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Older women being active in fitness gyms: benefits or constraints? Results from a qualitative interview study (southern Germany and East Coast of USA)

Introduction

Age(ing) as a social construct

While gerontological research was already firmly established in the USA in the 1970s, this scientific discipline only gained a foothold in Europe in the 1980s (van Dyk & Lessenich, 2009; van Dyk, 2015). As in the USA, the development in Europe was initially characterised by a strong dominance of medical and biological approaches of a quantitatively oriented social and psychogerontological research tradition (Birren & Bengtson, 1988). Therefore, until the beginning of the 1980s, a biomedical deficit perspective on the ageing process as a life phase of decline and dependency was predominant in Germany (van Dyk, 2015; Tokarski & Karl, 1989). In the late 1990s, changes in social politics emerged and an activating welfare state was established. This can be interpreted as a reaction to economic effects of demographic changes in the context of the health and pension system (Lessenich, 2009). Consequently, the idea of age(ing) as something unavoidable changed into something more adaptable.

With the implementation of governmental policies, the demand on individuals to seriously assess their risks and to take responsibility for themselves became manifest (Vobruba, 1983). Social gerontological concepts take up the idea of self-regulation in their concepts of "active" or "productive age(ing)" and refer to the opportunity to strengthen physiological and psychological capacities of older adults through a healthy lifestyle (Butler & Gleason, 1985; Denninger et al., 2014). While the German-speaking discourse shifted from "'age as a problem' to 'age as liberation'" (van Dyk & Lessenich, 2009, p. 18), the US American discourse focused on age(ing) as a resource to be used. As a result, the concept of "successful aging" became popular. Havighurst et al. formulated the nowadays common term "successful aging" in 1968. However, the concept was made popular by Rowe and Kahn (1997). Although it is "one of gerontology's most successful ideas" (Katz & Calasanti, 2015, p. 26), it has been criticised for defining whether an individual has successfully aged or not. In addition, the availability or lack of resources is not considered. It emphasises the absence of illness, the optimisation of the physical and mental constitution and an active daily and social life. The WHO (2002, p. 12) also defines active ageing under the premise of optimising living conditions: "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age".

This includes dealing with physical risks by taking responsibility of one's own fitness and discipline in order to maintain the body's ability to function for as long as possible. Consequently, responsibilities for financial, social and physical risks of ageing are increasingly shifted from the government and other institutions to individuals. At the same time, negative connotations associated with old age, such as illness, dependency and the need for care, do not disappear, but continue to be powerful discursive instruments of discipline. While positive attributes of social participation, health and being active are associated with the third age, the deficit perspective reappears in the fourth age under the term 'old age' (Gilleard & Higgs, 2000).

In addition, it must be considered that physical ageing and age-related health risks, including life expectancy, depend significantly on a person's social position (Lampert & Kroll, 2014). This social position is highly determined by ethnicity, gender, education, occupational status, income and wealth. Social inequalities in living conditions are reflected in body knowledge and body strategies, for instance in health-related behaviour (eating habits, alcohol and tobacco consumption, preventive medical check-ups, etc.). In this sense, differences in age are not natural or biologically predetermined, but once they are constructed, they are treated as real facts (Schroeter, 2012).

Using the body as a medium to represent and realise (ibid.) gender-related norms of function, activity and health, results in body capital which opens up freedom of action. However, the health ideology that has shifted towards the individual and the trend towards active ageing in a sense of physical 'self-measurement' may also create social pressure for individuals to self-discipline and self-regulate their bodies. This study aims to shed more light on this field of tension.

Research status: Age, health and fitness

As demographic change has progressed, the proportion of the population in Germany aged 65 and older has increased from 15 to 21.8% between 1991 and 2019 (Statistisches Bundesamt, 2020a). Similarly, in the USA, the proportion of this population group has increased from 12.7 to 16.2% over the same period of time (World Bank, 2019). Therefore, not only is the number of older adults increasing, but also the relevance of (socio)gerontological research that examines the living environments and social attributions of this heterogeneous group of the population. Since the 1990s, a critical gerontology has established itself alongside the positivist mainstream perspective, initially in the USA (Katz, 1996; Öberg, 1996; Minkler, 1996). It primarily criticises the concepts used by the mainstream and reflects gerontology's self-perception as an advocate of old age (van Dyk, 2015). Additionally, besides the criticism of a biomedical deficit perspective on age(ing), the negative effects regarding the activity thesis (Havighurst, Neugarten, & Tobin, 1968) are also outlined. This activity thesis normatively presumes the desirability of a continued activity-based lifestyle up into old age (van Dyk, 2015) and serves as the basis for concepts of successful, productive and active age(ing). Criticism points to its radical optimism and the thus ignored negative effects of age stereotypes regarding older people. Discourses on active age(ing) have been developed mainly in Europe. Active age(ing) is, at least theoretically, a more holistic concept than successful age(ing) (Foster & Walker, 2015). For reasons of space, this article will not discuss productive age (e.g. voluntary work) in detail.

The following section demonstrates how individual management of physical risks through age is (structurally) supported by healthcare systems. In terms of their basic structure, the German and US healthcare systems are similarly divided into a public and a private sector. The distribution of the population between the two areas differs greatly in that a significantly higher number of Americans have private insurance (Land, 2018; Roth, 2018). In Germany, 87.7% of insured people are members of the public health insurance system (Statista, 2021). In the USA, on the other hand, 34.1% belong to the public sector and 68% to the private sector (U.S. Census Bureau, 2019). A further difference is that the US healthcare system appears to be as far more complex. For instance, while all German public health insurers operate the same way and offer a 95% predefined catalogue of benefits at almost the same conditions, regardless of personal preconditions (Land, 2018), the American healthcare system consists of a variety of different insurance programs, each with different conditions, benefits and eligibility criteria (Roth, 2018). Major drawbacks of a highly complex US healthcare system are its poor performance, social inequalities in health opportunities and enormous costs for insured persons. High insurance premiums, additional payments for medical treatment (even in government-organised Medicaid and Medicare programs) and increased prices for medication are significant reasons for a high under- and uninsured rate. In 2019, approximately 8% of the total population in the US was without health insurance coverage, compared to less than 0.1% of the total population in Germany (Statistisches Bundesamt, 2020b; US Census Bureau, 2019). Because of the costs, even the newest medical technologies and highly trained professionals are not accessible to everyone. After many years of intense political debate, the US healthcare reform, the so-called Obamacare, was passed in 2010. It aims to overcome the discrepancies just described. Deficits may be attested to the German healthcare system as well: In particular, the coexistence of public and private health insurance, the lack of quality and access to care, deficits in health promotion and prevention policy as well as social inequalities in health opportunities, disease risks and life expectancy are criticised (Gerlinger, 2018). However, these deficits seem to be not as significant as in the USA.

The US healthcare system creates an indirect incentive for self-responsible management of physical risks, especially because insurance premiums are dependent on health status. In addition to that, private insurance providers in particular reward physical activity through bonus programs. German health insurance providers also promote self-responsibility through bonus programs as well as coverage of costs (for instance through health-oriented fitness courses). However, the main difference in comparison to the American healthcare system is that the German system is based on the principle of compulsory contracting, which means that premiums and benefits (of public health insurances) are not dependent on personal preconditions. In general, it should be noted that the principle of solidarity, on which the public healthcare system in Germany is based on, is much less distinct in the US healthcare system.

The ways in which the idea of personal responsibility for active ageing is taken up by individuals in their practices are shown by a number of qualitative studies on health, sports and fitness. In modern western societies, acquiring a fit body is seen as an empowerment strategy, as fitness appears to the respondents as a symbolic marker of status, character and discipline (Sassatelli, 2014). It needs to be mentioned that every self-empowering body practice always entails a submission to social norms (Villa, 2008), with the aim of avoiding disadvantages or even stigmatisation.

Organized fitness training in a fitness gym or sports club is currently the form of exercise with the highest number of members. Out of 11.09 million memberships, 55.5% are women (DSSV, 2019). This trend developed during the second

half of the last century, which quickly created a commercial fitness market covering both North America and Europe (Wedemeyer, 1996). Möhring (2006) describes that individualised forms of taking responsibility for one's own body were prominent especially in the German gymnastics movement at the end of the 19th century. This may be interpreted as a precursor to today's fitness movement. Although the "imperative of the fit, healthy and beautiful body applies equally to women and men" (Meuser, 2014, p. 74), the heteronormative body ideals between physical expansion (men tend to add mass) and reduction (women tend to reduce body fat) are still prevalent (Sobiech, 2006). The creation of this difference in the body is based on different forms of training: Maximal strength training, for instance in the dumbbell area of a gym versus (strength-)endurance training within special courses such as Bodyshape, BodyArt, Bodystyling, etc. Through this kind of body work, the (re-)produced heteronormative, binary body ideal is being naturalised.

Some insightful interview studies on dealing with the fit older body exist, especially in Canada (Allain & Marshall, 2017; Quéniart & Charpentier, 2012). The respondents intend to work on signs of old age through fitness training in order to postpone old age for as long as possible. Eman (2012) describes how older adults in Sweden, who are active in sports, manage to protect themselves against negative age stereotypes through their sports performance ("capability-age") (ibid., p. 470). In German-speaking countries, Hartmann-Tews (2010) as well as Hartmann-Tews, Tischer, and Combrink (2012) show in their qualitative interview studies with active older people that sport is perceived as a positive contribution for anti-ageing.

Study idea and aims

Fig. 1 illustrates the overall project "Fitness and health in times of demographic change". In a first step, it followed the demand of critical gerontology, especially in German-speaking countries, with an approach based on sociology of the body (Riedel, 2017; Schroeter, 2012; van Dyk, 2015), to highlight the subjective perspective of older adults (Denninger, Dyk, Lessenich, & Richter, 2014). This meant that the question of how women who are active in the gym position themselves towards social discourses of active, productive and successful ageing had to be examined first. In a second step, the internet presence of Freiburg fitness studios was analysed through a critical discourse analysis (Hartung, 2018). This served to determine more precisely what role immanent body ideals, norms and rules of fitness culture in relation to health, ageing and gender play in the identity constructions of the interviewees.

Thirdly, 12 expert interviews were conducted: Due to demographic change, trainers in gyms are dealing with an increasingly older clientele. With regard to the respondents' self- and body perception, it was therefore interesting to know whether the trainers had undergone specific education for training older adults, whether they use appropriate training methods and what training goals they pursue in their courses.

The aim is to conduct an intersectional multilevel analysis (Winker & Degele, 2009), in which inequality-generating social structures, symbolic representations and identity constructions are understood as context-specific, object-related interactions that are linked to social practices (ibid.). While the discourse analysis covers the level of *symbolic representations* and the expert interviews refer to the meso level, this interview study aims to take a closer look at the micro level (*identity constructions*) and describes the interactions with the other levels.

The intersectional structural categories of present capitalist societies "class, gender, race and body" form the basis on the level of *power relations*: "classisms, heteronormativisms, racisms and bodyisms" (ibid.). Krekula (2007) has shown that an intersectional approach is particularly significant between the categories of age(ing), which belongs to the category of body, and gender. She emphasises that older women were made invisible or constructed as a problematic group in social gerontology. Although they may often be the object of research, the overgeneralised attribution of a dou-

Abstract

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Abstract

In the course of demographic change, the notion of age(ing) seen as something unavoidable has changed into something more adaptable. Through a healthy lifestyle, which aims at the self-responsible management of physical risks through fitness and discipline, individuals can expand their independence. However, the chances of doing so depend largely on one's social position. In addition, the shift in health ideology towards the individual and the trend towards active ageing may lead to social pressure for some individuals. This qualitative interview study attempts to shed more light on this field of tension: What are the benefits and constraints of working on the body in the gym? Furthermore, what similarities and differences can be identified in identity constructions in the two samples with regard to the different underlying healthcare systems? The evaluation of the interviews was based on qualitative content analysis and was carried out with technical support (MAXQDA). It appears that for the respondents creating a fit body results primarily in self-empowerment gains. At the same time, submissions to Western body and fitness norms are also evident. Inequalities in health opportunities exist in both countries: While the respondents in the German sample (26 interviews) rely on public health services, the privileged American women (14 interviews) are covered by private insurance. They indicate that claiming government benefits appears as a stigmatisation of one's own way of life. Consequently, a lack of resources in the form of cultural and economic capital prevents successful age(ing).

Keywords

Active age(ing) · Fitness · Health · Gaining distinction · Social inequalities

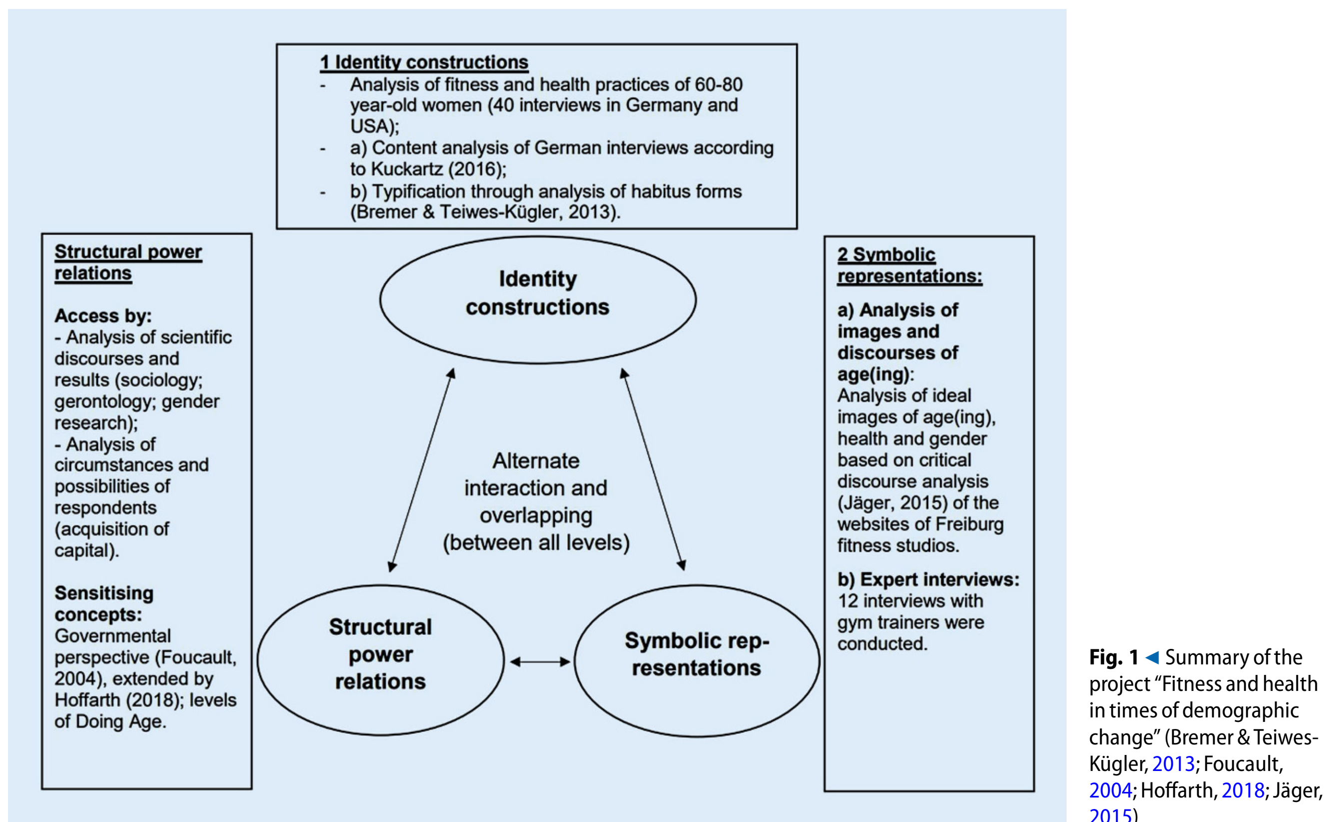

Fig. 1 ◀ Summary of the project "Fitness and health in times of demographic change" (Bremer & Teiwes-Kügler, 2013; Foucault, 2004; Hoffarth, 2018; Jäger, 2015)

ble threat through ageism and sexism tends to stigmatise older women and thus unifies them as a marginalised group (ibid.). Therefore, a major aim of this research project is to give older women a voice. For example, in popular media, older women are neither represent in sporting activities—this is also evident in the discourse analysis—nor in professional challenges. Older women are also marginalised in America. Additionally, 60-year-old women are part of the first wave of those who had very limited opportunities in organised sporting activities during their high school years (Smith, 2016). Another aim is to counteract the neoliberal decontextualization of self-responsibility as well. The partial results presented here are based on the following questions:

1. What are the benefits of an active lifestyle in the sense of continuous training in fitness gyms?
2. Is the trend towards age activation in the sense of physical self-measurement linked to social pressure for self-discipline and self-regulation?
3. What similarities, and especially what differences, can be identified in identity constructions of the German and American samples with regard to the different underlying healthcare systems?

Methods

Study design

The present study is a qualitative interview study that aims to give visibility to older women's subjective perspectives on active and successful age(ing). After introducing the project in selected classes at the gym, information about the purpose and benefits of participating in the study was given. Ethical issues related to anonymity and voluntariness. The interviews were conducted partly at the gym and partly in the respondents' homes.

Sample

Between February and December 2016, a total of 40 women between the age of 60 and 80 who are active in fitness gyms were interviewed: 14 interviews were conducted in Amherst (MA, USA), 26 in Germany.[1] The interviewees were recruited by directly contacting them in the gym. This means that the interviewer introduced the project in selected courses (e.g. Pilates) and recruited women who were between 60 and 80 years old and had been active in the gym for at least 2 years (snowball sampling plus determined criteria, Przyborski & Wohlrab-Sahr, 2009). The selected German fitness gyms (rural area of Kirchzarten/urban area of Freiburg) are in the middle price segment with a monthly fee of about 50 euros. The American gyms only offer individual training (up to 600 dollars) or group courses (up to 80 dollars). The recruitment of the interview partners was carried out under similar conditions as in Germany.

Before the interviews were conducted, the occupation of the interviewee's parents, siblings, children and life partners were noted in a social data query. Information regarding their own education, professional career along with their current housing situation was collected as

[1] The complete interviews are available on request from the first author of this article.

well. This way, all women in the German sample (G.s.)[2] may be allocated to the social middle class. Since all the women in the American sample (A.s.) have university degrees, they may be allocated to the upper middle class. One third of them even more, due to their profession (university lecturers).

Data collection

The focus of this qualitative research was on conducting and analysing qualitative, problem-centred interviews with an average duration of 70 min. According to Witzel (2000), problem-centred interviews should focus on the "most unbiased possible recording (…) of subjective perceptions and ways of processing social reality" (ibid., p. 1). Therefore, it was important for the researchers to keep a certain openness and to consciously avoid evaluations. A semi-standardised interview guide was used as the basis, in order to provide opportunities for follow-up questions and personal narratives. The guideline—with questions about sporting activities during the lifespan, transition to retirement, ageing, body and health, the training in fitness gyms and finally about the respondents' social situation—was tested during the first interview, then evaluated in the research team and complemented by further aspects that seemed central within the context of biographical research (Dausien, 2013). The method's attractiveness is particularly evident in the fact that it makes both the subjective appropriation and construction of society and also the social construction of subjectivity comprehensible. The statements of the interviewed women were therefore understood as subjective concepts of reality and patterns of interpretation. They do not necessarily represent an objective result; however, in their accumulated form they are suitable for demonstrating social patterns (Helfferich, 2011).

[2] The interview excerpts from the German sample presented in this article have been translated into English as accurately as possible and are therefore marked as quotations.

Data evaluation

The evaluation of the interviews was based on qualitative content analysis (Kuckartz, 2016) and was carried out with technical support (MAXQDA). On the one hand, the main categories were determined according to the interview guide, along with prior theoretical knowledge and the research questions. On the other hand, subcategories were inductively generated through the material (ibid.). This resulted in the following main categories: The first is entitled 'Biographical sub-lines' (1) in which all the statements about growing up, education, professional development, exercise and sports careers and the transition to retirement were collected. 'Age images/age concepts' (2) includes statements on age role models, own ideas of age(ing), potentials and losses due to age(ing), but also attitudes towards government activation through public policy programs, ideas about successful age(ing) and the active management of ageing processes. Another main category 'health management' (3) includes the interviewees' own definition of health and strategies for maintaining health, as well as past and current diseases and limitations. 'Body concept' (4) refers to statements on ideal body images and the body self-image. The category 'visiting the gym' (5) includes reasons for visiting a gym, the exact types of training, training goals and training procedures, as well as the perceived effects of training, training discipline and participation in sports outside the gym. Finally, in the category 'social networks' (6) all statements on current social relations were summarised.

Qualitative interviews have the purpose of looking closely at the case with its individual perspective and its inherent complexity (Flick, 2000). Therefore, after the content analysis, a type-building single/individual case analysis was carried out. This was intended to deepen the understanding of the subjective ways of dealing with government activation and to show and explain the social patterns and differences found in the biographies of the interviewees. For this purpose, the concept of habitus hermeneutics by Bremer and Teiwes-Kügler (2013) is currently applied to the material. Since this article focuses on the social patterns and thus the results of the content analysis, the results of the case analysis are not discussed in this article.

In the following, statements by respondents of the German sample (G.s.) are labelled with the letters A–C, while statements of the American sample (A.s.) are labelled with the letter D.

Results

Active ageing between benefits and constraints

The first thing to be mentioned is that the generation of the respondents historically represents a new group that is considered to be very privileged (Denninger et al., 2014). With one exception, all the interviewees were or are still employed, with some having an interruption during the period of bringing up children. Most of the interviewees of the G.s. worked among the mid-level working sector (e.g. as a nurse, saleswoman, teacher, medical assistant) and did not participate in regular sporting activities until later in their biographies. The interviewees of the A.s. work in professional positions that are more closely associated with a higher educational milieu (e.g. as professors, teachers, designers, art historians and teachers). A reason for this discrepancy with the G.s. may be that the interviewees were recruited from different fitness centres, which only offered personal training or group training (mainly pilates classes). A significant difference in the membership fees of the US fitness gym in comparison to German fitness gyms only became apparent during the analysis: More than one-third of the American respondents use high-cost "personal training" (up to $600 per month). The average training frequency is 2–5 times a week. The way the American women do sports in the course of their biography is comparable to that of the women of the G.s. After graduating from high school/college, there was a longer phase in which they had no time for sporting activities due to work and bringing up children. While the women of the A.s. have been gym mem-

bers for a shorter period of time (between 2 and 5 years), most of the interviewees of the G.s. have been members for longer (between 10 and 20 years), their training frequency is 2–7 times a week. The respondents prefer going to fitness gyms because they offer a wider range of activities (especially courses such as *Bauch Beine Po*, back exercises, Pilates, Yoga, Zumba, etc.), have better qualified trainers and offer more favourable opening hours than sports clubs.

What benefits do the respondents perceive from regular training in the gym?

For the interviewed women, growing old and doing something about it seem to be synonymous. Being old in the sense of stagnation, immobility, loss of ability and lack of will happen later. Consequently, functional training is about maintaining physical and mental fitness in order to remain independent and mobile for as long as possible:

(...) it's more so that I can do things that I want to do. Just being able to go wherever I want to go and travel, you know, being able to do things like travel by myself, you know (D3, 68 years, A.s.).

Active self-shaping is supported by health-conscious nutrition, which requires specific nutritional knowledge as well as an educated and self-caring individual. The interviewees are conscious of eating regional, seasonal products, fresh vegetables and fruits as well as lots of fish and little meat. The ongoing health debate that not only focuses on the absence of illness but rather emphasises the expression of well-being and the harmony of the body, mind and soul as well as being socially embedded is internalised as part of everyday practices. Being socially integrated ("Now I also know fellow gym members", B4, 72 years, G.s.) includes the joint workouts in fitness rooms, creates a subjective sense of well-being, vitality, and an overall positive attitude to life. These components are felt especially on the physical-affective level after a workout:

Recognizing that it really gives you the clear head, and you just feel so much better. Yeah. (...) Yes. Yeah, I can feel sluggish if I haven't worked out (...) and so when I do work out, I feel, 'whoo' ready to go, you know, more energized, better outlook, happier (D7, 64 years, A.s.).

Another advantage in their work on their own bodies is the ability to be more physically active outside the fitness gyms. The goal of fitness training is being able to travel long-distance with high levels of physical activity or to be able to keep up with peers in joint activities.

Individuals who have experienced serious diseases such as cancer or other physical and psychological impairments especially benefit from training in the gym. Forms of exercise are chosen in a way that quality of life can be maintained or restored through their exercise. But not only serious diseases seem to be overcome through working on the body. Interestingly, the respondents gain self-empowerment through fitness training, which not only helps to reduce medication use, but also leads to successful pain management:

I have arthritis in my fingers, in my hips, in my right knee and in my left big toe, but with diet and exercise you can manage it wonderfully (A6, 71 years, G.s.).

Which disciplinary practices and which constraints may be associated with fitness training?

Disciplinary processes are inherent to physical activity in the gym, regardless of the form of training: The demand for regular participation, the mirror that encourages self-observation, as well as appraising glances of fellow participants and the trainers creates an awareness of one's own physical shortcomings:

Oh yes, so as a woman one is probably not really satisfied (laughs). I would like to have less around the middle. (...) Well, I am firm and muscular. I just have a bit around the belly. (...) I would also like to have a slimmer upper body, but it is like it is around the chest and my buttocks is a little bit more rounded (...) (C2, 60 years, G.s.).

If self-control and self-discipline are considered fundamental requirements for a healthy lifestyle, the belly quickly becomes a 'problem zone' because non-conforming belly signals a lack of will and poor self-management. The resulting negative feelings and a guilty conscience create incentives to change this condition. The depicted relevance of the belly region is evident in both samples:

I'm such a fan of a really flat belly too (C5, 62 years, G.s.).
I wanted a tight belly. (...) I always fight with my belly. Always! (C3, 63 years, G.s.).
You know, when I look at my body shape I see that the belly area is a little bit wider (...) So that's a problem zone, right there (D4, 74 years, A.s.).
Well, I mean I guess—a problem zone, you could say is—sure I'd like to have a smaller stomach (D9, 67 years, A.s.).

Thus, the respondents consider fitness training as a means to manage their weight: "lose some weight" (D1, 63 years, A.s.), to "influence body shapes" (C8, 62 years, G.s.) and "not to get out of shape" (C2, 60 years, G.s.). However, they tend to have a realistic assessment of "whole-body training", with which they cannot produce the "body of their dreams" (B3, 65 years, G.s.). Similarly, they follow the logic of the fitness culture, to constantly improve and optimise themselves, only to a certain extent. Therefore, the goal associated with the logic of pushing oneself to physical limits is not an option for the older women who are active in the gym:

At 63, you can no longer do what someone at 35 does. (...) There are certain limits. That is the level of maturity that you have reached in your old age. Especially when you realise that there is also another way (C5, 62 years, G.s.).

This ambivalence between realistic self-assessment and the demands to discipline oneself to achieve the set goals leads to a strategy that imposes self-observation and body control as a daily 'must': "Paying attention to your figure is very important to me. So, I weigh myself every day. But just to check, according to the motto 'Nip it in the bud'!" (C1, 65 years, G.s.). Another strategy associated with the ideal of having a fit, slim and healthy body relates to social comparison. It is about a judgemental view of other bodies

that do not fit this ideal. While some of the German interviewees devalue those who do not want to or cannot undergo the relevant body shaping strategies, the Americans tend to point out the social milieu and a lack of cultural capital as a source of overweight/obesity. Structural problems are pointed out as well: Healthy nutrition is not accessible to all and education is also conveyed very differently:

(…) our area has really not so many overweight people, but if you travel to other parts of the country, they're very overweight (…). A lot of them really don't have—not only don't they have the money, but they don't have the education about what's nutritious (D4, 74 years, A.s.).

Negotiating successful ageing in the context of the different healthcare systems

For the respondents of both samples, the individual obligation to self-responsibility, which is also visible in the idea that: "Age is a risk that you can postpone or even stop by working on yourself" (B4, 72 years, G.s.) is part of their self-image. Their concept of 'ageing successfully' touches on ideals of autonomy and independence, coupled with fear of illness and decline, which results in the desire to avoid them. The interviewed women associate successful ageing with the maintenance of mobility, agility and independence. "To die healthy" (C5, 62 years, G.s.) is the goal in order not to be a burden to others, to pursue one's own (educational) interests and to be able to be with one's partner or children. The dimension of performance associated with the adjective 'successful', which presupposes physical and mental functioning, is something all respondents are aware of. They work on their bodies in gyms and are actively involved in their daily lives in order to avoid illness, later dependencies etc. as much as possible. However, they do not realize that concepts of successful ageing fail to address the question of which resources individuals are able to draw on. The following section discusses the responsibility that is attributed to the healthcare systems in this context. For instance, A10 (72 years, G.s.) is very upset with the fact that her commitment towards personal healthcare through physical activity is not rewarded by the government. She suggests that others who do not take this responsibility for themselves should face restrictions from "legislative authorities": "If someone smokes a lot, drinks a lot, is too fat, then not everything should be paid for". Similarly, C7 (62 years, G.s.) expresses her negative opinions very drastically as she interprets claiming government welfare benefits by sick and socially disadvantaged people as a heavy burden on the healthcare system:

You know, I worked for years in the benefits department of a big health insurance company (…) If I had something to say, I would cancel all preventive programs of the health insurance company because the money is flushed down the drain anyway. (…) After ten times (of a prevention offer) they (those who take advantage of such an offer) never move their asses again (C7, 62 years, G.s.).

Overall, strategies that make use of health services[3] predominate when physical complaints cannot be eliminated by oneself (e.g. in case of a necessary hip surgery). However, regulations by the government or health insurance companies to maintain health in old age(s) are mostly rejected.

The respondents of the American sample support government-regulated health programs (as they exist in Germany), but believe that such policies cannot be implemented in the USA because the American freedom of choice is too valuable and cannot be restricted: "Well, I think it's a marvellous idea. I don't see that flying in the United States" (D8, 68 years, A.s.). Nevertheless, reference is made to the government's duty to provide education in order to support people with little cultural and economic capital. The American respondents consider the government-organised Medicaid programs to be inadequate. People who are eligible for public insurance seem to avoid the membership for as long as possible. This is because it would reveal the lack of economic and usually also cultural capital, which leads to a low social standing. In this way, individuals feel stigmatised and not recognised as full members of society:

Because not everybody has an equal opportunity to do that (to take responsibility for one's own health). Yes, yes, that was my-my brother's case. It's because he-he—his health was failing, he thought he was going to die, and he didn't have—he wasn't old enough to get social security, and he didn't have any way of supporting himself or his health—and so, and he didn't want to accept Medicaid. Now an, an—if-if he would have died—if I wouldn't have convinced him (laugh)… I don't know if it was me, but to do it. But he didn't have the … In that you can blame people but there was no blame, there, it was just that in his life he didn't have the retirement and the work situation where he had the means to do it. So yes, I felt like the government needed to step in (D5, 69 years, A.s.).

Nutrition programs for which the government is responsible do not seem to have the intended success either:

I mean, look at the crap everybody eats. I mean, most of the people I know who are very ill with diabetes and things like that, not-not cancer, but something like that, ahhh. A lot of their illness are from lifestyle. American's like large amounts of greasy food at a fast restaurant. They like it. I mean, all you have to do is watch them. […] To tell an American how to eat… every time that the Department of Health and Social Services in the United States tries to make a plan, people get very upset about that (D8, 69 years, A.s.).

Here, the importance of individuals' freedom of choice is addressed once again. The respondents describe ageing as an unavoidable process that has to be accepted: "Aging is a process that our bodies go through, whether we like it or not" (D6, 70 years, A.s.). At the same time, however, they refer to possibilities of being able to take personal responsibility for their own age(ing): "Doing your best to stay healthy" (D4, 74 years, A.s.). As in

[3] While all respondents in the German sample have public health insurance, all respondents in the American sample have private health insurance.

the G.s., for the American respondents successful ageing means gaining independence by maintaining physical and mental activity as well as social participation: "(...) to be really engaged, but not just physically, but mentally and intellectually, and to be reading, thinking, talking politics, and continuing to learn" (D3, 68 years, A.s.). These are activities that are also reflected in the women's attitude and appearance: "I feel like I'm in my forties. (laughs) Just my whole outlook and—and that I'm physically capable" (D11, 69 years, A.s.).

Discussion

Question 1: Benefits of an active lifestyle?

In order to answer the first research question, the following section outlines the benefits associated with an active lifestyle in terms of continuous training in fitness gyms. The results presented above demonstrate that for the respondents in both samples creating a fit body is primarily associated with gaining self-empowerment. Through their sporting activity they are able to detach themselves from constricting beauty norms. Evaluations focus more on what individuals are capable of achieving and not so much on how they look (Eman, 2012), even if taking action towards one's body moderately remains a central and disciplined body-shaping strategy.

Another significant benefit is that mental and physical health is improved or maintained. Stenner, Buckley, and Mosewich (2020) demonstrate, on the basis of numerous international studies, that older adults' sporting activity is often associated with health-related motives. Woll and Servay (2013) confirm, as stated by medical (training) science studies, that sporting activity has a positive impact on the mental and cognitive performance of older adults, which in return has a positive influence on a variety of chronic diseases that leads to improvements in general well-being. For the respondents of both samples, health is highly important. This is also reflected in their eating habits: They make sure to eat fresh vegetables, fruit, lots of fish and little meat. The importance of a balanced diet for health promotion and prevention, especially for older adults, is also highlighted on the homepage of the German Federal Ministry of Health (Bundesgesundheitsministerium, 2021). By having a fit and healthy body, the respondents gain additional autonomy, mobility and independence. They do not want to be a burden to others and want to pursue personal interests such as travelling or education.

Furthermore, those who have experienced serious diseases such as cancer or other physical and psychological impairments benefit greatly from training in the gym. Furthermore, results of this study reveal that fitness training helps to reduce consumption of medication and leads to a successful pain management. In contrast, the German Pain Association (Deutsche Schmerzgesellschaft, 2021) states on its homepage that women suffer more often from various types of pain, are considered to be more "sensitive to pain" and therefore take more medication, compared to men. Consequently, training in the fitness gym may be associated with gaining empowerment through successful pain management, which is atypical for women.

A final beneficial effect of the respondents' gym memberships relates to social involvement in sporting or communicative settings with their peers. The fact that being socially involved motivates older people to be physically active has been demonstrated by numerous international studies (e.g. Stenner et al., 2020; Appleby & Dieffenbach, 2016; Dionigi, 2002).

In summary, the presented empowerment gains may be interpreted as improving quality of life in the form of subjective well-being. According to Phoenix and Orr (2015), this aspect of 'feeling good' through physical activity is underestimated in many studies. It seems that physical activity gives older adults a sense of regaining control over their ageing process (Massie & Meisner, 2019). Allain and Marshall (2017) demonstrate similar results: Through sporting activity older people intend to work on signs of old age in order to postpone old age for as long as possible.

Question 2: Social pressure for self-discipline and self-regulation?

In order to examine social phenomena and thus to answer the question of what constraints arise through self-disciplined and self-regulated work on the body, sensitising concepts are needed (Blumer, 1954). Here, the approach of Foucault is particularly suitable, who has pointed out in many places that producing a fit body is always a question of power that occupies these bodies. This power determines what "the body" is and how we have to deal with it (Sobiech, 2017). In a neoliberal society, which is organised along the principles of the market and competition, activation programs set incentive structures, so do active ageing programs. In the context of these mechanisms of power, the body appears as "raw material" that is only transformed into a better self through interventions by oneself (Wagner, 2017). Health and fitness can be interpreted as central categories of contemporary work on the body, in which self-relationship is determined by self-observation and self-disciplining. Graf (2013) points out that fitness as a body practice goes beyond the gym and has become the guiding principle of current subject constitutions. When working on one's own body, according to cultural, also media-mediated body ideals (Meuser, 2014), fitness becomes a self-empowerment strategy. Through time and work invested in the body and through training, nutrition, cosmetics and care, body capital can be acquired. This body capital carries the promise of extending life expectancy. Furthermore, by producing a fit and healthy body, the aim is to develop a willingness to constantly discover new opportunities for optimisation in order to adapt oneself to an ideal condition (Straub & Balandis, 2018). Generally, a fit and healthy body is associated with a "symbolic added value" of determination, willpower, discipline and flexibility (Duttweiler, 2016).

In which way can the strategies of the interviewed women be interpreted?

Although all the respondents see the call for active ageing as the right way to maintain their quality of life, they fol-

low the logic of the fitness culture, to constantly improve and optimise themselves, only to a certain extent. Thus, the goal associated with this logic of pushing oneself to one's physical limits in order to achieve an increase in performance is not an option for the women of both samples. Allain and Marshall (2017) interpret the increased acceptance of physical limits as a resistance strategy against such sport ethic. This ethic is also part of the fitness culture and leads to a rational acceptance of risks and pain in order to constantly get better. On the one hand, it is the increased ability to act due to a reflexive process through ageing, as the interview excerpts show. On the other hand, it is the social positioning as an active person that protects the respondents from the logic of an ever-greater performance. Functional training is more about maintaining physical and mental fitness to remain independent and mobile for as long as possible.

Graf (2013) points out that the fit body is predominantly represented by an urban middle class that has actively contributed to hegemonic discourses and benefits from them, but at the same time distinguishes itself from bodies of other people and defines them as fat or sick. This strategy is also evident among the women interviewed in the G.s. While the Americans reflect their privileged position more strongly, the G.s. displays discriminating devaluations of inactive, unwilling and overweight people: They are described as weak in character and incapable of taking responsibility. It needs to be mentioned that the increased prevalence of obesity in disadvantaged milieus cannot be explained by incorrect behaviour and nutrition alone. Rather, the precarious living and working conditions caused by material hardship, as well as the resulting everyday problems and increased psychological stress, contribute to obesity becoming a problem of social stratification (Gnedt, 2018). Possibly, the gains in distinction associated with devaluations of others are directed towards strengthening individual resources and one's own position in society. This strategy is not relevant to the interviewed Americans, who hold a secure position in the upper middle class. Distinction gains for the respondents of both samples result from the idea that frailty and decline in the so-called third age can be avoided through physical training. The consequence of this, however, is that the oldest members of society are excluded and stigmatised even more in the fourth age (Collinet & Delalandre, 2017).

Question 3: Differences and similarities in underlying healthcare systems?

In order to answer the third research question, it should be mentioned again that social inequalities in health opportunities exist in Germany as well as in the USA: The lower a person's social status (usually measured by education, income or occupational position), the more severe are health disadvantages. A social gradient in health is apparent in a number of diseases (e.g. diabetes, heart disease, depression), in life expectancy, in functional limitations, but also in subjective health assessment (Lampert & Hoebel, 2018; Mergenthaler, 2018; Dickman, Himmelstein, & Wollhandler, 2017). However, social inequalities (in health opportunities) are much more significant in the United States. As mentioned above, this is caused by high costs of the US healthcare system (Gerlinger, 2018). Another reason—and this is the main difference—is that, based on the principle of the compulsory contracting, in the German healthcare system premiums and benefits (of public insurances) are not dependent on personal preconditions. It seems that the principle of solidarity, on which the public healthcare system in Germany is based on, is much less distinct in the US. Although according to Beckfield and Bambra (2016), life expectancy could be extended through an increased welfare state redistribution. An individualistic habitus, which has developed over the course of history, is apparently anchored in large parts of the American population (Mennell, 2020). Many US citizens are critically opposed to a more social healthcare system: For instance, 73% of Republican voters have a generally unfavourable opinion of the healthcare reform passed in 2010 (Kaiser Family Foundation, 2020).

This attitude is also reflected in the interviews of the A.s. Although the respondents are aware of social inequalities and are in favour of government-regulated health programs, they are convinced that a healthcare system as the one in Germany cannot be implemented in the USA. Another aspect refers to the fact that many people do not want to sign up for health insurance, despite the fact that they would be eligible for the government's Medicare program. A conscious decision against health insurance (Roth, 2018) is possibly related to the perceived stigmatisation, as mentioned in the A.s. In contrast to the American sample, the German respondents rely on government benefits to age actively. One strategy is directed towards demanding governmental regulation, including reward or punishment systems. However, regulations by the government or health insurance companies to maintain health in old age(s) are mostly rejected.

Limitations

The present study examined the found orientations for action and patterns of interpretation in their interactions with social structures (class, gender, body). Limitations result from the selection of respondents in terms of gender and milieu, as well as from focusing on practices within the fitness culture. Furthermore, only women who are already members of a gym were interviewed. Reasonable cancellations of gym memberships were not recorded. Neither was the question examined as to whether individuals belonging to other milieus prefer other sporting activities or are inactive. Qualitative–interpretative social research does not claim to be representative. However, the principles of an appropriate subject matter, openness, communication, processuality and reflexivity (Strübing, 2018) associated with this form of social research attempt to identify a part of social reality and reveal social patterns.

Conclusions

One of the main findings of this study is that working on the body in the gym and thus taking responsibility for one's

own health, which aims at improving or maintaining quality of life into old age, is a central strategy of the women interviewed. This allows them to acquire symbolic capital (recognition) that positions them as successful older people in society. The dimension of performance associated with the adjective 'successful', which presupposes physical and mental functioning, is something all respondents are aware of. They work on their bodies in gyms and are actively involved in their daily lives in order to avoid illness, later dependencies etc. for as long as possible. However, concepts of successful ageing focus on self-care for health and well-being for the ageing body, but they fail to address the question of which resources individuals are able to draw on. According to Bülow and Söderqvist (2014), the concept of "successful aging", understood as the optimisation of human development over the course of life, is to be interpreted extremely critically. This is especially the case when old age in the fouth age appears under a deficit perspective again.

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