivated to change their lifestyles. Indeed, the insights gained from other studies are very illuminating in this respect. As Marteau and Lerman (2001) have observed in their review of the limited evidence base that is currently available, people who are known to be at genetic risk of conditions such as breast cancer, bowel and prostate cancer, and heart disease, do not appear to differ in highly significant ways from others in terms of their screening (*e.g.* mammography) and (health-relevant) lifestyle behaviours (*e.g.* smoking and physical activity).

It is becoming increasingly recognised that, for health promotion messages to be effective, they must tap into an existing corpus of meaning, fitting into 'a self-image already at least partially formed' (Lupton, 1994: 115). By looking at the perspectives and experiences of those for whom health promotion messages do indeed appear to strike a responsive chord, this study's findings are very telling: namely, that it is amongst those for whom secondary prevention is pertinent, that health promoters have had – and are likely to continue to have – their most receptive and sympathetic audience. This is an observation that policy makers may wish to consider seriously when they make decisions about the targeting of scarce resources in the future.

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Notes

1 One component of the study was concerned with the financial provisions people had made for later life and is reported elsewhere – see Lawton and Pyatt (in press).
2 This was an exploratory study, its aim being to identify themes and to open areas of enquiry that could be pursued by more in-depth research in the future.
3 While the imposition of 'age-determined' categories provides a convenient way of organising the data, it is important to acknowledge that the labelling of some people as 'young', 'middle-aged' and 'old' may be incongruent with the ways in which they actually perceive themselves (see Thompson 1992).
4 It is now widely recognised that people age physically at different rates (Anstey *et al*. 1996, Gilleard and Higgs 1998, Renner *et al*. 2000). The findings of various studies indicate that, whilst women within most Euro-American countries have higher life expectancies than men, non-fatal morbidity appears to be higher amongst the former (Kirby *et al*. 1999, Verbrugge 1985). Significant socioeconomic inequalities in health have also been reported (Smith *et al*. 1990).

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