



Healthy food talk as action in everyday mealtime conversations of families with a low socioeconomic position



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ABSTRACT

To date, little is known regarding if and how healthy eating is discussed, and how the concept of healthy eating is used in everyday interactions of families with a low socioeconomic position (SEP). This is an underrepresented study population in which many health benefits can be gained. By deploying an interactional approach to healthy eating, this study explored how healthy eating is constructed and oriented to during evening mealtimes in families with a low SEP. The data corpus comprised video recordings of 79 mealtimes from ten families with a low SEP. Healthy eating was rarely oriented to explicitly, as shown by the identification of only sixteen cases in which family members referred to (un)healthy eating. Using discursive psychology and conversation analysis, the examination of these cases showed that, how and with what function health claims were produced and designed as either identity-centered health claims or food-centered health assessments. By deploying identity-centered health claims parents constructed a desired prospective identity for their children to manage their eating behavior, whereas by deploying food-centered health assessments speakers accounted for their own behavior, particularly eating or providing food. The findings give a unique insight into how healthy eating is oriented to and constructed in the everyday life of families with a low SEP. In addition, the findings extend the discursive psychological body of literature on healthy eating talk during family mealtimes, and add to the knowledge base on discursive practices deployed to get children to eat.

1. Introduction

1.1. Background

Dietary and health inequalities continue to prevail between populations with various socioeconomic positions (SEPs), in the sense that populations with a low SEP consume relatively poorer diets than populations with a higher SEP (Giskes, Avendaño, Brug, & Kunst, 2010; Kontinen, Sarlio-Lähteenkorva, Silventoinen, Männistö, & Haukkala, 2013). Moreover, the prevalence of diet-related health problems such as obesity, diabetes mellitus, and stroke is relatively higher in populations with a low SEP (Volaco, Cavalcanti, Filho, & Précoma, 2018; Marshall et al., 2015). Thus, engaging in a healthy lifestyle could yield substantial health benefits for populations with a low SEP; especially children, who have the highest potential of healthy life years to be gained, and considering that the socioeconomic discrepancy in diet quality already emerges in childhood (Mech, Hooley, Skouteris, & Williams, 2016; Van

der Velde et al., 2019).

However, populations with a low SEP are least reached by interventions promoting a healthy lifestyle, including healthy eating (Beauchamp, Backholder, Magliano, & Peeters, 2014), even though healthy eating is perceived as important by populations with a low SEP (Van der Heijden, Te Molder, Jager, & Mulder, 2021). This may be due to the interventions being insufficiently adapted to the complexity of their everyday life (Bukman et al., 2014). In order to successfully engage populations with a low SEP in interventions promoting a healthy lifestyle, including healthy eating, more insight is needed into the role that health and healthy eating play in the complex everyday life of populations with a low SEP. However, populations with a low SEP are underrepresented in current research, and acquiring those insights comes with substantial challenges. Populations with a low SEP are difficult to reach with conventional recruitment and research methods (Stuber, Middel, Mackenback, Beulens, & Lakerveld, 2020). If researchers do not make an explicit effort to include populations with a low SEP, this target

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group is likely to be passed over.

Furthermore, research in the field of healthy eating often relies on people's accounts of what they believe, and accounts of how they ostensibly treat healthy eating in everyday life, for example by means of interviews or questionnaires. Although this provides useful insights in their own right, a problem that arises with this approach is that accounts of beliefs about healthy eating might not correspond to what people actually *do* in everyday life, or to how healthy eating is explicitly oriented to in everyday practice (Wiggins, 2004).

1.2. The interactional approach to healthy eating

Discursive psychology (DP) and conversation analysis (CA) provide suitable approaches to research how healthy eating is oriented to in the course of everyday life. DP and CA are methodologies for the analysis of everyday conversation, i.e., real life talk-in-interaction (Edwards & Potter, 1992; Potter, 2021; Schegloff, 2007; Sidnell & Stivers, 2013; Wiggins, 2017). DP and CA assume language is action-oriented, i.e., that talk is used to accomplish social actions. Deploying DP and CA can thus provide insight into how healthy eating is *constructed* and *used* in talk-in-interaction in everyday life, and how healthy eating talk accomplishes *social actions*. To illustrate, food preference, i.e., to like or dislike a food, is shown to accomplish social actions such as complimenting the cook, fishing for more food, or rejecting food (Wiggins, 2001; Wiggins & Potter, 2003).

Moving towards the domain of how healthy eating is oriented to and constructed in everyday family mealtime interactions, two studies were identified. Wiggins (2004) studied how family members constructed and managed healthy eating advice to one another, focusing on claims about what food contains or consists of, such as vitamins or herbs. When health claims were constructed as generic, universal advice, and the focus was on a category of foods rather than one specific item, health claims were used to, e.g., account for eating that food or to justify choosing it for the family meal (e.g., “herbs are good for you”, or “your body needs it”, in which “you” and “your body” are generic). When health claims focused on an individual and applied to a specific food practice in the present moment, e.g., “you haven't eaten your salad, but it contains vitamins”, the claims could accomplish other actions, such as holding an individual accountable for their eating practices (Wiggins, 2004).

Furthermore, Veen, TeMolder, Gremmen, and Van Woerkum (2012) studied how medically required dietary restrictions were treated and managed in families with a child suffering from coeliac disease. In everyday conversations during mealtimes, it was not the foods' safety or healthiness that was used to account for eating those foods, but rather the food's tastiness, whereby family members constructed eating a gluten-free diet as a matter of choice (Veen et al., 2012).

Both studies on how healthy eating is oriented to and constructed in everyday family mealtimes provide detailed analyses and insights. However, they focus on a specific interactional environment, i.e., advice-giving or managing a disease-related diet, and do not topicalize SEP. Therefore, a continued exploration of how health claims are produced and oriented to in talk-in-interaction is warranted, and is essential for our understanding of how healthy eating is constructed and oriented to in the everyday life of families with a low SEP.

1.3. The interactional approach to ‘getting children to eat’

Previous studies identified that parents referred to food healthiness as one of various argumentative strategies to get their children to eat (Bova & Arcidiacono, 2014; Bova, 2019; Edelson, Mokdad, & Martin, 2016). A body of literature deploying DP and CA, focusing on how talk accomplishes specific social actions, also addresses the matter of getting children to eat in family mealtimes. Although health is not specifically topicalized in these studies, they may provide directions for further analysis on how healthy eating is constructed and oriented to in talk-in-interaction in everyday life, and how references to health

accomplish social actions. Several studies investigated how parents manage children's behavior during mealtimes, for example how parents construct and use requests, directives, admonishments and threats, and how children may respond to those (Antaki & Kent, 2015; Craven & Potter, 2010; Hepburn, 2020a, 2020b; Hepburn & Potter, 2011; Kent, 2012a, 2012b; Potter & Hepburn, 2020). Craven and Potter (2010) explain how directives differ from requests in terms of the extent to which a speaker (in this case, a parent) displays entitlement to direct a recipient's (in this case a child's) actions. Unlike requests, the design of directives reduces the contingency of the directed course of action by the speaker on the capacities or desires of the recipient (Craven & Potter, 2010). Kent (2012a, 2012b) highlights how children can respond to directives, e.g., by displaying compliance, resistance, legitimate non-compliance, or incipient compliance. In addition, Hepburn (2020a) analyzed parental practices of managing “problematic” child behavior in the context of socialization, and identified how instead of deploying “invasive” management behavior tools such as directives, admonishments or threats, parents can also provide a child with opportunities for self-direction. Rather than telling children what to do, parents let children seek their own solutions to their problem behavior, a practice through which child socialization is interactionally achieved. Moreover, allowing a child to correct its own problem behavior can avoid undesirable consequences of more invasive practices, such as the emergence of conflict (Hepburn, 2020a).

1.4. Study aim

It is unknown if and how healthy eating is discussed, and how the concept of healthy eating is actually *used* in everyday interactions of families with a low SEP, an underrepresented study population in which many health benefits can be gained. By deploying an interactional approach to healthy eating, the aim of the present study is to explore how healthy eating is constructed and oriented to during evening mealtimes in families with a low SEP, by identifying interactional patterns regarding how, when, by whom and with what function health claims are produced.

It should be noted that in discursive psychological and conversation analytic research, it is assumed that interactional patterns transcend linguistic and cultural diversity (Schegloff, 2007), and it is deemed controversial to categorize research participants based on pre-existing categories such as SEP. However, there is a growing body of literature that disputes the stance that participants' categories should only be addressed in the analysis when oriented to by the participants themselves in the interaction, arguing that what is *not* explicitly oriented to is also relevant for the interaction, and can unravel a taken-for-granted worldview of the participants in the interaction (Kitzinger, 2000; Whitehead, 2020). Moreover, since populations with a low SEP are underrepresented in research, and given the urgency of the topic at hand, i.e., the potential health benefits that can be gained if lifestyle interventions can be successfully tailored to the everyday life of families with a low SEP, we argue it is both scientifically and societally relevant to conduct the present research in families with a low SEP. This, however, does not imply that interactional patterns identified in the present research are only characteristic for families with a low SEP, nor that they are there ‘because’ families have a low SEP. Rather, identified interactional patterns provide insight in how families from an underrepresented study population talk about healthiness of food, and the findings are *at least* applicable in this population.

2. Methods

2.1. Data corpus

Video recordings of 79 evening mealtimes, made by ten families with a low SEP, were collected for this study. Families consisted of at least one parent and at least one primary school-aged child. The specific

composition of each family is described elsewhere (Van der Heijden, TeMolder, Huma, & Jager, 2022). Low family income and a low or medium education level of at least one parent (CBS, 2021) were used as indicators for low SEP. Education level and demographical information (i.e., age of the family members) were assessed before the families started recording. Nine families were recruited from food banks in the Netherlands, indicating a low family income. One family was recruited via snowball sampling.

All families were provided with two cameras and recorded their evening meals themselves. No researchers were present during the recordings. The two cameras were placed on tripod stands next to the dinner site, enabling recording from various angles and capturing verbal as well as embodied interaction. Families received meal boxes as reimbursement for their participation after they completed the recordings.

All family members were informed about the purpose of the study (i.e., to capture naturally occurring conversation during mealtimes) and were given ample opportunity to ask questions. All recorded family members provided written informed consent (written informed consent for children was provided by their parents). This study was approved by the Medical Ethical Review Board of Wageningen University & Research, the Netherlands (METC-WU, file number: NL64893.081.18).

2.2. Analytical procedure

First, a verbatim transcript of the recordings was made by a transcription service. The researchers manually searched the verbatim transcripts for sections in which the (un)healthiness of foods was discussed. Detailed transcriptions of these sections were made by the researchers, using the Jeffersonian notation (Jefferson, 2004) and including embodied actions (such as eye gazes and hand gestures) that were derived from the video recordings. Sections were marked as being about health when the (un)healthiness of food was literally mentioned (e.g., “this food is (not) healthy”) or when physical outcomes of eating a food were mentioned (e.g., “this food is (not) good for you”; “eating this food makes you strong”). The analysis draws on a collection of sixteen cases that met these inclusion criteria.

Discursive psychology (DP) and conversation analysis (CA) – qualitative, inductive methodologies for the analysis of real-life talk-in-interaction – were used to analyze the data (Edwards & Potter, 1992; Potter, 2021; Potter & Hepburn, 2005; Schegloff, 2007; Sidnell & Stivers, 2013; Wiggins, 2017). Rather than aiming to gain insight into cognitive processes through talk, DP and CA focus on how conversational practices accomplish specific actions in talk-in-interaction (such as complimenting, persuading, or accounting) (Potter & Hepburn, 2005; Sidnell & Stivers, 2013). Moreover, as interactions are highly normatively organized, they can reveal taken-for-granted social and interactional norms (Garfinkel, 1967), including norms on healthy eating in the context of everyday life.

Each individual case was examined in detail and in an iterative, analytic process interactional patterns were identified. The analysis will show that and how the interactional environment shapes the format of a produced health claim and its function, i.e., the social action that is accomplished with the claim. All analyses were performed on the original Dutch data. The structure of sentences in the English translations resembles the structure of the original Dutch versions in order to allow readers to optimally follow the presented analysis. Consequently, the translations do not always display grammatically correct English sentences.

3. Analysis

First, it should be noted that the identification of only sixteen cases in a data corpus of 79 evening mealtimes shows that healthy eating is rarely oriented to explicitly during evening mealtimes in families with a low SEP. This scarce number is an important finding considering the rationale and aim of the study, with implications that will be elaborated upon in the

discussion section.

Furthermore, our analysis of the identified sixteen cases distinguishes two formats in which interactants produce health claims, that accomplish distinctive social actions in the interactional context in which they are produced. First, *identity-centered health claims* were produced in the interactional environment of managing children's behavior, in the large majority of cases in argumentative sequences, to overcome (potential) food resistance. Parents constructed a desired prospective identity for their child to manage their child's behavior and to cajole them to consume a particular type of food. Second, *food-centered health assessments* accounted for a speaker's own behavior, particularly for eating or providing a specific food. These were produced in various interactional environments where managing other people's behavior was not the main issue. Both types of health claims will be elaborately explained and substantiated with evidence in the following two sections.

3.1. Identity-centered health claims

Identity-centered health claims were most frequently produced in the data corpus (9 times). The first example shows how a parent produces an identity-centered health claim in the context of a child's food resistance. Excerpt 1 features Mum, Dad, Marie (11 years old), Benjamin (8 years old), and Claire (3 years old). The family is eating dinner on the couch by the television (not switched on). The meal consists of schnitzel, red cabbage and potatoes. The target claim is produced by Dad on line 7.

The sequence starts with Claire addressing Mum and stating that she does not need to eat. After a 1-s silence, indicating an upcoming dispreferred response (Schegloff, 2007), Mum produces a directive in which she orders Claire to eat (line 3) (cf. Craven & Potter, 2010). Mum's response displays her understanding of Claire's turn as *resistance to eat*, as her directive is directly countering the possibility that Claire resists eating her dinner (line 3). Subsequently, Dad produces a similar directive to Claire, also displaying his understanding of Claire's turn as *resistance to eat*, and countering it (line 4). Following a 1-s silence, Claire starts what will turn out to be an account for her prior statement and a continued display of resistance. Taking advantage of Claire's somewhat disfluent production of her turn (note the colon within “j:e” in line 6 indicating the lengthening of the sound), Dad comes in with an account grammatically designed as an increment to his prior turn (Couper-Kuhlen & Ono, 2007): “Otherwise you never become big and str:ong.” After a 1-s silence, Claire restarts the account she had not finished: “IF (1.0) if you don't want to = eat you:should not e:at” (line 10), which is subsequently countered by Dad (line 11).

A striking feature of this excerpt is *how* Dad manages Claire's behavior, i.e., by producing a directive (line 4) for which he provides an

Excerpt 1

You should always eat.

- | | | |
|----|------|--|
| 1. | CLA: | <i>((looking at Mum))</i> Mama k = <u>hoef</u> nie te eten.
<i>((looking at Mum))</i> Mummy I= <u>don't need</u> to eat.
(1.0) |
| 2. | MUM: | <i>((scooping potatoes onto Dad's plate, briefly glances at Claire))</i> Jawel je = gaat wel eten,
<i>((scooping potatoes onto Dad's plate, briefly glances at Claire))</i> Yes you= <u>are going to eat though</u> , |
| 3. | DAD: | Je gaat wel eten schatje,
You're going to eat darling,
(1.0) |
| 4. | CLA: | ↑ <u>Als</u> j::e =
↑ <u>If</u> you::= |
| 5. | DAD: | [= Anders word je ↑ <u>nooit</u> groot en st:erk,]
[= <u>Otherwise you</u> ↑ <u>never</u> become big and str:ong,] |
| 6. | DAD: | <i>[[shaking his head to Claire]]</i>]
(1.0) |
| 7. | CLA: | ↑ALS (1.0) als je <u>niet</u> wil = eten m::oet je <u>niet</u> e::ten
↑IF (1.0) if you <u>don't</u> want to=e:at you sh::ould <u>not</u> e::at |
| 8. | DAD: | Jawel, (.) je moet <u>altijd</u> ↓eten
Yes though, (.) you should <u>always</u> ↓eat |

account (line 7). In his account, Dad *constructs a prospective desired identity* for Claire: “Otherwise you ↑never become big and strong,” (line 7). The combination of Dad’s directive and identity-centered health claim to account for it, makes it interactionally difficult for Claire to continue her resistance. First, because compliance to a directive is, in light of interactional norms, the preferred response option (Kent, 2012a). Second, the identity-centered health claim further encourages alignment by offering a further inducement to comply and thus making it more difficult for Claire to continue resisting.

Note that the inducement is recipient designed for Claire’s resistance here-and-now. Recipient design means that a speaker constructs his turn to orient to a specific recipient and the interactional context in which the talk is produced (Sacks & Schegloff, 1979; Wilkinson, 2011). The claim, “Otherwise you ↑never become big and strong,” is about *you*, i.e., Claire; “you” is even the grammatical subject of the sentence; she is the center of the claim. In addition, the option that Claire will not acquire the desired identity as constructed by Dad, is projected by Dad as a direct consequence of Claire’s behavior in the present moment (refusing to eat), thus orienting to this particular context. The alternative reality projected with this claim (that is not being said), is that resisting Dad’s directive (thus not eating) will prohibit Claire from acquiring the desired prospective identity (cf. Billig, 1987). If eating will make her big and strong, while alternatively not eating will not, it becomes not only interactionally difficult but also illogical for Claire to continue resisting to eat. Thus, Claire is also being made *accountable* for her presumed resistance to eat.

In the other cases displaying identity-centered claims throughout the data corpus, the identified phenomenon was similar: interactants (parents) produced identity-centered health claims in the context of managing someone else’s (a child’s) behavior, and their claims were also recipient designed. Due to space limitations, each of these particular features will not be repeated in the next example. Instead, the focus is on notable similarities or differences from the first example.

The next example shows how an identity-centered health claim can be collaboratively produced by parent and child. Excerpt 2 shows Mum and Levi (4 years old) about to have dinner together at the dinner table in the

Excerpt 2

Also you will eat beans.

- | | | |
|-----|------|---|
| 1. | LEV: | <i>((bends over to the bowl with chicken wings, grabs into the bowl))</i> |
| 2. | LEV: | [Kipjes zijn <u>↑zo</u> <lekk:er.>]
[Chickens are <u>↑so</u> <tast:y.>] |
| 3. | MUM: | <i>[(comes from the kitchen)]</i> |
| 4. | | (1.0) |
| 5. | MUM: | Maar <u>luister</u> .
But listen. |
| 6. | MUM: | <i>((puts a plate with green beans and potatoes in front of Levi))</i> |
| 7. | MUM: | <i>((in high pitch))</i> <u>↑Ook</u> eet jij wel <u>↑boontjes</u>
<i>((in high pitch))</i> <u>↑Also you will eat</u> <u>↑beans</u> |
| 8. | LEV: | <i>((in sad voice, looking disappointed))</i> : A::wwh,
<i>((in sad voice, looking disappointed))</i> : A::wwh, |
| 9. | MUM: | Ja <u>jammer</u> hè,
Yes sad huh, |
| 10. | | (9.0) <i>((Mum walks back to the kitchen and takes out cutlery, meanwhile Levi is eating green beans with an angry face))</i> |
| 11. | MUM: | Want (.) van <u>boontjes</u> word jij?
Because (.) from beans you become? |
| 12. | | (2.0) <i>((Mum looks at Levi; eventually he looks back at her))</i> |
| 13. | MUM: | Wat > word je < van <u>↑boontjes</u> ?
What > do you < become from <u>↑beans?</u> |
| 14. | | (1.0) |
| 15. | LEV: | <Sterk,>
<Strong,> |
| 16. | | (1.0) |
| 17. | MUM: | <↓Goed z:o > van <u>boontjes</u> word jij sterk. (1.0) heel goed.
<V:ery ↓good > you become strong from <u>beans</u> (1.0) very good |
| 18. | | (11.0) <i>((Mum humming in background from the kitchen, Levi is already eating green beans and potatoes.</i>
<i>Then Mum comes back from the kitchen and sits down at the table too.))</i> |
| 19. | MUM: | Zo. (.) <u>£Nou</u> . (1.0) heh.£ (.) we zitten aan <u>tafel</u> . (1.0) <u>↑woeh::oe</u>
There. (.) £Well. (1.0) heh.£ (.) we're at the table, (.) ↑weeh::oo |

kitchen. Levi is sitting at the dinner table while Mum is still in the kitchen, walking back and forth with food. She already put a bowl of chicken wings on the table.

After a directive from Mum to Levi to eat beans (line 7), Levi displays displeasure about having to eat beans (line 8). In line 9, Mum displays her understanding of Levi’s “A:wwh,” including his embodied behavior, as disappointment (“Yes sad huh,”). Although Levi is eating the beans (line 10), thus not completely resisting them, his angry face and the preceding lines are understood by Mum as “non-defying resistance”, as displayed by her subsequent initiative to collaboratively agree on eating beans (starting from line 11). Her initial inquiry to Levi is not responded to (lines 11/12). After repeating her question (line 13), Levi completes the question-answer summons by stating “<Strong,>” (line 15). Mum then compliments him, produces a full identity-centered health claim that repeats what she and Levi collaboratively achieved, and compliments him again (line 17). After this, the meal continues and Levi eats his green beans.

Notable in this excerpt is how Mum initiates a collaborative completion sequence before producing a full identity-centered health claim herself. By providing Levi the opportunity for self-direction, i.e., letting Levi find a solution to his own potential problematic behavior (resistance to eating beans), Mum does not only overcome the potential resistance, but also interactionally deploys a socialization practice by reinforcing Levi’s bean eating behavior on future occasions (as “you become strong from beans” is not bound to this particular time and place; rather, it conveys a general rule) (cf. Hepburn, 2020a).

According to Huma, Stokoe, and Sikveland (2019), persuasive conduct consists in speakers engaging in reciprocity management, and here this takes the form of producing a recipient designed identity-centered health claim to overcome (potential) resistance to eat that makes (continuation of) resistance interactionally difficult. Completing the claim collaboratively, as in this excerpt, seems like an even more effective way to manage someone’s behavior (e.g., to overcome potential food resistance), as it makes resistance even more interactionally difficult. That is, it would imply that Levi would have to counter a statement he just co-produced – which would make him accountable for, e.g., being inconsistent.

To conclude, this section showed that and how interactants produced identity-centered health claims in the context of managing someone else’s behavior. In the large majority of cases this was in a persuasive context and entailed parents attempting to overcome (potential) food resistance by a child, but also to reinforce good (eating) behavior (data not shown due to space limitations). Various ways in which the identity-centered health claims were deployed can be linked to food socialization practices. The excerpts underscore how interactants extensively designed their claims to orient to the specific recipient and context in which they were produced.

3.2. Food-centered health assessments

The following section will show how interactants produced food-centered health assessments, i.e., evaluations regarding the (un)healthiness of foods, to account for a speaker’s *own* behavior, rather than managing someone else’s behavior. Such accountable ‘own behaviors’ particularly included eating or providing a specific food. Whereas identity-centered health claims were predominantly produced in argumentative sequences to overcome (potential) food resistance by a child, food-centered health assessments were produced in a wider variety of interactional contexts, such as offering food. Food-centered health assessments occurred 7 times throughout the data corpus. Excerpt 3 displays Mum and Levi (4 years old) at the dinner table. Mum’s meal consists of soup and Levi’s meal of chicken, broccoli and potatoes. Mum is feeding Levi and produces a food-centered health claim on line 11.

Mum is playing a ‘game’ with Levi while feeding him, as if the eating were a race (“O:ne, >two three,< (.) go”, line 1) pretending to put bites intended for him into her own mouth (lines 1–9). In line 11, Mum offers

Excerpt 3

Do taste a bite.

1. MUM: E::en, >twee drie, < (.) go
O::ne, >two three, < (.) go
2. (1.0) ((Mum pretends to put Levi's potato into her own mouth instead of his))
3. MUM: Hap,
Snap,
4. (2.0) ((Levi didn't take the bite yet, Mum again pretends to put Levi's potato into her own mouth instead of his))
5. MUM: ↑Hap,
↑Snap,
6. LEV: ((laughs)) hehehehe (1.0) heheh
((laughs)) hehehehe (1.0) heheh
7. MUM: Hap. ((actually eats Levi's potato, chews))
Snap. ((actually eats Levi's potato, chews))
8. (2.0)
9. LEV: ((rhythmically)) [Klaas, (.) klaas. (.) klaas (.) klaas (.) ka. (.) ka, (.) ka, (.) ka] *
((rhythmically)) [Klaas, (.) klaas. (.) klaas (.) klaas (.) ka. (.) ka, (.) ka, (.) ka] *
[((mashes his food with his fork))]
11. MUM: ((in high pitch)) Doe een hapje proeven (.) deze is he:el ge|zond (.) en |lekker
((in high pitch)) Do taste a bite (.) this one is very |healthy (.) and |tasty
12. LEV: ((rhythmically)) [Kla, (.) kla. (.) kla. (.) bla. (.) bla, (.) blaas?]
((rhythmically)) [Kla, (.) kla. (.) kla. (.) bla. (.) bla, (.) blaas?]
13. LEV: [((is playing with his fork))]
14. MUM: ((offers Levi a bite of food on a fork))
15. MUM: E::en, (.) twee drie [>go<
O::ne, (.) two three [>go<
16. MUM: [((pretends to put the bite into her own mouth, but then puts it in Levi's))]

Levi another bite and produces a food-centered health assessment: “Do taste a bite (.) this one is very |healthy (.) and |tasty”. With this claim, Mum accounts for offering this particular bite to Levi.

Firstly, it is notable that the food-centered health assessment is a claim centered around a *food* rather than a person. The claim is about “this one” (line 11), i.e., this particular bite, which also appears as the grammatical subject of the sentence. Note how this is a major difference from the identity-centered claims, where the center of the claim was a particular person and a constructed prospective identity for that person. Secondly, note how in this case, the stretch of talk does not involve managing someone else's behavior, such as persuading someone to eat who resists their food, or reinforcing “good” eating behavior (as with the identity-centered health claims). Levi is not resisting his food or displaying other behavior that should be “managed” and/or calls for food socialization practices. Rather, Levi seems distracted from the food, as displayed by his laughing and rhythmical “singing” (lines 6, 9 and 12), which could be understood by Mum as an opportunity to offer bites to Levi, for example in an attempt to proceed with the meal. Thus, Mum's food-centered health assessment functions to account for her food offer to Levi.

Similarly, in the next example, the produced food-centered health assessment functions as the speaker's account for eating a particular food herself, as well as for providing this food to the family. Notably, this example shows a claim about something being *not* healthy. This was rare, as it occurred only two times in our collection. **Excerpt 4** shows Mum, Dad, Marie (11 years old), Benjamin (8 years old), and Claire (3 years old), sitting on the couch and stools in front of the television (switched on), and eating white buns with eggs and hamburgers. The excerpt features the interaction between Mum and Claire, while Dad and Benjamin simultaneously have a separate conversation about “who can be silent the longest”. The food-centered health assessment is produced by Mum on line 10.

Mum produces a positive taste assessment about the food directed at Claire; possibly in response to Claire's displayed happiness (line 2). Claire does not provide a clear response to her, apart from growling and singing to nobody in particular (lines 5, 7, and 9). In line 10, Mum produces a

Excerpt 4

Hamburgers are not so healthy.

1. BEN: ((to Dad)) Wie het langste stil kan zijn,
((to Dad)) **Who can be silent the longest**,
2. MUM: ((to Claire, who is happily bouncing on her chair)) Lek|:::er
((to Claire, who is happily bouncing on her chair)) **Tast|yyy**
(2.0)
3. BEN: ((to Dad)) Oké?
4. BEN: ((to Dad)) **Alright?**
5. CLA: ((growls, still happily bouncing)) Grrrrr,
((growls, still happily bouncing)) **Grrrrr**,
6. BEN: ((to Dad)) ↑Tot (2.5) e:::h (1.0) ik > klaar ben met eten.< (1.0) oké?
((to Dad)) ↑Until (2.5) e:::h (1.0) I > am done eating.< (1.0) **alright?**
7. CLA: [Rrr, (.) rr, (.) rrrrr.
[Rrr, (.) rr, (.) rrrrr.
8. BEN: ((to Dad)) [Drie (.) >twee |een< (.) go
((to Dad)) [Thr:ee (.) >two |one< (.) go
9. CLA: ((in singing rhythm)) De. (.) di:e, (.) e:::h (.) pff (.) pff (.) pff (.) pff (.) pff (.) dit is =
((in singing rhythm)) The. (.) th:ee, (.) e:::h (.) pff (.) pff (.) pff (.) pff (.) pff (.) pff (.) this is =
10. MUM: ((to Claire)) = Hamburgers zijn dan wel niet zo ge|zond (.) >maar °wel [↑lekker toch? °<
((to Claire)) = Hamburgers are not so |healthy then (.) >but °they are [↑tasty right? °<
11. CLA: [MAM:::A?
[MUMM:::Y?
(2.0)
12. (2.0)
13. CLA: oh (.) u::h (.) welke naam is deze ham<burger,>
oh (.) u::h (.) which name is this ham<burger,>

food-centered health assessment directed at Claire: “ = Hamburgers are not so healthy then (.) >but °they are [↑tasty right? °<”.

By producing a minimized assessment about the hamburgers' presumed unhealthiness in line 10 (i.e. “not so healthy” rather than, e.g., “unhealthy”) (see, e.g., Wiggins (2017) for an explanation of minimization in interaction), Mum provides a possible alternative evaluation of the hamburgers. However, by using the minimized format followed by the contrasting (indicated by “but”) positive taste assessment, Mum constructs the hamburgers' unhealthiness as excusable or compensated by their tastiness. The hamburger-eating is constructed as collaboratively enjoying something, without feeling guilty. This particular construction may function as an account for Mum to eat them herself as well as to provide them to her family, despite their “not so healthiness”.

The collection of food-centered health assessments also included two cases that appeared in the form of a “fusion” between identity-centered health claims and the above displayed format of food-centered health assessments. These contained characteristics of both, in a similar sense that speakers can produce assessments constructed by lexical terms that point to both subject- and object-side evaluations (cf. Edwards & Potter, 2017). As they fulfilled functions similar to the described examples, due to space limitations no example of these is shown.

As a final example of food-centered health assessments, a deviant case is presented. The analysis of this deviant case confirms the observed function that food health assessments account for an interactant's own behavior. In **Excerpt 5**, a child resists his food. Following the analysis until this point on cases in the context of food resistance and managing someone's behavior, a parent producing an identity-centered health claim would fit the pattern. However, in this case, the parent produces a food-centered health assessment. We have Mum and Levi (4 years old) at the dinner table, at a different occasion, where Mum eats a salad while Levi is offered broccoli with cheese. Levi has repeatedly refused the broccoli with cheese and has now left the dinner table on his own occasion. He started playing in the living room while Mum is still at the dinner table. The food-centered health assessment is produced by Mum on line 8.

Throughout the meal, Mum offered bites of broccoli with cheese to Levi and engaged in various attempts to persuade him to eat, amongst

Excerpt 5

Broccoli with cheese.

1. MUM: [(has her head tilted towards the living room where Levi is)]
2. MUM: [Ja = maar ik heb spet^{cial} voor jou met kaas gemaakt. dat > you jij < hebben.]
[Yes=but I made est^{cially} with cheese for you. >you wanted < to have that.]
3. (2.0) ((Mum is preparing a new bite of broccoli and cheese on Levi's fork))
4. MUM: h:é dat wou jij hebben, (.) met kaas.
h:ey you wanted to have that, (.) with cheese.
5. LEV: Ne:e
N:o
6. (5.0) ((Mum still has her head tilted towards the living room where Levi is, seemingly waiting for a response))
7. MUM: ((tilts her head back and looks down to her plate, adjusts a lock of her hair))
8. MUM: Ma = is wel gezond, (.) ho:or,
But=it is healthy, (.) **th:ough**,
9. (6.0) ((Mum tilts her head towards the living room again, seemingly waiting for Levi to respond; after 6 seconds, a sound from a toy is hearable, after which Mum tilts her head back, takes her salad and walks to the kitchen, with a frustrated facial expression))
10. (9.0) ((Mum is cleaning up in the kitchen, sighing and mumbling audibly, then sits back at the dinner table))
11. (5.0) ((Mum rumbles with the food on the table, puts the smoked sausage on the other side of the table))
12. MUM: hhhh > well < hh
hhhh > well < hh
13. (2.0)
14. MUM: [(tilts her head towards the living room where Levi is)]
15. MUM: [Levi,]
[Levi,]
16. (3.0)
17. MUM: Zulle we sa::men (.) kom (.) samen,
Shall we toge::ther (.) come (.) together,
18. (1.0) ((Mum repositions Levi's chair))
19. MUM: [(tilts her head towards the living room where Levi is)]
20. MUM: Ik vin = t wel gezellig als je bij me komt zitten.
I would like=it if you come sit with me.

other things by referring to Levi's seeming own request for broccoli with cheese (lines 2 and 4). However, so far, Levi has been resisting the bites offered to him by, e.g., turning away his head, walking away from the dinner table, and producing various forms of “no” (of which an example is displayed in line 5).

There is a notable difference between this case and all other cases in the context of food resistance throughout the data corpus. While in all other cases, the parent produced a health claim while *still dealing* with (i.e., possibly overcoming) the resistance, thus still attempting to manage the child's behavior, in this case, the health claim is at the point in the interaction where Mum has seemingly already “lost” the battle of managing Levi's behavior, i.e., persuading him to eat.

This can be derived, first, from Mum's unsuccessful attempts at persuasion, ending with a clear “N:o” produced by Levi and a 5-s silence in which Levi is not even at the table anymore (lines 5–6). Second, throughout the excerpt, Mum's embodied behavior displays attempts to engage Levi in the interaction, as she has her head tilted towards him while speaking to him, and repositions his chair when she summons him, thereby increasingly making him accountable to respond to her attempts at persuasion; a speaker gaze makes a recipient in an interaction increasingly accountable to respond (Stivers & Rossano, 2010) (lines 1 and 6). However, when Mum produces her food-centered health claim, she is looking down at her plate, displaying no embodied attempt to engage Levi in the interaction (lines 7–8). Decreasing response relevance specifically at this point in the interaction, increases the plausibility that this claim is not an attempt at persuasion. To illustrate Mum's embodied behavior, Fig. 1 displays stills of Mum in line 6, where she still has her head tilted towards the living room where Levi is, and in line 8, where she produces her food-centered health claim while looking down at her plate. Third, the subsequent interaction displays that Mum is no longer trying to persuade Levi to eat. When Mum addresses Levi again, verbally but also embodied by tilting her head towards him, rather than persuading him to come and eat, she invites him to come sit with her (“I would like = it if you come sit with me.”, line 20). In sum, in this excerpt Mum's food-centered health assessment highlights the presumed healthiness of the broccoli with cheese, and functions as an account for her own behavior, i.e., providing this food to Levi, rather than as a means to manage Levi's behavior.

In conclusion, food-centered health assessments were produced in a variety of interactional contexts where they accounted for a speaker's own actions, particularly for eating a specific food oneself or for providing a particular food to family members. This contrasts the identity-centered health claims, that functioned to manage someone else's behavior. This pattern is confirmed by the analysis of a deviant case, which shows that even in the context of a child's food resistance in which an identity-centered claim might be expected, rather, the claim is produced in the format of a food-centered health assessment where it does not accomplish any action involving the management of another interactant's behavior.

4. Discussion

The present study set out to outline how healthy eating is constructed and oriented to during evening mealtimes in families with a low SEP. The study was warranted, as it was unknown if and how healthy eating is discussed, and how the concept of healthy eating is used by family members of this underrepresented study population in their everyday interactions. The analysis revealed that healthy eating was *rarely oriented to explicitly* during evening mealtimes in families with a low SEP. In the

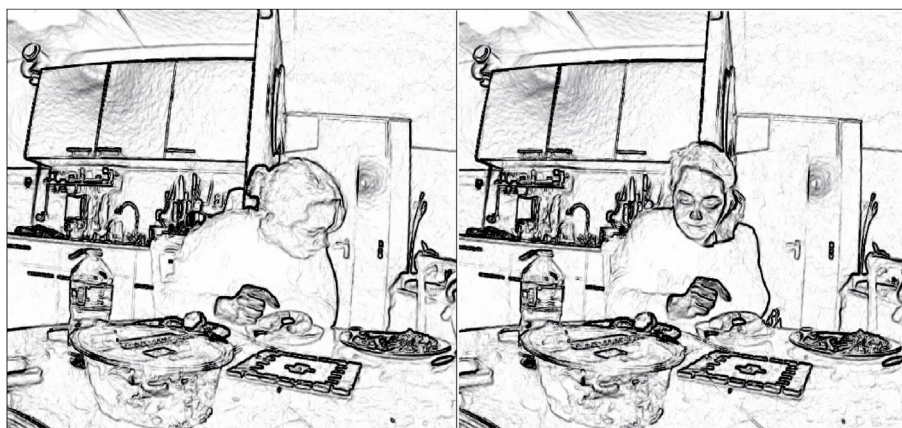


Fig. 1. Mum's embodied behavior in line 6 (left) and line 8 (right).

rare instances when healthy eating was oriented to, interactants produced health claims in two different formats, accomplishing a variety of actions in distinctive interactional contexts. *Identity-centered health claims* were produced in the interactional environment of managing someone else's behavior. Parents constructed a desired prospective identity for their child to manage their child's (eating) behavior and to cajole them to consume a particular type of food, in the large majority of cases in an argumentative context to overcome (potential) food resistance by a child, but also to reinforce good eating behavior. By contrast, *food-centered health assessments* accounted for speakers' own behavior, e.g., for eating or providing a particular food, rather than managing other interactants' behavior. It is notable that the identity-centered health claims had a clear, particular function, while the food-centered health assessments accomplished a less specific variety of actions in their interactional context. This could be explained by the observation that identity-centered health claims occurred in highly similar interactional contexts, i.e., (potential) food resistance by a child, in which they accomplished specific and similar actions. By contrast, food-centered health assessments occurred in more various interactional contexts, such as offering food and constructing eating as collaboratively enjoyable, where they fulfilled different functions. Thus, food-centered health assessments accomplished different actions depending on the interactional environment, similar as to how food taste assessments accomplish different actions in various interactional environments, such as complimenting, fishing for food, or rejecting food (Wiggins, 2001; Wiggins & Potter, 2003).

The findings extend the discursive psychological body of literature on healthy eating talk during family mealtimes (Veen et al., 2012; Wiggins, 2004). In addition to how the construction of healthy eating advice can accomplish different actions (Wiggins, 2004) and how food health and safety are oriented to in context of managing a chronic disease (Veen et al., 2012), our paper documents how, when and by whom claims about food (un)healthiness are produced to accomplish specific actions in various interactional contexts. Moreover, the findings add to the knowledge base on discursive practices deployed to get children to eat, as it is shown that parents projected a prospective desired identity onto their child in attempts to persuade their child to eat. Furthermore, the findings add to literature on identity construction in interaction, a thoroughly studied phenomenon in the field of discursive psychology (Potter, 1996; Sacks, 1992), also in relation to the domain of food and health (e.g., Sneijder & Te Molder, 2006; Sneijder & Te Molder, 2009).

The findings give a unique insight into how healthy eating is oriented to and constructed in the everyday life of families with a low SEP. As populations with a low SEP are largely underrepresented in research on healthy eating and only one prior study deploying DP and CA specifically topicalized SEP (Van der Heijden et al., 2022), the paper provides a valuable contribution to (interactional and other) research on healthy eating. The identification of only sixteen cases in a data corpus of 79 mealtimes is striking. It indicates that healthy eating and healthiness of foods are scarcely discussed topics in these families. The scarcity becomes especially visible when compared to utterances of food liking and tastiness in the same data corpus: 96 taste evaluations were identified, and these included only the ones produced by children, not the parents (Van der Heijden et al., 2022). Furthermore, the cases for the present study were identified in video recordings of six out of the ten families. In four families, no references to food healthiness were identified. Moreover, a relatively large part of the cases (six cases) occurred in one family (Mum and four-year-old Levi). This further implies that talking about healthy eating and healthiness of foods is very rare in these families, and the families who do, seem an exception to the rule.

The study is subject to some limitations. As mentioned, the collection included sixteen cases. This allowed for the identification of interactional patterns in a rare to find phenomenon. However, including more cases (e.g., from existing or yet to be developed data corpora) might lead to more robust conclusions about the construction and functions of various types of health claims. For example, more light could be shed on how

particular interactional contexts shape the actions accomplished by food-centered health assessments. Furthermore, the cases for the present study were provided by recordings of six out of the ten families, and six cases occurred in one family. In terms of robustness of identified interactional patterns and conclusions, cases would ideally be divided more equally over all families. Finally, as the data corpus comprised families with a low SEP, it is clear that the findings are applicable in these families – however, they might not be *exclusive* for families with a low SEP. It is entirely possible that some findings, such as constructing a prospective identity to manage a child's behavior, are also applicable in families with higher SEPs. However, as families with a low SEP are underrepresented in research and substantial health benefits can be gained in this target group, it was warranted and a strength of the study to conduct the present study in families with a low SEP.

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CRediT authors' contribution statement

Amy van der Heijden: Conceptualization (equal); Data Curation (lead); Formal Analysis (lead); Investigation (lead); Methodology (equal); Project Administration (lead); Visualization (lead); Writing – Original draft preparation (lead). Hedwig te Molder: Conceptualization (equal); Funding Acquisition (equal); Methodology (equal); Supervision (lead); Writing – Review & Editing (supporting). Bogdana Huma: Conceptualization (equal); Formal Analysis (supporting); Investigation (supporting); Methodology (equal); Writing – Original draft preparation (supporting). Gerry Jager: Funding acquisition (equal); Project Administration (equal); Supervision (supporting); Writing – Review & Editing (supporting).

Data availability statement

The research data underlying this manuscript, audio and video recordings, are confidential and cannot be made publicly available. Upon request, the recordings are available in an anonymized format for peer-review. The lead author has full access to the data reported in the manuscript.

Ethics approval statement

This study was approved by the Medical Ethical Review Board of Wageningen University & Research, the Netherlands (METC-WU, file number: NL64893.081.18).

Declaration of competing interest

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

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