

**"Mothers and Daughters": Account of health in
the Grandmother generation**

DATA

These data consist of 46 taped transcripts as listed below, of interviews with the grandmother generation of the study "Mothers and Daughters", funded by ESRC 1977. The grantholder was Mildred Blaxter, MRC Medical Sociology, Aberdeen, the principle interviewer was Elizabeth Paterson and the tapes were transcribed by Sheila Murray.

The 47 "grandmother" respondents are defined as women who had a child in [city] in 1950-3, who were at that time in social class IV or V, who had a daughter who had a child or children born in the same city, herself in social class IV or V at the time, and still living in [city] and in touch with the grandmother. The respondents were thus aged around 50, and had disadvantaged social histories.

Individual particulars of the respondents (age, number of children, housing) may be found in the transcripts or annotations to them. The selection of the sample, method of the study and background are detailed in Document 2, with a summary of the respondents' characteristics.

The interviews covered health and social history, beliefs and attitudes to health and to medical care, and intergenerational relationships.

Other data used in the parent study included interviews with the "daughter" generation and with professionals, maternity data from both generations, and service data on the third-generation children. None of this is available.

58 families were studied, though only 47 grandmothers were available, and the numbering goes up to 71 (with some numbers unused). As noted in the list of transcripts, a few of the last interviews are in part summarised, with less relevant passages omitted, rather than being transcribed in full.

In the transcripts, the description G1, G2, etc. denotes the grandmother of family 1, 2, etc. (There is one great-grandmother, GG9.) The initials LP/MB are those of the interviewer. Occasionally M1, M2, etc. denotes the presence of the young family's mother, D another daughter, or H a husband.

Blaxter, M., and Paterson, E. (1982) "Mothers and Daughters: a three-generational study of health attitudes and behaviour". London: Heinemann Educational Books.

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1 Health and the 'Cycle of Deprivation'

In the context of a freely available National Health Service, how is it that successive generations of families in poor circumstances continue to suffer deprivation in health? This question is the starting point for the study described in this volume.

There is a great deal of evidence that those people who suffer social disadvantage of various sorts are likely to experience more illness (especially chronic illness) than those in more fortunate circumstances.¹ Obviously, it is the children who are particularly relevant to any hypothesised 'cycle of disadvantage'. And despite the very real general improvements in child health in Britain, there is known still to be a relative disparity between social groups at birth, and a health deficit among poorer families in childhood. The effects of this may persist to adult life² and may have repercussions on the health of the next generation. Health problems are known to be particularly acute among groups who suffer multiple deprivations.³

There are certain obvious explanations. Heredity must have a part to play, as must the physical environment. But though the relationship between social disadvantage and health is well established, the nature of the association and the role played by various social, economic and cultural factors is not wholly understood. It is often suggested that aspects of behaviour are involved, since 'those who most need services tend to use them least',⁴ and it is in the areas of preventive medicine and health maintenance that there is most concern.

This study began with no assumptions about the existence or nature of any more general 'cycle of disadvantage'. Its objective was to examine, in an exploratory and intensive way rather than at the level of large-scale statistics, the health and health care of children as one possible mechanism in the perpetuation of disadvantage through generations.

Models of Explanation

There is a long research tradition in the sociology of health and

poverty, principally deriving from the United States, which seeks to examine the relationship between attitudes to health and health 'deprivation'. In early work, social maladjustment—of which patterns of health-related behaviour could be a part—was viewed primarily as a function of personality. In the past, the notion of hereditary defect was stressed, giving way more recently to an emphasis on the results of psychosocial deprivation. The work of social anthropologists has been influential in turning attention to what was held to be a well-defined 'culture of poverty', characterised by marginality, a low level of social organisation, helplessness, dependence, and a feeling of inferiority.⁵ Apathy and fatalism, it was thought, might explain the underuse by the poor in the United States of medical services, and the low value which appeared to be placed on the maintenance of health. Preventive health behaviour, in particular, requires an orientation towards the future which may be incompatible with fatalism.⁶

This subculture, it was suggested, was alienated from the values of modern medicine. Medical professionals and their middle-class patients shared a rational or scientific approach to health and to the postponement of immediate gratification, but these were foreign to the subculture of poverty.⁷ And, essentially, this subculture was self-perpetuating:

The culture of poverty may originally be based on a history of economic deprivation, but it seems to be a culture exhibiting its own rationale, and structure, and reflecting a way of life that is transmitted to new generations.⁸

In more recent years, this model of a continuing subculture has been severely criticised⁹ and has given way to one which emphasises rather the conditions under which health care is given, stressing the practical barriers which may face poorer families. Much attention has been paid to the relationship of various 'predisposing' and 'enabling' factors which may influence health behaviour.¹⁰ This mode of explanation alters the focus of inquiry from the individual patient to the manner of service-delivery, and its possible mismatch with the values of particular groups of clients.¹¹

In Britain, in a different society and with a very different system of health care, there has been little work at an equivalent theoretical level, and the relevance of these models has rarely been tested. Evidence about the differential use among social groups of services for the cure of illness is equivocal, though there is certainly long-standing concern that aspects of preventive care (such as antenatal services, or the immunisation of children) are neglected among

poorer families.¹² The suggestion is frequently met with among service-providers that it is possible to identify families whose health care is inefficient, and whose attitudes to health are passed down from one generation to another.

Echoes of the 'culture of poverty' and of the 'systems barriers' models of explanation for this poor health care may be found in the British literature or in policy statements: it was concluded in a report of the National Child Development Survey, for instance, that

the answer must surely be that either the statutory services are not in general seen as being relevant to their children's welfare—or else there are barriers, physical and psychological, to their attending¹³

and the Court Report on services for child health commented:

An effective health service and especially an effective child health service must be knowledgeable about the social and economic circumstances of those it serves and have developed a philosophy of how its expertise and facilities can best be made available to those in need of them.¹⁴

Aim of the Study

These questions are considered in this study in the particular context of continuity and change within families. The hypothesis with which it began was that perceptions of health experiences might, in poor socioeconomic circumstances, create attitudes of apathy towards health care and conflict with health professionals, and that these attitudes might be transmitted through generations, especially among the female members of the family. The aim was therefore to obtain from an older generation of women information about their past and present perceptions of the structure and functions of health services. These would then be compared with the attitudes of their daughters, young women with children of their own, to see to what extent values and beliefs appeared to be transmitted or to recur throughout generations.

It is, however, the practical consequences of the relationship between attitudinal and behavioural variables which are of the greatest importance, in terms of the health care of the children of the next generation. Therefore it was also proposed to document the health-care behaviour of the mothers in detail over a longitudinal period, in order to examine this relationship. Obviously changes in the structures of service available, and changes in the social environment of the two generations, were factors which had to be taken into consideration. Inevitably, we are dealing with a changing society. However, the effect of social change was minimised by excluding

upwardly mobile families and confining the study to daughters who were, like their mothers, in the lowest social classes.

In order to attempt to offer explanations for the health behaviour of these families, it was necessary to try to understand it within their own frame of reference. A further objective of the study was therefore to document the group's social approach to health and illness and their informal body of knowledge, knowledge which, as Fabrega has noted,

...serves as the lay basis of orientation and action towards illness... and includes names of illnesses, lay beliefs about causation, standard remedies and routines for home treatment, and a body of rules and expectations which serve to pattern the behaviour of lay persons who are ill and those who come into contact with them.¹⁵

How this knowledge is learnt is obviously a relevant topic. The study could not hope to explore every aspect of this, but did hope to examine the extent to which health attitudes, knowledge and beliefs are passed from one generation to another. Although there are few studies which have dealt directly with health learning, it is generally believed that patterns of health-service utilisation are acquired within a family setting.¹⁶ There is some agreement on the central role of the mother in the transmission of attitudes,¹⁷ and on the continuing importance of the mother-adult daughter relationship.¹⁸ It has been found, however, that a mother's attitudes are rather poor predictors of attitudes in children,¹⁹ and Litman's study of three-generation families in a midwestern metropolitan area of America suggested that it was generational differences which were most salient.²⁰ Continuity in attitudes and/or in behaviour might or might not be evident in the group being studied here, and if it were, there might of course be several alternative mechanisms of explanation.

In summary, the following questions are the ones which were being addressed: Is there evidence that the children of these families are indeed 'health deprived', in the sense that their health care is poor and the service-use of the families is troubled? Is this deprivation related to the attitudes to health of the young mothers and their perception of the organisation and function of health services? Are the attitudes of the young mothers, in turn, similar to those of *their* mothers: does it appear that intergenerational continuity exists which has a familial element, and is the result of beliefs and experiences overtly shared between the generations? Or does it seem that any apparent continuity is due rather to continuity in the socioeconomic or cultural environment?

As the following chapters will show, our conclusion is that the

original hypothesis about the transmission of health deprivation through continuity in cultural beliefs and attitudes was not supported in its original simple form: reality was very much more complicated. We would not wish to exaggerate the degree of health deprivation which we found, for there is no doubt that in this social group and this geographical area the advances made in child health during the fifty or so years covered by the lifetimes of the three generations have been outstanding. Nevertheless there must still be some cause for concern about the children of the present generation, and we hope that our detailed data may not only help to explain why health deprivation still occurs, but also help to suggest ways in which improvements can be made.

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2 Method of the Study

The sample chosen for the examination of these issues consisted of 58 three-generation families. It was obviously not possible to consider both attitudes and behaviour in an intensive way in a large and random sample of families representing all the variables that might be relevant: social class and education, economic status and environment, geographical region and subculture, age and degree of close association between the generations. Therefore, the strategy was adopted of studying the 'most likely' case, choosing families who probably belonged to a close subculture and where it was known that continued contact between mother and married daughter was common.

The families all lived in one Scottish City, and had broadly the same structure of health services available to them. They were, by definition, neither geographically nor socially mobile. The older women, the *grandmother* generation, had borne their children in this city, and had at that time been in social classes IV or V, semi- or unskilled manual occupations. They still lived in the City. Their daughters, the *mother* generation, had also borne a child or children in the City, still lived there, and had been in the same social classes at the time of the last child's birth. It was amongst these families, if anywhere, that the 'transmission' of attitudes might be found. It was also among these families that one might expect to find some evidence of poorer health among children.

A note on the selection of the sample is included at Appendix A, and the social circumstances of the families are described in chapter 3. Some of them were indeed socially disturbed or in poor economic circumstances. It must be made clear, however, that they are certainly not defined *a priori* as a 'deprived' group. Though almost all of the young families remained in the same social classes, many were socially stable and economically secure. Comparisons will be made within the group between the more, and the less, disadvantaged families. The group as a whole is defined simply as a working-class group, located within a particular subculture and environment, in a range of socioeconomic circumstances.

Data Collection

The phenomena being examined are of several different sorts. We wished to study, and if possible to make connections between, the health histories and social histories of the families, the attitudes and beliefs of each generation, the health-related behaviour and health-service use of the young mothers, and the actual health experience of the children. The topics thought to be relevant, besides general concepts of health and orientations towards medicine, included family-building behaviour, antenatal care, preventive behaviour, accidents, nutrition, the use of lay remedies and lay advice, and many others. Several different methods of data collection, used in combination, therefore seemed most fruitful.

(1) Firstly, the co-operation of the young mothers was sought for a longitudinal study of the health and health-service use of the children over six months in each family. At monthly visits, the women were asked to report any symptoms which their children had experienced during the past four weeks, and to talk about the actions taken, the advice sought, and the services used. From these accounts we attempted to establish at what level of symptomology the mother perceived that ill health existed, and at what level of ill health she took action of what sort. Thus, a picture of the children's health over six months can be presented, though the focus is not so much upon actual morbidity as upon response to illness and utilisation of services. Interaction with other services besides general practitioners—dentists, health visitors, social workers, child health clinics, specialist clinics, children's hospital, school health services—was also recorded.

The reliability of these data will be discussed in the relevant sections, but in general we believe them to be reasonably complete and accurate. The use of the technique of health diaries had been considered, but we believe it would have been successful in only a proportion of the families.

(2) On an initial visit to each young mother, information was obtained about her own health and her husband's, her education, working and married life, and her perception of her children's general health and health history. During the six-months' survey period this information was supplemented by wide-ranging discussions of different aspects of health-related behaviour, emotional, financial and housing problems, relationships with grandparents, friends and neighbours, and many other topics relevant to the upbringing of the children. Our own observation during the regular and often lengthy visits, though necessarily limited, was also sometimes useful.

(3) Obviously, we can be less sure of the accuracy of the data on the children's health history than on the events at the present time, since the accounts may cover many years and are likely to have been rewritten, at least to some extent, in the respondent's memory. We were, however, able to examine various records concerning the children (maternity, child health clinic, pre-school assessment, health visiting) in order to compare them with the mother's accounts. From these records information could be extracted on each child's birth condition, 'At Risk' status, accounts of illness, injury and development problems during each year of the child's life, assessments of home conditions, immunisation records and the results of routine screening. Also, after the six-months' survey was completed, the health visitor who was in contact with each family was interviewed. We discussed with them the general health of the children and the health care provided by the mother, and explored their view of their role in helping these young families. For events occurring during the survey period, we were also able to compare the perceptions of the mother and the health visitor about what had happened.

(4) Data of a different sort, concerned with the attitudes of the women of each generation, their norms, values, beliefs and perceptions of past and present structures of health services, were obtained by interviews which were usually tape-recorded and lasted from one to three hours. The interview with the mother, at the conclusion of the six months, included a discussion of the events that had been reported, and a more general review of ideas about health. The interview with the grandmother focused upon her health and health history, her own childbearing and child-rearing practices, and her attitudes to illness, doctors, and health services. Since not all grandmothers agreed to be interviewed, there are 47 of these interviews.

(5) We have, of course, no independent data on the health behaviour or health-service use of the older generation at the present time. Advantage was taken, however, of the existence of extensive information from a study of women of this generation at the time of their first delivery in 1950-53, followed up five and ten years later.¹ At that time 455 women (of all social classes) had been studied, though only a small number could be traced who now filled the requirements for the present sample. Thirty of our 47 grandmothers are in fact from the original study. For these women, their current presentation can be compared with the information which was recorded in the 1950-53 study, on such topics as family planning, antenatal care, living conditions, marital relationships, and the health of their children during the early years. It may perhaps be of

interest to note that though there were a few topics on which the women's memory was faulty, or they preferred to be vague (e.g. attendance at antenatal or child health clinics), the accuracy of the information on most subjects, after twenty-five to thirty years, was surprising.

The Nature of the Data

It will be obvious that two very different types of data are being used in this study: on the one hand, 'factual' information about the health of the children and about health-related behaviour in the young families, and on the other, data of a different sort, concerned with attitudes and perceptions. It is suggested that both types are useful, and that a combination of them is essential if explanations are to be sought. We wished to ascertain facts as reliably as possible, and at the same time to explore the meaning of these facts to the individuals concerned, attempting to offer explanations for their behaviour in terms of their perception of events. Since different methods of analysis are appropriate for different sorts of data, the variety of methods used in succeeding chapters is a deliberate attempt to apply several different techniques to particular aspects of the same subject.

These methods do not include the categorisation of health or the measurement of attitudes by means of structured questionnaire. There is a research tradition of measuring concepts such as 'medical fatalism' or 'medical orientation' by the scored agreement or disagreement with abstract or hypothetical statements such as 'People have no control over whether they become sick or not'² or 'I have my doubts about some things doctors say they can do for you',³ and to describe self-perceived health by the answers to checklists of symptoms. With large studies, such methods may be necessary. It has, however, frequently been shown that the recognition of one's own ill health in a structured list may be problematic: 'People fail to recognise their rheumatism in a question about swollen and painful joints'⁴ and that

For many people there seems to be a frame of reference... that may only be discovered either by giving them carte blanche to talk about their health or by using exactly their own terminology.⁵

The intention in this study was therefore not to impose a frame of reference upon the respondents, nor to apply preconceived categories or concepts of 'health' or 'disease'. Rather, the women's words were examined to discover their own terminologies, and their models of sickness, ideas about disease, and views of health services were derived from the transcripts of their conversations.

All interviews were semi-structured, i.e. based on a list of topics to be covered or items of information to be obtained, but adapted in each case to the individual history and situation. For instance, generalised questions such as 'What do you think about medical science?' were as far as possible avoided; instead, the question to the older women might be, 'You say you have this arthritis, do you think they'll ever find a cure for it? Is this true of most things?' In a similar way, the mothers were encouraged to talk about the reported incidents concerning the child's health.

The attitudes displayed may well be multi-dimensional and not necessarily consistent, of course; people may hold incompatible beliefs concurrently, or express different attitudes in different contexts. We hope that the analysis allows for this. Nor are the histories given, the accounts of illnesses in the past, or the reports of what happened during interactions with doctors, necessarily factually correct. It is the woman's story, true or false, which represents her perception of the social fact of sickness, and it is on this that attitudes are based.

We were fully aware that the survey situation itself might affect the nature of the accounts which were given, and might even affect the behaviour of the young mothers. Despite attempts to guard against this by taking a completely neutral stand on all the topics which were discussed, it is probable that some contamination did occur. For example, after comparing the behaviour during the survey with the previous behaviour noted on health-visitor or clinic cards, it appears likely that a few women were prompted to take their children for immunisation or assessment, to specialist clinics and to general practitioners, when they might otherwise not have done so. This perceived influence is noted in the relevant sections.

Presentation

After a description of the families, and a general discussion of concepts of health and illness, each aspect of the children's health and the mothers' health-care behaviour is dealt with first in a quantified and factual way, and then by a more descriptive or ethnographic treatment of the mothers' perception of these events.

Throughout, there are many direct quotations from the respondents, who can often speak most eloquently for themselves. All material which is in quotation marks, or set off from the rest of the text, is directly quoted from transcripts or verbatim notes. To identify the families and individuals, the grandmother in each family is referred to as G1, G2, G3, etc. and the mother as M1, M2, M3, etc. The reader is thus able, if he wishes, to identify the material

which refers to the same family in different sections, to relate mothers to grandmothers, and to compare different quotations from the same individual. Exceptions are made only in a few cases where it seemed better, in the interests of confidentiality, to avoid this linking. Of course, every care has been taken to avoid the possibility that any family or individual could be recognised.

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Appendix A A Note on the Selection of the Families

In the original 1950-53 sample of Thompson and Illsley there were 455 women, of all social classes. It was thought of interest to include as many as possible of these women's families, although it had not been expected that many would be available, after more than 25 years, who filled the rather complicated criteria for inclusion: grandmother in social class IV or V at the time of her delivery, grandmother still alive and still living in the City, grandmother having had a daughter, her daughter having had children herself in the same City, being in social class IV or V at the time, and still living in the City. A total of 124 young families were identified from the maternity records as being potentially likely to fill the criteria. Of these, 90 were found not in fact to do so, since the older woman was dead, either generation had moved away from the City, or the family was simply not now traceable. To add to the potential sample, 87 young families were identified from the maternity records, with a mother who was born in the City, and in which the grandmother would at least be of the same generation as the 1950-53 sample though not in fact a subject of that study. In a similar way, 51 of these were untraceable or found not to fill the criteria.

After a small pilot study, letters were written to all the young mothers potentially thought to be suitable, asking them if their mother was living in the City, and if so whether they would be willing to take part in the study. Of the 70 who were in fact eligible, 4 replied by letter declining, and 23 replied by letter agreeing. Personal visits were made to the remainder (and, of course, to many more who had not replied but who were found not to fill the criteria). Of the 43 eligible families who had not replied, 6 declined when visited and 37 agreed. The point may be made that, in this particular social group, reliance on postal replies is likely to be unprofitable, and non-reply certainly does not mean that the respondents are reluctant to take part in research.

We could not be sure, when initially accepting the young family into the series, that the grandmother would be equally willing to

participate, and there are in fact 47 interviews with the older generation. In a few cases the grandmother eventually declined to be interviewed, one died and one moved away, and there are two pairs of sisters among the young mothers. In three cases, the 'grandmother' is in fact the young mother's mother-in-law; where her own mother was dead and the paternal grandmother was close by and seen frequently, it seemed acceptable to include her in the place of the maternal grandmother. The relationship in these cases seemed very similar to that in the other families: the mother-in-law had adopted completely the role typical of the maternal grandmothers.

It must be stressed that a great deal was being asked of the families, over an extended period, and their willingness to co-operate was remarkable. None of the 60 families originally included in the series terminated their participation during the survey period, though the disturbed lives of a few did present some practical difficulties in maintaining regular contact. One family was relinquished because of distress over a bereavement, and another moved away, leaving a final series of 58 young families.

The design of the research meant that a truly random sample was hardly possible, though we have no reason to think that these families are not typical of their social group. The series is defined simply as a group of families who have been in this City and these social classes for at least two generations. Those who have dispersed geographically, and those who up to the last child's birth had been upwardly mobile, are by definition excluded. It must be noted that the three-generational design will also be likely to exclude those families who are most unstable.

Appendix B The Index of 'Disadvantage'

In order to examine the association of social circumstances with possible differences in attitudes and behaviour within the sample, it was necessary to categorise families on some dimension of relative disadvantage. It must be noted that of course none could be called advantaged: none was wealthy, most had received a minimum amount of education, and all had been categorised occupationally as semi- or unskilled working class families in the maternity records from which the series was derived. Initially it had been thought that the categorisation might be easily if crudely made by distinguishing 'good' from 'bad' housing areas.

In fact, this simple design proved to be inadequate, and a multi-dimensional score of relative disadvantage was developed. By coincidence, 29 of the families were scored as 'more' disadvantaged, and 29 as 'less'. The categorisation is not, we would emphasise, presented as an absolute or universally applicable one: it is relative within this group of families, and intended to cover those dimensions of social circumstances which might be expected to have a potential effect upon health behaviour.

It may be useful to summarise some of the problems which were met. Firstly, it was obvious that three dimensions had to be separated, and any one of them would have been meaningless on its own. The economic circumstances of the family had to be considered separately from the environmental, and the social circumstances from both. The wages which the family earned were not necessarily correlated with the standard of housing they occupied, and within the household families earning the same amount might choose to spend it in very different ways, providing different environments for the children. In the worst environments one would, as might be expected, find some socially troubled families with disturbed marital relationships: on the other hand, several single-handed mothers with the most conflict-full marital histories had been allocated relatively good housing in the better environments.

Within each of these three dimensions there were also problems