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Title Page

**Intergenerational learning about keeping health: A qualitative regional Australian study.**

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## **INTERGENERATIONAL LEARNING ABOUT KEEPING HEALTH: A QUALITATIVE REGIONAL AUSTRALIAN STUDY**

### **SUMMARY**

Understanding the conditions under which families try to influence members' health related practices can provide information to build concepts adding to models of health promotion. This paper reports on an exploratory qualitative study examining the influences of intergenerational relationships in shaping beliefs, knowledge, and practices about health and illness in a regional Australian city. We conducted semi-structured interviews with twenty-seven adults with family members of other generations living in the city, all of whom had experience of asthma. We found that overall people's experience of health and illness, particularly in childhood, was taken

for granted and not reflected upon. It was in the face of serious illness or death of a family member that objective knowledge about health and illness was sought and integrated within the family leading, in most cases, to significant lifestyle changes or 'doing things differently'. We drew on Bourdieu's concept of the three forms of theoretical knowledge in analysing our findings. We found the concept of knowledge as 'primary taken-for-granted experience', and the concept of praxeological knowledge as the knowledge created by the dialectical relationships between an individual subject and objective structures, were helpful. To influence individual health practices we need to acknowledge how the family context confirms the taken-for-granted health practices of an individual and the family circumstances that might lead families to seek objective knowledge and make lifestyle changes to promote health.

## **INTRODUCTION**

The notion that health related messages transferred between family members of different generations might shape health practices of a particular family member has intuitive appeal. If family influences operate in the acquisition of health messages then it is important to understand just how extensive this might be and how and when these messages might be transferred. Then it might be possible to offer families information about preventing illness and maintaining health at times when they are most open to receiving and passing on this information. The study explored the influences of intergenerational relationships in shaping beliefs, knowledge, and practices about health and illness. Our findings have implications for the wider debate around the importance of understanding the family context, and the place in which people live, to enable people to make health promoting changes in their lives.

This was an exploratory study designed to add information about the role of family members of different generations passing information about health and illness. Currently, there is little theory to draw on. The starting point was an examination of how a family member, with access to other generations living in the same regional Australian city, recalled messages about health and being healthy and how they described these messages affecting their health practices. Our question was: How is knowledge about health and illness described across generations of a family and with what implications? We made the assumption that the close proximity of other generations would not only affect their understandings of health and being healthy but also the consequence of messages transferred across generations of their family. The concept of health used to discuss health and illness was health as the absence of disease. We used this concept consistently throughout the study. We were looking for participants' recollections of attitudes, beliefs, or practices about health or illness or keeping healthy or becoming ill. In the interviews we used the words 'messages about health or illness' or 'health practices' rather than 'attitudes, beliefs, or practices about health or illness'. We thought that using the term 'messages' might assist recall. If we had used a concept of health as 'wellbeing' then the messages recalled may have been different.

To place our interview data into context we applied Bourdieu's (1930-2002) concept of three forms of theoretical knowledge (Bourdieu, 1973). Bourdieu's theoretical work is useful in that it suggests that people's primary experience of the social world is "natural and self-evident, is not self-reflective by definition, and excludes all forms of interrogation about its own terms of possibility" (Bourdieu 1973, p. 3). People's experience of health and illness and messages about it from family might be this

taken-for-granted primary experience form of knowledge. The second form of knowledge, objectivist knowledge that challenges the possibility of practical experience, is that which people use when they break with primary experience. This could include the acquisition of objective health information from medical and other sources. The third type of knowledge, and of importance to Bourdieu, is praxeological knowledge or that which is concerned with the knowledge between individual subjects and objective structures in their social space (Bourdieu 1989) and the dialectical relationships between them. Objective structures determine what is right and as such support objective knowledge and vice-versa. Praxeological knowledge presupposes investigation into the limits of objective structures and objective knowledge. This does not mean benefits derived from for example, objective health information, is discounted. Rather, what is excluded to achieve a benefit of objective knowledge is explored and integrated into knowledge.

## **BACKGROUND**

Increasingly, epidemiological studies are investigating possible influences on adult health of factors operating across the life course and between adults, their offspring, and their grandchildren (Chapman & Scott 2001; Martin et al., 2004). The intergenerational factors thought to contribute to health status at different life stages include genetic transmission and the influences of shared environment and behaviour (Hyppönen et al., 2005). For example, Modin et al. (2009) explored the effect of early 20<sup>th</sup> century illegitimacy on three generations. Other studies examined the influence of the education level of the mother's mother on infant mortality (Bender and

McCann, 2000) and intergenerational social mobility and self reported health status (Chittleborough et al., 2009).

Of particular interest to health promotion are studies which examined intergenerational influences at particular times and around specific topics. Examples include a study by Whitehead (2007) in the United Kingdom examining intergenerational factors and teenage pregnancy and a study in the United States of America of intergenerational values expressed in family food and nutrition management. (Abye et al., 2006)

Rupp et al. (2006) and Mark et al. (2010) described intergenerational transfer of douching information from mothers to their daughters. Warren-Jeampierre and Miller (2010) found that intergenerational transfer of gynaecological health care information by African American mothers influenced help seeking behaviour of their adolescent daughters. In considering novel approaches to health promotion Mosavel (2011) suggested that there is a possibility for upward flow of health care information from daughters to their mothers. However, these studies are ‘one off’ and they have not been designed to add theory or concepts about intergenerational relationships and their importance to health promotion.

## **METHODS**

### **Setting**

The city in which the study was conducted has a population of approximately 20,000 people. Because of its narrow industrial base (natural resource extraction and processing) the economy is subject to international market fluctuations and the level of socioeconomic disadvantage in the city is relatively high, for example in 2003, 29% of the population were receiving income support payments. There are known health

issues in the city with levels of asthma higher than the state average. There is no evidence to suggest that having asthma is associated with naturally occurring or fugitive dust from the resource extraction processes. Participants described the city as including people from different cultural backgrounds and as working class. Almost all participants expressed a strong attachment to the city. This was shaped by a number of factors including a sense of connection to the community and family, ease of access to facilities, friendliness, and the weather. Overall it was the connection with the family network and the community that was most strongly expressed.

### **Participants**

The study reported on in this paper was a sub-study of a larger intergenerational study of health in a regional city in Australia (Haren et al. 2012). The larger study was a population-based study of randomly selected residents measuring the prevalence of conditions including diabetes, asthma, and psychological well-being. The randomly selected households that had registered for the larger study became the sampling frame for this sub-study. We wanted a sample of information rich sources to discuss intergenerational messages about health and illness. Consequently, we made a pragmatic choice to use asthma, a common condition in the city, as a lead in to the substantive focus for our discussion. Our focus of interest was not asthma but intergenerational messages about health and illness

Accordingly, we used the condition of asthma to define sampling frame. A recruitment letter was sent to the first 61 registrants in the larger study whose questionnaire data indicated that they had a diagnosis of asthma from a doctor at some stage in their life. A secondary requirement, stated in the invitation letter, was that participants had (or

until recently had) a member of another generation living in the city. Six men and 17 women responded to the invitation to participate in the study and were interviewed. Once an interview had been held with the participant, if agreeable, he or she was given an information sheet to invite a family member from a different generation for an interview. Two men and two women responded to this invitation. In all we interviewed 27 people. We were keen to interview members of different generations of the same family but were able only to this with four families. Consequently we had a limited opportunity to trace connections among messages across generations of the same family.

Our participants were similar in that they were older with 25 aged 40 or more, most had lived in the city for ten years or more, and 17 had three or four generations living in the city. A little more than half were born in the city or the state and 11 were born in the United Kingdom and most of the men interviewed had worked in roles associated with the major industry in the town - natural resource extraction and processing. Almost all women interviewed had connections through family members to the industry.

Semi structured interviews of up to one hour (usually about 45 minutes) were held with participants at a place convenient to them. Topics included the experience of having asthma, perceptions of health and illness in childhood, and recall of messages about health received from, and passed on to, parents, children, or grandparents. We also explored contextual factors about living in the city. Interviews were digitally recorded, transcribed verbatim by a professional transcriber, and a summary of

findings was sent to all participants. Ethics approval for the study was granted by the institutional Human Research Ethics Committee.

### **Analysis**

To identify recurring themes, we used a method that was an adaptation of Ekman and Segesten's (1995, p. 1008) broad framework. Their analysis framework consists of five stages and we followed this in our analysis: (a) each interview was read in its entirety to give a sense of the whole; (b) transcripts of family members were analyzed using the family dyad as the unit of analysis (Eisikovits and Koren, 2010); (c) after reading all interviews codes were structured in which to group data – for example participants childhood messages received about health and illness (d) assumptions gaining consensus from authors were identified as relevant and patterns of meaning, contradictions, and inconsistencies were elicited; and (e) the themes resulting from the previous step (experience of messages from family in childhood and messages to and from family in adulthood) were discussed within Bourdieu's theoretical constructs. Data saturation was achieved in an interview when no new information, issues, or “stories” emerged (Silverman, 2006).

### **RESULTS**

Overall participants reported that they experienced themselves as healthy. This was most apparent when talking about their childhood when it appeared that there was an internalization of a state of being healthy or ill as part of life. Almost all participants told us of a healthy childhood. “Oh, yes I was very healthy. I was an absolute tomboy. I climbed trees, I rode bikes with the boys, and I swam in the local creek.” Childhood illnesses were recalled but were not considered out of the ordinary – just

everyday events that were part of daily life as this older man recalls. “I don’t even remember getting very sick. I had my tonsils removed which was a normal thing; I had whooping cough measles, chicken pox, mumps and all that.” Another older man could not recall feeling ill as a child even though he reported having had measles, chicken pox, and was hospitalized twice for scarlet fever.

### **Stand out messages from childhood**

Perhaps because being healthy in childhood was taken for granted, it was difficult for participants to recall childhood messages about health or illness received from their parents or grandparents. However, there were some stand out messages from parents related to hygiene and eating habits. One older woman’s growing up in the United Kingdom had included experiences of maintaining a high level of cleanliness. “I think it was just something [cleanliness] drilled into us. We had a lot of friends as kids and I look back now and I think ‘If I was my mum, I wouldn’t have let me play with them kids’. Marion [the mother] didn’t keep her kids clean”.

This participant considered that she had passed on messages about cleanliness to her children: “They [the messages] follow you. I could always remember mum saying ‘If you go to the toilet, wash your hands’ and I drilled that into my kids, one of the first things I probably would have told them, ‘wash your hands’.” This participant’s daughter was interviewed in our study but she did not recall this message.

Eight of our participants remembered childhood patterns of eating and messages about food. One participant recounted parental responses to his poor eating: “The one thing I can remember was that I was an extremely bad eater and a very skinny little

boy so Mum used to sit there and play little games to get me to eat.” Another participant had a comparable story: “I was skinny as a rake as a kid. My Mum used to be worried but the doctor said ‘forget about it; as long as he’s eating anything, let him go’ which she reluctantly did and I survived.” This participant’s son gave a similar account of this story and how it influenced his approach to nutrition with his own family. “When my dad was a kid my grandma took him to the doctor’s and he said ‘as long as he’s healthy no problem’ so he’s conveyed that same message to us and we have taken it on.” This is the only example of a message given by one generation to another being recalled during the interview. There were several other examples of parental influence on what was healthy eating. “I’ve always been brought up to eat properly. My gran was a stickler for meat and veg, although she always used to say to me, ‘you don’t need to eat meat every day’.”

### **Experience of asthma**

Unlike in childhood, health in adulthood was not always a taken-for-granted experience and was subject to some reflection and analysis. Most participants discussed the experience of asthma, which was a diagnosed condition for all of the participants, as an irritant rather than a condition. Participants were reluctant to consider the asthma as an intrusion or an important influence in their life and they attempted to integrate illness into everyday experience. One of the ways they did this was to avoid labeling symptoms as “having asthma”. One man commented: “Well the doctors say I’ve got asthma but I’ve been hard to convince of that actually.” Another older man also expressed reluctance at “having asthma.”

The doctor gave me some medication. I did tests for asthma and he gave me a preventative, and I've been taking that for over 10 years. But I've never had an asthma attack. I take it, just because he told me to do it. I suppose it is asthma, but I regard it as very light.

Here is another example of a woman minimizing symptoms of asthma and considering it as an irritant rather than a disease or condition.

About 10 years ago I developed this cough and I had what I thought was a bad chest infection. I went to the doctor and he said it was asthma. I don't like taking it [medication] but I find that I cope with it. It doesn't interfere greatly with my life. As far as I'm concerned, it's nuisance value rather than a debilitating disease.

Even when participants told of very uncomfortable symptoms, a normalizing process appeared to occur where the condition was integrated into his or her daily routine. In this example, a young woman participant told of severe breathlessness but did not see the condition as serious. "I don't see it as an illness – it is just something that I have. Like it is really mild so I don't even see that I suffer from it." Often the normalization process began in childhood as was the case with this older woman. "Through my younger years it was always [name] and her cough– we all just got used to it."

One of the consequences of this integration of illness into everyday experience was that participants did not seek objective knowledge about the condition. Here is an example of an older woman who works in the health promotion field. She had symptoms of coughing that kept her awake at night and eventually she went to the doctor. "I was surprised when I heard it was asthma. I didn't really expect that." This

participant was rather embarrassed to admit that she used very little information about asthma. Although information was available, she appeared not to be able to access it. This finding is consistent with how Bourdieu (1973) conceptualizes the forms of theoretical knowledge. The primary experience of the social world, which in this case includes the experience of illness, is not reflected on and the participant did not seek objective knowledge about asthma.

### **The impact of serious illness or death of a family member**

The most significant intergenerational influence revealed in descriptions about what shaped health understanding and practice was the experience of a serious illness or death of a member of another generation. Almost three quarters of participants described their experience of the death or serious illness of a parent or child and the resultant changes in their health practices. In some cases the death or illness had a profound impact – even resulting in a desire to move away from the city or to shun certain occupations to avoid illness. An older man, who grew up in the United Kingdom, was prevented by his coal miner father from entering the coal mining industry. In reflecting back on this event the participant expressed a sense of gratitude.

My father died in the 60s. He was a coal miner. Not silicosis, pneumomycosis. He wouldn't let me get a job around the mine. All my friends that didn't go to grammar school left school at 14 and got a job at the pit. I didn't have to. I thanked my father for that.

As a consequence of serious family illness one participant made changes in the family eating habits.

Dad was diabetic and he had a couple of really bad strokes when the boys were quite young. After he had the strokes they put him on a salt-free diet and I thought right, I'm going to get this mob healthy, they're going on a salt-free diet and we still don't put salt in food.

Here is another example of an illness in a parent having a direct influence on the health behavior of an adult child.

My father has chronic renal failure caused by dehydration as he worked in ship loading and he didn't drink water and neither did I. Then I got to thinking I'm 56 now and I don't want to go down the same path as him so I try to drink water during the day.

The influence of serious illness in another generation was apparent in discussions about smoking and eating. Adult children and grandchildren recalled previous or current parental smoking and inappropriate diets. There were numbers of examples of parents who had smoked and had suffered serious illness related to this. "My mother had emphysema and she dies of it of course. I told my children not to smoke because of what happened to my mum." Anti smoking attitudes were acquired from parents smoking even if there was no illness involved as one participant explains. "She did lead a very healthy lifestyle except for her smoking, of course. She was quite a heavy smoker and dad was too for some time. But I became wary of it."

## **DISCUSSION**

We found the processes of uncovering messages about health and illness complex. Perhaps it was difficult because messages were subtly integrated into people's primary experience of their social world. For example, regardless of a participant's age, gender, or the place of upbringing, the experience of being healthy or ill, particularly in childhood, was largely taken for granted or experienced as a given. It could be that what health messages are learnt, might be at the pre-reflective level. By this we mean that people might not reflect on their experiences rather just accept them as part of life which is consistent with Bourdieu's first form of knowledge (Bourdieu 1973).

After some discussion, about one third of our participants could recall messages. Recall was strong when the messages related to the normative components of the social fabric of their childhood world – messages about cleanliness and “proper” eating habits. Possibly this was because the discourses could be described as indicative of class structures and patterns or norms; those objective structures operating in the participant's social space (Bourdieu, 1989). These objective structures became integrated into the participants' experiences of health and illness. This represents Bourdieu's second form of knowledge (Bourdieu 1973).

Participants did not describe life-threatening illnesses of other family members as taken-for-granted primary experiences of the social world. They sought knowledge from external sources and integrated this in a subtle and complex manner to produce particular social or health practices. This is the finding that is of relevance to those interested in changing health practices. The process of integrating knowledge represents Bourdieu's (1973) third level of theoretical knowledge where the focus is

on the relationship between individual subjects and objective structures. The nature of the resulting practice is influenced by the relationship, (including power relations) between generational influences and economic, social, and environmental conditions (objective structures) occurring in this regional city. Our participants gained a greater awareness of health issues through this process and some participants then engaged in direct practices that were intended to maintain health and avoid illnesses suffered by other generations of their family. Participants described this as “doing things differently.”

Clearly, the observation that serious illness of a family member can result in changed health practices and “doing things differently” requires further clarification through research if it is to be useful to health promotion practitioners. If there is further data about the conditions under which families try to influence members to change their health behavior then this would provide the opportunity to add to conceptual models of health promotion. This data may enable practitioners to use novel concepts in addition to the more traditional individualizing models of health promotion (Whitelaw et al., 2000).

#### Study limitations

The pragmatic choice of asthma as a basis to select participants may have resulted in particular types of messages. Had we not focussed on an illness the findings may have been different. In addition, the choice of a concept of health as an absence of disease, rather than health as wellbeing might have resulted in a focus on illness and avoiding illness.

We had a limited opportunity to trace connections among messages across generations of the same family. Our intention was though to better understand the messages that participants perceived they received from and passed on from their families rather than whether or not those messages were corroborated.

## **CONCLUSIONS**

Our study found that many important intergenerational influences on health were integrated as primary experiences of the social world rather than being subject to self reflection and integration with objective knowledge. However, serious illness in family members did bring altered practices. Most participants sought objective knowledge, integrated it, and instituted practices aimed at keeping family members healthy. They “did things differently” in relation to their own or their family’s health. In these situations a possibility existed for the individual to be able to think differently about what had become self-evident to them. Bourdieu’s concept of three forms of theoretical knowledge provided a useful framework from which to explore our findings.

To bring about different health practices, it would seem to be important for practitioners to link objective knowledge about illness prevention with occasions where serious illnesses or death of another generation has occurred. Health promotion applications might make it possible for an individual to reflect on their experience, integrate new information, and take on new practices that might help avoid illness. Currently, most health promotion models are focused on individuals and the opportunity for consideration of the broader family context in which the individual operates is limited. Development of models of health promotion that enable the

consideration of family processes that impact on health are called for (Whitelaw et al., 2000)

As this was an exploratory study further research is necessary before we can tell how extensively family influences affect the acquisition of health messages. In particular, we need to know more about how of the serious illness or death of a family members might be an opportunity for the acquisition of objective knowledge. Research that is condition specific, as well as that which is targeted on a particular population group, is of importance. In addition, research about the specific motivations for change that operate at the time of serious illness in a family member may assist health promotion practitioners.

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