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Family health competence: Attachment, detachment and health practices in the early years of parenthood

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ABSTRACT

During the first years of a baby's life, parents develop ways of caring that affect the child's health later in life. In this paper, we focus on eating and sleeping, as social practices that mediate between socioeconomic and cultural conditions and health outcomes, such as weight status. We argue for an analysis of what we call 'family health competence', meaning emerging know-hows and resources relevant to healthy living produced, embodied and shared by household members, to understand the development of health practices of first-time parents and their children. In an ethnographic panel study in the Netherlands, we follow households pre-birth until the first child turns age four. Our analysis suggests that across different families, competences develop enabling parents to balance a) attaching and b) detaching in particular ways. Parents learn how to observe and interpret their newborns, bracket doubt, build trust, manage time pressures and mobilize support networks. These competences are partly class and gender-specific while there is also significant diversity within class and gender. The competence to balance attachment and detachment can be understood as the effect of contradictory social norms and institutional (labour market and care) provisions typical for late-modern welfare states.

1. Social parenting competences

The 'first 1000 days' of a child's life are considered 'sensitive' (Cashdan, 1994) in the development of health practices crucial for the child's cognitive, emotional, neural and physical development (da Cunha et al., 2015; Gemeente Amsterdam, 2015). In particular, the nutritional status and related risk factors such as sleep duration in this period have been linked to a lifetime risk of obesity (Navarro et al., 2016; Taveras et al., 2008), which is in turn associated with decreased quality of life and overall life expectancy, and increased risks for diabetes mellitus, stroke, coronary artery disease, hypertension and several cancers (Yu et al., 2011).

In addition, the knowledge framework in developmental psychology and public health studies promotes 'attachment', defined as "lasting psychological connectedness between the infant and caregiver" (Bowlby, 1969/1982, p.194, cited by Verhage et al., 2016; Wolff and IJzendoorn, 1997). 'Secure' attachment involves infants developing a sense of trust in the world through parents' (and especially mothers') 'sensitivity', meaning a receptivity to understand their child's expressions and needs (Bretherton and Munholland, 2008).

These understandings are a basis for maternal and child health services across numerous high, middle- and low-income countries (U.S. Department of Health and Human Services, 2011; World Health Organization and UNICEF, 2012). They advise parents about feeding, sleeping and physical interaction to promote positive attachment and cognitive, physical and social health outcomes, and to decrease healthcare utilization later in life (Feeney, 2000). The focus is often on the first 1000 days, during which first-time mothers and fathers need to acquire a new set of competences to ensure their child's healthy development while managing other domains of their lives (Cardoso et al., 2015; Nielsen et al., 2014).

In this study we focus on the Netherlands as an exemplary case of this broader trend. The Dutch Local Public Health Services (GGD) offer child healthcare services at neighbourhood-based children's health centres, where healthcare professionals see over 90 per cent of children aged 1–4 (CBS, 2010). Dutch public health guidelines have in recent years promoted breastfeeding, weaning and stable sleeping routines (NJC, 2013; 2016). In 2018, the central and municipal governments furthermore implemented health strategies focused on "attachment" in children's "first 1000 days" (Ministerie van Volksgezondheid, Welzijn en Sport,

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2018) as a “blue print” of children’s lives. (NJC, 2018).

This paper builds on qualitative interviews with first-time parents and provides an account of the competences these parents develop against the background of a cultural script on “good enough parenting” that should enable “attachment and foster the child’s basic sense of security”, which is deemed “essential for subsequent mental health and self-esteem” (Hoghghi and Speight, 1998, p. 294), as conveyed by medical expertise and scientific knowledge. In our paper, we do not contribute to attachment theory in itself, but analyse the household practices informed by it. We thus approach attachment as a social practice which, as we will demonstrate, is juxtaposed to detachment. We consider the interaction between ‘social’ variables of education, occupation, gender, social network and cultural knowledge and the different ways in which parents engage with the cultural script of attachment and other forms of knowledge they deem salient.

2. Family health competence

New parents often experience a unique and stressful phase in their lives (Grunow and Veltkamp, 2016). Parents may be under pressure to quickly learn to care for their new-borns, shift from a partner to parental relation, and juggle work and care tasks under labour market pressure. Taken together, this could easily affect their identities and wider social relations (Mills et al., 2011).

From a critical sociological perspective, medicalization (Christiaens et al., 2013) and scientization (Ramaekers and Suissa, 2012) of pregnancy and childbirth have turned parenting into a public health issue (O’Connor et al., 2007:27). Health professionals are increasingly central in teaching parents how to care for their child in line with scientific findings in a potentially sensitive and pressure cooker period (Lee et al., 2010). This might lead to responsibilisation, particularly of mothers, in public, clinical, and policy discourses (e.g. Macfarlane and Lakhani, 2015). Science-based expert advice and ‘intensive parenting ideology’, establishes mothers as ‘risk managers’ and encourages them to place their child’s needs central rather than their other tasks (see Hays, 1996; Knaak, 2010). The parental role seems increasingly narrowed to a technical means to achieve public health outcomes. (Raemakers and Suissa, 2012; Lee et al., 2010).

While these studies highlight the critical and cultural aspects of modern parenting, we know little about what kind of competences parents develop in responding to these multiple pressures. One stream of research for instance approaches parenting competences as individual skills and techniques such as breastfeeding, preventing accidents or burping the baby (e.g. Cardoso et al., 2015). Competence and other related constructs such as parental self-efficacy, confidence and satisfaction are in this sense often used interchangeably (e.g. Črnec et al., 2008). In other research, the term parenting ‘practice’ usually refers to parents’ behavioural strategy or techniques used to manage a child’s eating, such as pressuring, restricting, rewarding, and modelling (Ver-eijken et al., 2011).

We argue, instead, for a social approach to competences which acknowledges that the chances of developing competences in health are unequally distributed according to class, gender and culture (Blane, 1995; Panico et al., 2019). However, competences are not determined by social background but develop pragmatically and are relational and embodied (Lupton, 2013). Following a practice perspective, we thus argue that cultural, material, and structural contexts pragmatically co-constitute the development of parents’ competences (See Cohn and Lynch, 2017; Shove et al., 2012). These health competences (Blue et al., 2016; Shove et al., 2012) encompass material (im)possibilities, symbolic meanings and forms of embodied and practical know-how.

At the level of the household and family, we point to ‘family health competence’ which links health practices (e.g. diet, sleeping ritual) to time management, career planning, partner interactions, housing and the availability of, for example, food. The social practice approach we employ is not biased towards the role of the mother or father but

considers the web of relations in practice. Hence, such a conceptualization of competences provides a link between structural and cultural difference and institutions on the one hand and individual behaviour and associated health outcomes on the other hand. The social practice approach thus enables us to show parents’ diverse attempts to do ‘the right thing’ in line with moral imperatives.

3. Methods

Our research follows a qualitative design with two-time-point interviews (n = 12 cases; 24 interviews) with first time parents residing in Amsterdam, the Netherlands, triangulated with participant observations at the family home, to document and understand the development of health practices in everyday lives within diverse social contexts (Hammersley and Atkinson, 2007). With a longitudinal approach, we aim to examine practices and competences as they unfold and stabilize over time, in response to life changes. Participants were purposefully recruited in 2016 and 2017 through advertising at midwife clinics and playgroups and through snowballing when the mother was still in the last trimester of pregnancy; or the child was less than 12 months old. Time-point two interviews were conducted approximately 6 months after the first interviews. These data are part of an ongoing longitudinal ethnographic panel study. The study has received formal ethical approval of the Ethical board of our University (AISSR Ethics Advisory Board). Participants were recruited with a one-page information leaflet and received additional extensive information prior to the first interview about the longitudinal character of the study, anonymity and being able to end their participation when desired, after which informed consent was provided.

To capture relationships between the social contexts and the competences parents developed, we included parents with different gender, age, educational levels, cultural backgrounds and (inter)national migration histories. Hence, our participants were aged between 18 and 41; their educational levels varied from high school to postgraduate; we included mothers (14; 12 birth mothers and 2 non-birth mothers) and fathers (4), and parents had Dutch (10; including 2 Dutch-Moroccan) as well as other Western (3; US and Northern Europe), Eastern (3; Japan, Russia and Eastern Europe) and Southern (2; South American) backgrounds. The sample size is suitable for our interest in ‘theoretical generalisation’ (Meyer and Lunnay, 2013), by showing contextualised accounts of how new parents develop specific kinds of competences in their social and cultural contexts.

For half of the families (6), parents were interviewed together and for the other families (6), mothers were interviewed alone. Interviews were conducted at participants’ homes or in a cafe in the presence of their child and were supplemented by observations. Interviews were audio-recorded and subsequently transcribed verbatim, and transcripts for interviews conducted in Dutch were translated into English. Field notes for observations were taken either during or immediately after the session, depending on which was considered appropriate at the time. During the interviews, participants were asked about: their everyday care activities relating to the child’s eating and sleeping; their expectations and experiences of these activities; how they tried to understand their child’s needs; and sources of and access to information and practical support.

The data was analysed abductively through collective thematic analysis (Timmermans and Tavory, 2012) in a team of seven researchers. We obtained inter-rater reliability through joint coding sessions (using Dedoose software) in which the interviewers’ positions and potential influences on the data were discussed. We first performed open coding to look for themes that enabled an understanding of the patterns in how parents dealt with and attempted to regulate their child’s eating and sleeping at the two time points. In an iterative process of studying the data and theoretical concepts able to explain parts of the variance in our data, we started a second round of analytic coding, in which we looked with further scrutiny for ‘competence’ (‘knowledge

construction', 'knowhow' and 'sources of knowledge') which we related on the one hand to practices of eating and sleeping over time and on the other hand to (references made to) respondents' background characteristics such as their education, occupation, age, cultural background and being a mother or father. We subsequently coded for the competences that emerged to understand coherent variance in household level practices (a science-led focus on child signals; a practical focus on regulation of patterns; and a focus on the parental role and position itself). In our results section, we show the similarities within and differences between the groups of parents who had developed these competences in how they attached to and detached from particular perspectives on their child and how this was influenced by factors in their social context.

4. Balancing attachment and detachment

We now describe three different family health competences in infant care, which allowed the parents to go back and forth between attaching to and detaching from particular perspectives (Latimer, 2007), and accordingly, their child (see Table 1). These competences are 1) monitoring the child's needs, 2) managing family needs and 3) building parental authority and confidence. These competences are conceptual examples or ideal types and can co-occur in one household. However, our findings show that new parents leaned towards certain competences, and these tendencies were related to their social contexts.

4.1. Monitoring infants' health needs

One of the recurring practices we identified was in line with the 'cultural script' on 'good', 'science-led' and 'intensive' parenting. We found that parents developed a competence in tracking and monitoring their child's health needs. In line with the public health advice related to caregiver-infant attachment, in which 'sensitivity' and 'responsivity' is central to early parental care, parents sought to monitor, interpret and respond to the signals their child expressed in order to decide and manage the 'when, what, and how' of infant eating and sleeping (Schneider et al., 2016), while at the same time producing a sense of security.

Parents leaning toward this competence had a (post)graduate educational level. They clearly embraced scientific research findings and medical and professional advice to breastfeed and to monitor and manage risks. Paul and Anouk for instance reflected on risks related to formula feeding their daughter Anne.

"[With formula milk] there is a risk of overfeeding, having your child gain weight and that has been linked – I've seen some research – to possible patterns of obesity later in life and, of course you don't want that." [Paul, Anouk and Anne (5 months at T1); university degree, Dutch and Eastern European background, aged 30+]

The practice of monitoring the child entailed that parents actively tracked the range of possible (health) needs of the child. Paul and Anouk for example paid careful attention to the tone and rhythm of their daughter Anne's expressions to assess her needs in terms of feeding, sleeping and attention. For parents who primarily developed this competence, compared to the other parents in our study, the opportunities and desires to exchange knowledge with the own parents was limited, firstly because grandparents' ideas were deemed "unproven" [Karlijn and Niek (2 months at T2); Dutch background; higher vocational degree; aged 30+] and secondly because grandparents lived further away, since this group of parents in our study had often moved within or across countries. This also related to less assistance of grandparents with everyday tasks and less everyday conversations about caring practices compared to the other parents in our study. During phone calls or family visits, disagreements came to the fore between parents' and grandparents' experiences and what they perceived as 'good' practices, in which the parents prioritized expert knowledge.

"You have more traditional aspects, so ways in which Anouk's parents have raised her, and the ways in which my parents have raised me, and we also filter those. [...] We don't agree with everything and we don't do it. [...] We really filter them and we don't do anything that the medical professionals would disagree with." [Paul, Anouk and Anne (5 months at T1); university degree, Dutch and Eastern European background, aged 30+]

Hence, for these parents a weaker intensity of direct contact and involvement in caring practices within their family network coincided with a weaker sense of being on the same page.

A scientific perspective on parenting provided parents with "one place from which to see" (Latimer, 2007, p.104) and this affected how they attached to their child through eating and sleeping practices. At the same time, parents moved back and forth from 'attaching' to and 'detaching' from their child. With detachment, we refer to distance, or 'separation', between parent and child, as the opposite of closeness and connectedness (see Beyers et al., 2003, p.351 and Feeley et al., 2016). Hence, parents balanced attachment and detachment through technical processes of objectifying and observing how their child related to bodily

Table 1
Development of family health competences.

FHC	Attaching	Detaching	Social context
1. <i>Monitoring child's needs</i>	Child's needs/vulnerabilities in line with a) professional knowledge and b) scientific findings	Child (objectifying child's behavior) Parental needs and spontaneity (channeling into 'scientific' expert-led child rearing)	- (Post-)graduate level education - Parental leave - Western/Eastern (European) descent - More distance from family/grandparents
2. <i>Managing family needs</i>	Family members' needs/vulnerabilities in line with a) professional knowledge and b) employment/daily routine	Child's (and parents)' immediate needs and spontaneity (channeling into workable structure)	- (Post-) graduate/higher vocational level education - Continuing (full-time) career and work life - Dutch descent - Family and external childcare as caregiving resources
3. <i>Building parental authority</i>	Being the responsible and knowledgeable parent in line with a) professional knowledge and b) social and familial norms	Child's and professionals' desires and demands (channeling into decency and parental authority)	- Lower, mediate and higher vocational level education - Focus on parental role in work/care balance - Dutch and Southern descent (including mixed couples) - Close ties to extended family/community

sensations, needs, discomfort, tiredness, people and things around him/her. For example, after reading medical information about formula feeding and potential weight gain, Paul and Anouk started systematic observations of their daughter's eating and sleeping, which they kept record of in a logbook about the type, amount, frequency, and duration of feeding, sleep, and the timing and contents during diaper changes.

"We got used to the system [of record keeping] and you can see quickly what she has eaten, and was it enough? You add those pieces of information for a quick diagnosis. In combination with the kind of crying she had, I knew that probably she wants a bit of extra milk" [Paul, Anouk and Anne (5 months at T1); university degree, Dutch and Eastern European background, aged 30+].

Hence, while monitoring the child's needs was a way to establish 'attachment', it was also a detour via scientifically informed knowledge and in that sense a form of 'detachment'. We found such practices of attachment and detachment in monitoring the child for both mothers and fathers in our study. Yet, gendered feeding practices affected how to interpret and act upon the child's needs could differ. Paul reflected on the degree of distance in relation to breastfeeding, and in turn how this affected the interpretation of the child's needs:

"So, we were both anxious [about the production of mother milk] for [Anne's] own sake, it's just that I was able to judge the feeding situation a bit better because I had a bit more distance and I was relying more on this [logbook and the volume markers on the milk bottle] and so. Whereas for Anouk, probably as a mother, with mother instinct, she was tempted to try at breast[feeding] all the time". [Paul, Anouk and Anne (11 months at T2); university degree, Dutch and Eastern European background, aged 30+].

The parents in our study who leaned towards monitoring their child's health needs understood the benefits of breastfeeding for the infant in relation to its nutritional values and, often more importantly to them, attachment. Generally, these parents had an occupation that allowed them to have extended periods of leave. With the exception of Paul and Anouk, who dramatically reduced their working hours to perform a model of shared parenting, the breastfeeding mother in these couples took an extended maternal leave and specialized in tracking health needs more clearly than the father/non-lactating parent, who focused on performing a more traditional breadwinner role.

"[Christian] is really caught up in his work, and when I get this baby, I suppose that this will be like my work he will always be a little outside, because in the beginning I'm the milk machine, and he's the money machine" [Emily and Britt, pregnant in T1; university degree, Western European background, aged 30+]

This division of labour meant that breastfeeding and non-breastfeeding parents had different roles in monitoring the child. Hiromi (the birth mother who took an extended maternity leave) and Julie were two mothers who distinguished between themselves referring to 'mum' and 'mom'. They had to deal differently with their child's demand for (breast) milk prior to falling asleep:

Hiromi: [Julie] can still put Miki to sleep, but only when [Miki] knows that I'm out and not at home. [...] She gives up when she realises that there's no breast, only a bottle, and I'm not around. So, there's only mom, not mum, and only then she would fall asleep. [...] There are breasts also, but she knows these breasts don't produce milk. So, she also sucks on Julie's breasts, a little bit, if you push them to her, but she'd immediately let them go. So, even when Julie is holding her, she knows that there's no breast milk in these breasts." [Hiromi, Julie and Miki (5 months at T1); university degree, US and Japanese background, aged 30+]

Within 'monitoring' families, both parents struggled and feared adverse consequences when the non-breastfeeding parent was less able

to respond to the child's needs. Emily explained that, after observing that Britt bonded with her much stronger than with Christian, they tried to actively foster attachment between Christian and Britt. They did this by Christian spending time with Britt at her bedtime, in a process of 'trial and error' in attuning to Britt's need for bonding.

"She was really, really attached to me. So, when Christian would put her to bed, she would be making a huge scene. Really, really upset, screaming and crying [...] I'm afraid of letting her down in the evening, like that it will destroy our bond. [...] Or, if she only cries with Christian then it will do something to their bond." [Emily and Britt (7 month at T2); university degree, Western European background, aged 30+]

Taken together, we found a linkage in our data between 'intensive parenting ideology' (Hays, 1996; Faircloth, 2014a), risk management and a form of proto-professionalization in which parents strongly incorporated professional and scientific knowledge, intertwined with cultural knowledge, in how they sought to affect their child's health and well-being over time and in how they related to their child. These practices shaped parents' particular attachment to *and* 'detachment' from their child, while particular roles within the family could differ along lines of gender, breastfeeding and parental leave.

4.2. Managing health practices to ensure the collective well-being of the household

For the first-time parents in our study, especially mothers, the imperative to balance their own health, paid employment and the ideal of attachment parenting at home created tensions. In response, some families developed the competence to manage health practices with a focus on the collective household instead of just the child.

What these families shared was that both partners worked (nearly) full-time and valued their jobs and careers, in line with their (post) graduate or higher vocational educational level background. These couples often had a Dutch background and were firmly embedded in the labour market. Working hard was not so much dedicated by scarcity, but part of individualized work and development ethics and aspirations for professional career progression. These couples also actively used arrangements endorsed by Dutch policy: short paternity/maternity leave, flexibility in work and a model that supports early-on sharing of care between spouses, grandparents, day care and/or certified paid individual childcare (Knijn and Saraceno, 2010).

We found that professional knowledge about attachment and healthy food was acknowledged among these parents, but strongly mediated by considerations about how to establish feasible daily routines. For example, although breastfeeding was aimed for and tried out by all families in our study, it was also perceived and experienced as particularly challenging to combine with employment after maternity leave. A part of the parents in our study who returned to work decided to stop breastfeeding once they faced this challenge, and others anticipated already during pregnancy that they would not combine (exclusive) breastfeeding with their jobs.

"Our child will go to day care when I'll be working. [...] So then, I'm not going to breast pump at work, that won't work out. So maybe some other way, a combination; breastfeeding in the evening and morning and then off to work, and the child gets formula during the day. [...] I've talked to some friends [about breastfeeding] and everyone says: 'you should see how it works for you' [...] I'm not like those women who are like 'this must succeed' and when it doesn't ... complete drama. No, we'll see. When it works out: fine, when it doesn't ... [...] we'll find another way." [Svetlana and Noah (pregnant at T0); university degree, Russian background, aged 30+].

Hence, Svetlana, who expressed in the interview at T1 that she stopped breastfeeding shortly after birth, distanced herself from the

moral claim to breastfeed at all cost, based on practical considerations and informed by her social network of like-minded friends. By detaching from the imperative of breastfeeding –one of the cornerstones of ‘the first 1000’ days frame - Svetlana created space for her employment and for alternative ways to relate to her child through feeding (see also Dykes, 2005).

Likewise, almost all participants specifically mentioned having physical and emotional closeness with their infant as desirable for his/her healthy psychosocial development. However, sensitivity to the child’s immediate needs and expressions at all times was not practical in their everyday lives, as it interfered with paid employment, household work, intimate partnership and other needs and forms of social engagement (see also Forsberg, 2009). In order to maintain their own health and the collective health and wellbeing of the household, these families developed a competence in managing conflicting needs and controlling infants through routines that were compatible with their everyday lives.

Creating a routine often required teaching the child to follow a certain pattern and rhythm of daily life that might not necessarily be consistent with the bodily messages and cues, as ‘pure’ and ‘natural’ wishes and desires (Murcott, 1993) of the child. Parents thus learned to ignore some cues and to choose when and how much to bond. Furthermore, they saw a workable routine contributing to a “house that is harmonious” (Nynke, T2), which was beneficial for both parents and their child’s health. Nynke and her mother expressed in a joint interview how Nienke prolonged the feeding intervals for her son Douwe.

Nynke: “At some point my mother said: ‘try to achieve a rhythm with 4 hour [feeding] intervals’. [...] When you feed on demand, well: I didn’t sleep at all.” [...]

Grandmother: “And he was growing very well.”

Nynke: “He is huge [...] I see it in the graphs of child healthcare. Yes, that’s based on objective data. [To grandmother] So that was last year, that you figured, he can handle [4 hour feeding intervals].”

Grandmother: “Yes, I was also looking at you in particular, like: can you still handle it? Because you were very tired back then”

Nynke: “That’s true, I was really tired. And it helped, it was very convenient to anticipate a certain rhythm”. [Nynke, Robbert and Douwe (8 months at T1); university and higher vocational degree, Dutch background; aged 30+]

Once Nynke returned to her paid work near-full time, she stopped breastfeeding and they distributed care responsibilities amongst parents, grandmothers and paid day care. Instead of monitoring the child directly – as seen above – these parents exchanged practical knowledge on how to handle feeding and sleeping routines across familial and professional care-takers.

Managing household routines included not responding to the immediate perceived needs of the child and not responding to one’s own emotional impulse. For example, at 6 months Nynke and Robbert arranged Douwe to sleep in his own room at night to improve everyone’s sleep patterns. Nynke explained that she often struggled to resist the temptation to stay with Douwe:

“Then I’m tucking him in nicely and I’m consciously leaving the room, since I want him to fall asleep by himself. [...] So that you’re not tempted to stay with him and watch him fall asleep. While this is very cute, but ... no, I really try to walk away, close the door and make myself doing that” [Nynke, Robbert and Douwe (8 months at T1); university and higher vocational degree, Dutch background; aged 30+].

Hence, it was perceived as important for Douwe to develop solid individual skills; he needed to fall asleep “by himself”. Managing the household with routines was not juxtaposed to children’s needs, but these

needs or cues were managed through routines. Farah and Marlijn mentioned for example how their son Luuk was a bit out of rhythm on the days that he attended day care, and they invested in keeping him awake until he arrived at the day care centre in the morning to support him having a good sleep there [Farah, Marlijn and Luuk (6 months at T2)].

“It sometimes takes a bit too long in the morning for Luuk, you can notice that. [...] When you’re at home, already at 8.30 or 9.00 o’clock he’s like: ‘put me in bed’. So, when he starts to get tired before he has to go to day care, he’s a bit grumpy, not being able to choose his own rhythm and to sleep when he wants to. But well, he’s just a very flexible boy, when you get him along, it works out fine” [Farah, Marlijn and Luuk (6 months at T2); university degree; Dutch and Dutch-Moroccan background, aged 30+ and 40+)].

While these parents recognized the child’s needs, they also perceived Luuk as “flexible” and helped him to “get him along” or adapt to the daily routines.

Similar to monitoring the child’s needs, managing household needs also went back and forth between attachment and detachment. Parents were attuning to their child’s needs while at the same time pragmatically channelling these needs, together with those of other household members. This competence enabled parents on the one hand to detach themselves from direct intimacy when it was not deemed possible or practical, while particular eating and sleeping rituals on the other hand became important moments and sites for family bonding and attachment.

Farah: “Around 17.30, we are usually home and have dinner. [...] It’s actually cosy.”

Marlijn: “You would miss it when you would give a sandwich, it would be different than a hot meal.”

Farah: “Exactly, that moment of [sitting together]

Marlijn: “It provides rest. [...] From the moment I leave to work at 8, it’s one rat race” [Farah, Marlijn and Luuk (6 months at T2); university degree; Dutch-Moroccan and Dutch background, aged 30+ and 40+)].

As with the other family health competences, the competence of managing health practices was in particular developed in managing contradicting needs for attachment and detachment.

Nynke: “When I go to work for instance, cliché, he is crying intensely, and I am told later that it lasted for 2 s and then he continued playing.”

Interviewer: “How do you deal with this?”

Nynke: “Yes, I am ... I am soft. So, I try to be cool, but my heart always breaks a little. But I do leave.”

Interviewer: “And what do you say to him?”

Nynke: “Bye, bye”. Cheerful. Yes, not dramatic. That won’t help him”. [Nynke, Robbert and Douwe (16 months at T2); university and higher vocational degree, Dutch background; aged 30+].

As this excerpt shows, these parents prioritized and legitimized managing their emotions and those of their children in cases of contradicting needs for closeness and distance, in order to ensure the work-life balance and collective well-being of the household.

For most of these families, breastfeeding, parental leave or part-time work was less prominent in their practices, especially after maternity leave. Daily routines where on the other hand often shared and a division of tasks in terms of attachment was uncommon. Most of the couples worked full-time, or both parents had one day off to care for their child. Within the interviews and observations both partners appeared to be equally engaged in feeding practices, sleeping rituals and intimacy.

Accordingly, we witnessed a stronger focus on attuning the different daily rhythms with day care and other caregivers.

Nynke: “We’re doing it entirely 50/50 and Robbert has [Douwe] on Mondays and I’m at work.”

Interviewer: “Is it different, when [Robbert] is at home [...] compared to when you are at home?”

Nynke: “No. No. I think the difference relates to when [Douwe] has been to day care yes or no. [...] After such a whole day, a rush hour emerges. Coming from work, picking him up from day care, do we have food? Groceries, that needs to be quick, quick, otherwise he is tired.” [Nynke, Robbert and Douwe (16 months at T2); university and higher vocational degree, Dutch background; aged 30+].

Taken together, managing meant that families incorporated knowledge about healthy habits, such as breastfeeding, fresh vegetables, no sugar, regular sleep and sensitivity, in their everyday practices and balanced this knowledge with labour market demands and norms of individual development. We watched them striving for a healthy and ‘harmonious’ family as well as for healthy family individuals, capable of managing and adapting eating and sleeping behaviours and their emotions relatively independently and practically.

4.3. Investing in parental authority and confidence regarding the child’s health

The third competence we found in our study was trusting in parenting experience and authority. This combined learning by doing, trusting in yourself as a parent, relying on the experience in the family network, especially those of grandmothers, and on social norms regarding parenting and children’s health behaviours.

Among parents leaning towards this competence, there was more variety in and less emphasis on educational backgrounds and occupations, and a more central focus was placed on the parental role. Confidence, we found in this sense, was an important way of relating to the child, as well as responding to changes in the environment and becoming competent in feeding and sleeping matters. Marijke for instance described in a rather common-sense manner how she dealt with feeding and sleeping practices of her daughter Tessa. During the interview, she brought her daughter to bed for a second time, after the first time did not work out. When asked how she did it, she said:

“She already closed her eyes. So, I ... caressed her head for a while, held her hands, pushed her pacifier back. And then she fell asleep after all” [Marijke, Amaro and Tessa (6 months at T2); higher vocational and university degree; Dutch and South American background; aged 30+]

Marijke seemed to be at ease and straightforwardly got Tessa to bed again once she was confident that time had come. Marijke trusted her own judgment and took on a position of authority. She was not negotiating or ascribing individuality into Tessa, but rather took the lead herself.

It stood out that family ties and extended family networks were relatively strong for parents developing this competence. Hence, when in doubt, trust could be invested in other family members’ – mostly grandmothers’ – experiential knowledge. Kimberley, a young mother who was still a teenager when she became pregnant pointed to getting information from her mother about breastfeeding, which produced a feeling of confidence in her that it would all turn out well.

Interviewer: “How much confidence do you have in feeding [...] do you have places where you can find information?”

Kimberley: “My mother. She herself has breastfed three children.” [She says] that it’s going automatically, when you just hold [the

child] correctly, it will all go automatically” [Kimberley (pregnant at T1); high school degree; Dutch background; aged 18+].

Once her daughter Dewi was born, Kimberley did describe problems with breastfeeding when asked, but dealt with them straightforwardly and optimistically and thus developed her sense of confidence further.

The parents in this group, often including non-Western or mixed backgrounds repeatedly referred to knowledge within the wider family network and communities in the Netherlands and abroad. Manar for instance pointed to the key role her mother played in starting to feed her son Amir solid food, a bit earlier than the recommendations of child healthcare.

“At a certain point, my mother returned from Morocco, and she said: ‘why are you still not giving him anything? Just give it to him.’ And: ‘you know when he’s ready for it or not’. And [indeed] the first day, he already finished his plate” [Manar and Amir (5 months at T2); mediate vocational degree; Dutch-Moroccan background, aged 30+].

While grandmothers’ roles turned out to be particularly important in terms of concrete advices, the above excerpts also show that grandmothers encouraged parents, especially the mothers, to develop and follow their own intuition. This was reflected in the way that the parents expressed with a certain confidence how they just ‘knew’ their children and their needs; a source of knowledge that shaped their attachment to their children, which was at times prioritized above professional knowledge.

“I don’t always listen to child healthcare [advices]. Because they are too much focused on ... on what’s common. [...] I mean, I know my child. [...] For instance, things like: ‘you can only give him two bites of food’, well, I mean: he wants to eat, I’m not going to force it. Or: ‘you’re giving him too much milk’. I’m not giving him too much milk, he wants it. And they think it’s strange when I mention this. But I know my child.” [Manar and Amir (5 months at T2); mediate vocational degree; Dutch-Moroccan background, aged 30+].

As this excerpt shows, parents investing in their own authority were especially critical towards professionals who did not acknowledge their expertise. The experience-based knowledge of these parents, as well as their close ties to the wider family (see also Rapp, 1998), could serve as a means to detach from risk perceptions within professional knowledge and advices, which were not always perceived as helpful and realistic.

Naomi: “They’re sometimes scaring you a little bit, you know, these parenting professionals. [...] Just everything you read, pregnancy preparation courses, midwives; it seems like they’re making you uncertain. [...] What they did back in the days, when I hear about everything that my mothers and grandmother did, I’m like: well, gee, ok.”

Ricardo: “My mother always allowed me to sleep on my belly, from day one. And now they’re saying: ‘you can’t do that, the baby might choke, it can’t turn its head, this and that” [Naomi, Ricardo and Fabio (2 months at T2); mediate and higher vocational level; Dutch and South American background; aged 20+].

The parents in our study who developed the competence of ‘parental trust and authority’ were employed and valued their jobs. However, having varying levels of (lower, mediate and higher) vocational educational backgrounds, their focus on having a career was not as strong as compared to other couples. Marijke, Amaro, Naomi and Ricardo for instance decreased their working hours after birth to three or four days per week to have more time for their parental role.

The case of Kimberley was a more extreme one, showing how a less secure socio-economic position compromised Kimberley’s attempts to develop much needed authority and trust. This confidence was firstly compromised by her job in a retail shop which – with a minimum of six

long days per week with ample time for breast pumping – was hardly compatible with breastfeeding and caring for her child and she soon saw no other choice than to quit her job. Secondly, it was compromised by financial constraints and housing problems: Kimberley described how she was increasingly anxious when carrying her child on the steep stairs within the apartment they temporarily rented from a family member.

Her partner Jeroen (aged 20) worked six and later seven days per week in construction and demolition. Different than the parents in this study who were driven by aspirations or entrepreneurship, Jeroen felt a strong need to provide for his family, according to Kimberly. He rather struggled with the demands this placed on him than with his role in relation to his child's needs, as we described for other parents in this study.

“[Jeroen] is working a lot. [...] And when he gets home, he is exhausted. And then I want to take a quick shower and ask him ‘do you want to hold her for a minute?’ [and he is like] ‘huh, I’ve been working all day and now I need to hold her on top of that.’” [Kimberley and Dewi (2 months at T2); high school degree; Dutch background; aged 18+].

While the parents in our study who leaned towards parental authority varied in how they shared working and caring tasks and the degrees to which fathers became involved and experienced in the parental role, parental trust and expertise was more easily developed by mothers and grandmothers than by fathers.

The focus on confidence and parental authority also enabled these parents to ‘detach’ from their children, for example by delegitimizing a child's demands. Below, Amaro and Marijke discuss putting their daughter Tessa to sleep:

Amaro: “There was a period when she didn’t want to sleep”

Marijke: “Yes, [...] I couldn’t stand that very well, so, that’s why I often walked away. [...] When she was so restless. I was like: well, she’s only acting funny [laughing and playing]. I leave her be for a while” [Marijke, Amaro and Tessa (6 months at T2); higher vocational and university degree; Dutch and South American background; aged 30+]

Detaching from children's desires was also informed by norms of parental authority, as was for instance mentioned by Kimberley:

“I think many parents are [calming a child] wrong. [...] In the store [where I work] at the pay desk, they start whispering ‘can you put this [toy] away secretly, otherwise she’ll start crying’. I say: ‘you’re the one in charge, aren’t you? No means no.’ [...] And at the table, should we ever go to the restaurant, [my daughter] should not be ruminating or eating with her hands, but eating with manners. [...], for everyone to know: that one is decent” [Kimberley, pregnant at T1; high school degree; Dutch background; aged 18+].

Hence, it appeared to be important to show and produce decency in their children (see [Kiter Edwards, 2004](#)), whereas authority and decency norms counterbalanced professional knowledge about health risks and the ‘cultural script’ of being sensitive to the child.

5. Discussion and conclusion

Building on scholars who have encouraged the study of health practices as mediators between socioeconomic structures and health inequalities ([Blue et al., 2016](#)), our study explored how particular health practices concerning eating and sleeping developed during earliest childhood. The practices we have identified constitute a fundamental ‘family health competence’: the ability to attach to *and* detach from a new-born. The parents in our study continuously balanced cultural norms and different demands of their child, their own demands and those of the wider society. In doing so, they related to different degrees

and through situated practices to the ‘cultural script’ on and child healthcare pressure towards (breast)feeding, secure attachment and stable sleeping routines, promoted to enhance children's healthy development. Family health competences that pragmatically developed in health practices of caring for young children concerned 1) monitoring infants' health needs, 2) managing health practices to ensure the well-being of the collective household, and 3) developing parental confidence and authority regarding their child's health. These competences appeared to be mediated by parents' social positions: in relation to the labour market, family policies, their ties to the (extended) family network, and their educational and cultural backgrounds.

Our study indicates that the health practices of caring for young children are embedded within a health risk and prevention context in which parent are implied as – uncertain - risk managers. Child care is also embedded in a context which pressures labour market participation without sufficient leave opportunities. Families with diverse socioeconomic, educational, cultural and gender backgrounds relate to these political and cultural contexts and ‘scripts’ in different ways, providing them with different opportunities for compliance and resistance, which accounts for the specificities of their practices and associated health behaviours. The families in our study who predominantly focused on monitoring infants' health needs were most concerned about the health implications of eating and sleeping as informed by professional knowledge. Families who focused on managing health practices for the collective household on the other hand balanced this knowledge more clearly with other competing demands like employment, while those families who focused on parental authority and confidence negotiated professional knowledge with their own knowledge of their children, advises from relatives, and social norms about authority and decency.

Our study shows that health practices and family health competences are influenced by social structures of gender and class. Yet, our data also points to variance within practices of families with overlapping background characteristics. In presenting the three competences in attaching and detaching, our aim has been to demonstrate how practices that parents develop are linked to their social, cultural and material contexts. While we do not assume the three competences we described here make up a complete list of family health competences, they can serve as useful concepts in understanding the particular ways through which new parents deal with tensions that arise out of juggling social, relational, cultural and institutional demands in their effort to practice ‘good enough’ parenting. The participants in our study showed different competences at different times and contexts, but they had leaned towards one form.

Earlier ethnographic studies have investigated ‘health literacy’ in how diverse people deal with (professional) knowledge about health, as a creative social practice ([Samerski, 2019](#)). When it comes to parenting and children's health, psychological and epidemiological health studies have examined and theorized attachment relationships and parental sensitivity (see for instance [Meins et al., 2001](#)) as well as parents' and children's health behaviours (see [Thompson et al., 2016](#)). Our study relates the concept of ‘attachment’ to embodied and longitudinal processes of knowledge construction as intertwined with parents' social positions and perspectives towards science, professionals, the labour market and their social network. Furthermore, we argue that parental practices and competences in ‘detachment’ were equally salient in all family health competences and parental experiences. Forms of detachment were also driven by (perspectives on) health, labour market arrangements, family policies and parenting norms, which is much less emphasized or even criticized in health and developmental studies ([Faircloth, 2014b](#)).

In this paper, we have studied interviews with and observations of a sample of new parents at two time points before and within the first year after child birth. A limitation of this study is that not all time points were similar and the new-borns differed in age at the timing of the interviews and observations. Moreover, we did not capture here how practices and competences within families developed after the first months or year of

child's life. Further research could consider to what degree and in relation to which social characteristics and life events family health competences stabilize over a longer period of time.

Shedding light on diverse health practices of caring for new-borns and the varying competences developing within these practices is potentially informative to strategies in public child healthcare to support children's health and to reduce social inequalities in health. The current clinical guidelines that focus primarily on educating and assessing parents on technical aspects of parenting may not be fulfilling the needs of first-time parents (Barnes et al., 2008), since they are not reflexive about the underlying 'cultural script' on good parenting which – as we have shown – does not resonate with the need for detachment. Yet, professional encounters can open up space and allow negotiations of (bio)medical knowledge, when parents, are acknowledged as “participants” with “divergent perspectives” (Nunes et al., 2014). Our findings could therefore stimulate professionals and policy makers to pay attention to parents' situated competencies and strategies to support their child's health and thus the degree to which professional knowledge is embraced and or balanced with practical considerations, employment, the parental position, experiential knowledge and the social network, and therefore it allows for new possibilities in providing early parenting support.

CRedit authorship contribution statement

Gerlieke Veltkamp: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Project administration. **Mutsumi Karasaki:** Conceptualization, Methodology, Formal analysis, Investigation, Writing - original draft, Writing - review & editing. **Christian Bröer:** Conceptualization, Methodology, Formal analysis, Investigation, Writing - review & editing, Supervision, Funding acquisition.

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