"Everything is Connected": Health Lifestyles and Teenagers' Social Distancing Behaviors in the COVID-19 Pandemic

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Abstract

Social distancing during the COVID-19 pandemic requires people to engage in new health behaviors that are public, monitored, and often contested. Parents are typically considered responsible for controlling their children's behavior and instilling norms. We investigated how parents and teens managed teenagers' social distancing behaviors. Analyzing 100 longitudinal (2015-2020), dyadic qualitative interviews with teenagers and their parents in 20 families from two middle-class communities in which social distancing was normative, we found that preexisting health lifestyles were used to link social distancing behaviors to specific identities, norms, and understandings of health. The pandemic presented challenges resulting from contradictory threats to health, differing preferences, and conflicting social judgments. Parents responded to challenges by adhering to community norms and enforcing teens' social distancing behaviors. They drew on preexisting, individualized health lifestyles as cultural tools to justify social distancing messages, emphasizing group distinctions, morality, and worth in ways that perpetuated inequalities.

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In the COVID-19 pandemic, many have been asked or required to engage in "social distancing" behaviors, defined as minimizing interactions, wearing masks, and staying 6 feet/2 meters apart (Goldberg, Gustafson, Maibach et al. 2020). Social distancing behaviors, which are new health behaviors for most in the US, have rapidly become imbued with outsized cultural meanings (Kushner Gadarian, Goodman and Pepinsky 2020, Oosterhoff, Palmer, Wilson et al. 2020). As publicly performed, contested behaviors that directly impinge on others' health, social distancing behaviors may be particularly influenced by group-level processes.

Young children are exempted from some social distancing recommendations, but teenagers are typically expected to follow them. Parents are de facto enforcers of social distancing guidelines for teenagers, and as with other adolescent behaviors, parents are often judged if their teenage children do not comply. Because of their lower risk of dying from or developing serious complications of COVID-19 (Centers for Disease Control and Prevention 2020), teenagers could be less motivated than their elders to socially distance. These conditions set up a challenge for parents and teenagers. Here, we investigated *how parents and teens managed teenagers' social distancing behaviors in two middle-class communities in which social distancing was normative.* We analyzed longitudinal interview data with parent-teen dyads, spanning four waves of data from 2015-2020, to examine how parents and teens drew on earlier health lifestyles, identities, and understandings of health to make sense of, enforce, or resist new social distancing behaviors. Previous data allowed for longitudinal analyses of how social distancing fit into

earlier narratives and health lifestyles. The findings contribute to the literature by illuminating how norms and identities emerge around new health behaviors and articulating processes through which new health behaviors are incorporated into existing *health lifestyles*—an individual's set of health behaviors that are undergirded by group-based identities, norms, and understandings of health (Cockerham 2005).

This study's findings underscore the importance of a health lifestyle approach for understanding how teenagers and parents manage teens' social distancing behaviors. Health lifestyles are an important construct for understanding health behaviors and their embeddedness in social groups and structures (Cockerham 2005, Korp 2008). While health lifestyle behaviors are often measured, the social psychological processes undergirding them have rarely been analyzed using empirical data. The COVID-19 pandemic upended families' health lifestyles, resource configurations, and everyday interactions. Thus, pandemic responses can illustrate how families deal with sudden changes and threats when new health behaviors are emerging rapidly. Families' decisions and narratives during this crisis may shed important light on how they think about and deploy health lifestyles. This can provide insight into the perpetuation of inequalities, as research has found that health behaviors are increasingly used as a form of cultural capital that reinforces the advantages and morality of privileged groups (Bourdieu 1986b, Luna 2019, Mollborn, Rigles and Pace 2020).

Our analyses found that families attempted to balance multiple threats to teenagers' health during the pandemic, with risks of viral exposure pitted against risks from compromised lifestyle behaviors, mental health, and opportunities for cognitive and social

development. Preexisting health lifestyles led families to subscribe to differing notions of balance and seek to accommodate social distancing in distinct ways. Despite variation in their personal opinions, parents consistently enforced social distancing behaviors with their teens. Parents relied on the preexisting health lifestyles they had been working to instill in their children in making sense of how to manage teenagers' social distancing while minimizing other negative impacts. To enforce social distancing, parents encouraged their teens to internalize identity statements, group distinctions, and ties between social distancing and morality. In doing this, parents drew heavily on health lifestyles. When some parents made exceptions to social distancing, they also justified these decisions using health lifestyles. Ultimately, teens tended to conform to community social distancing norms, driven by internalization of parents' messages and a combination of parental control and teen agency. These findings illuminate how norms and identities emerge around new health behaviors and processes through which new health behaviors are incorporated into existing health lifestyles.

BACKGROUND

Parenting, Health Lifestyles, and Inequalities

Even before the COVID-19 pandemic, researchers documented rising stresses and competing pressures for contemporary US parents. The dominant ideology of *intensive parenting* (Shirani, Henwood and Coltart 2012), which particularly targets mothers (Hays 1996), demands that parents expend more time, energy, and money than was typical in previous generations to closely manage every aspect of their children's lives. Intensive parenting builds social, human, and cultural capital (Bourdieu 1986b), resulting in

inequalities, as some families can expend more resources on these demands than others to safeguard their children's future status (Duncan and Murnane 2011, Milkie and Warner 2014). These pressures are experienced by US class- and race-advantaged and disadvantaged mothers alike (e.g., Blair-Loy 2003, Elliott, Powell and Brenton 2015). Tensions around intensive parenting play out within a broader "culture of fear" (Glassner 2010) around children's safety, well-being, and future economic stability (Cooper 2014). The combination of intensive parenting pressures, a culture of fear around childhood, and increased public scrutiny of many parents' behaviors (Thelen and Haukanes 2010) shaped contemporary parenting experiences during our pre-pandemic data collection.

As part of these trends, *intensive parenting around children's health* has increasingly become tied to parents' morality and worth (Elliott and Bowen 2018). For example, scholarship has articulated processes through which differently situated people defend their own morality and identities as "good" parents by feeding their children in certain ways and by crafting narratives around these practices, such as talking about keeping their children "pure" by feeding them organic foods (Cairns, Johnston and MacKendrick 2013, Elliott and Bowen 2018).

Such links between health behaviors and underlying identities, group norms, and understandings of health are the focus of a growing sociological literature on *health lifestyles*. Health lifestyles are features of both individuals and groups, blending structure and agency (Cockerham 2005). The idea that people choose a lifestyle from those available according to their social position dates back to Weber ([1921] 1978). Health lifestyles bridge individuals and collectives (Frohlich and Potvin 1999) because they integrate an

individual's constellation of health behaviors that arise from group memberships with group-level processes such as identities and norms. Parents have considerable control over children's health lifestyles in early life, and a "received" health lifestyle develops into an "achieved" health lifestyle as children age into adolescence and beyond (Mollborn, James-Hawkins, Lawrence et al. 2014).

Health lifestyles are not just a theoretical construct used to contextualize a person's health behaviors and understand why specific behaviors are often resistant to change if the lifestyle that undergirds it is ignored. Health lifestyles are also deployed by privileged groups as cultural tools to *create distinctions between social groups* by shaping cultural capital, leading to inequalities by condemning less advantaged groups for "choosing" "inferior" health behaviors (Bourdieu 1986a, Korp 2010, Mollborn et al. 2020, Williams 1995). The linking of morality and discipline to specific health behaviors and bodily appearances that are typical of advantaged individuals (Cairns and Johnston 2015, LeBesco 2011, Luna 2019, Saguy and Gruys 2010) furthers these processes of distinction, putting more pressure on parents to enact specific health lifestyles for their children (Cairns et al. 2013, Elliott and Bowen 2018).

Health lifestyles in adults are often measured using combinations of behaviors, including developmentally appropriate behaviors such as car seat use for preschoolers and seat belt use for teenagers (e.g., Burdette, Needham, Taylor et al. 2017, Hill, Ellison, Burdette et al. 2007, Mollborn et al. 2014). What has not been studied is *what happens to people's health lifestyles when new health behaviors emerge*. How do people make sense

of and enact new health behaviors? How do they integrate them into their existing health lifestyles, or alternatively, change their health lifestyles to incorporate new behaviors?

Health Behaviors and Health Lifestyles during COVID-19

The COVID-19 pandemic has rapidly altered human experiences in ways that will reverberate for years (Settersten, Bernardi, Härkönen et al. 2020). For many, changes to everyday life have strongly influenced health behaviors including physical activity, diet, sedentary and screen time, sleep, and substance use. Beyond these shifts, *new health behaviors*—at least in the US—have emerged as social distancing measures have been enacted to slow the spread of the virus. Rooted in scientific evidence (e.g., Cheng, Wong, Chuang et al. 2020, Zeng, Li, Ng et al. 2020), state and local governments, and at times the federal government, have recommended or required social distancing measures such as sheltering in place, staying six feet apart, and wearing masks. These guidelines have varied over time and place within the US, resulting in variation in levels of social distancing (Goldberg et al. 2020, Katz, Sanger-Katz and Quealy 2020). Social inequalities have also shaped who is able to social distance and who is more at risk for contracting COVID-19 (Garcia, Homan, García et al. 2020).

We focus on *teenagers' social distancing behaviors*. Based on evidence about the impacts of cataclysmic events such as the Great Depression on the life course (Elder 1974), scholars expect the COVID-19 pandemic to have a stronger long-term effect on the lives of surviving children and youth compared to many adults (Settersten et al. 2020). Yet children and adolescents experience much lower rates of serious illness and mortality from COVID-19 (Centers for Disease Control and Prevention 2020, Vermund and Pitzer 2020),

potentially influencing their perceptions of risk. Indeed, an early social media-based study of adolescents found that being socially responsible and not wanting others to get sick were by far teens' strongest motivations for engaging in social distancing (Oosterhoff et al. 2020), while concern about getting sick themselves was less prevalent. Most teens in that study reported engaging in social distancing "a great deal" or "a lot." Parents' social distancing rules, local lockdowns, and demographic characteristics such as race/ethnicity (white and Hispanic respondents were less likely) and class (those with more highly educated parents were more likely) also shaped teens' likelihood of socially distancing (Oosterhoff et al. 2020). Early research on adults found that Democrats were more likely to engage in various social distancing measures compared to Republicans (Kushner Gadarian et al. 2020).

During the pandemic, understandings of health—an important underpinning of health lifestyles—likely changed, as exposure to infectious disease assumed renewed importance in a context where chronic conditions have long dominated mortality (Masters, Hummer, Powers et al. 2014). The emergence of and extreme importance frequently assigned to social distancing behaviors suggest that they may have rapidly become part of health lifestyles, at least in contexts where they are normative. Understanding how this happened can inform literatures on health lifestyles, health behaviors, and inequalities.

The tensions that tend to occur between parents' and teenagers' control over teenagers' behaviors (Elliott 2012, Schalet 2011) add additional complexity for understanding teens' social distancing and the implications of these behaviors for teenagers' health lifestyles. Because social distancing behaviors are publicly performed

and because of evidence that wearing a mask protects others more than the wearer, conditions are ripe for teens' social distancing behaviors to feel especially important to others and for teenagers and their parents to feel judged if they violate local norms.

METHODS

Data

This study analyzed longitudinal qualitative data collected in two neighboring middle- to upper-middle-class US communities between 2015 and 2020. The primary data source was 100 interviews conducted across four waves of data collection with parents and teenagers from 20 families. Additional contextualizing data came from earlier in-home observations and focus groups with members of some of these families; observations, parent interviews, and community focus groups with other families; and key informant interviews with adults who worked with children in the communities.

Wave 1 was collected in 2015-2016 in the US interior West. We recruited participants broadly for a study on "parents, kids, and well-being," diversifying the sample by identifying participants from different community segments (Lofland, Snow, Anderson et al. 2006) through social media postings, email listservs, referrals, personal contacts, and public flyers. The resulting nonrepresentative sample was sociodemographically varied and included many neighborhoods, social networks, and families from 23 elementary schools plus homeschoolers. Thirty-three interviews were with parents from 30 fourth- or fifth-grade families who also participated in home observations, and 21 were with parents of elementary-aged children who only participated in an interview. 20 of these families ultimately participated in 2020.

Wave 1 in-home observations lasted several hours on a weeknight, and community-specific focus groups included some interview participants and other parents. Semi-structured interviews covered diverse topics related to children's well-being and health-related behaviors. We focused on elementary age because families strongly influence children, joined by community, schools, and peers. Our study design, data collection, and instruments were refined through pilot research and abduction (Timmermans and Tavory 2012) that led us to sample from multiple communities.

At Wave 2 two years later, 21 Wave 1 parents from 20 families—mostly observation families—were re-interviewed. Of these families, 18 participated in 2020. Interviews focused on technology use but also investigated the transition to middle school that children in nearly every family had experienced.

Wave 3 was conducted with 23 parents from 20 families, using online interviewing in April-May 2020. Data collection occurred during and immediately after a statewide COVID-19 stay-at-home order, with schools closed and most people working from home. We first collected baseline data about the teen's pre-pandemic everyday life, health lifestyle, and technology use for fall 2019, then collected information about the same phenomena during the pandemic. Most families had at least one child in high school.

In Wave 4, we conducted online interviews with 24 teenagers from 18 of the 20 families who had participated in Wave 3. Their ages ranged from 12-18, averaging 15. All but one of these interviews were conducted in July-August 2020, when a statewide "safer at home" order was in place and all but one family (who lived in a neighboring county)

were required by county regulations to wear masks and practice social distancing. Teens usually sat in a private space for the interview.

Across study waves, we followed the 20 families for almost five years as their children progressed from elementary school into middle, then high school. We compared families' health lifestyles and narratives in the two waves before the COVID-19 pandemic with the two waves of interviews collected during the COVID-19 pandemic and compared parents' and (sometimes multiple) teenagers' data from the same family during the pandemic. Throughout the study, participants were paid $50 for a standalone interview, focus group, or key informant interview; or $200 for a home observation with parent interview. Each wave was institutional review board approved.

Wave 1 parent participants' average age was 43, and 80 percent were mothers. 77 percent were married, 17 percent divorced or separated, and small numbers single or widowed. 86 percent of parents identified as white, 8 percent Asian American, and 6 percent Latino, so we had little capacity to analyze data based on racial/ethnic variation. Some parents and very few teens were foreign born. Children at Wave 1 ranged from ages 2 to 15, with at least one fourth or fifth grader (ages 9-11) per family. Based on parent and partner education, occupations, and observed housing, we roughly classified 59 percent of Wave 1 families as upper-middle-class, 29 percent middle-class or mixed socioeconomic status (e.g., higher income but lower education), and 12 percent working-class or poor.

Community Sites

Each wave's sample was roughly divided between the communities (which, like participant names, are represented by pseudonyms). They are middle- to upper-middle-

class mid-sized cities within the same large metropolitan area (US Census Bureau 2017). The communities have many demographic similarities. Their median household incomes are near the state average, and their high proportions of residents identifying as white are somewhat above the state average. One fourth of Springfield's population identifies as Latino, almost three times higher than Greenville. Greenville's median housing value is double Springfield's, and nearly twice the proportion of residents (about 75%) hold a Bachelor's degree in Greenville compared to Springfield (US Census Bureau 2017). Both communities have higher rates of healthy behaviors and lower obesity rates than many demographically similar places. Importantly, *social distancing was strongly normative in these communities*, reflective of their location in a politically liberal county during a time when social distancing represented a strong political dividing line. When asked, "How often do you wear a mask in public when you expect to be within six feet of another person," about 80 percent of respondents in these communities answered "always," resulting in about a 75 percent chance that across five random encounters, everyone would be masked (Katz et al. 2020). Interview data supported these pro-social distancing community norms.

Analyses

Electronic copies of interview transcripts were manually coded. We coded social distancing-related content at Waves 3 and 4. We read entire transcripts to identify important emergent themes, which were then coded in other transcripts. Many themes discussed here came from this category. Health lifestyle-related content, which emerged as important, was previously coded in Waves 1 and 2. Finally, we conducted longitudinal and

dyadic analyses of teens' and their parents' Wave 3 and 4 interview transcripts, combined with Wave 1 and 2 interview transcripts and Wave 1 observation field notes for that family.

Our methodological approach was inductive and interpretive, using data to explore processes through which parents and teens made sense of, communicated about, and performed social distancing behaviors. Our analysis focused on narratives and their implications for health, families, and inequalities, grounded in what participants told and showed us about their experiences and sense-making (Lofland et al. 2006). Our goal was not to adjudicate whether social distancing was good or bad or to what extent parents should influence teenagers.

RESULTS

Analyses combined data on the study's families from all four waves, embedding pandemic responses in earlier health lifestyles. We found that the pandemic presented challenges resulting from contrasting threats to teens' health, differences between parents' and teens' preferences, and conflicting social judgments. Regardless of their personal opinions, parents responded to these challenges by adhering to community norms and enforcing social distancing behaviors for teens. They drew on preexisting, individualized health lifestyles as cultural tools to justify and communicate social distancing messages to teenagers, emphasizing group distinctions, morality, and worth in ways that perpetuated inequalities.

New Health Lifestyle Challenges

Our analyses show that families were challenged by competing threats to teenagers' health during the pandemic. *The threat of exposure to the COVID-19 virus conflicted with*

threats from compromised lifestyle behaviors, mental health, and opportunities for cognitive and social development. The spring 2020 stay-at-home order, transition to online schooling, and social distancing regulations in this study's state and county were intended to protect people from contracting and spreading COVID-19. Yet these protective health measures resulted in negative impacts on other areas of health. As parent Pam put it (see Table 1 for demographic characteristics of all quoted participants), "the social piece is torture" for teenagers. Teenager Victoria elaborated:

> [The stay-at-home order] impacted my mental health, my physical health, my connections with my friends, my leaving the house, normal life. Everything is connected. Everything shut down because of the pandemic. It's so much harder to be active. It's so much harder to find motivation. Just feeling lonely all day because you don't have your friends. I think the teenage mind needs peers the most. … I need people who are similar ages to me. Not having and just being completely cut off from them impacted me in so many ways.

As stay-at-home measures eased in summer, Victoria felt these other aspects of health improved: "As things have started to open up, it's definitely gotten better. I hang out with my friends every day. I go outside. We try not to be inside too much, and if we go anywhere, we wear masks." Victoria felt a balance between social distancing and interpersonal interaction improved her health in ways that she considered particularly important for teenagers. Her statement that "everything is connected" emphasizes how participants considered social distancing behaviors, even though they were totally new, to be embedded within a web of interrelated health lifestyle behaviors.

TABLE 1 HERE

Different people had different notions of appropriate balance between new health behaviors intended for protection from the virus and preexisting health behaviors impacting

other aspects of health. The *health lifestyles* to which they subscribed before the pandemic led them to value some aspects of health over others, even as the pandemic and new social distancing behaviors presented challenges to their priorities. Some people, like parent Jessica, felt that avoiding face-to-face friendship interactions was wisest and that healthy diet and exercise, which were very important to her previously, could be managed in the absence of social interaction. Others, like teenager Oscar, subscribed to a different balance in which social distancing guidelines should be relaxed substantially to instead support social interaction and mental health—priorities he had long held. Oscar said, "I feel like it's stupid to be this cautious. … I think it's more of a danger to be that isolated than the actual disease is. … Definitely, from a mental health standpoint, I feel like that's way more dangerous than actually getting the disease." He viewed himself as having lower health risk than his parents because he enacted a different kind of balance, spending a lot of time with friends.

Regardless of how participants thought they should balance these threats, they considered sacrifices to their ideal health lifestyle necessary to accommodate social distancing. Parent Laura told us that the pandemic had been stressful for her family, with her children struggling from having missed out on special milestones and extracurricular activities. She was concerned about their mental health, noting that they seemed sad and uncommunicative and were sleeping too much. For Laura, the way to address these mental health issues was not to ease social distancing, but to be less strict about health behaviors such as diet, exercise, and screen time. She told us, "I've been trying not to be hard on them. If they want to bake cookies, they can. If they want to watch five movies in a row, I

let them. Just kind of let them do what they need to do, and don't worry about it right now." Laura, like most other parents we interviewed, considered this balancing act to be parents' job to manage, and she implicitly judged herself for struggling. The emotional tenor of the pandemic interviews with parents was charged with stress, as most emphasized the difficulties of balancing different health threats. In contrast, most teenagers seemed less stressed in interviews and tended to anticipate fewer longer-term effects of the pandemic.

Although the COVID-19 pandemic and social distancing behaviors were new, parents readily fit them into an existing framework of intensive parenting around health. The idea that parents are supposed to intensively manage their children's health by carefully balancing its various aspects is not unique to the COVID-19 pandemic (author forthcoming). Parent Caitlin articulated these expectations pre-pandemic:

> I think it's stressful being a parent. I think you have to be very confident and comfortable in what you're doing because I feel like I'm doing a pretty good job. There's always ways I can improve. … It's all about choices. … I think that you have to weigh the balances and weigh what works for you and your family. Like, I could do more for my kids.

For Caitlin as for many others we interviewed, parenting healthy children is a balancing act that parents can never get completely right and for which parents are constantly judged.

Besides managing new threats to health, families were also negotiating competing pressures around social distancing. For parents and teens, managing teenagers' social distancing behaviors *pitted judgments from community members against real or imagined pushback from teenagers*. Social distancing behaviors, being public, high stakes, and contested politically, were ripe for judgment. Teenager Elinor said, "In Greenville, if you don't wear a mask, you'll probably get judged, or you might get denied service in some

places, I think, if you don't have a mask or if you don't social distance." Springfield residents also considered social distancing normative and judged in their community.

Victoria—the teenager who described the balancing act of COVID-19 and health above—and her mother Karen illustrate this tension between social judgments and teens' preferences. Karen described the importance of others' judgments for her efforts towards enforcing social distancing with Victoria:

> The judgment part has been really hard, trying to talk about that with [Victoria]. Because everyone judges everybody, and we do, too. Like, why aren't you wearing your mask? And, well, how come you're letting your kid do that? … And I'm pretty adamant about the gloves and the masks. So I wear them everywhere. And even when the kids are walking the dog, some lady yelled at my daughter, so now she doesn't like being yelled at, so she wears it now. But it's hard when you're running and hiking. Ugh, glasses get all fogged up. … So it's hard to know whether I should expect them to wear it or not, or is it okay if they don't wear it? Is it a reflection on me?

Karen was acutely aware of her children's needs, her parenting, and others' judgments of her when publicly enacting social distancing behaviors. Andrea and Brian summarized these tensions for parents: "How do you keep it so you stay safe, but you don't get paranoid?"

These social pressures conflicted with widespread perceptions of teens' preferences. Karen's daughter Victoria noted that teenagers in general had reason to be less motivated to socially distance compared to adults:

> I think the likelihood of kids getting sick is less than adults, so adults are more motivated. They're going to be better about wearing their masks than kids are, and they're more aware of social distancing. But I think kids and teens and that generation is a lot less aware of it. We're more, "Whatever. We don't have to be six feet. We don't have to wear a mask. We'll be fine."

Yet Victoria's *own* motivation to social distance, as was typical for many other teens we interviewed, was stronger than her perception of peers' motivations. Instead, Victoria noted conflicting "peer pressures" and "huge judgments" "around the teenage world" regarding mask wearing that were distinct from the uniformly pro-social distancing pressures her mother described. Victoria said teens were judged no matter what they did: "There's high expectations. If you see people that don't wear [a mask] and you're wearing yours, they judge you, because they're like, 'Why are you wearing that? No.' Then there are those people who are more accepting of it and are like, 'Yeah, we need to wear a mask.'" These social pressures on parents versus teens that Victoria and Karen described led to tensions between them. Some teens faced judgment from adults as "irresponsible," and some parents faced judgments from their teenage children as "paranoid" or "germophobes."

Responses to New Challenges

Given these two difficult challenges, it is not obvious what parents' rules and teens' social distancing behaviors would actually be. But in our data, the answer was clear: Among families still living in our study communities (all but one, discussed below), *parents said they were enforcing social distancing behaviors with their teens in ways that aligned with community norms*—although some made specific exemptions to the rules (see below). By and large, *teens' accounts of their own social distancing behaviors also adhered to these norms*. This was true for Victoria and Karen. Although Victoria at times questioned the need to socially distance, she said she practiced social distancing and only met friends face to face if they were masked and properly distanced.

Teens usually reported practicing social distancing. Hazel described teenagers' compliance: "Well, I think adults take it a lot more seriously than teens, but teenagers also just do whatever their parents tell them. So if their parents are like, 'Oh, you don't need to do anything,' then they won't stay six feet apart and they won't wear masks. But if their parents are like, 'You have to do it,' then they'll be like, 'Okay, fine.'" Although Hazel describes unquestioning compliance, some teen participants negotiated specific social distancing exemptions from parents, mostly to see friends. When away from the family, teens presumably had agency to decide whether to follow parents' social distancing guidelines.

Community members' perceptions of teenagers' social distancing behaviors often matched what we heard from participants. Parent Kim favorably compared the social distancing behaviors of community members who were members of families with those of college students. She said, "I think high school kids in this community—because of their parents, right? And the fact that they've had to leave school early and go to online learning, right? And they have deeper ties into this community—I think even a lot more of the high school students that I know of and see are being much more responsible." Kim linked social distancing to morality: "I know because of being in touch with other parents who have high school aged kids, none of them are having sleepovers. None of them are having birthday parties. They're not often doing things [with friends]. But if they're rarely doing things, like bike riding, they are doing it with some elements of responsibility." Kim equated social distancing with responsibility, praised local teenagers for practicing it, and attributed that success to their parents and community.

Although most parents agreed with the pro-social distancing norms in our study's two communities, a few parents also talked about *disagreeing with the need for careful social distancing*. Yet these parents *ultimately enforced community norms*, like others in the sample. The three parents who had previously told us that they had chosen not to vaccinate their children all expressed some degree of disagreement with the need for social distancing and distrust in the government's social distancing recommendations. Pam said, "Myself, I'm one of those rare people who doesn't have a strong opinion on it [social distancing], because it just feels like we don't have enough information yet to know." But like the others, Pam ultimately yielded to the will of the community. She said, "What I have learned is that people have very strong opinions on this one way or the other. … What we are doing as a family [is] when we are out in public, we are wearing masks, … more out of respect to the community than out of concern for our safety." Pam obscured her personal misgivings and communicated the same identity and morality to her children as did parents who fully supported social distancing, using statements about what "we" do and drawing on moral concepts such as "respect to the community."

Lynn's communication around social distancing drew more on rule following than on morality, but she too encouraged her daughter to conform to community norms. She said:

> Maybe you are healthy, and you can get sick and nothing is going to happen to you. But public health says, you have to wear a mask, you need social distance. You have to follow the law. … There are consequences of not following [laws around mask use]. And it doesn't matter if you agree with them, but we need to follow them because some of the other consequences can be worse than following them. We are definitely enforcing wearing masks.

Justifying Social Distancing Using Preexisting Health Lifestyles

The new challenges that arose from needing to socially distance while managing other aspects of teens' health, and balance social pressures on and motivations of teens versus adults, were solved by parents and teens through adherence to broader community norms. Even when they did not fully agree with them, parents ultimately enforced community norms around social distancing. *We found that in doing this, parents relied heavily on their preexisting health lifestyles to make sense of how to manage teenagers' social distancing while minimizing other negative impacts to health.* We show how parents' earlier health lifestyles shaped their approaches to social distancing, prioritization of social distancing within an interrelated web of health behaviors, and strategies to influence teenage children's behaviors.

Earlier waves of data collection found that parents in these class-privileged communities articulated carefully crafted health lifestyles for their children. Although these lifestyles were *presented as individualized narratives customized to particular children* that relied on distinct values and understandings of health, they *ultimately prescribed similar, socially classed performances of health* that adhered to community norms and yielded cultural capital for children (author 2018, 2020). Similarly, during the pandemic, *families relied on their pre-existing individualized health lifestyle narratives* to dictate and justify their management of teens' social distancing behaviors as a public, highly salient performance of health. But although different individualized health lifestyles prescribed prioritizing different aspects of health as described above, these *individualized narratives led to high conformity in social distancing behaviors following local norms*.

Andrew and Helen exemplified how individualized health lifestyle narratives shaped the management of teenagers' social distancing. In past waves, Andrew described feeling that societal cohesion had declined, especially among younger people, because of increasingly prevalent technologies that led children to have less, and less meaningful, social interaction. In response, Andrew and Helen fostered a health lifestyle narrative for their daughter Nicole that encouraged self-sufficiency, connection to family, and attention to stress and diet. Reflecting his earlier narratives, Andrew's opinion of community members' social distancing behaviors was dim: "A lot of people not wearing masks. I don't see them keeping their social distance. … My perception is a lot of people don't think it's very serious… [But] it just takes enough people out there, sick, integrating with enough people, and then it just explodes exponentially. I don't think people realize that." Andrew explained that while he consistently wore a mask, many others did not. "[At Walmart], I saw a woman, a young girl … working where you go in and out, … not wearing a mask. So if she was sick, she could potentially get other people sick." Andrew and Helen taught Nicole to wear a mask and judge those who did not. Helen explained, "[Nicole] knows to wear a mask. She knows to stay away from other people, and she'll come back and report and tell us how many people were wearing masks. … We talk about it all the time." Andrew and Helen were explicitly teaching Nicole to respond to the pandemic in ways that reinforce their preexisting health lifestyle narrative: to approach social distancing deliberately, pay attention to scientific evidence, not trust others, and take responsibility for her own health in an anomic world.

Although Helen and Andrew focused heavily on social distancing and infection risk, other parents' health lifestyle narratives emphasized other aspects of health. Carol similarly worried about infection risk, but her focus (carried over from her earlier health lifestyle) was on physical health behaviors, which she argued were crucial for boosting immune defenses. She emphasized that her messages to her teenagers during the pandemic strongly reflected her earlier health lifestyle. Carol told us:

> Before the virus, I would talk to the kids, and I said that there are three things: You need enough sleep, you need exercise, and you need to eat well. I still think that's the same [during the pandemic] because you can't control the outside. You could get the flu, you could get coronavirus, you could get cancer, whatever. But, I mean, you take those steps. You work to keep at your optimum and deal with whatever happens, right?

For several parents who had earlier prioritized within-family social relationships as fundamental to their health lifestyle, the pandemic actually solved some problems of everyday life. Robyn previously articulated that she viewed time with family as the prescription for good health because it reduces stress:

> When I'm balanced, there's just a lower stress level in my life. I think being healthy is having enough fresh air in your day and having good food to eat, having exercise, having family time, having friend time. I feel that's what I do in my life. For myself and my family, I try to puzzle together—like balance it out, so that we're all getting nourished on all those levels. … And sometimes it's unbalanced. So it's like, okay, we need to have some family time. … I kind of orchestrate it, I think, in our family.

Robyn carefully "orchestrated" balance in her family toward the goal of well-being and health, viewing "family time" as a treatment to heal stress and imbalance. Social distancing measures made it easier to apply this treatment. During the pandemic, she said, "I feel like just overall that our stress in the home has really decreased. … For us, I feel like it's been a blessing, actually, to just slow down and unplug a little and have more time, just have

more time to not be so scheduled." She thinks her son Aidan interacting with just three close friends has further contributed to the pandemic being "really good" for him. Like those of some other parents, Robyn's preexisting health lifestyle narrative helped her incorporate social distancing without threat.

Communicating Social Distancing Norms Using Preexisting Health Lifestyles

Parents not only used preexisting health lifestyles to justify social distancing; they were also a tool for communicating and enforcing teens' social distancing behaviors. As some parents' narratives have articulated, a primary strategy to influence teenagers' social distancing behaviors was to *explicitly communicate health lifestyle messages to teens in hopes that they would internalize the links parents drew between social distancing and specific identities, group distinctions, and notions of morality and worth*. The goal of internalization was attractive because if it could be achieved, the teen would act agentically to adhere to social distancing norms without parents needing to control their behaviors. But we found this internalization of parents' messages may also strengthen social inequalities.

Robyn recounted her communication with Aidan about social distancing:

> Whenever we go biking, or hiking, or out to the stores, whatever, Aidan knows … to do the social distancing or the mask-wearing. … It's like, he understands it, and he kind of takes it seriously, and he washes his hands. Of course, we were educating him, like, 'Before you go do anything or go outside the house, wash your hands, wash your hands, wash your hands.' So I feel like it's just become part of what we do. … And as we just get educated about it, we're just following the rules so that we can protect the greater community.

Robyn articulated communicating two important aspects of her health lifestyle to Aidan: a family *identity* described above (with several references to what "we" do), and links between social distancing behaviors and *moral* notions of "respect" and "responsibility."

She emphasized that Aidan had *internalized* her "education," as evidenced by Aidan reminding her to put her mask on around others. This combination of identity and morality talk was common among our parent participants. Laura used medical information to "educate" her children about COVID-19 and what "we" do to combat it. She pointed out an elderly neighbor and said of their social distancing measures, "It's for him." She emphasized her efforts' success, saying that her children were "very compliant" about social distancing.

Shannon, like many others, talked readily about her efforts to communicate with her children about social distancing, which represented an intensive parenting exercise requiring considerable time, effort, and planning. She talked about the importance of:

> anticipating those conversations and trying to be transparent in your thought process so that now they have context. They know what's happening out in the world. They're aware that there are people who are not following the rules. Then it'll be a matter of just being very transparent about like, "Here's what other people are doing. Here's why we're not going to be doing that."

Shannon thus relied both on identity and morality talk and on *drawing group distinctions through social judgments* when articulating a health lifestyle narrative to help her children understand the importance of social distancing. Shannon tightly bound her family's pre-pandemic health lifestyle to a *shared identity and morality*, saying, "We're all nerds, and we're all very conscientious about our choices" around health. Shannon considered friends' social distancing behaviors as showing their "true colors"—a measure of their moral worth—and using those behaviors to, as she said, "separate the wheat from the chaff" and unfriend on social media anyone who did not share her pro-social distancing values. For

Shannon as for some others, this distinction-drawing had a sharply political dimension, echoing divides playing out around the country.

Andrea and Brian similarly communicated judgments of others over social distancing: "It is hard when you go out and people seemingly either haven't read the news or don't care [about the pandemic]. We're not sure what the narratives are in their heads." Drawing these *group distinctions* and culling the ingroup based on ideological, informational, or scientific litmus tests serves to strengthen *group identity* and tie it even more strongly to *morality*. Whether a parent adopted Shannon's stricter "unfriending" approach or Andrea and Brian's gentler statements, *teenagers learned to draw boundaries between themselves and others on the basis of social distancing and to attribute morality and worth to their ingroup.*

Interestingly, despite parents' carefully crafted efforts to convince their children to internalize their health lifestyle narratives, some teenagers did not view their parents as having played an outsized role in their understandings of health or their views on the pandemic—in contrast to their views on parents' power in enforcing teens' social distancing, which they tended to see as substantial. Shannon's daughter Avery acknowledged that regarding social distancing, "my views with my parents' are incredibly similar. But I don't think my views are coming from them, but they are similar." She cited practical reasons why her family needed to be especially careful and limit viral exposure as the grounds for her willingness to socially distance. Not only were Avery's social distancing behaviors similar to her parents', but she enacted similar social judgments of peers. She was considering refusing to return to school in the fall, saying, "I'm concerned

that they won't be monitoring mask wearing and distancing appropriately and that they won't execute it well." Avery's social distancing behaviors and group distinctions reflected her parents' socialization, but she did not view them as having influenced her—which may be indirect evidence of full internalization of her parents' messages. Peers, teammates, and community members were other influences teens cited on their approaches to social distancing.

Although parents' lifestyle-based messaging around social distancing through identity and morality talk and the drawing of group distinctions appeared to influence teenagers' behavior, preliminary analysis suggests that they also *upheld or strengthened inequalities*. Parents and teenagers in our study tended *not to acknowledge that people were compelled to face social distancing risks unequally* along class, race, and gender lines. Resource constraints that others faced were elided in most parents' judgments, making it easier to justify a lack of social distancing as a moral failing and prop up their own privileged group's deservingness. Helen said, "We went out on a walk with Nicole once, and she was really good about, 'Oh, look, those people are standing too close together.' … She was commenting on people. You know, 'Why is he working?' We went by a construction site—'How come he can work?'" By not addressing possible constraints on workers' ability to physically distance and by calling Nicole "really good" for making social judgments, Helen perpetuated class and race inequalities and judgments of disadvantaged people. And by naturalizing teens' "really good" adherence to social distancing as evidence of strong character and others' lack of adherence as character flaws,

rather than adherence resulting from unequal structural pressures, parents reinforce inequality as moral and inevitable.

Using Health Lifestyles to Justify Exemptions from Social Distancing

Although verbal communication was the main way in which parents sought to influence teenagers' social distancing behaviors, some used their preexisting health lifestyles in enacting other strategies. These strategies typically became necessary when the teenager agentically resisted behaving in ways that conformed to parents' social distancing messages, spurring parents to use other strategies beyond convincing the teen to internalize those messages. Most commonly, many parents compromised with teenagers by making specific exemptions to social distancing, justified using existing health lifestyles. Lynn's daughter Mackenzie struggled during the stay-at-home order. Lynn said, "I don't know if she's depressed, but definitely into that realm of feeling sad … She feels she misses her friends." Because Mackenzie and her best friend were in quarantine and "going crazy," Lynn began to allow regular sleepovers in different rooms, despite the ongoing stay-at-home order. Lynn drew on her earlier health lifestyle, which emphasized self-regulation, self-care, and independence from authorities, when justifying her relaxing of social distancing. The most common exceptions to social distancing came from families who regularly allowed their teenagers to engage in non-socially distanced sports and exercise. Parents readily justified these exemptions by leaning on pre-existing health lifestyles that prioritized physical activity and time with friends.

The Exception that Supported the Rule

One study family *did not ultimately encourage social distancing* for their teenage children. This exception made sense in ways that supported the general rule. After Wave 1, the Williams family moved from Springfield to a nearby small town in a politically conservative county that did not enact the same social distancing restrictions as did Greenville's and Springfield's more left-leaning county. (About twice as high a percentage of votes went to Biden in 2020 in the latter county compared to the former.)

Rachel Williams felt it was "really hard to explain" to her children why they could not visit friends during an earlier statewide stay-at-home order, because she questioned the necessity of social distancing. She said, "That's made me question, like, should we be looking at this [pandemic] more seriously? What are really the statistics of the kids that are getting sick right now from this?" For Rachel, taking the pandemic "more seriously" meant not socially distancing more strictly, but using statistics to question whether those behaviors were necessary. She drew a distinction between Springfield parents, who expressed fear over their children playing organized sports, and parents in her town, who "are like, 'When is this going to be over? My kid, I got to get them moving. I got to get them out. We need some mental health.'" She viewed the latter more favorably, drawing similar group distinctions as other participants, but from the other side of the divide. Using her earlier health lifestyle narrative that emphasized mental health and time outdoors with friends, Rachel justified a decision *not* to impose social distancing on her children—a decision that *ultimately reflected the social distancing norms in her home community*, just as other participants' opposite decisions reflected their communities' norms. Rachel's teenagers had sharply differing approaches to social distancing, with Chase taking a

similarly strict approach as Springfield and Greenville peers but Tyler evangelizing against mask wearing and noting the "power" that being in public without a mask gives people over others who fear them. These participants' distinct social distancing behaviors reflected more agency than was usual for teenagers in the study.

DISCUSSION

In this study, we analyzed longitudinal qualitative data from teenagers and their parents collected during the COVID-19 pandemic and five years leading up to it to investigate how families managed teens' social distancing behaviors in two middle-class communities in which social distancing was strongly normative. Teenagers and their parents perceived competing challenges to health during the pandemic, with stricter social distancing behaviors threatening mental and physical health and social interaction. Challenges also resulted from balancing social judgments from peers and community members against teens' agency. Preexisting health lifestyles were fundamental for understanding how parents and teens addressed these challenges.

Our findings contribute to scholarship by illuminating how health lifestyles shape and incorporate new health behaviors. When new health behaviors create pressures on existing health lifestyles, as social distancing behaviors have, those lifestyles must change to accommodate them. The health lifestyle narrative to which parents and teens already subscribed supplied them with narrative tools to make sense of how and why behaviors must change, which parents communicated to children using identity-based and normative language and drawing group distinctions. Parents experienced these health lifestyle narratives as highly individualized and tailored to their family's unique needs. Ultimately,

though, the new health behaviors—at least in the case of teenagers' highly visible and monitored social distancing—uniformly complied with community norms, even though the narrative routes by which parents justified them varied.

This conformity to community norms, sometimes in opposition to people's own preferences, speaks to the importance of local social contexts for shaping health behaviors. Because they are novel, visible, and publicly performed, social distancing behaviors may be especially prone to normative control within groups and communities and to being used as a source of intergroup distinction (Hechter 1988, Willer, Kuwabara and Macy 2009). Furthermore, social distancing behaviors were understood to impact the health of others at least as much as oneself; mask wearing provides some protection from COVID-19 exposure to the wearer but more protection to others (Cheng et al. 2020). This epidemiologic phenomenon likely encouraged many to view social distancing as a group problem, even as others regarded it as an individual choice. These dynamics help explain the fundamental importance of community norms for understanding our participants' sensemaking around social distancing behaviors. They also reinforce the need to attend to characteristics of and social processes around specific health behaviors when seeking to understand how they can be changed.

The power of health lifestyles as a cultural tool for enacting and reinforcing inequalities (Korp 2008) was maintained or even exacerbated as those lifestyles changed to incorporate social distancing behaviors. Parents and teens regularly used "othering" (Schwalbe, Godwin, Holden et al. 2000)—especially of political opponents, class- and race-disadvantaged groups, community outsiders, and college students—to draw

intergroup distinctions around social distancing, thereby strengthening in-group identities and tying them to these behaviors. By focusing on inherent morality rather than structural circumstances as the reason for people's social distancing behaviors, participants justified and naturalized the worth of their advantaged in-group.

These findings contribute to health lifestyles research on multiple fronts. They are novel in articulating concrete pathways through which earlier health lifestyles shape later ones, a finding that has been identified in quantitative research but not fleshed out. Our findings emphasize the importance of multilevel conceptualizations of health lifestyles as individual behaviors and narratives that are deeply rooted in group-level norms and identities. This multilevel perspective has been articulated in health lifestyles theory (Cockerham 2005) but rarely demonstrated empirically. We illustrate how health lifestyles are transmitted intergenerationally within families and communities. Finally, the tensions between structure and agency—in parents' management of teens, teens' behaviors, and people's attributions of others' social distancing behaviors—speak to the core conceptualization of health lifestyles as the confluence of "life chances" and "life choices" (Cockerham 2005), demonstrating how that confluence plays out in everyday life.

This study also has implications for understanding the COVID-19 pandemic. Although the pandemic led to new health behaviors, understanding these behaviors and people's sensemaking around them requires a longitudinal perspective that incorporates past behaviors and lifestyles. By examining social distancing behaviors, our analyses provide some information about the formation of a "pandemic health lifestyle," but to paint a fuller picture, future work should examine pandemic-induced changes to behaviors that

were already part of people's health lifestyles. We plan to investigate this in future analyses of these data. The importance of community norms for understanding families' social distancing behaviors highlights the need for a multilevel perspective that embeds individuals in their local contexts. It also points to community norms as a potentially effective policy lever for encouraging behaviors such as mask wearing.

Two other policy implications of these findings are worth mentioning. First, parents' and teens' social distancing behaviors are interdependent, so policies that target families more than individuals may be effective. Second, our analyses suggest that preexisting strong cultural distinctions between groups—which arise in part from inequalities—created fertile breeding grounds for judgments around social distancing to form along these dividing lines. Reducing inequalities and social polarization could result in more universal adherence to social distancing guidelines in future pandemics, serving as added protection against the strengthening of existing inequalities by global public health crises. This study illuminates the importance of this dynamic because we anticipate that the health lifestyle processes we analyzed will teach the teenagers in our study to prop up the existing advantages of white, higher-SES families in politically liberal places, widening societal chasms.

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Table 1. Characteristics of quoted and named interview participants, in order (others not included)

Pseudonym	Age	Gender	Race/ethnicity	SES	Community	Waves family participated
Pam	48	Female	White	Mid	Springfield	1, 2, 3
Victoria	16	Female	White	High	Greenville	1, 2, 3, 4
Jessica	40	Female	Multiracial	High	Springfield	1, 2, 3, 4
Oscar	15	Male	White	High	Greenville	1, 2, 3, 4
Laura	50	Female	White	High	Greenville	1, 2, 3, 4
Caitlin	45	Female	White	High	Springfield	1, 3, 4
Elinor	13	Female	White	High	Greenville	1, 2, 3, 4
Karen	52	Female	White	High	Greenville	1, 2, 3, 4
Andrea	44	Female	White	Mid	Greenville	1, 2, 3, 4
Brian	44	Male	White	Mid	Greenville	1, 2, 3, 4
Kim	50	Female	Multiracial	Mid/working	Greenville	1, 3, 4
Hazel	14	Female	White	High	Greenville	1, 2, 3, 4
Andrew	55	Male	White	High	Springfield	1, 2, 3, 4
Helen	55	Female	White	High	Springfield	1, 2, 3, 4
Nicole	15	Female	White	High	Springfield	1, 2, 3, 4
Carol	49	Female	White	High	Greenville	1, 2, 3, 4
Robyn	51	Female	White	High	Springfield	1, 2, 3, 4
Aidan	14	Male	White	High	Springfield	1, 2, 3, 4
Lynn	50	Female	Latina	High	Greenville	1, 2, 3, 4
Mackenzie	14	Female	Latina	High	Greenville	1, 2, 3, 4
Shannon	49	Female	White	Mid	Springfield	1, 2, 3, 4
Avery	15	Female	White	Mid	Springfield	1, 2, 3, 4
Rachel	43	Female	White	Mid/high	Other	1, 2, 3, 4
Chase	18	Male	White	Mid/high	Other	1, 2, 3, 4
Tyler	16	Male	White	Mid/high	Other	1, 2, 3, 4