HHS Public Access

Author manuscript

J Health Soc Behav. Author manuscript; available in PMC 2022 September 01.

Published in final edited form as:

J Health Soc Behav. 2021 September ; 62(3): 388–403. doi:10.1177/0022146521997813.

Contributions and Challenges in Health Lifestyles Research

Stefanie Mollborn[a,*], **Elizabeth M. Lawrence**[b], **Jarron M. Saint Onge**[c]

[a]Institute of Behavioral Science and Department of Sociology, University of Colorado Boulder, UCB 483, 1440 15th St, Boulder, CO 80309-0483, USA

[b]Department of Sociology, University of Nevada-Las Vegas, 4505 S. Maryland Pkwy, Las Vegas, NV 89154

[c]Departments of Sociology and Health Policy and Management, University of Kansas, 716 Fraser Hall, Lawrence, KS 66045-7556

Abstract

The concept of health lifestyles is moving scholarship beyond individual health behaviors to integrated bundles of behaviors undergirded by group-based identities and norms. Health lifestyles research merges structure with agency, individual- with group-level processes, and multifaceted behaviors with norms and identities, shedding light on why health behaviors persist or change and on the reproduction of health disparities and other social inequalities. Recent contributions have applied new methods and life course perspectives, articulating health lifestyles' dynamic relationships to social contexts and demonstrating their implications for health and development. Culturally focused work has shown how health lifestyles function as signals for status and identity and perpetuate inequalities. We synthesize literature to articulate recent advances and challenges and demonstrate how health lifestyles research can strengthen health policies and inform scholarship on inequalities. Future work emphasizing health lifestyles' collective nature and attending to upstream social structures will further elucidate complex social processes.

INTRODUCTION

Health behaviors have important consequences for health and well-being; display strong and consistent disparities across age, race/ethnicity, gender, and socioeconomic status; and are influenced by a complex interplay of social factors. The past two decades have seen intensive health promotion, yet many indicators of health behaviors have worsened over time, suggesting that new approaches are needed (Becker, Sewell, Bian et al. 2020). Individual health behaviors have been studied extensively within many disciplines, but only recently have researchers begun to harness theoretical and empirical insights that result from considering multiple health behaviors simultaneously (Prochaska, Spring and Nigg 2008). Yet frequently, these efforts lack theoretical rigor to conceptualize and integrate the meanings and implications of health behaviors beyond individual risk factors and health outcomes.

[*]Direct all correspondence to: Stefanie Mollborn, UCB 483, University of Colorado Boulder, Boulder, CO 80309-0483; mollborn@colorado.edu; telephone: 303-735-3796.

A particularly promising concept is *health lifestyles*. Health lifestyles are constellations of health behaviors underpinned by group-level identities and norms, which are consequential for health and well-being. Such behaviors include engaging in or abstaining from specific activities, and encompass different domains, such as food consumption or physical activities. Substantial research has documented important associations among a person's health behaviors, finding that an individual's health lifestyle does not simply reflect the accumulation of their agentic choices, but rather comprises a meaningful combination of behaviors that reflects social positions, class status, and group identities (Burdette, Needham, Taylor et al. 2017; Cockerham 2005; Cockerham, Wolfe and Bauldry 2020; Lawrence, Mollborn and Hummer 2017; Saint Onge and Krueger 2017). That is, although we usually observe health lifestyles in individuals, they are also a group-level phenomenon (Cockerham 2005; Krueger, Bhaloo and Rosenau 2009).

We highlight core contributions of health lifestyles research since 2000 and identify current theoretical and methodological challenges. We propose future conceptual, methodological, theoretical, and policy directions to build on prior contributions, address these challenges, and produce new understandings. Twenty-first century health lifestyles research is more empirical than previous work, driving further theoretical advancements. Readily applicable to quantitative and qualitative methods, a health lifestyles approach provides a practical application of theory to advance empirical research and policy.

Health lifestyles offer a perspective for understanding social behavior that engages *macro, meso, and micro levels of sociological analysis*. To examine health lifestyles, we must recognize structural constraints and opportunities, as well as individual agency and preferences. Cockerham (2005) emphasized the importance of focusing on structural influences on health lifestyles, and recent literature has risen to this challenge. Health lifestyles are emergent indicators of population health, responsive to macrolevel policies and norms and local contexts. Yet adopting a health lifestyle also marks one's identity at the micro level, an expression of preference and style reflective of social class and other group memberships (Bourdieu 1986a; Cockerham, Rütten and Abel 1997; Korp 2008; Williams 1995). Health lifestyles both influence and are influenced by social network ties at the meso level. By articulating how social structures both shape and are shaped by individuals' configurations of health behaviors, health lifestyles connect racism, sexism, and other interlocking systems of oppression to disparities in health and mortality.

Health lifestyles thus offer a lens into the production and maintenance of social inequalities.

Health behaviors are a key mechanism through which socioeconomic status (SES) influence health and longevity. However, healthfulness can also justify policies that exacerbate social inequalities. Lifestyle behaviors both serve as a scapegoat for blaming disadvantaged individuals and allow the advantaged to praise themselves for earning and deserving their good health, representing "embodied neoliberalism" (Luna 2019). Despite these attributions, health lifestyles research has demonstrated that the lifestyles of those most advantaged are not uniformly healthful, nor are those of those least advantaged consistently harmful (Saint Onge and Krueger 2017).

CONTRIBUTIONS

Table 1 *summarizes key contributions from recent health lifestyles literature*. Largely following the structure of this section, the table begins with a definition, highlights the influences on health lifestyles, identifies sources of change in health lifestyles and their consequences, and considers how they perpetuate inequalities.

Conceptualizations of Health Lifestyles

Today's "lifestylization" (Knudsen and Triantafillou 2020) of health, which focuses on individual responsibility for health behaviors, is so widespread that it is easy to forget that modifying individual behaviors has not always been at the center of health promotion. Indeed, health behaviors are a recent social construct that has assumed importance and become a target of heath policy and individuals' health-promoting efforts in the past few decades (Armstrong 2009). Specific health behaviors—such as children's sleep guidelines or diet recommendations—are socially constructed, changing over time and place. For example, seat belt use is only relevant in a society with cars and roads where belts can mitigate injuries from crashes. Yet public health often decontextualizes health behaviors, approaching them in isolation as targets for intervention.

The idea of health lifestyles that transcend specific health behaviors is even more recent but builds on a long history of social theory about lifestyles (e.g., Bourdieu 1986a; Giddens 1984; Simmel 1950; Sobel 1981; Weber [1921] 1978). In particular, Weber articulated lifestyles as visible everyday manifestations of social inequalities (Cockerham 2021). Cockerham and colleagues (1997:321) drew on this literature to develop theory about *health* lifestyles, defined as "collective patterns of health-related behavior based on choices from options available to people according to their life chances." Health lifestyles are theorized to be a blend of social structure and individual agency, including conscious behaviors and gradually acquired habitus, "taken-for-granted, routinised knowledge and practices which, for the most part, we carry out unthinkingly and unreflectively" (Williams 1995:598).

Health lifestyles comprise both an individual's health behaviors and group-level identities, norms, and understandings of health (Cockerham et al. 1997; Cockerham 2005). Health lifestyles are collective, "a group attribute resulting from the interaction between social conditions and behavior" (Frohlich and Potvin 1999:S11). Alcohol use exemplifies these tensions between group and individual levels and between behaviors and social psychological phenomena such as identities and norms. People abstain from alcohol use for individual-level reasons such as past problem drinking, taste preferences, or health conditions and group-level reasons such as family norms or religious adherence. The relationship between abstention and mortality is different depending on the reason why a person abstains—although the behavior is the same (Rogers, Krueger, Miech et al. 2013). Group contexts and individual factors similarly influence young adults' binge drinking, ranging from partying to dinners with friends to stress-related drinking while alone (Wamboldt, Khan, Mellins et al. 2019). In these examples, both binge drinking and abstention co-occur with other health behaviors in patterned ways according to different identities, norms, and group contexts. To understand the consequences of alcohol use and effective policy solutions, then, individual and group factors must be synthesized along

with underlying behaviors and social psychological phenomena. Using a health lifestyles framework to understand health behaviors achieves this goal.

Measurement of Health Lifestyles

Health lifestyles are difficult to measure because of two ways in which they are conceptualized as having an inherently dual nature. First, as discussed, they are both a group-level phenomenon and an individual-level characteristic. Second, they include both a set of health behaviors and the norms, identities, and understandings that underlie those behaviors. These dualities, along with the diversity and complexity of health behaviors, have posed fundamental measurement challenges, resulting in theoretical developments outpacing empirical investigations of health lifestyles. They have also led scholars to articulate a need for both qualitative and quantitative data (e.g., Blaxter 1990; Cockerham et al. 1997; Frohlich and Potvin 1999).

Several quantitative measurement approaches have provided empirical information about health lifestyle behaviors but not yet captured their dualities. Methods including exploratory factor analysis and cluster analysis have been used to group observations by shared behavioral characteristics. Some empirical studies have used an explicit or implicit health lifestyles lens but analyzed specific health behaviors separately (e.g., Ferraro, Schafer and Wilkinson 2016; Krueger et al. 2009; Øvrum, Gustavsen and Rickertsen 2014).

Other research has combined multiple health behaviors into a single measure of healthfulness, using varied terminology such as a “healthy lifestyle score” (e.g., Costa-Tutusaus and Guerra-Balic 2016; Saneei, Esmaillzadeh, Keshteli et al. 2016). Capturing the overall level of healthfulness of a person’s health lifestyle behaviors can distill information in a more straightforward and replicable way than can a more inductive approach, such as a latent class analysis (LCA) approach described below. Supporting this approach, some articulations of health lifestyles theory expect lifestyles to vary in their objective healthfulness, ranging from generally healthy to generally unhealthy (e.g., Cockerham et al. 1997; Cockerham 2005). Yet, this approach has drawbacks. Importantly, people’s behaviors do not always coalesce into concordantly “healthy” or “unhealthy” patterns as implied by a single scale of healthfulness (de la Haye, D’Amico, Miles et al. 2014). Discordance in lifestyle behaviors may represent important information that is lost when condensing data into a single healthfulness score. And the designation of behaviors as “healthy” or “unhealthy” is a social construction that can change across time and place (e.g., amounts of fat, sugar, and protein in a “healthy” diet).

Recognizing this, much recent health lifestyles research has expected that the diverse and often inconsistent motivations, identities, and norms underlying health lifestyles often lead not to *concordant* health lifestyles in which an individual’s behaviors are either uniformly healthy or unhealthy, but to *discordant* lifestyles comprised of healthier and unhealthier behaviors within the same person (Cockerham 2021; Daw, Margolis and Wright 2017; Saint Onge and Krueger 2017). Studies that empirically model a set of discrete health lifestyles that may be concordant or discordant typically use variants of latent class analysis (Collins and Lanza 2010). LCA uses a structural equation modeling approach to identify latent, or unobserved, subgroups using observed, categorical variables—in this case, multiple health

behaviors. LCA and similar methods such as latent profile analysis for continuous variables are particularly well suited to identifying health lifestyles because they take a person-centered, rather than variable-centered, approach, allowing relationships among variables within people to emerge inductively from data. LCA ignores researchers' expectations about groupings or concordance. LCA has drawbacks: It is sensitive to the behaviors included in analyses, often leading to different predominant health lifestyles across studies. LCA is also limited in addressing underlying group-level phenomena such as norms or identities.

Health Lifestyles as Structural Manifestations of Inequalities

Our discussion has so far focused on quantitative, survey-based, behavior-focused studies that comprise the bulk of health lifestyles scholarship, especially in North America. This research has made empirical strides in combining individuals' health behaviors in innovative ways, but it has ignored one side of each of the two dualities of health lifestyles, measuring individual behaviors but not the group level, and operationalizing behaviors but not identities, norms, or understandings of health. Quantitative and behavior-focused health lifestyles research has yielded intriguing findings about what health lifestyles are, how they serve as structural manifestations of inequalities, and their links to health, development, and status attainment across global settings. We focus on four key contributions here: discordance, social contexts, stability and change, and consequences.

1. Health lifestyles are often discordant combinations of healthier and unhealthier behaviors within individuals,—as described above (Saint Onge and Krueger 2017). Using LCA, which allows a population's predominant patterns of health behaviors to emerge inductively, researchers have now identified substantial discordance within many health lifestyles, as well as some typical types of discordance that emerge across multiple studies and datasets. This discordance is theoretically interesting because it provides strong indirect evidence for the importance of other factors besides maximizing health—such as group-based norms, identities, and understandings of health —for understanding health lifestyles. An academic, for example, might display low consumption of junk food, high vegetable consumption, abstinence from tobacco use, high caffeine and alcohol intake, limited sleep, and frequent sedentary time. This combination of behaviors is discordant in its healthfulness but may be consistent with the norms of that individual's social group and may be difficult to alter without understanding nonbehavioral aspects of the health lifestyle.

In other examples, higher-SES Costa Rican adults more frequently have high-calorie diets but also exercise more (Rosero-Bixby and Dow 2009). Similarly, in Denmark, higher SES simultaneously spurs greater interest in both cooking, leading to higher body mass index (BMI), and exercise, leading to lower BMI (Christensen and Carpiano 2014). Among US adolescents in 1995, 15% had a health lifestyle comprised of unusually good nutrition and exercise levels, typical amounts of screentime and sleep, high rates of cigarette smoking, and near-universal binge drinking (Burdette et al. 2017). To better understand causes of such health lifestyle concordance and discordance within individuals, health lifestyles research has made substantial strides in translating insights from the *life course theoretical*

perspective (Elder 1994) into informative findings (Cockerham 2021). The other three contributions described here have arisen from such work.

2. Health lifestyles are structured by social and geographic contexts.— Multidimensional and dynamic conceptualizations of social contexts, a key facet of the life course perspective (Elder 1994), are important for understanding health lifestyles. Parents, siblings, peers, social networks, and schools have all been shown to matter for health behaviors and lifestyles (Daw, Margolis and Verdery 2015; Mollborn and Lawrence 2018). For example, one study of US adolescents found that both people's selection into friendship groups and the influence of their friends shape their health lifestyles (adams et al. 2020). Teens select into and are influenced by social networks across multiple behaviors, strengthening the conclusion that lifestyles, and not just specific behaviors, spread within networks (Gremmen, Berger, Ryan et al. 2019).

But less empirical evidence has established pathways through which social contexts shape health lifestyles. One important exception is research on families, which influence children's health lifestyles through parents' sociodemographic group memberships, resources, health behaviors, and parenting practices (Mollborn, Lawrence, and Krueger 2020). Family influences encompass material and cultural components and are linked to macro- and meso-level contexts. This work further hints at the importance of child agency and reciprocal socialization between parents and children for understanding health lifestyle development in early life, but data limitations have prevented the establishment of directional relationships. Beyond families, theory would suggest that changes to social or geographic contexts can shift a person's health lifestyle through changing structural constraints, group memberships, exposure to norms, and identities. Blaxter (1990) demonstrated that socioeconomic context and living environment impact a person's ability to practice effective health lifestyles, with higher-status individuals more likely to have resources to achieve healthy lifestyles.

Geographic contexts have received less attention as potentially powerful influences on health lifestyles. Health lifestyles theory expects group norms and understandings of "healthy" behavior to vary from one place to another. Prevalent health behaviors and lifestyles are locally specific (Lee, Seo, Middlestadt et al. 2015), perhaps responding to local differences in social contexts. Regional differences in prevalent health behaviors and lifestyles appear to be one reason why the relationship between education and health varies from place to place (Kemp and Montez 2020); more research examining geographic variation in health lifestyles is needed.

3. Health lifestyles display both continuity and change across a person's life.—Developmental processes also shape lifestyles over time. Life course theory posits that earlier experiences are associated with later ones, while the meanings and expectations across different roles and contexts, such as attending school or being a parent, shift over life stages (Settersten 2004). Infants engage in health behaviors via a "received health lifestyle" (Mollborn et al. 2014), but many behaviors are beyond their autonomous control. Health-related parenting (Augustine, Prickett and Kimbro 2017) attempts to regulate behaviors such as feeding and sleep duration. Parents often seek to socialize children into becoming "health-promoting actors" (Christensen 2004) who exercise agency in ways that parents

deem healthy or appropriate. Growing children gain agency, developing habitus as a form of implicit or routinized agency (Kohli 2019). The habitus makes many health behaviors largely automatic and potentially more difficult to adopt or change later in life (Bourdieu 1986a; Cockerham 2018), even though habitus can also be flexible (Cockerham 2018); for example, upwardly mobile people often try to change their class-related habitus and distance themselves from the health behaviors of their groups of origin (Curl, Lareau and Wu 2018). Shifts in social roles also appear influential for health lifestyles (Mize 2017). As parents' control over young people's health behaviors lessens, they transition to an "achieved health lifestyle" in adulthood (Mollborn et al. 2014), informed by earlier lifestyles and often more stable than at younger ages.

Both SES and gender matter for health lifestyles (Olson, Hummer and Harris 2017; Södergren, Wang, Salmon et al. 2014), but they do not predict health lifestyles consistently across life (Øvrum et al. 2014). Extant health lifestyles theory has articulated ideas about childhood gender socialization leading to typically gendered health behaviors (Cockerham 2018)—with women generally displaying more favorable health behaviors except for physical activity. But gendered patterns are not consistently reflected in US adolescents and early young adults, emerging first in late young adulthood (Mollborn, Lawrence, and Hummer 2020). Furthermore, differences in health behaviors *within* genders far outstrip the magnitude of differences *between* genders (Mollborn, Lawrence, and Hummer 2020). Evidence on the gender-health lifestyles relationship across the transition to adulthood supports the importance of a dynamic, life course, and multilevel perspective that articulates macro-, meso-, and microlevel influences. Although other status categories such as race, ethnicity, or sexual identity have not received sufficient attention (see Cockerham et al. 2017 for an exception), similar processes may apply, and unique findings have yet to be documented.

Research on the SES-health lifestyles relationship has similarly documented a mixture of stability and fluidity across age. Although higher parental SES tends to predict healthier lifestyles in adolescence, and higher levels of socioeconomic attainment in late young adulthood are related to healthier lifestyles, the SES-health lifestyle relationship in early young adulthood (ages 18-24) is absent or even reverses (Lawrence, Mollborn, Goode et al. 2020). As others have found for health behaviors such as smoking and alcohol use (e.g., Chen and Jacobson 2012), at this age, socioeconomically or racially privileged young people often have higher levels of risky health behaviors as they pursue a socially sanctioned "age of independence" (Rosenfeld 2007) from adults' normative controls and adult responsibilities. Yet in later life there is evidence of socially classed health lifestyle "lock-in," with relatively little change within individuals (Rees Jones et al. 2011). These studies support a conceptualization of SES and its relationship to health lifestyles that incorporates both stability and change across life.

4. Health lifestyles matter for health and development across different life phases.—The life course perspective stresses that earlier life circumstances influence later ones (Elder 1994). Much health lifestyles research has focused on adults, but recently there has been expansion to children and adolescents (e.g., Burdette et al. 2017; Mollborn and Lawrence 2018). (Research has used observational data, establishing associations and time

ordering but not causality.) In early childhood, health lifestyles have been linked to parent-rated health status, cognitive development, and socioemotional development (Mollborn et al. 2014). The finding that children who are otherwise sociodemographically similar, but who have health lifestyles with differing levels of health risk, experience distinct developmental outcomes (Mollborn et al. 2014) provides additional support for the conclusion that health lifestyles matter for development and health. Adolescents' health lifestyles are associated with health outcomes in adolescence and young adulthood (Burdette et al. 2017). Similarly, adolescent and young adult health lifestyles predict young adult health outcomes (Lawrence et al. 2017), and adults' health lifestyles are associated with health and mortality (Saint Onge and Krueger 2017; Zhang 2020). There are many complexities to consider, as relationships can vary according to the different behaviors enacted in a lifestyle, as well as having different health effects from the same behaviors. For instance, routinized physical activity required in a manual labor job may provide exercise but also increase health risks through repetitive motion injuries and reduced exercise variation.

New research has begun documenting complex interrelationships between health lifestyles and other aspects of health. Depending on a person's situation, life phase, and social contexts, worsening health can shape their health lifestyle in favorable or unfavorable ways. Qualitative research from class-privileged communities found that having a family member with a disability or serious health condition can improve health lifestyles of all family members because they no longer take health for granted (Rigles 2019). Further, experiencing new health problems in later adulthood can compromise health lifestyles (Cockerham et al. 2020), limiting healthy behaviors such as exercise, which in turn could compromise health. In sum, health lifestyles are structural manifestations of social inequalities that matter for people's future health and development in complex ways.

Health Lifestyles as Cultural Drivers of Inequalities

So far, we have emphasized one side of each duality by focusing on behaviors and individuals. Another active body of theory, developed primarily by European and North American scholars and supported by some qualitative research, lays out a culturally focused perspective that extends beyond behaviors to explicitly consider identities and norms (e.g., Korp 2010; Teuscher, Bukman, van Baak et al. 2015). Not all of this research engages explicitly with the term "health lifestyles." In this perspective, *health lifestyles are a visible manifestation of social inequalities used by individuals, groups, and institutions as a cultural tool to perpetuate further inequalities*. As Ortner (1998) noted, lifestyles reflect class-based habitus and are more socially acceptable to discuss and assign blame for than social class. And in the US context, race and class are intimately intertwined in people's lifestyles (Ortner 1998), making exclusion on the basis of both class and race feasible through leveraging lifestyles. We highlight four core contributions of this perspective: health lifestyles as cultural capital, symbolic boundaries, links to morality, and implications for social disparities.

1. *Health lifestyles are an increasingly important form of cultural capital* (Bourdieu 1986b)—

used by advantaged families and communities to their benefit. For example, in two middle-class US communities, parents sought to instill particular health

behaviors, norms, and understandings of health in their children that would lead them to engage in classed and raced "performances of health" (e.g., possessing a thin body, engaging in specific types of physical activity, and refusing to eat inexpensive "fast food") that presumably yield future socioeconomic and health benefits (Mollborn, Rigles and Pace 2020). Many parents deliberately chose communities and schools that reinforced the same health lifestyle messages for their children, further leveraging class and race advantages into children's cultural capital. Cultural tastes shape network ties in ways that stratify people by privilege, thus converting cultural capital into social capital that yields important resources (Lewis and Kaufman 2018).

2. *Health lifestyles function as meaningful political and symbolic boundaries* (Lamont and Molnár 2002).—The cultural and social capital they yield makes health lifestyles an effective form of *distinction* to set advantaged people apart from lower-status groups (Abel 2008; Pampel 2005). Individual tastes in health behaviors have rich historical precedents and symbolic meanings. Examples include class- and race-based variation in alcohol (e.g., beer versus wine) and tobacco use (e.g., menthol cigarettes versus vaping products). Thus, lifestyles are an increasingly important form of distinction and intensifying form of social control (Abrutyn and Carter 2015; Carlisle, Hanlon and Hannah 2008). This distinction must constantly be maintained and updated to be effective because those with less status often seek to mimic higher-status lifestyles (Ridgeway 2014). As new health information becomes available, it is often "appropriated" by those with more resources who change their behaviors, improving the health of those who need it the least (Carlisle et al. 2008; Link and Phelan 1995). And even when actual behaviors look similar across statuses, people's portrayals and justifications of behaviors can create distinctions that feel meaningful (Katainen 2010).

Thus, as Korp (2008:25) noted, "The notion of 'healthy lifestyle' is fundamentally political. It exercises symbolic power in the sense that it legitimises certain ways of thinking, feeling and acting at the expense of others." People "do health" in political ways. The symbolic boundaries that health lifestyles create are particularly effective because health behaviors are often rooted in habitus that is developed over long periods of time early in life, making privileged habitus hard for the less privileged to replicate (Bourdieu 1986a). Particular behaviors, norms, and understandings of health, rooted in social group memberships, can become routinized, so people do not need to make conscious decisions to enact a particular health lifestyle. For example, putting on a bicycle helmet may be done out of habit. People also make conscious choices about their health in ways that differentiate groups (Talukdar and Linders 2013). Because conscious effort can alter behaviors, understanding health lifestyles as solely resulting from habitus does not attend sufficiently to dominance hierarchies or symbolic power (Korp 2010).

3. Health lifestyles' links to morality make them especially effective at perpetuating inequalities.—Morality, which is socially constructed and intimately tied to symbolic power and social inequalities, is important for understanding how health lifestyles perpetuate inequalities. Health lifestyles are increasingly linked to self-control, discipline, and hard work in ways that imbue them with morality (Fielding-Singh 2019;

Luna 2019). Cairns and Johnston (2015:171) summarized the cultural logic through which scrutiny of someone's body and physical attractiveness is seen to yield useful information about their health and morality: "The healthy feminine subject *chooses wisely* in the interest of *health* and will 'look good' as a natural outcome." This logic leads to social judgments based on physical appearance that can be consequential for future prospects. Someone who does not embody the correct "performance of health" may be considered morally suspect and lose access to socioeconomic opportunities or appropriate health care. This strong link between health lifestyle and morality is particularly evident among *parents* across the spectrum of privilege, who face high social standards for ensuring the health of their children's bodies (Elliott and Bowen 2018).

4. Research from the cultural perspective shows how health lifestyles comprise a powerful contemporary mechanism for increasing health disparities and socioeconomic inequalities.—Those with more resources can more easily meet guidelines or expectations, particularly ones that change frequently. For example, pressure on mothers to feed children in increasingly intensive ways can increase inequalities because highly resourced families can devote more time and money (Elliott and Bowen 2018). Although much of this research has focused on individuals or families, research on communities' collective health lifestyles may be increasingly important. Socioeconomic segregation of neighborhoods is strong, perhaps in part a result of higher-SES US adults self-segregating to form "overrider enclaves" that are intended to protect against a "default American lifestyle" comprised of multiple unhealthy behaviors (Mirowsky and Ross 2015). Because communities are important for understanding how health lifestyle-related habitus and cultural capital are instilled (Mollborn et al. 2020), this segregation may cause increasing social disparities in health lifestyles that could lead to strengthening inequalities in people's health and socioeconomic attainment.

CRITICAL DIRECTIONS FOR FUTURE RESEARCH

The health lifestyles framework contributes to understandings of health, health disparities, and social inequalities by integrating individual- and group-level influences and synthesizing constellations of health behaviors with underlying social psychological phenomena including norms and identities. While health lifestyles research is advancing rapidly, many challenges and opportunities remain. Concentrated efforts are needed to conceptually map and integrate extant research into a cohesive narrative that facilitates an interdisciplinary field of research and improves understanding of health lifestyles.

Conceptualization Challenges

Conceptualizing and operationalizing health lifestyles poses a challenge to researchers who must contend with both theoretical and practical considerations, including data availability. Most studies focus only on measuring behaviors. Yet as Cockerham, Rütten, and Abel (1997:338) have noted, "A health lifestyle is not simply a collection of behaviors nor is it merely a variable." *Broader operationalizations* beyond behaviors are needed. For example, large-scale surveys could measure definitions of health, multiple group-level identities, and group-based norms (through perceived embarrassment at engaging in a behavior or through

perceptions of others' approval of a behavior). In surveys with group-based sampling such as schools or social networks, these measures plus health behaviors could be aggregated to identify prevalent health lifestyles among specific friendship or identity groups.

Even within behaviorally focused studies, configurations and patterns of behaviors included in quantitative lifestyles research reflect current national-level health objectives that are most often linked to negative health outcomes among adults (e.g., cigarette smoking). When new behaviors emerge (e.g., vaping), data are not immediately available to capture them. Research continues to be limited by questions included in prominent data collection efforts, which lag behind changes in populations' actual behaviors.

Further, studies often use the same measures over time, life course stages, and contexts, promoting consistency but suppressing innovation. More nuanced and dynamic measurement of health-related behaviors could lead to new insights. For instance, new techniques in nicotine consumption, variation in legal cannabis use, engagement in telemedicine, or social distancing and mask wearing during pandemics were not foreseeable health behaviors until recently. Nontraditional health behaviors such as gun ownership are becoming increasingly integrated into public health research (Wertz, Azrael, Hemenway et al. 2018). Measuring different health behaviors across historical periods and life stages more accurately captures their consequences and how and why these behaviors are enacted. Yet using different health behaviors to operationalize health lifestyles makes it unlikely that the same health lifestyle groups can be identified across analyses. Greater consensus about which domains to measure could improve consistency in findings across studies.

Conceptualizing *agency* is another research challenge (Abel and Frohlich 2012). The agency-structure divide is messy, and agency can be conceptualized in different ways depending on age and neurotypicality (Landes and Settersten 2019). Behaviors differ in their health effects, visibility, importance to the individual or social group, and level of agency relative to constraints.

Measuring health lifestyles *locally* requires additional consideration. Health lifestyles are group- and local-level phenomena with meanings unique to one's school, neighborhood, city, state, country, etc. While there is some consistency in patterns within and across countries, lifestyle meanings remain localized (Cockerham, Hinote, Abbott et al. 2004; Saint Onge and Krueger 2011). Multilevel approaches could consider health lifestyles' meanings in various settings. The ability to achieve health is structured by local norms and opportunities, further complicated by selection into areas and local meanings of health behaviors. Religious groups tend to be geographically concentrated and frequently regulate health lifestyle behaviors such as diets, substance use, and health care seeking (Hill, Ellison, Burdette et al. 2007). Politically conservative areas may provide limited opportunities for some behaviors (e.g., cannabis use, multiple sexual partners) due to local laws and punitive social norms. Rural areas may have inadequate infrastructure for sustained exercise, preventive health services, or food options, with implications for collective lifestyles. Deviating from local, geographic norms may affect identity and social standing in one's community.

Methodological Challenges

Methodological advancements can benefit health lifestyles research, which in turn offers opportunities to apply new methods. While latent class approaches are a predominant quantitative method for identifying lifestyles, research lacks consensus on how to address current limitations or analyze complex substantive questions. Regardless of methodological choices, assessing conceptual frameworks will require further consideration of behavioral relationships to control variables, mediating mechanisms, or distal outcomes, as well implementation of moderating effects or causal inference over multiple levels of analyses. Current approaches are unsatisfactory for multiple reasons, but there are emergent statistical solutions to some problems (see Bakk and Kuha 2018; Masyn 2017), and best practices may soon be feasible in existing software.

Longitudinal—studies add further methodological complexity. Longitudinal methods seeking to identify groupings over time, such as latent transition analysis or latent class growth models, allow researchers to model their stability and change. Because these approaches require the same variables over time, they are suitable for health lifestyles studies conducted across ages when meanings of health behaviors are stable (e.g., Burgard, Lin, Segal et al. 2020). More frequently, modeling health lifestyle development within individuals can be challenging using current approaches, both because the health behaviors people typically engage in change with age and because ways in which behaviors combine within individuals likely change over time. For such studies, there is no definitive longitudinal method, and consensus around best practices is needed. Continued empirical advances in grouped trajectory models or age-period-cohort approaches have potential for modeling stability and change in lifestyles.

The inductive nature of commonly used quantitative methods nearly guarantees inconsistencies in the lifestyles being identified in different studies, depending on how variables are included and measured. This is frustrating but also an area for advancement. New theoretical conceptualizations grounded in findings are more important than the compositions and prevalence of specific classes, per se. Strict adherence to model selection based on mechanical criteria can overshadow an intention to summarize data in a parsimonious and theoretically informed fashion. The operationalization of health lifestyles should be aimed at representing approximations or snapshots of a much more complex reality. Caution must be taken not to portray bundles of behaviors as reified social facts. Indeed, the utility of these analyses arises from the research questions, approach, and interpretation more than from model precision.

Qualitative methods—show promise for bridging the dualities of health lifestyles that have not been captured in quantitative research, by analyzing health lifestyles as both individual- and group-level phenomena and as both collections of behaviors and underlying identities, norms, and understandings of health. Multiple qualitative methods are necessary to paint this complex picture but are resource intensive. For example, studying how health lifestyles relate to cultural capital, Mollborn, Rigles, and Pace (2020) sampled families within two communities and observed families, interviewed parents and community

members who worked with children, and facilitated focus group interactions with multiple parents in the same community.

The methods used to study health lifestyles are interdisciplinary, but sociology can offer particular insight into how to *decolonize* these tools (Connell 2018). Health lifestyles offer researchers the opportunity to examine inequality from perspectives other than a deficit model focused on problems or disadvantages. Health lifestyles research puts advantages and disadvantages on equal footing, considering structure, agency, resiliency, and constraints across multiple dimensions of (dis)advantage. The cultural perspective articulates how allegedly "healthy" lifestyles perpetuate inequalities, which is at odds with the goal of reducing health disparities through promoting healthy lifestyles. Health lifestyles research could challenge hegemony through decentering dominant groups, shifting research questions from population prevalence and composition of health lifestyles that often center majority groups to considering contextual factors that give rise to different or similar lifestyles for diverse populations. Health lifestyles research would benefit broadly from consideration and examination of health lifestyles across different ethnic and national origins within various international settings beyond the dominant Western health perspective. We advocate for reflecting on researchers' positionality in conceptualization and measurement. For example, although great strides have been made in analyzing how age, gender, and social class shape health lifestyles, race and ethnicity are rarely deeply studied in a health lifestyles framework, reflecting the Western-, White-dominated demographics of health lifestyles researchers.

Health lifestyles should heed *methodological pitfalls* common in multiple disciplines. Arbitrary significance values should be used thoughtfully and in conjunction with other information. Fortunately, many health lifestyles studies provide answers by synthesizing a wide variety of data points rather than relying on a single significance test. Such complex studies can be difficult to publish, but we expect improved understandings of the interpretation of statistical results will ease this process. We caution against replication studies of health lifestyles because current approaches are highly sensitive to a number of specifications. Further, researchers should take care to recognize that data on health lifestyles can be used as marketing tools or to justify further marginalizing disadvantaged groups (Lamont and Molnár 2001).

Theoretical Challenges

Health lifestyles research has had a consistent theory-building tradition that will continue in future work. One promising direction is further integration of ideas laid out here. Quantitative and qualitative approaches—both focused on the reciprocal relationship between health lifestyles and social inequalities—are spawning distinct literatures that rarely converse. Yet it is not inherently contradictory to acknowledge that health lifestyles are both quantitatively measurable configurations of behaviors and a cultural means to perpetuate inequalities. Integrating these perspectives' insights can push health lifestyles theory forward but requires communication across methodological and disciplinary boundaries.

The *social psychological underpinnings* of health lifestyles—including group-based norms, identities, social control, and understandings of health—must be more clearly articulated. Theoretical advances within social psychology and cultural sociology have laid fruitful

groundwork for understanding why health lifestyles are often discordant, why they change, and how they influence people. Cultural sociologists have studied how sets of behaviors are cognitively abstracted as schemas (Strang and Soule 1998) that diffuse through networks and result in automatic cultural differentiation (Goldberg and Stein 2018). Lifestyles may follow similar processes. Sociological research has articulated ways in which culture becomes a source of group distinction and social stratification (e.g., Eliasoph and Lichterman 2003). And the proliferation of research on agency (Hitlin and Elder 2007), dual-process cultural models (Vaisey 2009), moral identities (Stets and Carter 2012), norms (Horne 2001), political ideology (Metzl 2019), and stigma (Link and Phelan 2014) provide fertile ground for developing health lifestyles theory.

Integrating research and theories on power and systems of oppression offer insights into health lifestyles. For example, state and local mandates for social distancing and face coverings have faced political resistance during the COVID-19 pandemic, bolstered by the proliferation of misinformation campaigns, suggesting a need to understand the roles of power and politics. Critical race theory (Graham et al. 2011) can also elucidate how health lifestyles operate as cultural tools. Better measures of systemic racism or discriminatory contexts can improve understanding of health lifestyle mechanisms. Further, examining how historical and contemporary institutions and organizations shape constraints, opportunities, motives, and means that guide health lifestyle routines could reveal structural mechanisms perpetuating and creating inequalities in health lifestyles and subsequent outcomes.

Health lifestyles research should further integrate *intersectional*, transitional approaches. For instance, health lifestyles should be further integrated into theories of gender identity. Sexuality, immigrant status, disability, and other identities are important to accurately portray health lifestyles and can also inform social processes resulting in marginalization or health disparities.

Policy Challenges

Health promotion has focused heavily on changing individuals' health behaviors (Knudsen and Triantafillou 2020). Although biomedical, treatment-focused health care is still prioritized, this move partially upstream is more cost-effective than waiting to treat health problems that result from unhealthy behaviors (Benmarhnia, Dionne, Tchouaket et al. 2017). Adopting a health lifestyles perspective moves farther *upstream* by emphasizing social/contextual factors that underlie groups of behaviors, rather than blaming or rewarding individuals for specific behaviors. This upstream focus cannot be achieved unless health lifestyles researchers begin to study both individuals' behaviors and group-based processes such as norms and identities, as well as the structural environment that envelops health-related decisions and actions. Fulfilling the promise of health lifestyles theory in future empirical research can simultaneously achieve the goal of moving policy implications upstream.

Findings from health lifestyles research have important implications for health policies, public health, and medical practice. For example, health behaviors combine in ways that make it essential to intervene differently for different lifestyle groups (Wamboldt et al. 2019). Efforts to curb binge drinking may be more successful if they account for the fact that

all binge drinkers do not have the same health lifestyle (Burdette et al. 2017; Lawrence et al. 2017). Another implication of health lifestyles research is that the *timing* of intervention is important. Because health lifestyles are partially path dependent throughout life, earlier intervention is generally better, although there may be important critical periods. Bauldry and colleagues (2012:1311) have argued that "efforts to promote healthy behaviors in young adulthood, after the completion of secondary school, may be especially strategic in the promotion of health in later adulthood." Yet health lifestyles have potential for change across life.

Many health behavior interventions have not worked (Baum and Fisher 2014). Perhaps in response to these limited successes when targeting single health behaviors, some interventions have taken a *modified health lifestyle approach* targeting multiple behaviors, experiencing varying degrees of success upon evaluation (e.g., Ling, Robbins, Wen et al. 2017). Evidence suggests such interventions can lead to identity changes that have unintended consequences for other health behaviors. For example, safety interventions on oil platforms that reframed masculinity as taking care of the collective good changed men's identities and interactions in a multitude of ways (Ely and Meyerson 2010). But other lifestyle-focused interventions that initially seemed promising were ultimately not effective (e.g., Lloyd, Creanor, Logan et al. 2018). Both basic research on health lifestyles and initial findings from interventions suggest that a *contextualized* approach that considers sets of behaviors, group-based factors, and structural drivers is promising. More multidimensional approaches to targeting health behavior changes are needed, especially "salutogenic" approaches that encourage healthy behaviors more than discouraging unhealthy ones (Becker et al. 2020).

But a health lifestyles approach to policy cannot universally solve the problem of social inequalities. Insights from the cultural health lifestyle perspective are particularly valuable for understanding the *perils of using a health lifestyles framework to inform intervention programs*. Caution must be taken to avoid "lifestyle drift" from broad social determinants toward emphasis on and investment in individual-level lifestyle behaviors (Williams and Fullagar 2019). Promoting certain behaviors and lifestyles as inherently "healthy" instills them with moral values and sets them up as a goal to which people may aspire but ultimately be limited in achieving because of unequal resources and life chances. Labeling behaviors as "healthy" or "unhealthy" can further heighten intergroup distinctions by race and class. Inequalities can be perpetuated by seemingly well-intended promotion of health behaviors that only the privileged can realistically enact. Effective health lifestyle interventions must ensure that any promotion of a specific lifestyle is paired with full access to the necessary resources to enact and sustain that lifestyle.

But even if that difficult goal is achieved and social disparities in particular health lifestyles are reduced, *new lifestyle-based forms of distinction* will probably arise because health practices and forms of intergroup distinction are always evolving to maintain inequalities (Carlisle et al. 2008; Link and Phelan 1995; Pampel 2005). Thus, interventions that focus on promoting or discouraging specific health lifestyles, rather than addressing their upstream causes, may well result in an endless game of "whack-a-mole" in which new lifestyle inequalities arise when old ones are successfully addressed—or may even inadvertently

exacerbate the intergroup distinctions they are seeking to reduce. For this reason, attending to upstream causes of health lifestyles and reducing underlying group-level disparities may be the most effective strategies for health policy.

CONCLUSION

Health lifestyles are highly consequential for health and longevity. They are also quotidian, present in every person's daily routine, whether consciously or not. Health lifestyles research is inclusive, relevant for all populations: Everyone has a health lifestyle. Health lifestyles are a promising construct for understanding social disparities in health by combining insights from disparate literatures within and beyond sociology. They bridge structure and agency; individual and population health; micro-, meso-, and macrolevel explanations; behaviors and social psychological group processes; and conceptions of health as an objective status to be attained and a cultural tool deployed to maintain inequalities.

Sociology is leading the way in understanding health lifestyles, but they are relevant for numerous disciplines. Although theoretical development has outpaced substantive research, the latter is expanding rapidly, improving knowledge about how health lifestyles are transmitted across generations, developed within individuals, shaped by social contexts, and consequential for health and status attainment. Studies integrating life course approaches with health lifestyles show that understanding lifestyles within and across historical periods, birth cohorts, and developmental stages or biological age sheds light on how and why they develop, change, or remain stable (Burgard et al. 2020; Cockerham et al. 2020).

Health lifestyles highlight the inherently social nature of health behavior, applying a sociological imagination to reveal how health behaviors are not isolated individual decisions, but embedded in our deeply complicated social lives. Future research must push health lifestyles beyond a behavior-only operationalization that risks perpetuating the individualization of health. Viewing health behavior as individualized elides the group-level nature of health lifestyles and the powerful structural forces that constrain people's behaviors. Extant research has made important strides in identifying groups and upstream influences, documenting fluidity and discordance in health lifestyles that underscore the importance of moving beyond specific health behaviors to take a more integrated approach. Future research articulating group-level lifestyle processes that underlie bundles of health behaviors can continue to shift scholarly attention to groups and to upstream policy influences on health. Integrating a cultural perspective on health lifestyles as a tool that maintains inequality is another important future goal. Achieving these aims will provide an evidence base that can further inform policies, potentially making them more effective at addressing social inequalities.

Acknowledgments

This research is based on work supported by a grant from the National Science Foundation (SES 1729463). We are grateful to the NIH/NICHD funded CU Population Center (P2CHD066613) and the Lund University Centre for Economic Demography (Sweden) for general support. We thank Kim Truong-Vu, Laurie James-Hawkins, and Richard Rogers for their contributions to this work.

REFERENCES

Abel Thomas. 2008. "Cultural Capital and Social Inequality in Health." Journal of Epidemiology and Community Health 62:e13. [PubMed: 18572429]

Abel Thomas and Frohlich Katherine L.. 2012. "Capitals and Capabilities: Linking Structure and Agency to Reduce Health Inequalities." Social Science & Medicine 74(2):236–44. [PubMed: 22177750]

Abrutyn Seth and Carter Michael J.. 2015. "The Decline in Shared Collective Conscience as Found in the Shifting Norms and Values of Etiquette Manuals." Journal for the Theory of Social Behaviour 45(3):352–76.

Adams Jimi, Lawrence Elizabeth, Goode Joshua, Schaefer David R., and Mollborn Stefanie. 2020. “Peer Network Processes in Adolescents' Health Lifestyles.” SocArXiv. Accessed at https://osf.io/preprints/socarxiv/xnd39.

Armstrong David. 2009. "Origins of the Problem of Health-Related Behaviours: A Genealogical Study." Social Studies of Science 39(6):909–26. [PubMed: 20506744]

Augustine Jennifer March, Prickett Kate C. and Kimbro Rachel Tolbert. 2017. "Health-Related Parenting among US Families and Young Children's Physical Health." Journal of Marriage and Family 79(3):816–32. [PubMed: 28959075]

Bakk Zsuzsa and Kuha Jouni. 2018. "Two-Step Estimation of Models between Latent Classes and External Variables." Psychometrika 83(4):871–92. [PubMed: 29150817]

Bauldry Shawn, Shanahan Michael J., Boardman Jason D., Miech Richard A. and Macmillan Ross. 2012. "A Life Course Model of Self-Rated Health through Adolescence and Young Adulthood." Social Science & Medicine 75(7):1311–20. [PubMed: 22726620]

Baum Fran and Fisher Matthew. 2014. "Why Behavioural Health Promotion Endures Despite Its Failure to Reduce Health Inequities." Sociology of Health & Illness 36(2):213–25. [PubMed: 24528303]

Becker Craig M, Sewell Kerry, Bian Hui and Lee Joseph GL. 2020. "Limited Improvements in Health Behaviors Suggest Need to Review Approaches to Health Promotion: A Repeated, Cross-Sectional Study." American Journal of Lifestyle Medicine:1559827620909378.

Benmarhnia Tarik, Dionne Pierre-Alexandre, Tchouaket Éric, Fansi Alvine K. and Brousselle Astrid. 2017. "Investing in a Healthy Lifestyle Strategy: Is It Worth It?" International Journal of Public Health 62(1):3–13.

Blaxter Mildred. 1990. Health and Lifestyles. London: Routledge.

Bourdieu Pierre. 1986a. Distinction: A Social Critique of the Judgement of Taste. London: Routledge & Kegan Paul.

Bourdieu Pierre. 1986b. "The Forms of Capital." Pp. 241–58 in Handbook of Theory and Research for the Sociology of Education, edited by Richardson JG. New York: Greenwood Press.

Burdette Amy M., Needham Belinda L., Taylor Miles G. and Hill Terrence D.. 2017. "Health Lifestyles in Adolescence and Self-Rated Health into Adulthood." Journal of Health and Social Behavior 58(4):520–36. [PubMed: 29172769]

Burgard Sarah A., Lin Katherine Y. P., Segal Brian D., Elliott Michael R. and Seelye Sarah. 2020. "Stability and Change in Health Behavior Profiles of U.S. Adults." Journals of Gerontology: Series B 75(3):674–83.

Cairns Kate and Johnston Josée. 2015. "Choosing Health: Embodied Neoliberalism, Postfeminism, and The ‘Do-Diet.’" Theory and Society 44(2):153–75.

Carlisle Sandra, Hanlon Phil and Hannah Margaret. 2008. "Status, Taste and Distinction in Consumer Culture: Acknowledging the Symbolic Dimensions of Inequality." Public Health 122(6):631–37. [PubMed: 18234253]

Chen Pan and Jacobson Kristen C.. 2012. "Developmental Trajectories of Substance Use from Early Adolescence to Young Adulthood: Gender and Racial/Ethnic Differences." Journal of Adolescent Health 50(2):154–63.

Christensen Pia. 2004. "The Health-Promoting Family: A Conceptual Framework for Future Research." Social Science & Medicine 59(2):377–87. [PubMed: 15110427]

Christensen Vibeke T. and Carpiano Richard M.. 2014. "Social Class Differences in BMI among Danish Women: Applying Cockerham's Health Lifestyles Approach and Bourdieu's Theory of Lifestyle." Social Science & Medicine 112:12–21. [PubMed: 24788112]

Cockerham William C, Hinote Brian P, Abbott Pamela and Haerpfer Christian. 2004. "Health Lifestyles in Central Asia: The Case of Kazakhstan and Kyrgyzstan." Social Science & Medicine 59(7):1409–21. [PubMed: 15246170]

Cockerham William C., Rütten Alfred and Abel Thomas. 1997. "Conceptualizing Contemporary Health Lifestyles: Moving Beyond Weber." Sociological Quarterly 38(2):321–42.

Cockerham William C. 2005. "Health Lifestyle Theory and the Convergence of Agency and Structure." Journal of Health and Social Behavior 46(1):51–67. [PubMed: 15869120]

Cockerham William C. 2018. "Health Lifestyles and the Search for a Concept of a Gender-Specific Habitus." Social Theory & Health 16(2):142–55.

Cockerham William C. 2021. Sociological Theories of Health and Illness. New York: Routledge.

Cockerham William C., Bauldry Shawn, Hamby Bryant W., Shikany James M., and Bae Sejong. 2017. "A Comparison of Black and White Racial Differences in Health Lifestyles and Cardiovascular Disease." American Journal of Preventive Medicine 52(1): S56–S62. [PubMed: 27989294]

Cockerham William C., Wolfe Joseph D. and Bauldry Shawn. 2020. "Health Lifestyles in Late Middle Age." Research on Aging 42(1):34–46. [PubMed: 31709904]

Collins Linda M. and Lanza Stephanie T.. 2010. Latent Class and Latent Transition Analysis: With Applications in the Social, Behavioral, and Health Sciences. Hoboken, NJ: Wiley.

Connell Raewyn. 2018. "Decolonizing Sociology." Contemporary Sociology 47(4):399–407.

Costa-Tutusaus Lluís and Guerra-Balic Myriam. 2016. "Development and Psychometric Validation of a Scoring Questionnaire to Assess Healthy Lifestyles among Adolescents in Catalonia." BMC Public Health 16.

Curl Heather, Lareau Annette and Wu Tina. 2018. "Cultural Conflict: The Implications of Changing Dispositions among the Upwardly Mobile." Sociological Forum 33(4):877–99.

Daw Jonathan, Margolis Rachel and Verdery Ashton M.. 2015. "Siblings, Friends, Course-Mates, Club-Mates: How Adolescent Health Behavior Homophily Varies by Race, Class, Gender, and Health Status." Social Science & Medicine 125:32–39. [PubMed: 24673889]

Daw Jonathan, Margolis Rachel and Wright Laura. 2017. "Emerging Adulthood, Emergent Health Lifestyles: Sociodemographic Determinants of Trajectories of Smoking, Binge Drinking, Obesity, and Sedentary Behavior." Journal of Health and Social Behavior 58(2):181–97. [PubMed: 28661779]

de la Haye Kayla, D'Amico Elizabeth J., Miles Jeremy N. V., Ewing Brett and Tucker Joan S.. 2014. "Covariance among Multiple Health Risk Behaviors in Adolescents." PLoS One 9(5):e98141. [PubMed: 24858838]

Elder Glen H. Jr. 1994. "Time, Human Agency, and Social Change: Perspectives on the Life Course." Social Psychology Quarterly 57(1):4–15.

Eliasoph Nina and Lichterman Paul. 2003. "Culture in Interaction." American Journal of Sociology 108(4):735–94.

Elliott Sinikka and Bowen Sarah. 2018. "Defending Motherhood: Morality, Responsibility, and Double Binds in Feeding Children." Journal of Marriage and Family 80(2):499–520.

Ely Robin J. and Meyerson Debra E.. 2010. "An Organizational Approach to Undoing Gender: The Unlikely Case of Offshore Oil Platforms." Research in Organizational Behavior 30:3–34.

Ferraro Kenneth F., Schafer Markus H. and Wilkinson Lindsay R.. 2016. "Childhood Disadvantage and Health Problems in Middle and Later Life: Early Imprints on Physical Health?" American Sociological Review 81(1):107–33. [PubMed: 27445413]

Fielding-Singh Priya. 2019. "You're Worth What You Eat: Adolescent Beliefs About Healthy Eating, Morality and Socioeconomic Status." Social Science & Medicine 220:41–48. [PubMed: 30391640]

Frohlich Katherine L. and Potvin Louise. 1999. "Collective Lifestyles as the Target for Health Promotion." Canadian Journal of Public Health 90:S11–S14. [PubMed: 10686752]

Giddens Anthony. 1984. "Elements of the Theory of Structuration." Pp. 1–28 in The Constitution of Society: Outline of the Theory of Structuration, edited by Giddens A. Berkeley: University of California Press.

Goldberg Amir and Stein Sarah K.. 2018. "Beyond Social Contagion: Associative Diffusion and the Emergence of Cultural Variation." American Sociological Review 83(5):897–932.

Graham Louis, Brown-Jeffy Shelly, Aronson Robert, and Stephens Charles. 2011. “Critical Race Theory as Theoretical Framework and Analysis Tool for Population Health Research.” Critical Public Health 21(1):81–93.

Gremmen Mariola C., Berger Christian, Ryan Allison M., Steglich Christian E. G., Veenstra Rene and Dijkstra Jan K.. 2019. "Adolescents' Friendships, Academic Achievement, and Risk Behaviors: Same-Behavior and Cross-Behavior Selection and Influence Processes." Child Development 90(2):e192–e211. [PubMed: 29450883]

Hill Terrence D, Ellison Christopher G, Burdette Amy M and Musick Marc A. 2007. "Religious Involvement and Healthy Lifestyles: Evidence from the Survey of Texas Adults." Annals of Behavioral Medicine 34(2):217–22. [PubMed: 17927560]

Hitlin Steven and Elder Glen H. Jr. 2007. "Time, Self, and the Curiously Abstract Concept of Agency." Sociological Theory 25(2):170–91.

Horne Christine. 2001. "The Enforcement of Norms: Group Cohesion and Meta-Norms." Social Psychology Quarterly 64(3):253–66.

Katainen Anu. 2010. "Social Class Differences in the Accounts of Smoking - Striving for Distinction?" Sociology of Health & Illness 32(7):1087–101. [PubMed: 21039618]

Kemp Blakelee R. and Jennifer Karas Montez. 2020. "Why Does the Importance of Education for Health Differ across the United States?" Socius: Sociological Research for a Dynamic World 6(First Published January 23, 2020).

Knudsen Sine Grønborg and Triantafillou Peter. 2020. "Lifestylisation of the Social: The Government of Diabetes Care in Denmark." Health. Accessed at 10.1177/1363459319899454.

Kohli Martin. 2019. "The Promises and Pitfalls of Life-Course Agency." Advances in Life Course Research 41:100273.

Korp Peter. 2008. "The Symbolic Power of 'Healthy Lifestyles'." Health Sociology Review 17(1):18–26.

Korp Peter. 2010. "Problems of the Healthy Lifestyle Discourse." Sociology Compass 4(9):800–10.

Krueger Patrick M., Bhaloo Tajudaullah and Rosenau Pauline Vaillancourt. 2009. "Health Lifestyles in the United States and Canada: Are We Really So Different?" Social Science Quarterly 90(5):1380–402. [PubMed: 20190868]

Lamont Michèle and Molnár Virág. 2001. "How Blacks Use Consumption to Shape Their Collective Identity: Evidence from African-American Marketing Specialists." Journal of Consumer Culture 1(1):31–45.

Lamont Michèle and Molnár Virág. 2002. "The Study of Boundaries in the Social Sciences." Annual Review of Sociology 28:167–95.

Landes Scott D. and Settersten Richard A. Jr. 2019. "The Inseparability of Human Agency and Linked Lives." Advances in Life Course Research 42(100306):1–10.

Lawrence Elizabeth, Mollborn Stefanie, Goode Joshua and Pampel Fred. 2020. "Health Lifestyles and the Transition to Adulthood." Socius 6:2378023120942070.

Lawrence Elizabeth M., Mollborn Stefanie and Hummer Robert A.. 2017. "Health Lifestyles across the Transition to Adulthood: Implications for Health." Social Science & Medicine 193:23–32. [PubMed: 28992538]

Lee Chung Gun, Seo Dong-Chul, Middlestadt Susan E. and Lin Hsien-Chang. 2015. "Does the Relationship between Cigarette Smoking and Other Key Health Behaviors Vary by Geographic Area among US Young Adults? A Multilevel Analysis." International Journal of Behavioral Medicine 22(4):481–88. [PubMed: 25424168]

Lewis Kevin and Kaufman Jason. 2018. "The Conversion of Cultural Tastes into Social Network Ties." American Journal of Sociology 123(6):1684–742.

Ling Jiying, Robbins Lorraine B., Wen Fujun and Zhang Nanhua. 2017. "Lifestyle Interventions in Preschool Children: A Meta-Analysis of Effectiveness." American Journal of Preventive Medicine 53(1):102–12. [PubMed: 28237633]

Link Bruce G. and Phelan Jo. 1995. "Social Conditions as Fundamental Causes of Disease." Journal of Health and Social Behavior 35:80–94.

Link Bruce G. and Phelan Jo. 2014. "Stigma Power." Social Science & Medicine 103:24–32. [PubMed: 24507908]

Lloyd Jenny, Creanor Siobhan, Logan Stuart, Green Colin, Dean Sarah G, Hillsdon Melvyn, Abraham Charles, Tomlinson Richard, Pearson Virginia and Taylor Rod S.. 2018. "Effectiveness of the Healthy Lifestyles Programme (HELP) to Prevent Obesity in UK Primary-School Children: A Cluster Randomised Controlled Trial." The Lancet Child & Adolescent Health 2(1):35–45. [PubMed: 29302609]

Luna Jessie K. 2019. "The Ease of Hard Work: Embodied Neoliberalism among Rocky Mountain Fun Runners." Qualitative Sociology 42(2):251–71.

Masyn Katherine E. 2017. "Measurement Invariance and Differential Item Functioning in Latent Class Analysis with Stepwise Multiple Indicator Multiple Cause Modeling." Structural Equation Modeling: A Multidisciplinary Journal 24(2):180–97.

Metzl Jonathan M. 2019. Dying of Whiteness: How the Politics of Racial Resentment Is Killing America's Heartland. Hachette UK.

Mirowsky John and Ross Catherine E.. 2015. "Education, Health, and the Default American Lifestyle." Journal of Health and Social Behavior 56(3):297–306. [PubMed: 26272989]

Mize Trenton D. 2017. "Profiles in Health: Multiple Roles and Health Lifestyles in Early Adulthood." Social Science & Medicine 178:196–205. [PubMed: 28262326]

Mollborn Stefanie, James-Hawkins Laurie, Lawrence Elizabeth and Fomby Paula. 2014. "Health Lifestyles in Early Childhood." Journal of Health and Social Behavior 55(4):386–402. [PubMed: 25413801]

Mollborn Stefanie and Lawrence Elizabeth. 2018. "Family, Peer, and School Influences on Children's Developing Health Lifestyles." Journal of Health and Social Behavior 59(1):133–50. [PubMed: 29298103]

Mollborn Stefanie, Lawrence Elizabeth M., and Hummer Robert A.. 2020. "A Gender Framework for Understanding Health Lifestyles." Social Science & Medicine. Accessed at 10.1016/j.socscimed.2020.113182.

Mollborn Stefanie, Lawrence Elizabeth M., and Krueger Patrick M.. 2020. "Developing Health Lifestyle Pathways and Social Inequalities across Early Childhood." Population Research and Policy Review. Accessed at 10.1007/s11113-020-09615-6.

Mollborn Stefanie, Rigles Bethany, and Pace Jennifer A.. 2020. ""Healthier Than Just Healthy": Families Transmitting Health as Cultural Capital." Social Problems. Accessed at 10.1093/socpro/spaa015.

Olson Julie Skalamera, Hummer Robert A., and Harris Kathleen Mullan. 2017. "Gender and Health Behavior Clustering among U.S. Young Adults." Biodemography and Social Biology 63(1):3–20. [PubMed: 28287308]

Ortner Sherry B. 1998. "Identities: The Hidden Life of Class." Journal of Anthropological Research 54(1):1–17.

Øvrum Arnstein, Gustavsen Geir Wæhler and Rickertsen Kyrre. 2014. "Age and Socioeconomic Inequalities in Health: Examining the Role of Lifestyle Choices." Advances in Life Course Research 19:1–13. [PubMed: 24796874]

Pampel Fred C. 2005. "Diffusion, Cohort Change, and Social Patterns of Smoking." Social Science Research 34(1):117–39. [PubMed: 22485056]

Prochaska Judith J., Spring Bonnie and Nigg Claudio R.. 2008. "Multiple Health Behavior Change Research: An Introduction and Overview." Preventive Medicine 46(3):181–88. [PubMed: 18319098]

Rees Jones Ian, Papacosta Olia, Whincup Peter H., Wannamethee S. Goya, and Morris Richard W.. 2011. "Class and Lifestyle 'Lock-in' among Middle-Aged and Older Men: A Multiple

Correspondence Analysis of the British Regional Heart Study." Sociology of Health & Illness 33(3): 399–419. [PubMed: 21241333]

Ridgeway Cecilia L. 2014. "Why Status Matters for Inequality." American Sociological Review 79(1):1–16.

Rigles Bethany. 2019. "The Development of Health Lifestyles in Families Experiencing Disability." Journal of Family Issues 40(7):929–53.

Rogers Richard G, Krueger Patrick M, Miech Richard, Lawrence Elizabeth M and Kemp Robert. 2013. "Nondrinker Mortality Risk in the United States." Population Research and Policy Review 32(3):325–52. [PubMed: 25045194]

Rosenfeld Michael J. 2009, 2007. The Age of Independence: Interracial Unions, Same-Sex Unions, and the Changing American Family. Cambridge, MA: Harvard University Press.

Rosero-Bixby Luis and Dow William H. 2009. "Surprising Ses Gradients in Mortality, Health, and Biomarkers in a Latin American Population of Adults." Journals of Gerontology Series B: Psychological Sciences and Social Sciences 64(1):105–17.

Onge Saint, M. Jarron and Krsuegezr Patrick M.. 2011. "Education and Racial-Ethnic Differences in Types of Exercise in the United States." Journal of Health and Social Behavior 52(2):197–211. [PubMed: 21673147]

Onge Saint, M. Jarron and Krueger Patrick M.. 2017. "Health Lifestyle Behaviors among Us Adults." SSM-Population Health 3:89–98. [PubMed: 28785602]

Saneei Parvane, Esmaillzadeh Ahmad, Keshteli Ammar Hassanzadeh, Roohafza Hamid Reza, Afshar H, Feizi A and Adibi P. 2016. "Combined Healthy Lifestyle Is Inversely Associated with Psychological Disorders among Adults." PloS One 11(1).

Settersten Richard A. Jr. 2004. "Age Structuring and the Rhythm of the Life Course." Pp. 81–98 in Handbook of the Life Course, edited by Mortimer JT and Shanahan MJ. New York: Kluwer Academic/Plenum Publishers.

Simmel Georg. 1950. The Sociology of Georg Simmel, Vol. 92892: Simon and Schuster.

Sobel Michael E. 1981. Lifestyle and Social Structure: Concepts, Definitions, Analyses. New York: Academic Press.

Södergren Marita, Wang Wei Chun, Salmon Jo, Ball Kylie, Crawford David and McNaughton Sarah A.. 2014. "Predicting Healthy Lifestyle Patterns among Retirement Age Older Adults in the Well Study: A Latent Class Analysis of Sex Differences." Maturitas 77(1):41–46. [PubMed: 24144958]

Stets Jan E. and Carter Michael J.. 2012. "A Theory of the Self for the Sociology of Morality." American Sociological Review 77(1):120–40.

Strang David and Soule Sarah A.. 1998. "Diffusion in Organizations and Social Movements: From Hybrid Corn to Poison Pills." Annual Review of Sociology 24:265–90.

Talukdar Jaita and Linders Annulla. 2013. "Gender, Class Aspirations, and Emerging Fields of Body Work in Urban India." Qualitative Sociology 36(1):101–23.

Teuscher Dorit, Bukman Andrea J., van Baak Marleen A., Feskens Edith J. M., Renes Reint Jan and Meershoek Agnes. 2015. "Challenges of a Healthy Lifestyle for Socially Disadvantaged People of Dutch, Moroccan and Turkish Origin in the Netherlands: A Focus Group Study." Critical Public Health 25(5):615–26. [PubMed: 26430295]

Vaisey Stephen. 2009. "Motivation and Justification: A Dual-Process Model of Culture in Action." American Journal of Sociology 114(6):1675–715.

Wamboldt Alexander, Khan Shamus, Mellins Claude Ann, Wall Melanie M., Reardon Leigh and Hirsch Jennifer S.. 2019. "Wine Night, “Bro-Dinners,” and Jungle Juice: Disaggregating Practices of Undergraduate Binge Drinking." Journal of Drug Issues 49(4):643–67. [PubMed: 33833471]

Weber Max. 1978. Economy and Society: An Outline of Interpretive Sociology. Berkeley: University of California Press.

Wertz Joseph, Azrael Deborah, Hemenway David, Sorenson Susan and Miller Matthew. 2018. "Differences between New and Long-Standing US Gun Owners: Results from a National Survey." American Journal of Public Health 108(7):871–77. [PubMed: 29771618]

Williams Oli and Fullagar Simone. 2019. "Lifestyle Drift and the Phenomenon of ‘Citizen Shift’in Contemporary UK Health Policy." Sociology of Health & Illness 41(1):20–35. [PubMed: 30073681]

Williams Simon J. 1995. "Theorising Class, Health and Lifestyles: Can Bourdieu Help Us?" Sociology of Health & Illness 17(5):577–604.

Zhang Li. 2020. "A Latent Class Analysis of Health Lifestyles and Health Outcomes among Chinese Older Adults." Ageing & Society, online first. Accessed at: 10.1017/S0144686X20001063.

Table 1.

Contributions of Recent Literature to Understanding Health Lifestyles

Health lifestyles incorporate:
• An individual's constellation of health behaviors, often discordant in its healthfulness
• Identities, norms, and understandings of health in groups to which an individual belongs
• A combination of gradually developed habitus and deliberate agency
Influences on health lifestyles include:
• Social group memberships
• Macro- and mesolevel social contexts (e.g., families, social networks)
• Geographic contexts
• Age and life stage
• A person's own and family members' health
Health lifestyles evidence stability or change depending on:
• Age
• Social and geographic contexts
• New health behaviors emerging
• Social meanings of health behaviors
Health lifestyles influence:
• Subsequent health lifestyles
• Health and mortality
• Socioeconomic attainment
Health lifestyles perpetuate inequalities by:
• Serving as an increasingly important form of cultural capital
• Maintaining or strengthening intergroup boundaries and class distinctions
• Increasing their symbolic power through relationships to morality and discipline
• Strengthening group-based collectives that self-segregate and hoard resources
• Focusing on a limited set of culturally bound "health behavior" variables