

The management of situated risk: A parental perspective on child food allergy

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Abstract

Food allergy is an illness that requires constant risk management in everyday life. To date, there is no cure or preventive treatment, and the only way to manage the condition is therefore careful avoidance of the offending foodstuff and treatment of reactions when they occur. This article draws on a socio-cultural approach to explore parents' understandings and management of child food allergy in the context of everyday life, as 'situated' risk. A focus group study was carried out with 31 parents of children diagnosed with food allergy at two children's hospitals. The analysis of the focus group material reveals how the management of allergy risk seems to permeate most aspects of everyday life as well as how the parents draw on a dominant norm of risk avoidance as well as a counter-discourse of calculated risk taking. The patterns of risk management found in this study are discussed in terms of how risk avoidance and risk taking are intertwined and balanced in the context of moral parenthood.

Keywords

child food allergy, everyday life, parents, risk management, situated risk

Introduction

Some illnesses require constant risk management in everyday life. One such illness, and an 'important exemplar of risk' (Rous and Hunt, 2004: 829) is food allergy. Food allergy

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is not only an important exemplar of risk but has also become the focus of a growing media attention and even discussed as emblematic of contemporary life, a 'modern malady'. It has been described as comparable to many other risks of today such as food alarms or climate change in the sense that life with this condition involves uncertainties, danger and constant risk management (Jackson, 2006; Nettleton et al., 2009). Food is a fundamental human need that also has profound social and cultural significance (Ward et al., 2010). We all need to eat, but when suffering from food allergy, food can be reframed as innately 'dangerous'. In this context, children with food allergy can be seen as 'children at risk'. They face the risk of encountering allergens, the 'dangerous' food, in a variety of situations in everyday life.

Food allergy is an increasing paediatric public health problem in the Western world, affecting up to 12 percent of the child population depending on definition (Burks et al., 2012). Although most foods can cause allergic reactions, the most common among children are allergies to milk, egg, peanut and tree nuts (Arias et al., 2009). Allergic reactions to food in children are usually immunoglobulin E (IgE) mediated¹ and occur shortly after exposure with symptoms varying from mild oral itch to life-threatening conditions. There is to date no reliable method to predict the severity of subsequent reactions. Hence, a mild allergic reaction can be followed by a more severe reaction or by anaphylaxis, a potentially fatal reaction involving multi-organ systems. Also, children who develop one food allergy are at higher risk of developing more food allergies as well as other atopic diseases such as asthma.

A parental perspective

As in other cases of 'children at risk', this raises questions about parental experiences of responsibility as well as understandings and management of risk. Parents are the mediators of children's health and well-being, and in the case of food allergy, they have to protect their children from 'dangerous food'. It is already well known that there is a variety of negative effects from the constant vigilance needed to avoid allergens. Studies using quality-of-life instruments have shown that food allergy has a significant detrimental impact, particularly on aspects of physical function and emotional quality of life (Cummings et al., 2010; Ostblom et al., 2008). Even low levels of parentally perceived risk of severe allergic reactions can significantly reduce health-related quality of life (Madsen et al., 2010). In fact, allergy to peanuts has been reported to result in a lower quality of life than insulin-dependent diabetes (Avery et al., 2003). Also, parents experience worries and anxiety due to the constant vigilance (Mandell et al., 2005), and feelings of 'living with risk and fear' seem to be predominant when caring for a child with food allergy (Gillespie et al., 2007; Rouf et al., 2011). High levels of parental anxiety may lead to maladaptive coping and limit the child's participation in age-appropriate activities (Bollinger et al., 2006; Klinnert and Robinson, 2008), and parents can worry about handing over responsibility for allergen avoidance to their children as they grow older (Akeson et al., 2007). However, these studies have predominantly focussed on the psycho-social impacts of the condition, often with a clinical orientation to improve service quality. Less has been done to explore risk management in everyday situations more in depth from a parental perspective, taking

parents' observations, reflections and ways of defining illness and risk as points of departure.

In this article, we will address how parents themselves understand food allergy, how they identify risk and adopt strategies in dealing with allergy risk. As allergy risk is intertwined with the mundane daily activities and social lives of parents and children, we have chosen to study parents' risk management as carried out at the micro-level of everyday life, across the variety of situations where encounters with dangerous food can take place – as 'situated risk'.

The management of situated risk

In this study, we draw on a socio-cultural approach to risk, that is, with a focus on the way people 'respond to, experience and think about risk as part of their everyday lives' (Tulloch and Lupton, 2003: 1). Sociological research on how people make sense of and respond to specific risks demonstrates how different 'logics of risk' exist in different socio-cultural and historical settings, and that lay understanding of risk thus tend to be 'highly contextual, localized and individualized and reflexively aware of diversity and change' (Tulloch and Lupton, 2003: 2). Furthermore, the 'logic of risk' does not only vary across different cultural and historical contexts but also between the ways individuals understand risk more locally in the context of everyday life. People construct their risk knowledge based on close observations of everyday phenomena and the behaviour of other people around them, including the disparity between expert views (Tulloch and Lupton, 2003). The notion of 'situated' risk (Henwood et al., 2008) refers to how different situations in everyday life can be framed as risky by the individual. More specifically, this has to do with the awareness of the presence of danger in different situation which, if not correctly or skilfully managed, can result in harm or even death (Alaszewski and Coxon, 2008: 417).

In the case of food allergy, the dangerous foodstuffs, the allergens, should be avoided. However, due to the ubiquity of most food allergens and the small amounts needed to trigger an allergic reaction, complete avoidance is difficult. Also, the threat of an anaphylactic reaction might loom in the background even when there has been no such reaction earlier. As there is no cure to the allergic condition, and no preventive treatment, the only way to cope is therefore to develop strategies of risk management to avoid accidental exposure to the offending foodstuff and to treat reactions when they occur. However, as Rous and Hunt (2004) point out, the results of such risk management may be 'difficult to guarantee' (p. 289). Parents of children with food allergy are thus faced with the task to manage the risks the child faces in different situations. Drawing on the notion of 'situated' risk, the purpose of this article is to explore the ways parents understand and manage the food allergy risk, more specifically, how risk is contextualized and localized, and what strategies of risk management they adopt in everyday life.

The study

To explore parents' understandings and management of food allergy, focus group discussions were conducted with parents of children with food allergy. Focus groups are

particularly suited for the study of shared knowledge, opinions and underlying attitudes, and are typically used with people who share similar experiences or characteristics. Importantly, the focus group is not just an arena where we can get access to people's ideas and understandings. Focus groups make people 'think together' (Linell, 2001). The group dynamics in a group of 5–8, which often is recommended, can stimulate reflections as participants are allowed to comment and build on each other's experiences and thoughts, which can contribute to a variation of views on the discussed topics (Kidd and Parshall, 2000; Marková et al., 2007). When the topic is sensitive, emotionally charged and complex, or as in this case when participants are directly affected by the issue, smaller groups are often preferred (Morgan, 1996).

Participants were recruited among parents who in 2007 had attended the emergency department at two children's hospitals in Stockholm with a child suffering from a suspected acute reaction to food, and who after the hospital visit answered that the child was allergic to certain food(s) in a website survey. These parents were invited in 2009–2010 by letter and phone to participate in the study, and were told they could participate regardless of the severity of their child's acute reaction to food, and that their participation would not affect their contacts with the clinic. Forty parents accepted the invitation, but due to late cancellations 31 parents participated in the focus groups, 25 mothers and six fathers of children aged 1–17 years. The 31 parents were all native Swedish speaking, with a level of education varying from upper-secondary school to university. All children had been diagnosed with a food allergy, either single food or multiple, varying from mild allergy to potentially life-threatening allergy, and most of them were prescribed an adrenaline autoinjector. The control of anaphylaxis requires adrenaline given as an immediate injection, and children at risk of severe food allergic reactions are prescribed adrenaline that they can inject themselves (Simons et al., 2012).

The parents were allocated to groups according to the age of their child (above/below 9 years of age) as parenting a younger or older child can involve different experiences of risk management. Altogether 10 focus group sessions were scheduled to make possible for all parents to find time to participate. This meant that the number of participants in each group was fairly small. In eight groups, there were 3–4 participants. Two groups had just two participants, but as these dyads contributed with a rich material, we decided to include them in the material. These fairly small groups gave the participants opportunities to talk at length about their experiences.

All focus groups were carried out at the two children's hospitals, and moderated by the first author Marie-Louise Stjerna. The physician Mirja Vetander who invited the parents participated as a silent observer. Her presence gave the participants the benefit of having answers to some of their medical questions at the end of each session, important for ethical reasons. The moderator introduced the overall topic for the group discussion, and opened up for the participants to share experiences with a first question about how they had experienced the hospital emergency visit, and then followed up with questions about how life with the food allergic child had evolved thereafter. The notion of risk was thus not introduced to the parents as part of the introduction. The discussions were monitored according to a topic-guide used in all sessions covering everyday management of the allergy at home, in the nursery, school and other arenas. In addition, an adrenaline autoinjector was shown

as a trigger to encourage discussion between parents. The sessions lasted for 1.5–2 hours, and with the parents' permission, they were digitally recorded.

All focus group discussions were transcribed verbatim by the moderator and subject to a qualitative analysis. Drawing on a dialogical perspective (Marková et al., 2007), the face-to-face interaction in focus groups can be seen as an intricate web of meaning-making in which, in principle, every contribution is interdependent on previous and future contributions. Consequently, the unit of analysis is not the individual but rather the interaction and tensions between different thoughts, ideas and arguments as they appear in discussions. In line with this perspective, we analysed the content of the material, drawing boundaries between topical episodes that were held together internally as the participants discussed a certain topic during a sequence of time and also how these topics emerged, that is, how they were initiated, taken up or ignored by participants during the sessions. Attention was also given to topics that were treated as taken for granted and topics that were more debated and questioned during the group discussions. Risk turned out to be a salient issue in the discussions. In the analysis of the material, we identified recurrent topics in parents' talk about the ways they identify risk and adopt management strategies in different everyday situations that they themselves frame as dangerous or risky. These recurrent topics are here presented under the headings of two major themes, risk avoidance and risk taking.

Risk avoidance: a dominant discourse of constant vigilance

During the focus group sessions, the parents explicitly recognized the similarity in their experiences. They positioned themselves as a 'we' in contrast to 'others' who lacked the experiences of managing food allergy, and shared advice on how to manage everyday life with a food allergic child. Throughout the sessions, all participants took part in the discussion, albeit a few were less active claiming that other parents had experiences of more severe food allergies and thus had more to contribute.

To constantly be one step ahead

The parents provide detailed accounts of the precautions they take to protect their children from coming into contact with dangerous foodstuffs, how you always have to be in a state of alertness and to be prepared with the medicine at hand if something should happen. In the following excerpt, we see a typical example (children's names are fictitious; parents are given a number within each focus group (Fg)):

- Mother 1: You have to think about this all the time, and that is, you can never relax
- Mother 2: No, that's right
- Mother 1: You can never do anything without planning beforehand
- Mother 2: Just to go out for a coffee
- Mother 1: We are a bunch who go out for a coffee, but then we always have to find a place where Sofia (allergic to milk protein) can go, you always have to

bring everything, and you can't just go off, I think it is stressful, now that we are going to Italy, what is she going to eat

Mother 2: Yeah, chips

Mother 1: It is going to be stressful, you don't want her to get ill

Mother 2: No, of course

Mother 1: I can imagine myself, bringing bread and stuff from home. (Fg 4)

As we see here, these mothers argue that you can never do anything without planning, which means to constantly be a step ahead. In all focus groups, the parents discuss how they have to be aware of 'little details' that other people would not even think about, for example, that you must have a separate frying pan for eggs if you have a child allergic to egg, which was mentioned in one group. There is not much room to make mistakes as this could cause an allergic reaction, so you are never able to relax. The parents describe the ways they try to avoid risk by introducing and maintaining routines. This could be to 'check' every step in the process of purchasing and preparing food, to carefully check food labels or to always have separate cooking equipment or cutlery for the child. Even if all of these routines are followed, a foodstuff that has been safe earlier may not continue to be so:

Mother 1: I think we spend a good twenty minutes more than anybody else in the grocery shop because we read *everything* (on the labels), even on things we think we know one hundred per cent, we still have to read it, because suddenly it has changed and can contain traces of nuts, and that's the only life line we have, to read everything. (Fg 5)

The parents also question the trustworthiness of the information from the food companies, and give examples of contradictory food labelling. For example, one mother found that a bar of chocolate was labelled 'milk-free' in Swedish but labelled 'may contain traces of milk' in Finnish. Being one step ahead therefore means that purchasing groceries and preparing meals, routine 'everyday work', takes on a new significance when caring for the food allergic child. To be able to manage the child's allergy, the parents also get involved in various learning processes. They become 'experts' on food labels and find alternatives to the offending food. Even to identify different ingredients in the child's meal or snack is a rather complex endeavour, as the allergen could be disguised in a lot of foods that may not be immediately associated with allergens:

Mother 3: I am so pleased she is not allergic to milk protein any longer, I thought that was hard because there are so many products containing milk, you can't imagine, I can understand that people don't think about milk in mixed spices or margarine or bread crumbs. (Fg 3)

The parents talk about constantly being in a state of alert *if* something should happen: 'always having the mobile phone at hand' or always bringing the adrenaline autoinjector:

Mother 1: What I am most afraid of is that her throat is going to swell, anything else you can cope with, it could be unpleasant, but if your throat swells, you

cannot breath and then you die, so to speak, and this is when it (the auto-injector) helps. (Fg 2)

The parents talk about different types of allergy medication, but the adrenaline auto-injector has a unique position, in terms of its' symbolic value as a lifesaver and safe-guard. As one father explains, it is not the first choice, rather the last resort if nothing else works, the 'big artillery'. The ways the parents talk about the use of the autoinjector illuminate their understanding of the great danger of the severe food allergy reaction, which consequently needs a powerful management.

To make unsafe zones safe

The focus group discussions also revolve around issues of risk and safety in various social contexts and places where the child spends time, such as the home, nursery, school, playgrounds and other public spaces. Most parents talk about their homes as a safe zone where they can ensure that the child will not be in contact with the dangerous foodstuff:

Mother 1: We don't have eggs or milk at home, and no nuts, I think my husband had chocolate with nuts once, but that is tucked away, so there is nothing at home, so everybody can have what is in the house. (Fg 2)

However, even at home it can be difficult to be in control of everything. The home could be regarded as safe until the child suddenly has an allergic reaction, which proved that something unknown had 'slipped into' the safe zone:

Mother 3: She (daughter allergic to milk-protein and egg) had rashes all over her back and her arms, and then I thought, what could it be, I couldn't remember anything, I had run the dishwasher without detergent, just water, I know that her sister could have had some chocolate milk with ordinary milk the night before, that's all I can think of. (Fg 10)

Places outside the home are also continuously assessed as safe or unsafe. The nursery and school can be safe if you can trust the staff. But even minor deviations from the ordinary routine can make these places unsafe, as we see in the following example where a new day-care assistant does not understand the differences between milk protein and lactose, which leads to a major allergic reaction in one of the children:

Father 1: A new assistant at the day-care centre gave her (daughter allergic to egg, milk-protein, nuts) a sandwich with cheese, believing that she was lactose-intolerant, there is no lactose in this cheese, and when this happened, it was my wife who picked her up, she was completely swollen and had difficulties breathing. (Fg 3)

The parents describe how they try to regain control after incidents like this, when a place has become unsafe. They take various preventive measures, for example, letting

the child have his or her own glass and plate at nursery, or more meals at home to reduce possible 'mistakes'. As it is difficult to quite trust the level of knowledge about allergens in nurseries, schools and other places, they always have to be vigilant themselves and educate the staff about the dangers their children are running.

The parents also talk about other spaces where they have to be vigilant, such as the local neighbourhood and restaurants. One example is to try to make the playground safe by asking the neighbours to never offer the child anything to eat. Children's parties and visits to restaurants demands more active efforts: 'It is possible for us to go out for a meal to have some kind of social life, what I do is to bring something for her to eat, pancakes or something'. Travelling is another issue discussed in several groups. Even a trip with the commuter train could be risky if you end up in 'a crowded train with people eating biscuits and spreading crumbs around them'. Airline companies can have food allergy policies but may still not be completely safe:

Mother 2: They didn't sell any nuts on the plane, and we had ordered nut-free food, so it all seemed to work out, but on the tray there was a chocolate bar containing nuts, which made me suspicious about the whole thing. (Fg 3)

As we can see, the parents have to be vigilant at a very detailed level and be ready to act or instruct other people. Also, these places change in often unpredictable ways, as when one day a new teacher turns up at the nursery. Furthermore, children grow and the issue of safe and unsafe zones differs for younger and older children. The very young children cannot speak for themselves and are dependent on the vigilance of their parents. Older children have access to a broader range of social arenas in their daily lives, where they can also act more independently. 'Normal' behaviours for teenagers as they start to live more independently, spending time with friends, holiday trips and so on, are experienced as risky:

Mother 1: Just starting to go to the pictures on his own, I remember that was a nightmare, I was just sitting and waiting, calling when he was in the bus on his way home, all these ordinary things in life. (Fg 6)

What we see here is that parental vigilance means to constantly be aware of the changing conditions in the child's everyday life and in the surrounding food (and food labelling) landscape. This responsibility is expanded to a range of places and social contexts outside the home. These places demand different types of risk management, from concrete checking of everything that enters the home to educating others to make them understand how the allergy 'works' and constant vigilance in public places. The places children visit are not 'stable' but can change at any time, which is in line with Rous and Hunt's (2004) argument that parents have the responsibility to prevent potentially severe reactions in the often 'uncontrolled environment' of their child's everyday life. This is true for a variety of places that their children move through as they grow up, not once but repeatedly, and with somewhat different fears when parenting younger and older children.

Despite the fact that the children in this study had a food allergy diagnosis, the parents describe how they have to impel others to take precautions to protect their children. They

argue this could perhaps be due to the ‘disguised’ character of child food allergy, invisible until the moment when the child has a reaction, ‘they don’t really understand until it happens’. Negotiating food avoidance can thus be necessary *and* precarious in social interaction with others. Risk management could in this sense be described as a *social* project. It is social not only as it is located to different spaces but also in the sense that it is enacted by making others in these different spaces understand and perform according to the norm of vigilance. Parents’ wishes to involve other people in the care of their food allergic children is also reported by Rouf et al. (2011), but we would rather argue that these parents’ risk management is carried out *through* social interaction. Dealing with the child at risk means to constantly engage in a dialogue with others in order to protect the child. Management of child food allergy can thus be seen as taking place in a dynamic relationship between parents, the child at risk and ‘others’, and if something ‘goes wrong’ in this communication, the child might be in danger.

A counter-discourse of risk taking

Taking calculated risks

Against the back-drop of the dominant discourse of constant vigilance, a counter-discourse emerges: Parents not only do everything to avoid the allergens but also actively challenge the need for constant vigilance. Their efforts to prevent their child from getting into contact with dangerous foodstuffs are also seen as leading to undue restrictions in family social life. In some groups, the parents talk about taking calculated risks by introducing and testing ‘dangerous’ food in order to find out to what extent the child is really allergic to a specific foodstuff, as a way to become less circumscribed. The rights and wrongs in taking a calculated risk by testing new foodstuffs, which is counter to systematically protecting the child from allergens, is discussed more elaborately in one of the groups:

- Mother 2: I think you should always be paying attention, but all this reading (of labels) and all these traces of nuts everywhere nowadays, it’s ...
- Father 1: Yeah, we have decided, well of course you should be concerned, but somehow in the end you get so caught in a bubble. It’s not that you should be taking risks or be careless, but we have tested some products with that kind of label
- Mother 2: Oh, how scary
- Father 1: With traces of nuts, this is not what she is most allergic to, that’s milk and eggs and then nuts, but then we tested just a very small amount, gave her just a mouthful to see what the reaction would be. (Fig 3)

This father uses the metaphorical expression ‘to be caught in a bubble’, which captures the experience of how the food restrictions may affect and limit family life. To be less limited, he has taken a calculated risk by giving his daughter food with the label ‘may contain traces of nuts’ to test how she would react, at the same time stressing that this is not to be careless. He has chosen the food that she is not most allergic to, and in a

small amount. As we can see, Mother 2 objects by saying she thinks that sounds 'scary'. Mother 3 then agrees with Father 1 and says that not being too cautious is a way also for her family:

Mother 3: We are just like you

Father 1: Yes

Mother 3: Usually we try to test the stuff, even if it says, because otherwise you get so incredibly restricted

Father 1: Yes

Mother 3: It's not that, I understand both, but we have valued the social aspects more, so we have the medicine at home and let her test the new stuff at home and just small pieces at the time and we talk

Father 1: You recognize the symptoms

Mother 3: Exactly, we talk about how it feels, tickling on the tongue, in the throat, and observe her, because it has happened that she goes away when she has a reaction. (Fg 3)

This mother describes the precautions they take when they test new foodstuffs: They have the medicine within reach and keep a watchful eye on her all the time. The discussion continues to revolve around under what circumstances it can be acceptable to take calculated risks by letting the child taste a product one does not know if he or she will tolerate. Some of the parents argue that they have to do this to have a reasonable social life, others that it is too risky. However, they agree that it of course depends on the severity of the allergy, and that you have to do it under very controlled conditions. On the one hand, you can take a calculated risk; on the other hand, this argument is accompanied by elaborate accounts of the precautions taken while doing this.

Calculated risk taking is also discussed in relation to medication. Most parents stress that the adrenaline autoinjector should go with their children wherever they go, but some say they do not follow such a routine and explain why:

Mother 3: So, the first half year I was so extremely cautious, we had one at the nursery and one that was always in my bag, but I mean, I have thousands of bags and in the end I did not know which one the autoinjector was in, so it ended up with us keeping it in the front hall and bringing it if she was sleeping at a friend's or traveling. (Fg 7)

This mother points out that always bringing the autoinjector around creates stress in everyday life. She is aware of the risks of exposure but has tried to find her own solution, to bring it in some situations but not in others. Similar discussions are found among the parents of teenagers who worry that their children do not bring the autoinjector when they leave home. For example, one mother says that although her son recently had a severe reaction, was unconscious and had to be brought by ambulance to hospital, he still leaves the autoinjector at home when he goes to a friend's party, 'he doesn't want anybody else to know about it'. She worries about the allergy risk, but she also recognizes the 'social risks' that her son is running when his condition is exposed to others.

Sometimes you have no choice

Another argument in this discussion is that sometimes you actually have no choice. If your child is allergic to several foodstuffs, it is almost impossible to always avoid exposure. Under such circumstances, the best thing you can do as a parent is to teach the child how to live with the allergy, which also could mean that the child at times might have an allergic reaction. For example, one mother says that her daughter (allergic to egg, pistachio, cashew, hazelnuts, soy and sesame) has had so many allergic reactions, and sometimes they have not even been sure what she has reacted to, and it is therefore almost impossible to completely avoid the allergens:

Mother 3: It is more important that she knows about her symptoms

Father 1: Yes

Mother 3: Than trying to avoid everything, I think that is probably impossible and then it almost feels as if it's okay that she has her reactions and that we have a social life somehow. (Fg 3)

This is not so much a calculated risk taking as arguing that risk taking is unavoidable in certain situations. With a multi-allergic child, a great number of foodstuffs can cause a reaction, and complete control becomes impossible. You then have to learn to live with the allergic reaction.

The norm of risk avoidance is thus challenged both in active risk taking and in a more passive acceptance of the impossibility of complete avoidance. In a recent study, Fleischer et al. (2012) discuss non-accidental ingestion of known food allergens in infants and find it worrying that this 'may reflect parental testing for resolution of allergy' (p. 31). They argue that this calls for improved education of parents and others on the importance of persistent vigilance and accurate label reading. In this study, risk taking does not emerge as a lack of knowledge about vigilance. Taking calculated risks certainly amounts to actively risking an allergic reaction and the parents know that this would have to be accepted and dealt with. However, in doing so, the parents still draw on knowledge about allergen avoidance, but here this knowledge is evaluated in a different context: The benefits of vigilance and food avoidance are weighed against the benefits of a better social life. In order to have a better social life, not only for the child suffering from food allergy but also for the family as a whole, you have to take account of the child's health *and* the needs of the family.

Discussion

The norm of constant vigilance by and large seems to be taken for granted, and also reflects the medical view on food allergy management. The focus group discussions revolve largely around the constant vigilance parents adopt to avoid allergy risk, everything they do to be in control by being one step ahead and by involving others to be just as vigilant. However, some parents do not simply accept the limitations inherent in the constant vigilance but challenge these restrictions to have a less restricted social life. The fact that parents take risks has been shown also in other studies of food allergy (Fleischer

et al., 2012). It can be a way of putting the allergy into perspective, relative to other risks (Rouf et al., 2011). What we see in this study is that in taking risks, the parents do not abandon the dominant norm of vigilance. Holding tight to this norm or easing up restrictions both demand risk awareness and management. As a parent of a food allergic child you are in this sense never able to fully 'escape' the dominant discourse of constant vigilance.

Importantly, risk avoidance and risk taking do not emerge as global/overall strategies but localized in specific situations, at a specific time, where the 'danger' is observed and managed by the parent. For example, the nursery is discussed as an important arena. However, it is not the nursery per se that is framed as risky but the specific situations when staff and other parents do not understand the danger of a specific foodstuff. Travelling is also an issue. Not travelling at large but the difficulties in trusting the information about the available food or the behaviour of fellow passengers. Places, such as nursery or school, are not just safe or unsafe, they change over time. It is within these local contexts, in space and time, that risk is assessed and risk taking is balanced against risk avoidance – as 'situated' risk.

In the risk literature, risk-taking behaviour has been discussed as related to 'irrational' or 'ignorant' pleasure-seeking activities (Coveney and Bunton, 2003), or as a challenge of conventions in transgressing boundaries (geographical, bodily or symbolic) (Lupton and Tulloch, 2002; Lyng, 1990; Tulloch and Lupton, 2003). Studies have also illuminated the more positive side of risk taking, as a way to demonstrate personal agency and fulfilment. Life without risk would be 'too tightly bounded and restricted, as not offering enough challenges' (Lupton and Tulloch, 2002: 122). In this case of parenting a food allergic child, the risk-taking activity is not directly associated to pleasure. As Parker and Stanworth (2005) have pointed out, risk taking can sometimes be understood rather as a means to manage the initial problem. The parents' risk taking as a means to create a better social life in a situation that in itself involves limitations could in this sense be seen as an 'indirect' pleasure.

One conclusion from this study is thus that there is not necessarily a sharp divide between risk avoidance and risk taking; being in control is here a central part of risk taking. This is in line with Tulloch and Lupton's (2003) observations that control can be an aspect of adult voluntary risk taking. They discuss calculated risk taking as the tension between rational planning, not completely losing control and the experience of the adrenaline rush of voluntary risk taking. What we see in this study is a more active management of the relation between 'negative' and 'positive' sides of risk in the individual situation, where there certainly is a rational planning not to lose control, but in contrast to adult risk taking, there is no pleasure in the risk taking per se. What the parents do is to try to *balance* the norm of vigilance against risk taking by re-appropriating the meaning of this norm to the local circumstances of their own family life, finding their 'own solutions', similar to what has been shown also in other studies of parents of allergic children (Gunnarsson and Hydén, 2009; Olin Lauritzen, 2004). In other words, parents display control as well as agency.

It has been argued in the risk literature that what is at stake in risk management is ultimately the moral character of the risk-taker and how this moral character is constituted in social relations and recognitions from others (Hunt, 2003; Parker and Stanworth,

2005). In contemporary society, risk avoidance can be regarded an ideal, and different risk discourses often reflect this dominant norm (Tulloch and Lupton, 2003). In the context of parenthood, this norm of risk avoidance becomes even more salient, particularly as intertwined with the obligations of motherhood (Lee et al., 2010). In Western society, children are more generally seen as vulnerable and 'at risk' due to many aspects of modern life (i.e. food consumption and new technologies) and parents as risk managers are under scrutiny. Also, 'good' parenting (often mothering) means to conform the public health imperatives such as providing the family with a 'proper' meal (Bahr Bugge and Almås, 2006) or in an era of obesity crisis, to control children's food consumption (Keenan and Stapleton, 2010).

It is against these discourses of moral parenthood that we can understand the discussions in this study. When the parents account for their constant vigilance as well as how they choose to take risks, not only the child's health is at stake, but also they themselves as responsible parents. Talk about taking calculated risks is intertwined with accounts of precautions that legitimize risk taking: always testing under safe conditions, having the medicine at hand or staying close to the hospital. Constant vigilance and taking calculated risks can thus be seen as two sides of the same coin, parent responsibility, and being a 'good' parent can involve risk taking. In this sense, risk taking can actually be understood as a way to conform to conventional societal norms rather than breaking those norms. Interestingly, the norm of constant vigilance seems to come to the fore more explicitly in studies of children than of adults with an allergic condition. Research on adults has indicated that problems in dealing with the allergy are downplayed as they have gotten used to living with the condition, even if it at times could be more problematic (Nettleton et al., 2010; Scherman et al., 2002). Adults can take decisions about their own health, ignore symptoms or skip the medicine, but parents have the ultimate responsibility for the child. To depict their own efforts, to constantly look for signs of illness and to consult others to deal with the problem can be seen as 'moral' accounts of parenting that have been found also more widely in research on parents and child health (see, e.g. Young et al., 2002).

Finally, the analysis of the focus group material also reveals the ways risk management seems to permeate most aspects of everyday life, to an extent that perhaps makes food allergy different from many other chronic conditions. The parents in this study can be described as experienced, with access to medical expertise, and the focus group discussions took place in a medical setting. Still, the discussions predominantly concern their own close observations of everyday phenomena and the social lives of their families. Much of what the parents do in their daily lives to avoid allergy risk could in some ways be seen as a pragmatic consequence of the condition, but what is indicated here is something more. At a more symbolic level, risk management also involves moral, and as we would argue, existential aspects of parenthood. Management strategies, as well as the degrees of 'fear and uncertainty', can vary, but the ultimate risk of a severe reaction seems to remain a fundamental condition in parent's lives. There is always a threat of what *could* happen if not paying enough attention. Their risk management does not only have an impact on everyday life but also seems to 'colonize the future' (Giddens, 1991), as the parents live a 'never ending story' of efforts to constantly be in control, reflected in phrases such as 'you always have to be alerted' and 'you can never relax'. Thus, risk management has a multi-layered impact on parental life and cannot be understood only

in terms of specific strategies, such as asking for special food at restaurants or reading the content on food labels.

In this article, we have taken our point of departure in a notion of risk as context-dependent and ‘situated’ in different life situations. This case of child food allergy has given us an example of how different social contexts can offer different frames or conditions for risk management, and also how risk avoidance and risk taking can be intertwined and balanced within the context of parenthood. It has also demonstrated the impact of risk management on parents and family life, which can add to a more profound understanding of what is involved in parenting a child with food allergy, important also for clinical practice. Altogether, this case can add to our understanding of risk management as a complex, multi-dimensional endeavour, situated in space and time.

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Note

1. Food allergic reactions occur when the body’s immune system erroneously targets a non-harmful food as dangerous. This sets in motion an immune response that in most cases causes a reaction mediated through the antibody immunoglobulin E (IgE). IgE attach to mast cells and basophils, which leads to an immediate release of histamine and cytokines causing the symptoms of the reaction.

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