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"I just want her to be happy and healthy": Deploying broad understandings of health in class-privileged parenting

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ABSTRACT

This study examined the role of class privilege in parents' understandings of children's health and their navigation of the work of supporting "healthy" children. Cultural and institutional discourses tend to frame class-advantaged parents as making choices for their children that maximize health, but this is not always the case. Analyses drew on 45 interviews with predominantly white, class-advantaged parents of elementary-aged children and associated observational data. Parents were navigating intensive childrearing expectations that were impossible to fully meet. Class-privileged parents' narratives constructed very broad understandings of children's health and well-being that encompassed social connections and academic, extracurricular, and athletic achievement, as well as physical and psychological health. Although this broad definition made it irreconcilable for them to meet expectations for children's health on all fronts, it allowed class-privileged parents to de-emphasize specific health behaviors for the sake of social or achievement concerns instead, while still framing these priorities as safeguarding the child's health. Thus, participants were able to justify to themselves and others that their parenting practices that tend to maintain privilege were health-focused. Findings demonstrate how broad definitions of health can support advantaged parenting, potentially redirecting scrutiny toward disadvantaged parents.

1. Introduction

Concerns about children's health[1] in the U.S. have been rising steadily, permeating cultural, scholarly, and policy conversations about what is increasingly understood as a social problem. Additionally, health has become integral to what is considered "good" parenting work, influencing intensive parenting pressures and expectations (Cairns, Johnston, & MacKendrick, 2013; Reich, 2016). Considerable medical and scholarly research has focused on childhood obesity, diet, and physical exercise, disproportionately examining low-income and minority families who are viewed as "at risk" (Elliott & Bowen, 2018). Much of the discourse implicitly frames parents as making "poor" choices for their children, with class- and race-disadvantaged parents typically less able to skirt those judgments (Elliott & Bowen, 2018). Advantaged groups in general (Link & Garcia, 2021), and advantaged parents in particular (Elliott & Bowen, 2018), are often left out of critical conversations about parents making non-guideline adhering choices regarding children's health (see Reich's 2016 work on the anti-vaccination movement for an exception). This lack of examination implicitly suggests that advantaged parents are more likely to make expert-deemed "appropriate" choices, a suggestion we critically interrogate in the following study.

"Expert" (e.g., physicians, researchers, and government institutions) understandings of health are largely structured by physical bodily states, such as the American Academy of Pediatrics' (n.d.) suggestions to parents regarding "healthy living" for kids (which includes nutrition, fitness, sports, oral health, emotional wellness, sleep, and "healthy" weight). Embedded in cultural and scholarly conversations are assumptions about shared, universal understandings of what being healthy means and which kinds of parents are willing and able to support their children's well-being in "the right way." These assumptions drive public policies that are intended to support children's well-being, which focus on solving the generalized problems of childhood health by changing parenting

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[1] We, like many participants, use "health" and "well-being" interchangeably.

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practices via increasing parents' education about health or improving their access to resources (such as healthier foods or outdoor play/exercise programs). These approaches assume that if all parents had high health literacy or the resources to make expert-approved choices, the "problem" of children's health would improve, ignoring how parents interpret children's health as practiced in everyday life.

In this study, we interrogate taken-for-granted assumptions about how parents perform the work of "doing" children's health and examine how parents manage irreconcilable pressures around intensive parenting in the context of children's health. We focus on class-advantaged parents, who are often considered to have the resources necessary to support children's health in ways that meet social expectations. We explore how parents with often abundant resources interpret what it means to make "good" choices for their children's health and how they make sense of discrepancies between their parenting practices and perfect adherence to intensive parenting pressures, including socially approved health behaviors (as outlined by doctors, teachers, and other community members who interact closely with families). Our findings show that despite commonly held beliefs, advantaged parents' understandings and decisions do not necessarily follow all socially approved guidelines regarding children's health. We argue that advantaged parents' resources give them a partial ability to reconceptualize the meaning and doing of children's health in ways that support their social and achievement-oriented goals, allowing them to better manage both outside pressures and their own identities as "good" parents.

Our analysis draws on in-depth interviews with 45 parents of children grades K-5 living in two class-advantaged, predominantly white communities. We capture the process through which these parents use their constructed understandings of health as narrative strategies to account for how and why they prioritize some aspects of their children's well-being over others, ultimately diverging from some externally dictated health practices. These parents challenge assumptions about a universal, absolutist understanding of health, as well as assumptions (made largely invisible by the power of privilege) that class-advantaged parents adhere to dominant scripts about the "right" way to support children's health.

1.1. Constructing and surveilling children's health

Substantial literature investigates child health, demonstrating how experts define and discuss it. This largely quantitative research makes robust contributions but is less focused on constructions of health or processes through which these constructions play out in everyday life. The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (n.d.). However, this definition is not usually reflected in research, often due to measurement constraints. Instead, children's health is often operationalized through parent-reported general health status; diagnoses of physical health conditions such as asthma, autism, and disabilities; physical health behaviors; and physical risk behaviors (e.g., Kimbro, Brooks-Gunn, & McLanahan, 2011; Mistry, McCarthy, Lu, & Patel, 2009; Patnode, Erickson, Barr-Anderson, & Story, 2011). Self-reported scales measuring mental health, life satisfaction, and stress, widely used when researching adult health, are less commonly available for children. These limited conversations suggest a misalignment between some experts' definitions and everyday people's nuanced understandings of child health and well-being. This misalignment is reflected in some policy efforts, such as increasing parental "health literacy, " which has been critiqued for being overly simplistic and focusing excessively on health behaviors without substantial consideration of individual interpretations or of a person's holistic, complex life context (Chinn, 2011; Wills, 2009).

The issue of increasing parental "health literacy" has garnered much public health attention in efforts to increase children's well-being (Velardo & Drummond, 2013), and parenting practices regarding children's health are heavily surveilled (Reich, 2016). These outside influences matter for parents' understandings of children's health and their health behaviors. The issue of feeding children, in particular, has garnered significant attention in recent years and is a prime focus of "health literacy" for parents (Velardo & Drummond, 2013). Breastfeeding, for example, is a highly surveilled and contentious topic, demonstrating how much scrutiny is placed on mothers (Morrissey & Kimball, 2017; Olson & Simon, 2019; Wall, 2001).

A robust body of work considers the influence of social class on how children's health is connected to parents' (mainly mothers') moral identities (Cairns et al., 2013; Elliott & Bowen, 2018; Wall, 2001). Again, much of this attention is focused on feeding (Fielding-Singh, 2021). For example, Cairns et al. (2013) examined how mothers across class backgrounds worked on their own moral identities by emphasizing nutrition and narrating their construction of "organic children." Mothers demonstrated how they understood and cared for their children's health and well-being by keeping them "pure" by feeding them expensive organic foods, allowing them to meet expectations while reinforcing classed standards of "good mothering."

We build on this growing literature by exploring the narrative strategies of privilege that class-advantaged parents employ as they construct their own understandings of children's health and use those understandings to explain why they sometimes de-emphasize certain elements of their children's health in the service of other aspects that may support long-term socioeconomic success. We show how privilege works in two ways: first, by shaping parents' sense-making about what is best for their children in the long term (which, at times, conflicts with expert guidance), and second, as a tool in trying to minimize negative judgments as they navigate the impossible work of, as one parent put it, "doing everything, always" for their children's health.

1.2. Parenting, social class, and health

Scholars have long theorized about the connections among social class, parenting styles, and family well-being (Blair-Loy, 2009; Coontz, 1992; Lareau, 2003; Pugh, 2009; Shirani, Henwood, & Coltart, 2012), yet questions remain regarding their implications for how parents do the work of raising "healthy" children. Social class and other markers of privilege influence cultural and institutional expectations of parenthood and ideas about what is "best" for children. The ideology of intensive parenting—the expectation that motherhood (Hays, 1996), and increasingly, parenthood (including fathers; Shirani et al., 2012), should be child-centered, expert-driven, labor-intensive, and require emotional and financial resources—arose during the 20th century and has become dominant in U.S. culture. Intensive parenting requires that parents invest heavily in children using diverse resources, privileging parents who have greater means to achieve these expectations. However, although intensive parenting demands reflect the lives and access to resources enjoyed by class-privileged parents, the ideology sets the stage for what "good" parenting should look like for all parents (Elliott, Powell, & Brenton, 2015; Shirani et al., 2012).

Even among class-advantaged parents, intensive parenting demands can be constraining and burdensome. Blair-Loy (2009) found that among high-earning executive mothers, the demands of an intensive family life and dedication to children constrained both their choices and how they understood what would make their own lives worth living. The ideology of intensive parenting is set within an increasingly "de-privatized" context, necessitating public performances of parenting that are rigorously regulated by cultural and institutional scrutiny (Holstein and Gubrium, 1995b; Thelen & Haukanes, 2010).

Within this context, parents' work on children's health is rife with public evaluation. Concerns about "good" parenting and children's health have manifested in broader conversations about issues such as breastfeeding (Wall, 2001) and vaccinations (Reich, 2016). Children's health is used to evaluate parents and their claims to "good parent" identities across the spectrum of privilege. For example, Reich's 2016 study on parents who reject childhood vaccinations found that advantaged parents can be held publicly accountable for health choices they make for their

children, but race and class privilege work to protect them.

Lareau's (2003) study of parenting styles illustrated strategies that differently privileged parents used in navigating this complicated terrain. She found that class-privileged parents employ "concerted cultivation," intensively "cultivating" children's interactional manners, talents, and proclivities and building a constellation of cultural capital that they believe would prepare them for adult success. This included extracurricular activities, academics, and structured organized play, as well as learning how to interact with institutional actors, internalizing cultural knowledge and exhibiting interactional comfort across varying social settings. In contrast, class-disadvantaged parents were more likely to practice a "natural growth" parenting style, focusing more on unstructured time, giving directives (instead of emphasizing negotiations), and encouraging following authority. Like Lareau, other scholars have expanded the understanding of how privilege matters in parenting work to emphasize the importance of both race and class in how parents shape children's lives (Elliott & Aseltine, 2012; Lacy, 2007; Pugh, 2009).

A key aspect of this parenting work is health, and class-privileged performances of child health are an important part of the social transmission of advantage across generations in U.S. society through cultural capital and health outcomes (Mollborn, Rigles, & Pace, 2021). Parents balance medical and academic considerations in increasingly complex ways (King, Jennings, & Fletcher, 2014). Cooper (2014) demonstrates the considerable stress parents experience in attempting to protect their children and support multiple aspects of well-being, including health and access to healthcare, access to higher education, and transitioning into a secure adulthood. Whether the threats to children are actual or perceived, parents are raising children in a difficult context where economic and cultural shifts toward precariousness now frame the world they parent within (Cooper, 2014; Glassner, 1999; Nelson, 2010; Pugh, 2015). Thus, parents' understandings of what is best for their children now and in the future are influenced by their class and levels of privilege, changes in cultural and economic realities, and the challenges of everyday life.

2. Methods

This study is part of a larger project investigating children's health lifestyles that included 51 in-depth interviews with parents of children in kindergarten through fifth grade, 30 home observations, six focus groups, and nine key informant interviews. Here, we focused on 45 of the in-depth interviews with parents, centering on the solidly class-advantaged parents in our sample (see details for class categorization below). These interviews were collected during the 2015-16 school year in two primarily white, class-advantaged neighboring communities in the Mountain West we call Greenville and Springfield. Participants had at least one child in grades K-5. All community and participant names and potentially identifying details have been changed.[2] We recruited participants through local parent listservs, Facebook posts, and Craigslist advertisements, personal contacts, flyers posted throughout the community (such as apartment complexes, recreation centers, and libraries), and snowball sampling (Lofland, Snow, Anderson, & Lofland, 2006). Our diverse recruitment efforts tapped into different segments of the communities (Emerson, 2001; Lofland et al., 2006), including 23 elementary schools and homeschoolers.

The sample generally reflected the communities' demographics (see below). Eighty-three percent of parents identified as white, five percent as mixed-race, two percent as Asian-American, two percent as Indian American, and two percent as Latinx. Eighty percent were mothers, and 20 percent were fathers. Eighty-two percent identified as married, 13 percent as divorced, and five percent as single. Participants' average age was 44. We spent considerable time developing class categories, classifying participants, comparing across coders, and refining based on parents' self-reported educational attainment and occupation and (for observation families) housing and neighborhood quality. Six parents classified as lower SES are not analyzed here. We classified 44 percent of analyzed parents as middle-class or mixed (e.g., higher education but moderate income) and 56 percent as upper-middle-class or elite. Our research team (one faculty member, two graduate students, and three undergraduate students) varied across race, gender, and age. There were three white women with ages ranging from early thirties to early forties and three team members in their early twenties (a woman of color, a man of color, and a white man). All team members conducted observations, and the faculty member and graduate students conducted interviews.

Face-to-face interviews lasted approximately 1 h and were recorded and transcribed. Interviews consisted of open-ended questions providing a sense of children's daily routines, parenting in the community, and how parents compared their childhoods to their children's experiences. We asked parents what it means to them to be healthy, how that differs from well-being, whether they consider themselves and their child(ren) to be healthy and why/why not, what they think they're doing well or less well as parents for their family's health and well-being, what other influences outside the family shape their child's health and well-being, and (for some parents) how they decide which aspects of health and well-being to prioritize. Data were individually and collaboratively analyzed and coded by hand and using NVivo software. We analyzed the data inductively, with our grounded theory approach allowing themes to emerge organically (Charmaz, 2006). We coded data individually, came together to compare results, then collaboratively refined analytic categories for recoding. We examined the data for differences by child gender but found the processes analyzed here to be similar.

We consider interview data as an opportunity for participants to construct narrative accounts to explain their parenting choices (Scott & Lyman, 1968) and tell stories about their own and their children's lives (Holstein and Gubrium, 1995a), managing others' judgments and doing identity work. Thus, narratives are relational and embedded in specific social contexts. We do not treat parents' narratives as objective "truth," but rather as interactions in which parents talk through understandings and sense-making processes. We present our interpretive analysis to uncover *how* and *why* parents thought they made the choices they did for their children's health, rather than adjudicating what the "right" choices should be.

Participants lived in two neighboring communities located in a large metropolitan area in the Mountain West. Both have population sizes of mid-sized cities (U.S. Census Bureau, 2017) and are primarily liberal, white, and class-privileged. Based on Census data, we characterize both communities as middle-to upper-middle-class, although Springfield has more class, race, and ethnic diversity, and Greenville's median housing value is higher and its population more highly educated. Both communities' residents pride themselves on their involvement in outdoor activities and consuming "healthy" foods, and collective resources such as extensive community recreation centers and large farmers' markets support these practices. Interviews captured how parents constructed understandings of health from their individual, advantaged social positions, as well as their affluent local community cultures.

3. Results

Parents' narratives constructed very broad understandings of children's health and well-being that encompassed academic, extracurricular, and athletic achievements and social connections, as well as the more typical physical and psychological health. The multifaceted nature of class-privileged parents' understandings of health posed a problem: When health is viewed as virtually all-encompassing, it becomes impossible to nurture all aspects of it at once. But these multifaceted understandings also provided agency by allowing parents to define a variety of parenting behaviors as healthy. This allowed some to downplay outside expectations for specific health behaviors (outlined by children's doctors, schools and teachers, and other community members

[2] This study was approved by our institution's Institutional Review Board.

who interact with families) and prioritize social or achievement-oriented concerns instead, while still framing these priorities as safeguarding the child's health. Thus, many participants were able to justify parenting practices that tend to maintain privilege as health-focused, allowing them to manage both outside pressures and their own identities as "good" parents. In this context, these class-advantaged parents were able to define for themselves what made their children "happy and healthy" in a way that allowed them to simultaneously emphasize achievement and social connection and justify that work as prioritizing health.

3.1. Class-privileged parents defining health

We found that advantaged parents' understandings of what makes children healthy were broad and multifaceted, often including *physical health, psychological health, achievements (academic, extracurricular, and athletic),* and *social connections.* We asked parents how they conceptualized "health" and "well-being." Language is imperfect and symbolically meaningful, and the ways in which individuals construct and share meaning in interaction is not always clean or consistent. Parents moved back and forth between the terms "health" and "well-being." Thus, we stayed true to those constructed meanings and did not draw a hard analytic line between them. Parents' understandings of health were flexible and dynamic, constructed throughout the course of their narratives. Neatly explaining one's definitions of health and well-being was not always an easy task for parents, which mapped onto their feelings of tension around their ability to fully support all aspects of their children's health (see below).

Physical health. Parents' moral identities are closely tied to the work they do for their children's well-being (Wall, 2001), and parents' decision making, particularly around health, is an increasingly contentious and public topic (Reich, 2016). Many parents' definitions included aspects of physical health, although it was not as dominant as might be expected. These responses included biomedical factors such as diet, exercise, sleep, illness, disease, and disability. Physical health was uniquely meaningful, as it can easily be publicly judged, reflecting back on parents. In this vein, some parents emphasized the performance of physical health by highlighting their children's ability to (publicly) perform physical activity (such as participating in a neighborhood running or cycling club; Mollborn, Rigles, & Pace, 2021). Some parents emphasized their children's ability to portray knowledge of physical health through health talk, such as knowing to publicly disavow "bad" foods like sugar, soda, or fast-food. Jessica told us, "We take pride in the fact that our children think it's such a treat to go to a restaurant and get fizzy water from the soda machine." Emily shared, "If we go to a restaurant he'll ask for juice or a chocolate milk … like, neither of them [her children] drinks soda. They already have been taught to make healthier choices …". Jessica told us, "We have kids who are very bright, and with that comes a sense that they created themselves of what's right and wrong … the fact that they are horrified that anyone would smoke. That anyone would go to McDonalds. But it's just so bad for you, why would anyone do that?" These performances often happened in public spaces where participants' children demonstrated they had internalized parents' messages about health, reflecting favorably on their parents' influence.

Psychological health. Healthy also meant being psychologically and emotionally well, free from stress, emotional disturbance, depression, and anxiety. Cristian told us, "[We ask ourselves] so your well-being is, are you happy? Are you content? Do you have a sense of balance?" Emma integrated mental, emotional, and physical health: "Mental and emotional [health] is really important, so we kind of focus on stress, health, and healthy lifestyle." Danny conceptualized psychological health in tandem with other aspects of children's well-being, explaining:

> When I think of well-being, I think of the system. All the systems that are part of the being and the net effect of all those systems working together … and so you can have that piece of the pie that is a system that is literal [physical] health, and that can be compromised. And if other things are intact, like your mental well-being and your spiritual well-being, then it can absorb some unhealthy things.

For Danny, mental health was important on its own, but it also had potential to balance out other aspects of health that may be "compromised," demonstrating participants' tendency to "spend" some aspects of children's health as a kind of currency when prioritizing others.

Academic, extracurricular, and athletic achievements. Understandings of children's health and well-being also included academic, extracurricular, and athletic achievements. When answering what makes children healthy, some parents directly echoed aspects of concerted cultivation (Lareau, 2003), talking about academics, extracurriculars, and/or athletic achievements. As Hector told us when he emphasized the importance of a science-focused education for his children's health, "… what I would like to see as a successful, healthy child. Someone who understands what she reads in an anti-vaccine article that this is not true." Parents understood academic and other achievements as helping to prepare their children to make good health choices, as well as supporting their future economic positions, as Dora explained, "I think the stress of not having enough means can be really detrimental to health."

Other parents responded to our question about "what makes children healthy?" by redirecting the conversation to what they thought was best for their children, which often emphasized educational and extracurricular achievements. Parents' achievement-oriented health narratives often connected to the idea that achievement in childhood would mean stability, resource, and autonomy in adulthood – all of which would contribute to their children's long-term health and well-being. Erin told us, "I think that healthy means to be able to change the course of things that don't feel right …" Lila explained, "I feel so strongly about not following someone. You know, just really live on their own and be independent as long as they can."

Conversations about health via academic, extracurricular, and athletic achievements reflected advantaged parents' feelings of pressure regarding their children's ability to replicate their class status in adulthood (often represented by autonomy and access to resources). Studies of classed parenting styles show that class-advantaged parents use academics and extracurriculars to move children toward class-privileged adulthoods (Lareau, 2003). Focusing on achievements in these privileged spaces made sense, as parents understood themselves as helping children exhibit the necessary exceptionalism that would help propel them to secure socioeconomic attainment.

Social connectedness. Social integration, relationships, and social connectedness were also included in parents' understandings of health. Parents constructed social health around their children's ability to make and keep friends, be thought of as a "good person" in the community, and feel connected to family members. Throughout his interview, Ryan emphasized "togetherness" and said, "Somebody that's isolated is less healthy." He explained the importance of social connections: "People like to interact with people, are very social … It's just something that we fundamentally have." Ryan linked the need for social connections to something innate, but he later expanded his understanding of the importance of social health through connections. Ryan explained how important "socialization" was: "I think it's important to interact with different people. Not just people you go to school with, but people in your neighborhood." Lacking these skills "could hurt you down the road." In his narrative, Ryan demonstrated his commitment to intensive parenting, espousing heavy monitoring and emphasizing his parenting as child-centered and time/thought intensive. In this approach, he established that he was ensuring his daughter's health and linked his efforts to her future well-being.

Participants constructed understandings of children's health from particular social and cultural positions. Abundant community and family resources framed their sense-making. As Erin told us when trying to explain her understanding of what is best for her daughter's well-being:

> I want her to be healthy, I want her to be happy. I want her to have enough resources for her to see the world and travel. But I also want [her] to be a byproduct of a more important internal aspect, which is that if you search for happiness, if you search for wealth, you can get lost in those goals. But when you look, as a result of being a human being in balance, and in acceptance with your emotions and your spiritual life, happiness and wealth and resources come naturally in that state, into that mindset.

Erin's comments suggested little worry about her child's access to wealth, a privilege that is heavily shaped by class. She assumed that those resources would "come naturally" if her daughter attended to her spiritual and emotional state.

3.2. We can't do it all: Roadblocks in balancing comprehensive health

In describing these broad understandings of children's health, parents also revealed pressures and difficulties in attempting to support all aspects at once. Parents' stories were rife with feelings of conflict in their attempts to accomplish this impossible work, pointing to tensions they experienced in making choices that prioritized some aspects of health while de-emphasizing others. When her daughter Brinley first joined the soccer team, Erin was concerned about potential physical injuries but also expressed that it was important for Brinley to learn to become solid, independent, and resilient. She explained, "… and that's a fine line between letting your kid, how much you let your kid get hurt, for them to have the experience [that they can learn from]. I don't want to be a helicopter parent, so I had to do those things." Erin saw no option that could both allow her daughter to learn to manage herself (which she felt was important to her overall well-being) while being protected from physical injury. Erin described needing to prioritize Brinley's imagined future well-being over immediate physical safety.

Many parents similarly articulated the need to prioritize certain aspects of their children's health and well-being over others, explanations that were bound up in making choices that they thought would best set their children up for the future. Aria felt a lot of pressure surrounding choices to support her daughter's health. She told us that the aspect of her daughter Charlotte's health she worried most about was her weight, but figuring out how to balance that against other concerns was stressful. She said: "Her BMI is right on that margin, the overweight margin. … I just wasn't as aware of what the sedentary nature of reading was doing, and I could've been more active about that in getting her up and getting her moving." She continued, "I want to be really careful around shame and body image and that kind of thing … so it sort of is letting her be, maybe letting is the wrong word, but knowing that she is overweight and that kind of thing. That she could be healthier. I'm going to err on that side versus err on the shame." Aria explained that she thought reading was an important part of her daughter's psychological well-being. She also felt reading made Charlotte a better student and helped her achievement and long-term socioeconomic well-being. Aria felt it was her job to try to balance Charlotte's physical health against emotional health and academic achievement. Aria believed she had been de-emphasizing the former to prioritize the latter and seemed to have some regrets. In all, though, Aria said she prioritized making sure her daughter grew up to become a confident, intelligent woman. That way, she explained, Charlotte would have the best chance at having a stable, secure life.

3.3. Prioritizing achievements and social understandings of health

As Erin's and Aria's narratives show, deploying broad understandings of children's health and well-being resulted in parents being unable to support all aspects at once—but also allowed them sometimes to de-emphasize some physical health considerations in favor of prioritizing social connections, achievements, or emotional health in order to address longer-term parenting goals. Whether as drivers of behavior or post hoc justifications, these priorities were reflected in some class-advantaged parents' decisions. Some parents talked about their children's achievements (typically academics, extracurriculars, or athletics) as very important to their overall well-being, now and in the future. Although parents were often reluctant to discuss it explicitly, some implied de-emphasizing sleep, nutrition, or exercise to prioritize schoolwork and extracurricular activities.

Sofia and Hector were achievement minded when it came to parenting, with particular emphases on academics and extracurriculars including sports. When we asked about their definition of health and what makes kids healthy, Sofia began by telling us, "I think everything has to be in balance to be healthy … it's important to have friends, it's important to exercise, it's important to eat well …" Hector briefly explained, "… watch sugar, salt …" before telling us, "[and] to know other cultures … we like that." Sofia and Hector moved the discussion to the importance of their children "doing what they want to do" and "a six-year degree in something with numbers," when explaining their long-term goals for their children's well-being. Throughout the remainder of our conversation, Sofia and Hector's emphasis primarily focused on their children's academics and athletics. They told us about their daughter Isabella's typical day, when she would sometimes leave very early for sports practice and arrive home several hours after school ended. Isabella was a multisport athlete, getting extensive exercise at the cost of sleep and consistent mealtimes. During our observation, Isabella had sports practices back-to-back and arrived home late.

After Isabella had left the room, we asked if this was typical. Sofia responded uncomfortably, explaining that some days are harder than others. She told us that on some nights her children get to bed as early as 8 or 8:30 p.m. because they "like to be at school early." We asked if she thought they were actually going to sleep or if they were staying up, to which Sofia seemed unsure. She looked over at Hector, who chimed in, "No, I see them [the lights] 9:30 on …" Sofia shifted the conversation, explaining that balancing her daughter's extracurriculars was difficult, but that they worked hard to make good choices, even being willing to "drop" activities when necessary. She told us, "So you have to readjust for all these changes and activities, and sometimes things get dropped … there's always a readjustment." Hector nodded and told us that "they were having trouble waking up the next day, you know, not having enough—they are working—but they are waking up early in a good mood, active." Here, Hector first admitted that his children may have been getting too little sleep but shifted the conversation to point out their "good mood" and ability to be "active."

Although Hector and Sofia often emphasized their daughter's achievements over her sleep and diet, they felt some discomfort in the process. Understanding why Hector and Sofia made these choices was important. In our interview, they discussed their ideas about long-term well-being and how their approach to parenting fit into this vision. We asked them about their hopes for their children's future lives. Sofia responded, "I hope they end up doing what they want to do, that they have that privilege that a lot of people don't." She explained that "working hard" gets you that privilege of autonomy, which she thought was so important. Hector told us, "A scientific education so they are able to understand the world." For Hector, an advanced degree in science would equip his children with the ability to "understand," which would help them to make good decisions, to be a "successful, healthy child" (and future adult). Sofia and Hector's understandings of health rested in Isabella becoming a person with power, control, knowledge, and the privilege to make autonomous choices. This narrative of well-being framed their choice to prioritize achievements, particularly through Isabella's involvement in science and athletics, as working towards something bigger and more important in the long term. However, it also required them to account for some short-term disadvantages around more private aspects of her physical health (such as sleep).

Some parents instead prioritized social, rather than achievement-oriented, aspects of health over other aspects. They explained that children's relationships and feelings of connection with family, peers, and community mattered a great deal for their health. When we asked Teri

how she balanced different aspects of her children's health, she responded, "Sleep, exercise, or more homework? It's crazy to have to choose." Teri described feeling pressure but ultimately decided that having some free time, even at the expense of getting homework done, was important. She told us, "They're in school for so long, and I want them to be able to play, and I think most people do [back off homework]." For Teri, time to play was important to children's well-being, reducing stress and giving them time with peers, creating bonds and strengthening relationships. Teri connected herself to other parents in her community who, she told us, made the same choice. This helped Teri to bolster her claim that her decision was a good, "normal" choice that she felt made sense to her local community. And in advantaged communities like these, Teri's work to build her children's social capital can promote their future socioeconomic well-being, as social networks are fundamental for reproducing socioeconomic status (Chetty et al., 2022).

Teri was similar to some other parents in thinking a lot about her children's education, but she was ultimately unwilling to prioritize academics over social connections. This became especially clear when she told us about her daughter Amelia's recent difficulties making friends at school. Teri was afraid Amelia was struggling emotionally and was stressed by tenuous relationships with a few peers and the school's emphasis on standardized testing. Teri decided to pull her daughter out of her prestigious school and place her in a less academically rigorous school with less testing and more children with whom she felt Amelia would get along. Teri felt doing this was fundamentally important to her health. "Social, emotional, and connection is the most important," she told us. Like others, Teri felt as though she was able to emphasize aspects of Amelia's health that she thought were more important than others, facilitated by class-based resources.

Unlike some others, Teri's priorities were less explicitly focused on future academic success. Yet when we asked what she ultimately wanted for her children, she said, "I just want [them] to be happy … that's all I want. Well, okay, first, let me take that back. They have to go to college, and then they have to be happy." Although Teri had just finished explaining that she prioritized other aspects of health over academic achievement, she amended her story in describing what ultimately mattered for Amelia's long-term well-being, reflecting continued tensions in the choices she was making for her children.

3.4. Justifying parenting priorities and choices for children's health

Although their broad understandings of health and well-being allowed parents to pursue future-oriented socioemotional and achievement goals under the umbrella of focusing on bolstering their children's health, the need to de-emphasize other aspects of health left parents potentially open to criticism. This pressure was apparent in the interviews, as Teri's account above shows. Despite often abundant resources and privileged positions, the parents in our study struggled with the impossible intensive parenting pressures to meet all expectations for supporting children's health and well-being. Parents had a difficult time talking about prioritizing some aspects of their children's health over others, and some who did respond with stories that accounted for their choices by attempting to justify why they were the right decisions.

Kyra discussed at length the importance of academic achievement and adhered closely to intensive parenting expectations, detailing the extensive time, energy, and money she had put into her children's schooling. She described their average days, which started early. She said her children "rushed" to and from school, tutoring, and multiple therapies. Kyra tried to bring them back to school towards the end of the day so they could get some extra practice socializing with peers. The day usually ended with dinner and reading. At the end of the day, Kyra said they were all "absolutely exhausted." Kyra's narrative implied prioritizing her children's social health, prioritizing both achievement and connection, over some (but not all) physical and psychological health considerations. This required an incredible amount of work on Kyra's part. She emphasized how important it was not to let her children fall behind because of what it would mean for them later in life. She told us how much she worked to support her children's holistic well-being, then shifted to using class as a defensive tool to demonstrate her good parenting: "We have the means to make those [good] choices. We're not operating financially on survival mode. With me being an educated stay-at-home parent and my husband being in a field that's very well compensated, we have the time, space, and money to make good choices."

Kyra went on to speak about dietary choices she made for her children, shoring up her focus on this area of physical health: "If I were to write down how much time we spent focused on food … it would be laughable to a family where both parents are working full time and they don't have the money to put into the easier-to-cook whole food things. … We are very fortunate. And we're definitely seeing like more than one-to-one rewards." Kyra emphasized her intensive parenting work around nutrition, while pointing to her privilege ("we are very fortunate") as an explanation for how she is able to dedicate abundant resources to her children's achievement.

Kyra did not seem comfortable directly discussing de-emphasizing aspects of her children's health (physical and psychological) to focus more on others (achievements and connections). This was understandable, considering the irreconcilable pressures placed on parents to follow intensive parenting guidelines and support all aspects of children's health simultaneously. Kyra's use of multiple reframing strategies and her family's income also demonstrated that class privilege mattered for her ability to attempt to adhere to intensive parenting, while also navigating aspects that were out of reach (such as supporting all components of her children's health at all times).

Kyra was not alone in drawing on her privilege to discursively manage the health choices she described making for her children. For example, Jessica worked throughout her interview to justify her good parenting in the context of full-time work. She talked repeatedly about feeling that certain extracurriculars were curtailed for her children because of her work, but at the same time espoused the need for "balance" and said her children felt almost "overscheduled." She concluded, "They both are active, and they've got a lot on their plates, so I just leave it at that." Bolstering her identity as a good parent around health, Jessica focused in the interview on her efforts to provide a good diet, "cook everything from scratch," and emphasize good sleep. Jessica had a child with a serious health condition, so her focus on bolstering physical health was expected (Rigles, 2019). Other class-privileged parents' narratives showed that when child health concerns were absent, they were able to use their children's current health and their high-resource lives as a currency of sorts. This implied that they could responsibly downplay certain aspects of their children's health—to spend their currency—because they had the resources, and their child had good enough health (typically physical), to protect their children's overall *long-term* well-being (that was multi-faceted).

Like Kyra, some parents' comments suggested that their class-advantaged positions allowed them to make tradeoffs now to set their children up for later. Class-privileged parents from well-resourced areas often appeared to take certain aspects of their children's health for granted, allowing them to emphasize social achievements to give their children a "leg up" in what they considered to be a hyper-competitive, class-insecure world (Chinn, 2011; Pugh, 2015). Articulating these efforts under the umbrella of a broad understanding of promoting children's health helped class-privileged parents justify their decisions in ways that seemed to reduce potential social judgments and helped bolster their own sense of being "good" parents.

Children's health is a moving target, and the parents in our study displayed flexibility in how they constructed understandings and explained choices as they adapted to uncertainty. Participants' narratives demonstrated attempts to draw on resources as they tried to control conceptualizations of how parents should support children's health and manage their own "good parent" identities in the process. Parents demonstrated how privileged social positions can assist in navigating the complexities of supporting holistic health and well-being as they

reconceptualize children's "health." These parents were able to use often abundant resources in their efforts to define and enact for themselves "what makes children healthy," even if they still bumped up against negative judgments associated with impossible intensive parenting expectations.

4. Discussion

Our interviews with 45 class-advantaged parents show that their understandings of children's health were all-encompassing, incorporating not only physical health, but emotional, achievement, and social aspects. These broad understandings constrained them by making it impossible to fully support all aspects of health. Yet they also gave parents the opportunity to prioritize achievement and social aspects over children's physical health—thereby seeking to ensure future success—-while still under the umbrella of improving their child's well-being. Although what it meant to support children's health and well-being varied across their stories, parents' relative privilege consistently underlay their explanations and sense-making. These parents, living in advantaged communities and often possessing considerable resources, illustrated the use of privilege in constructing children's health in ways that serve long-term parenting goals while sidestepping social and self-judgments for at times not meeting impossible parenting expectations around health-promoting behaviors. Parenting with an eye to long-term socioeconomic attainment is concordant with parenting with an eye to long-term health because of the strong association between social class and health across the life course (Link & Phelan, 1995). Also, social connections, which often yield social capital, are fundamental for socioeconomic attainment (Chetty et al., 2022). Perhaps class-privileged parents' focus on achievement and social connections as health/well-being reflects an understanding that class and health are deeply intertwined in individual lives.

We focus next on the implications of our study for families, health, and social inequalities, but they come with caveats. Our study's qualitative focus and resulting empirical depth helped us more fully articulate processes surrounding class-advantaged parents' understandings, strategies, and constraints, but it also limited the findings' generalizability to other places and populations. We did not interview children, so incorporating their perspectives on understanding and prioritizing health is important for future research. Additionally, the inclusion of sufficient numbers of both mothers and fathers in future work could flesh out how gender is intertwined with parenting and interacts with child gender. Similarly, sufficient samples of participants from different racial/ethnic groups would assist future research in teasing out how race intersects with class. We also note an exception to participants' predominant pattern of using privilege to justify de-emphasizing physical or psychological health. This exception involved families who included someone with a disability or serious health condition (Rigles, 2019). Parents in these families explained that they could not take physical or psychological health for granted and thus could not spend the "currency" of good physical health in de-emphasizing some aspects of it, despite their advantaged positions.

We argue that the processes uncovered in this research have implications for understanding parenting and families. Social positions along advantaged and disadvantaged lines matter to parents' understandings and lived experiences. A growing literature highlights the link between class and racial privilege and how parents make health choices for their children (Cairns et al., 2013; Reich, 2016; Ristovski-Slijepcevic, Chapman, & Beagan, 2008). As a general sense of economic and social insecurity has grown in the U.S. (Cooper, 2014; Pugh, 2015), perceived danger and risk for children has swelled despite evidence to the contrary (Elliott & Aseltine, 2012; Kurtz 2002), and parenting work has come under increased surveillance (Thelen & Haukanes, 2010). This creates pressure for parents to visibly demonstrate "appropriate" parenting. Disadvantaged parents (especially mothers) have long been targets of controlling images and public scrutiny that cast them as making poor choices for their children (Elliott & Bowen, 2018; Elliott et al., 2015).

While there are also judgments directed at more class-advantaged parents who make socially unacceptable choices for children's health (e.g., Reich, 2016), disadvantaged parents receive the lion's share of scrutiny and subsequent negative judgments. Advantaged parents are largely assumed to make health decisions for their children that adhere to community, expert, and institutionally set guidelines for supporting health (Reich, 2016). Our findings demonstrate that despite these stereotypes, advantaged parents cannot always consistently conform to all socially approved guidelines. Instead, they seek to navigate pressures by constructing and following their own understandings of health for their children in ways that allow them to justify their efforts as health-promoting according to their broad definitions.

As our participants demonstrated, privilege can work as a currency parents use to attach specific meanings to health and recast their choices as well-designed and necessary, involving a great deal of thought and energy and adhering to expectations of intensive parenting. In this way, our participants attempted to redefine situations to sidestep some of the pressures they would otherwise experience. Other literature has examined one end or the other of the privilege spectrum, but more work is needed that looks across levels of social advantage to uncover variations and similarities in parents' understandings and strategies.

These parenting processes and the social privilege that undergirds them yield important implications for child health. Labeling parenting efforts as being in service of children's health is a powerful discursive tool, given its importance for cultural capital, parenting, and morality in today's society (Mollborn, Rigles, & Pace, 2021). Participants used their privilege to emphasize and defend the importance of some aspects of children's health over others, prioritizing children's long-term social status or social capital in the ways that made the most sense to them. However, parents recognized potential problems and judgments in these priorities. To manage this, parents' narrative strategies pulled on their resources to explain why they believed these choices would not ultimately harm their children. Parents were able to buy into privileged communities they described as "safe" and "tight-knit" and as areas where physical health was already prioritized and supported in the community and school. Supporting children's health was a communal effort, and parents believed they could lean on the community to help achieve this goal. They also relied on their children's typically good physical health as a "currency" they could expend to achieve social health goals; implicitly, their social privilege supported this good health and thus its use as a currency spent to generate other types of health. Participants believed that their decisions to prioritize children's social achievements or social connections would pay off for adult socioeconomic attainment or social capital, which typically lead to favorable long-term health outcomes (Link & Phelan, 1995), although there is no way for our data to adjudicate whether this will ultimately be the case for the specific group of parents and children in our study. The complex role of privilege in these parenting processes and their role in supporting child health thus have potential implications for how inequalities are perpetuated across generations. De-emphasizing physical (and at times, psychological) health could potentially secure children's class futures, and the more privilege a parent has, the more they can use that privilege to justify those decisions.

Ensuring children's health and setting children up for secure, healthy futures is a complex and imperfect task for all families, as well as for policymakers. Many policies directed at improving family health do not integrate a nuanced understanding of what health means to different parents or the variation in resources they have when trying to support children's health. Policies directed at improving children's health must incorporate parents' understandings and positionalities to more fully reflect their lived realities. Our findings suggest that parents' understandings and choices concerning children's health may be shaped by their relative positions and the local spaces and cultures they parent within. If so, then solely providing parents with education and resources is not sufficient to uniformly support children's health. Even with many resources, some privileged parents in our sample struggled to

consistently meet the many demands around children's healthy behaviors such as sleep, low stress, or unstructured play. The COVID-19 pandemic placed further stress on parents around children's health and well-being. Our later longitudinal data collected during the pandemic, as well as other social research, can be useful for studying how preexisting understandings of health have informed parenting behaviors in this new, challenging context.

This analysis suggests that strategies meant to support children's health, including at the institutional, community, and individual levels, should incorporate a broader, more nuanced approach to understanding parents' and children's social positions, contexts, interpretations, and lived realities. Efforts meant to support children's health must be willing to question taken-for-granted stereotypes and beliefs about differently situated advantaged and disadvantaged families, acknowledging that intensive parenting pressures potentially harm all parents by making it impossible for them to meet social expectations for "good" parenting regardless of their resources.

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Declaration of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

American Academy of Pediatrics HealthyChildren.org. (n.d.). Healthy Living. https://www.healthychildren.org/english/healthy-living/pages/default.aspx.

Blair-Loy, M. (2009). *Competing devotions: Career and family among women executives*. Harvard University Press.

Cairns, K., Johnston, J., & MacKendrick, N. (2013). Feeding the 'organic child': Mothering through ethical consumption. *Journal of Consumer Culture, 13*, 97–118.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Los Angeles, CA: Sage.

Chetty, R., Jackson, M. O., Kuchler, T., Stroebel, J., Hendren, N., Fluegge, R. B., et al. (2022). Social capital I: Measurement and associations with economic mobility. *Nature, 608*(7921), 1–14.

Chinn, D. (2011). Critical health literacy: A review and critical analysis. *Social Science & Medicine, 73*, 60–67.

Coontz, S. (1992). *The way we never were: American families and the Nostalgia trap*. New York: Basic Books.

Cooper, M. (2014). *Cut adrift: Families in insecure times*. University of California Press.

Elliott, S., & Aseltine, E. (2012). Raising teenagers in hostile environments: How race, class, and gender matter for mothers' protective carework. *Journal of Family Issues, 34*, 719–744.

Elliott, S., & Bowen, S. (2018). Defending motherhood: Morality, responsibility, and double binds in feeding children. *Journal of Marriage and Family, 80*, 499–520.

Elliott, S., Powell, R., & Brenton, J. (2015). Being a good mom: Low-income, black single mothers negotiate intensive mothering. *Journal of Family Issues, 36*, 351–370.

Emerson, R. (Ed.). (2001). *Contemporary field research: Perspectives and formulations*. Waveland Press, Inc.

Fielding-Singh, P. (2021). *How the other half eats: The untold story of food and inequality in America*. Hachette UK.

Glassner, B. (1999). *The culture of fear: Why Americans are afraid of the wrong things*. Basic Books.

Hays, S. (1996). *The cultural contradictions of motherhood*. Yale University Press.

Holstein, J. A., & Gubrium, J. F. (1995a). *The active interview* (Vol. 37). Sage.

Holstein, J. A., & Gubrium, J. F. (1995b). Deprivatization and the construction of domestic life. *Journal of Marriage and Family, 57*, 894–908.

Kimbro, R. T., Brooks-Gunn, J., & McLanahan, S. (2011). Young children in urban areas: Links among neighborhood characteristics, weight status, outdoor play, and television watching. *Social Science & Medicine, 72*, 668–676.

King, M. D., Jennings, J., & Fletcher, J. M. (2014). Medical adaptation to academic pressure: Schooling, stimulant use, and socioeconomic status. *American Sociological Review, 79*(6), 1039–1066.

Lacy, K. R. (2007). *Blue-chip black: Race, class, and status in the new black middle class*. University of California Press.

Lareau, A. (2003). *Unequal childhoods: Class, race, and family life*. University of California Press.

Link, B. G., & Garcia, S. J. (2021). Diversions: How the underrepresentation of research on advantaged groups leaves explanations for health inequalities incomplete. *Journal of Health and Social Behavior, 62*(3), 334–349.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80–94.

Lofland, J., Snow, D., Anderson, L., & Lofland, L. (2006). *Analyzing social settings: Aguide to qualitative observation and analysis*. Thomson Wadsworth.

Mistry, R., McCarthy, W. J., Yancey, A. K., Lu, Y., & Patel, M. (2009). Resilience and patterns of health risk behaviors in California adolescents. *Preventive Medicine, 48*, 291–297.

Mollborn, S., Rigles, B., & Pace, J. (2021). "Healthier than just healthy": Families transmitting health as cultural capital. *Social Problems, 68*(3), 574–590.

Morrissey, M. E., & Kimball, K. Y. (2017). #SpoiledMilk: Blacktavists, visibility, and the exploitation of the Black breast. *Women's Studies in Communication, 40*(1), 48–66.

Nelson, M. K. (2010). *Parenting out of control: Anxious parents in uncertain times*. NYU Press.

Olson, L. N., & Simon, J. M. (2019). *An ideological analysis of breastfeeding in contemporary America: Disciplining the maternal body*. Lexington Books.

Patnode, C. D., Lytle, L. A., Erickson, D. J., Sirard, J. R., Barr-Anderson, D. J., & Story, M. (2011). Physical activity and sedentary activity patterns among children and adolescents: A latent class analysis approach. *Journal of Physical Activity and Health, 8*, 457–467.

Pugh, A. J. (2009). *Longing and belonging: Parents, children, and consumer culture*. University of California Press.

Pugh, A. J. (2015). *The tumbleweed society: Working and caring in an age of insecurity*. Oxford University Press.

Reich, J. A. (2016). *Calling the shots: Why parents reject vaccines*. NYU Press.

Rigles, B (2019). The development of health lifestyles in families experiencing disability. *Journal of Family Issues, 40*(7), 929–953.

Ristovski-Slijepcevic, S., Chapman, G., & Beagan, B. (2008). Engaging with healthy eating discourse(s): Ways of knowing about food and health in three ethnocultural groups in Canada. *Appetite, 50*, 167–178.

Scott, M. B., & Lyman, S. M. (1968). Accounts. *American Sociological Review, 33*, 46–62.

Shirani, F., Henwood, K., & Coltart, C. (2012). Meeting the challenges of intensive parenting culture: Gender, risk management and the moral parent. *Sociology, 46*, 25–40.

Thelen, T., & Haukanes, H. (2010). Parenthood and childhood: Debates within the social sciences. In *Parenting after the century of the child: Traveling ideals, institutional negotiations and individual responses* (pp. 11–32). London: Ashgate.

Velardo, S., & Drummond, M. (2013). Understanding parental health literacy and food related parenting practices. *Health Sociology Review, 22*(2), 137–150.

Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender & Society, 15*, 592–610.

Wills, J. (2009). Health literacy: New packaging for health education or radical movement? *International Journal of Public Health, 54*, 3–4.

World Health Organization. Constitution of the world health organization (n. d.) https://www.who.int/about/governance/constitution.