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"Adults Control It Better." Health-related Practices as Bonding in the Narratives of Polish Children

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Abstract

This paper shows how everyday health-related practices are played out in respect to performing parent–children relationships. Based on research with children aged 8–11 years old, conducted in Poland in 2015–18 with the aim of studying their opinions about health, this paper shows that children frame health-related practices in a broader set of social networks. This paper suggests that negotiations concerning healthy lifestyle, common among modern families in Poland, represent rituals through which parent–child relationships are practiced. What is more, children play an active role in this process. Children feel responsible for their own and their family's health and consider health-related practices as a way of "doing family".

Keywords: health, family, Poland, children, responsibilities

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Introduction

Ania[1], a 9-year-old girl from Warsaw, Poland, tells us about how food is prepared at her home:

> We do all sorts of healthy things there [in the kitchen], we don't make cake there, for example. We make cake with gluten-free flour, which I make together with my mum. […] Yes. We simply grind the grains. We just use a blender and we made a walnut cake here recently, for example.

In this fragment, various meanings concerning health are at work. Modern calls for a healthy lifestyle are clearly present, with a gluten-free diet and homemade foods. There are material objects, like a blender, which helps to pursue such a lifestyle. There is also the belief that home-made is better. Evident here is a spirit of togetherness through spending time in the kitchen and taking care of each other's health. A touch of pride, indexing identity, and a sense of belonging is also noticeable.

In this paper, I present some results of a research project on children's understandings of what is healthy and what is not. I examine the various ways in which these findings relate to family bonding. In what follows, I discuss how middle-class children in Warsaw, Poland, talk about health and how, through their narratives, they talk about relationships in the family. I try to see the complexity of parent-child relations, the inconsistencies and fluidities in knowledge-building, and in pursuing practices that are framed as health-related by children. I present various modes of building responsibilities in families. In doing so, I employ entirely an emic notion of health (i.e. I relate to actions, objects, spaces, etc., which were framed as related to health by the research participants, no matter whether they, intuitively, seem as such to me as an adult researcher.) I observe what meaning the participants give to what is healthy and what is not, and how they actively interpret the realities of family life.

Methodology and Ethics of Research

Between 2015 and 2018, together with my colleagues from the Interdisciplinary Childhood Studies Research Team, I interviewed 8-11 year old children from Warsaw as part of a research project entitled, "Health in the Opinion of Children – A Perspective of Childhood Studies". In total, we spoke with 120 participants, in groups of 4–5 children, conducted by two researchers, or individually. The largest group of children were from the middle class (about 100 of them), and in this paper I analyze material from this part of research. Children who were interviewed were basically healthy (not hospitalized, nor with a serious disease at the moment of the interview). They were students of public and private schools in Warsaw, in grades 2–5, from various districts. In Poland, children enter compulsory school education at

[1] The interviews were anonymized.

the age of seven, and primary school education lasts for eight years. There are public and private schools available. The vast majority of children attend public schools, but some middle-class families choose to quit the public schooling system due to raising concerns about its quality. In this study, less than 20 children were students of private schools.

The majority of the research was conducted in the children's homes, as we tried to avoid spaces associated with hierarchy and pedagogy in our project. These were mostly apartments in the apartment blocks in the city, with a few exceptions of houses in the suburbs. In all cases, in the apartments there were living family members from two generations (parents and their children). Some focus groups were organized at community clubs or places where daycare is offered to children who stay in the city during holidays.

This study is based on qualitative research. One of the research techniques we used was mapping of the house (in response to the question: What in your home do you associate with caring for your health, or, on the contrary, with things that are unhealthy?) Children were also asked to draw a healthy and an unhealthy person. They completed tables concerning their likes and dislikes of things and practices that they associate with health. They created collages (leaflets for other kids about health) and constructed stories (*storytelling*). Some of them also took photographs of spaces in their homes that they associate with health. We mainly used art-based methods because they represent a way of communicating that is not only more "natural" for children than the traditional interview, but also because such methods reduce the distance between researchers and participants, allowing them time and space to think their answers through (Clark, 2011, Elden, 2013). The methodology used in this project was planned to be open-ended, giving the children the possibility to express freely their views. Due to the in-depth and exploratory character of this research, I was flexible about the scope or order of questions, timing in research, etc. I just wanted to gain as best contact with the participants as I could and listen to their views on health and family life.

This research, in accordance with the new childhood studies paradigm, was planned and performed in a way that takes into account the role of children as social actors, who understand, interpret and transform their social worlds. In this approach, children's views were important for me not only because they are future adults, but because they are complete members of the society, here and now (James, Jenks & Prout, 1998, Corsaro, 2005). As Daniel Thomas Cook has written, "no longer in need of completion by the seemingly inevitable processes of 'development' and 'socialization', the agentive child stands on its own as a competent social actor at any given moment, transforming into new instances of completeness at various points along the life journey" (Cook, 2004, p. 4). Such understandings of the role of children shed light on the need for more mindful approaches towards children as research participants.

Most data on children's well-being comes from majoritarian knowledge (Deleuze & Guattari, 2004; see also Lee, 2005). The knowledge of children, who have different experiences than adults, tends to be seen as non-normative, or even pathological. In this context, it was important in my research to acknowledge children as a social group, which as a whole can be treated as a minority group (James, Jenks and Prout, 1998, James and James, 2008), struggling for the position of active social participants (Jans, 2004). Children's input into the construction of social situations is usually not sufficiently recognized, especially in Polish research. In this paper, I assume the attitude of conscious work with matters of generation, in the footsteps of Mayall (2008). This involves going beyond two previously dominant paradigms: the recogni-

tion of the meaning of generational difference as one that strengthens the relation of power (the child as an object of examination conducted by the adult) and the negation of the importance and consistence of the generational gap ("child-like examiner" position postulated).

The ethical dimension of conducting research with children was very important in this project (see e.g. Alderson & Morrow, 2011; Maciejewska-Mroczek, 2018). Children are particularly vulnerable as subjects due to their position in the world, their scope of knowledge, and their ability to effectively influence reality. As such, research that involves their participation requires particular ethical consideration (Christensen & Prout, 2002; Hill, 2005; Gallacher & Gallagher, 2008). In this study, I especially took into account the specifics of children's communication methods (Christensen & James, 2008; Clark, 2011). Throughout the research process, these children were competent informants in matters concerning their lives (Mayall, 2008).

My colleagues and myself have tried to refine and strengthen these ethical considerations on conducting research with children in Poland as part of our work in the Interdisciplinary Childhood Studies Research Team, which operates under the auspices of the Institute of Ethnology and Cultural Anthropology at Warsaw University. With this aim, we prepared the first Code of Conduct concerning Research with Children in the Social Sciences (Maciejewska-Mroczek, 2017). The research, on which this article is based, was conducted in accordance with these rules. The most important requirement from the ethical perspective relates to obtaining informed consent. Participants in our research were informed about the scope, aims and methods of the project using information brochures. They were informed about the possibility to withdraw consent partially or in total. Separate brochures were prepared for parents and legal guardians. Both parents/guardians and participants filled out the consent/assent forms before the interviews (for more on consent, see Alderson & Morrow, 2011). We approached consent/assent as processual, and as such, throughout the entirety of each research meeting we remained especially attentive to children's will of participation, expressed directly and indirectly.

Children and Health-related Entanglements

My research is situated in a particular context; I study how health-related meanings are formed in the capital city of Poland in middle-class families. The time and setting of the research seem to be especially meaningful for me now, as I look back at this period in the midst of the Covid-19 crisis when this text is being written. The research which I present here was conducted in the years 2015–18, a period of relative economic stability in Poland. Unemployment rates were low, compared to those from a decade ago (GUS, 2020), and the financial profits of Poland being an EU member were visible. Although there was also a reported rise in social inequalities and instability of employment, it barely related to middle-class capital-city families where I did my research. Thus, notwithstanding some unwelcomed changes in the schooling system, or in healthcare, and, of course, some other obstacles in individual cases, in general, middle-class families in Warsaw experienced what may be called

a period of stability, if not prosperity. There was, at the same time, continuous growth of neo-liberal narratives about individual responsibility for one's well-being present. The state withdrew more and more from the responsibility for implementing policies which would ameliorate healthcare on a national level. Along with the political turn in which conservative Law and Justice came to power, the individualization of responsibility was strengthened via direct cash transfers and diminishing public services. The middle classes' answer was looking for resources and services independent of state: private schooling, extracurricular, after-school classes, private healthcare paid out-of-pocket, etc., which was framed as "the second wave of privatization" – after post-communist privatization in early 1990's (Pawłowski, 2020). This built a landscape for my study of intimate, ever-day family practices concerning health as seen through the eyes of children.

I ask, "By what means, in this specific context, are family relationships established in the area of health? How do they position parents and children? What types of activities, spaces and objects are defined as health-related, and which of them do children see as having potential for relationship-building and bonding?" Finally, can conflicts around health-related practices also be interpreted as a means of building family life? I ask about the responsibilities in the families. In this research, I acknowledge that the body is an especially crucial element of the socialization process in the area of health (Horschelmann & Colls, 2010).

My project came from a recognition that the results may be useful for a better understanding of the entanglements of health, childhood and family in contemporary Poland, filling the existing gap in research. Although in the international literature, healthy children's everyday perception of health and illness has been explored for a significant period of time (see for example, Mayall, 1994 and Christensen 2004), the Polish context remains under-researched. Attempts at understanding the point of view of children by analyzing their own narratives are still scarce in Poland. My focus here is on health. I am very aware of the elusiveness of the definition of 'health' in late modern times (see for example, Crawford, 2006), thus I will explore different ways of defining it, above all by taking into consideration the emic definitions, namely the ones proposed by children. Following Crawford's argument, I see health as one of crucial categories organizing social life. As Crawford notes:

> In a health-valuing culture, people come to define themselves in part by how well they succeed or fail in adopting healthy practices and by the qualities of character or personality believed to support healthy behaviors. […] The pursuit of health, in short, has become one of the more salient practices of contemporary life, commanding enormous social resources, infusing every major institutional field and generating an expansive professionalization and commercialization, along with attendant goods, services and knowledge. Health may be reasonably described as a social cynosure, a meaningfully and emotionally charged fixation – both a goal and a source of anxiety, a value for self and others, integral to identity, a state of being that is continually assessed and the organizing concept for a vast organization of social action (Crawford, 2006, pp. 402, 404).

Despite many changes in recent decades, the World Health Organization's (WHO) broad definition of health plays an important role. According to this international health organization, "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). It is still a broad definition, which extends popular thinking of health as a mere "lack of illness". What is interesting, children in my research also built a broad definition of health and health-oriented activities, somehow understanding health in a much broader way than might be expected. "Healthy" and "unhealthy" behaviours varied between children and adults in their narratives. Just as children practice their childishness by means of some activities, other types of behavior defined as health-related serve to separate the world of adults from the world of children, also in breaking the rules of a healthy lifestyle.

Taking care of one's health involves a complex set of activities, and in the case of children, who are at the same time dependent and priceless (Zelizer, 1996), and obliged by modern discourses to act as independent, self-reliant individuals (Spyrou et al., 2019), they may seem especially complicated and uneasy. Pia Christensen shows how many actions agentive child may perform in relation to health:

> For the child to develop independent agency in relation to their own (and others) health and well-being the key aspects suggested are: self-care (physically, emotionally and socially), personal care and hygiene, keeping fit and active (physically and mentally), developing and maintaining connections (including relations of care, responsibility and obligation) with parents and peers, balancing and managing everyday risks, developing knowledge and health-related skills and competencies, developing positive values and meaningful goals for own health, wellbeing and health behaviors, and the ability to consult and use healthcare services (2004, p. 379).

In my research, I searched for the children's knowledge and opinions about health-oriented activities in families; trying to employ such broad perspective.

Doing the Family through Health-related Practices

My primary research question in the broader project was: How do children define health, what does it mean to them, and how do they pursue it? The interlocutors started school 2-4 years ago, and while still heavily influenced by family narratives concerning health as well as particular parenting strategies, they were also affected by the official, state-endorsed discourses offered in their schools. I and my colleagues were curious to see how these varied sources of information framed health-related topics to kids and how children responded to them in turn.

Over the course of our research, the topic of intergenerational relations and how they are pursued through health-related activities surfaced. It ought to be noted that we did not suggest a list of such practices to the participants, nor did we suggest what they could be. It was the children who volunteered information about which places, activities and people they associate with, what is healthy or on the contrary, with what they consider to be unhealthy. Most of all, I asked about specific experiences, and were interested in the children's actual, practical knowledge. It appeared that children link health-related practices with family relationships in various ways.

Aleks, 11 years old, talking about pursuing health, said:

> Basically, parents watch children, but children can mention some things to parents, so it is in two ways, but actually these are parents who watch children. They should at last.

These words are a good example of children's views about parent-child relationships and each other's obligations towards health. Heath is, at first sight, an adult's responsibility. Children have some voice but are generally dependent on parents. However, in the course of study I found out that many children see these relationships and requirements more broadly.

For contemporary mothers and fathers, there exists the well-known image of upbringing as a story of "permissive" and "rational" parents (Buckingham, 2011). The former succumbs to children's "natural" tendencies like consuming and breaking the rules of modern-day health regimes concerning nutrition or leisure activities. The latter parents, in turn, are in the position of control: they define boundaries and act as advocates and practitioners of contemporary requirements in body management. In both cases, relations between generations vis-à-vis health-related practices appear antagonistic. The roles, meanwhile, seem permanently assigned. They include the more or less submissive but rational parents, and the children, who require education or discipline in the field of health regimens. At the same time, in this picture "a child is always a child" and therefore, in a sense, it "naturally" undermines these requirements. This, in a way, presents the essence of their childlike nature, as they contest a "healthy lifestyle". Such strategies are mediated through specific, childish, material culture (Diasio, 2018).

My research shows that while these strong cultural patterns function in children's worlds, children creatively transform them on their own. Practices defined by children as pertaining to health frequently become a kind of medium through which intergenerational relationships are determined and negotiated between parents and children. Caring for one's health can become a tool for creating attachment, establishing a closer relationship, or seeking and finding understanding. It might also serve to create meaningful space, prone to becoming a site of conflict. It is certainly not without significance that this is done on the level of bodily practices, frequently within the non-verbal realm. At the same time, negotiations concerning healthy lifestyles (variously defined in different families), that are an inherent part of the contemporary family and its everyday practices, can be understood as part of the relations between parents and children. The role of children therein appears to be active. Thus, pursuing health-related practices can be understood as a way of co-creating a network of intra-family

connections, of forming, practicing, and renegotiating family habits. An important factor here is the moral dimension of health-related practices. Like Jarret Zigon, I understand morality as a complex system that reveals itself every day in the form of individual moral dispositions, of which most are not conscious. Here, morality does not mean the same as ethics. Morality is embodied, relational, and practiced in action; it is powered and co-created by various social actors (Zigon, 2007, 2009; see also Boni, 2016).

In the opinions of the children that I talked to, health-related practices may include, for instance, the joint preparation of healthy meals. In their narratives, "home" food often appears in juxtaposition to "purchased" food, particularly fast food. A sense of community is created by responding to the calls of modern health-promoting discourses, like in Dorota's family:

> When we eat, for example, instead of sweet cereal you can make your own granola. We make that with mum, using bran, with nuts and cranberries. I eat that with yoghurt. And with honey from my grandfather, he's a beekeeper.

What is home-made is good, and in effect gains positive moral value. Efforts to provide healthy alternatives to store-bought food are those that join family members from different generations. It seems that being homemade, was for Polish children, the most important value in relation to food. Further, what usually constitutes a symbol of unhealthy lifestyle can be "domesticized", like in these examples given by a ten-year-old Marcin:

> I eat fast food, but I tried to make it at home once, with my mum, we tried to re-create fries from McDonald's, because this dude posted a film in the net how to make homemade McDonald's fries.

This fragment shows clearly that there is no such thing as a list of products or foods that are 'healthy' or 'unhealthy' in any objective way, and that healthy feeding is always relational (Boni, 2018). Although some foods epitomize "being healthy' (dishes made using kale or millet for some children, apples or meat chops for some others), it is not the product itself that gives this quality. What is healthy and what is not is rather formulated and negotiated throughout family's practices, and the fact that certain food was homemade gave it a special value. Food which is cooked together by children and parents gains special meaning, exceeding dominant discourses about nutritional aspects of eating and feeding.

Another way of practicing relations is the joint pursuit of various physical activities. Parents can act as models of this type of positively evaluated behavior:

> Cyprian: You can exercise. Run, ride a bike.
> Artur: Climb.
> Maja: I went biking today.
> Researcher: Already?
> Maja: In the morning, with mom.

A parent may be regarded as a role model in this respect. Children very often expressed pride when they could present their parent as someone who could be followed in the pursuit towards a healthy lifestyle. 10-year-old Dominika says:

> My dad, he's given up sweets and doesn't eat any sugar [...]. He runs and rides a bike. I bike too.

Children talked about sharing with their parents such varied activities as riding a bike, hiking in the mountains, climbing, roller-skating, shooting or training fitness with a popular coach on Youtube. The catalog of such activities shows that the scope of ways in which parents and children bond is varied and that they make use of what modern changes in lifestyles offer. There is a strong sense of togetherness, constructed while doing together something that is both pleasant and morally appropriate. These numerous accounts of togetherness, which is built through taking care of one's body through physical activities, show how the discourses of healthism (Crawford, 1980) and may be intertwined with modern ways of "doing family" (Morgan, 1996).

Yet children define what is healthy in a much broader manner than one could intuitively suspect. When discussing health, they make references to such activities as singing lullabies or caring for animals or plants. They engage with various objects and spaces at home, like electronic devices, beds, shelves in the kitchen, and hygiene appliances in the bathroom. Here again, the moral dimension of health is at work: what is good is also healthy. A fitting example is that of a space, associated with warmth and love, which can also be healthy, as in this fragment of an interview with 8-year old Dorota, who was supposed to mark "healthy" spaces on her home map:

> Here I marked my parents' bedroom because I simply love sleeping there. They have a double mattress there, it's more or less one mattress of this size and it's so great for jumping. It is so great for jumping that I just… I can never get bored with it. I also really like to lie there because mommy has really nice blankets and when I lie down there it's as if some lovely creature is covering me because I feel warm all over.

In this fragment, various meanings are expressed, and health is only a means to talk about other things that are important at home: sensory feelings of warmth and coziness, the bodily pleasure of jumping, the sense of being free to move in a safe space, and an affectual attitude towards the very space, which is familial and pleasant. Although parents are not directly present in this picture, their role in creating such space and maintaining its quality is obvious.

In the narratives of most children, an exclusive domain of adulthood was mainly that of stimulants: alcohol and cigarettes. On the one hand, their use was treated as a manifestation of adulthood, but on the other, it was judged negatively as being unhealthy. Some children positioned themselves as "too smart" to do that. They also differentiate their status (as children)

by defining particular "adult" activities as "unhealthy", like in this conversation with nine-year old boys:

> Cyprian: Adults drink wine, beer, cognac, vodka and all the other nasty things.
> Bartek: Some smoke cigarettes but kids eat sweets. They watch a lot of TV. Or eat hamburgers.

Here, the distinction between the adult's and the children's worlds is evident, and both generations have their own means of defining their boundaries like in this example of cigarettes and sweets. Cyprian described activities pursued by the adults very negatively; they are "nasty", and children are in the position to judge them. Bartek, however, adds some activities, which are very often judged and restricted by the adults. Here a kind of equality vis-à-vis the requirements of healthy lifestyles.

Who Controls It Better? Responsibilities and Relationships

Nevertheless, children participating in our research frequently defined their parents' role as that of regulating. First of all, adults in general were presented to have a stronger will and greater ability of self-control and moderation, and this refers especially to parents. As Buckingham writes, "parents are frequently urged to resist consumerism on behalf of their children: only then, it would seem, will children be able to experience a good or proper childhood" (Buckingham, 2011, p. 16). It is worth noting, however, that such an attitude towards child-parent relationships in the context of consumerism is very characteristic of the middle class, with its stress on individual responsibility and control, and differs, in general, from less privileged classes, who express the ability to support their families (i.e. "virtuous nonconsumers" vs. "stable providers", see Pugh, 2009). This ability of self-restraint refers not only to being assessed and controlled by some other adults, but also to what the children expect. Setting the example is what is required of parents also by their children:

> Ola: Maybe I could hold out for a week without sweets and those kinds of pleasures, but I don't think I could stand two weeks…[…]
> Nela: That's how kids are!
> Ola: […] Adults control it better. Even if they want something sweet, they will not want candy as fast. And the adults, not all of them, but some, eat candy less often… and children like sweets a lot, because sweets are good and… I am not saying the adults don't like sweets, cause they do just like kids do, but they behave with moderation.

Parents are therefore also responsible for setting down boundaries and regulating not only their own, but also their children's behaviour. This is what children expect from them. This is how, according to them, family relationships look like. Most frequently this occurs by establishing rules and limiting the use of electronics:

> Researcher: What does dad do to care for your health?
> Helena: He doesn't let us play.

Children respond to parental regulations with various subversive actions. It is through these actions that their childhood is performed. Being a child is not only about not being an adult. Rather, it is about directly expressing their lack of respect for norms laid out by adult health regimens (Reimann, 2018). Marcin expresses his enthusiastic view on fast food, although he is aware that this is against his mother's norms.

> My mom tells me, for instance, how unhealthy McDonald's food is. But I got myself some McDonald's food on Saturday and really liked it.

Here, the pleasure of eating at McDonald's comes from eating a delicious meal, but also has a flavour of rebellion. Being a rebel or a little rascal is a model embedded in Western culture. Performing this role is somehow a duty of the modern child (Laakso, 2018). In Poland, attitude towards fast food restaurants and "junk food" is additionally complicated, because for the after-transformation generation they epitomized modernization and "westernization", and therefore may be still regarded especially attractive.

Rebellion and even anger resulting from the feeling of dependency and the impossibility of breaking the norms and bans imposed by their parents can also be an answer, like in Anna's words:

> Me? I really try... but that computer... it's supposed to be mine. My very own computer. But dad won't let me play Sims because there's a password for his account and I just hate it that there's some kind of a password […] and these Sims are just gonna be the end of me!

Anna's critique of parental control over the use of electronics is a part of constant negotiations towards healthy lifestyles that are going on in families, and the child's quest for autonomy. Controlling the use of electronics is both expected and fought against by many of my interlocutors.

Despite still existing moral panics concerning "the disappearance of childhood"

(Postman, 1982), and the independence from the knowledge of adults that children are able to gain nowadays, my interviews showed that parents are not only regulators of behaviour, but also the main source of information concerning health for children. This gives parents a significant lead, ahead of educational institutions or doctors because as sources of information, parents were an unquestionable authority for my interlocutors. While children may express doubts concerning various actions, they do not undermine their parents' knowledge. This kind of knowledge is based on often non-discursive practices, on repetitions, routines, and doing things together. It has thus a very different quality and value from the official knowledge that is provided by specialists in educational settings (see Mayall, 1994).

And even though both mothers and fathers are present in children's narratives, it is mostly the mothers who are the guardians of health and bearers of knowledge on all health-related matters; they are "health managers" which is due to gendered roles in families and still-existing requirements about good motherhood. (On the complex role of mothers for the health of the family, see McKie et al., 2004. On contemporary requirements about feeding, see Carins et al., 2013). However demanding this role may be, it is widely recognized and valued by children. Mother is someone close, someone most present in everyday care. In effect, her role in managing the health of her family is obvious and uncontested, as demonstrated by this short conversation from my research:

> Researcher: Who cares for the family's health the most?
> Marek: Mum.
> Jacek: Mum.
> Ignacy: Mum.

In Lila's view, the duties and responsibilities of mother are embedded in closeness and emotional connection.

> Researcher: And why do you usually go with your mom [to see a doctor]?
> Lila: Because mum knows us best.

Mothers, as one child mentioned here, are the closest adults, thus their responsibilities and roles were the result of such a position within the family. Father's roles, in the narratives of children, were of a more regulatory, or activity-oriented character. Like in other countries in the western world, fathers' roles in families change towards being more equal and caring, but in my participants' views, the mothers are still those who are mainly responsible for everyday health-related care. A child's responsibility may be, for example, making this care easier by one's responsible behavior, like in the case of Mira, 9:

> For example, I try to make my mum pack some healthy additions to my lunchbox. I mean carrots, tomatoes… I am a kind of child who likes to try everything. And I like vegetables very much, and fruit. This is why it is a little bit easier [for mum].

Children may also have their own responsibilities towards their healthcare, and some of them may seem quite demanding, like keeping control over taking everyday portion of vitamins:

> Researcher: How do children take care of health at home?
> Mateusz: One must remember to take D3 vitamin. And communicate, for example, that you are sick. […]
> Researcher: Ok. And do you remember about D3? Is it more on you or on your mum?
> Mateusz: I mean, I try to remember, but sometimes I happen to forget, when I have a lot of homework and I want to go to sleep, and at eight in the morning I have, for example, Early Stage [extracurricular English class].

Mateusz sees his own role in health-related activities as active as he takes responsibility for everyday practices. He also mentions what seems very crucial; communication within family as a way of taking care of one's health.

Various rules concerning behaviours that children view as health-related are determined through intra- and intergenerational relations. For instance, an older sister of one of our interlocutors is free to watch TV after school, which clearly shows her hierarchical position in the sibling group (see McIntosch & Punch, 2009), but only until 5:00 pm when her father returns home and "takes over" the TV set. The teenager's freedom is clearly limited by her father's regulating actions. But her freedom to use the TV is not limited out of concern for her health. All parties similarly strive to use the "unhealthy" form of entertainment. There is no intergenerational difference here in terms of interest, but the hierarchical relations in the family regulate the child's and the adult's access to the TV.

The most intense negotiations are in areas that children associate with health concerned media and electronic devices. Interestingly, electronic media was very rarely valued positively, for example, as sources of knowledge. Using them was commonly defined as unhealthy by the children, therefore there was consensus expressed as to the fact that their use ought to be limited somehow. These material objects shaped the actions within the whole family, making control over them very difficult. (On parents' struggle for limits on electronic media, see Sikorska, 2020). However, according to children, "childish" behavior and the uncontrolled use of media and electronic devices is often the domain of adults:

Lena: My dad is often busy on his phone and I tell him…
Researcher: But what does he do?
Lena: He just can't get away from it.
Maks: My dad does the same.

The regulatory role of an adult may be intertwined with his own inability to control the use of electronic media. 10-year old Witek complains:

My dad lets me play on the Xbox for half an hour and then he plays on his own for three hours.

In this case, relations understood as those between rational adults and children who cross boundaries, are disturbed. They are not reversed, however, but rather equated. Everyone, adults and children alike, tend to succumb to small pleasures, even though that may be defined as "unhealthy". Further, family life is not only based on seeking togetherness, but on finding a balance between forming community and pursuing autonomy. For both children and parents, autonomy may also be achieved by means of breaking the rules, or temporarily ignoring the requirements of a healthy lifestyle. Sometimes, seeking autonomy leads to conflict, which also builds family life. But conflict is intertwined with performing love and care, and responsibilities concerning health in families are not only those of parents over children, but are multi-dimensional. In this fragment, we can see the richness of meanings concerning duties, responsibilities, and positions of control in the family.

Researcher: Who is responsible for health in your home?
Children [together]: The parents!
Marcin: Unless mum is smoking. But she only smoked like three [cigarettes]. I got mad at her, totally! I told dad!
Researcher: But why did it make you so angry that mum smoked?
Marcin: Because you're not supposed to smoke!
Researcher: So, is it the children who control health?
Marcin: Yes, they control it, right!
Researcher: Children watch that the parents don't do unhealthy things? […]
Ola: Or that they turn well, when driving.
Marcin: That they don't hit other cars or road signs. […]
Researcher: So, you need to watch those parents a bit?
Marcin: But my mum also watches out for my dad.

The rich network of responsibilities is constructed by the mutual care of children and parents, as well as between adults. This fragment shows very well that taking care of one

another's health may be an act of bonding, performed in the process of family making. It shows how Polish middle-class children regard caring for one's health not as merely individual responsibility, but as a network of responsibilities. Here, various actors are engaged, and reciprocal responsibilities negotiated. What's more, it shows that children see their role as being very important in this process.

Conclusion

Examples from my own research illustrate the wide spectrum of ways in which relations between parents and children are built through health-related practices. When participants in my interviews spoke about what is healthy and what is not, or about who cares for their health and how, they were, in reality, often talking about who they are as children and how they understand the world around them, including their closest social world. In so doing, they presented their own interpretations of social situations. In their stories, we can see some well-preserved cultural figures, such as that of the rascal child, or a responsible adult, who "controls it better". We can, however, also see a figure of a child who is a responsible individual. Children recognize modern discourses concerning health and talk about them proficiently. This research also showed that modern regimes of health are present and practiced in family life in contemporary Poland. Various activities, objects and spaces are engaged in the process of bonding through taking care of one's health. Yet a sense of togetherness was something more complicated and of greater importance than simple following rules of healthy lifestyles. The process of "doing family" was pursued not only by doing something good for your health together, but through mutual regulations and responsibilities. Thus, control over health-related practices in the families was performed in a multi-layered and complicated network of practices, bodies and objects, and certainly not always these are the adults who "control it better".

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