The Best Laid Plans: Why New Parents Fail to Habituate Practices

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Consumers regularly fail to habituate newly adopted practices. In contrast to established practices, this often occurs because understanding a practice is different from actually doing it. Our work explores this "messiness of doing" and explains why consumers successfully habituate some newly adopted practices after experiencing obstacles (i.e., misaligned practice elements) but not others. Utilizing a longitudinal approach that follows first-time parents from pregnancy through the first eight months postpartum, we track how parents plan for practices and how those plans unfold. We document a process whereby parents first engage in extensive planning and preparation prior to the birth of their child, during which parents build two realignment capabilities (anticipation and integration). After the baby's arrival, some practices invariably do not work. Parents respond to these misalignments by following one of five paths—differentiated by the capabilities parents build while planning—that result in practice abandonment, vulnerable habituation, or habituation. Our work highlights the challenges associated with translating a social practice into an enacted practice and the corresponding importance of accumulating realignment capabilities during planning. To facilitate habituation of newly adopted practices, *how* consumers make plans for these practices may ultimately matter more than what they actually plan to do.

Keywords: practice theory, new parents, practice misalignment, practice habituation, consumer planning, goal failure

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Throughout life, consumers often fail to integrate newly adopted practices into their lives. For example, 77% of US mothers and 89% of Canadian mothers start breastfeeding, but only 22% and 26% are still doing so after six months, respectively (CDC 2016; Gionet 2013). Ninety-three percent of the participants in massive open online courses do not complete the course (Parr 2013), and 15% to 20% of all dog adoptions are unsuccessful (Hill and Murphy 2016). Similarly, only 30% of patients stick to a new lifestyle regime after a medical challenge (e.g., heart attack), only 19% adhere to exercise recommendations, and only 35% follow physical therapy programs (Martin et al. 2005). As these statistics indicate, consumers' attempts to integrate newly adopted practices are often met with challenges that prevent the practice from habituating.

Why are consumers able to integrate some newly adopted practices into their lives after they encounter obstacles, while they abandon other practices? Prior work refers to these obstacles as "misalignments": situations where practice elements—materials, meanings, and

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competences—are not aligned with each other, resulting in practice instability. This instability can lead to a pernicious state of ontological insecurity where consumers feel unsteady in their lives (Phipps and Ozanne 2017). As misalignments inhibit newly adopted practices from becoming grounded elements of consumers' everyday rhythms, they represent a significant challenge for consumers.

While prior research does offer some insights into the reconfiguration of practices after misalignments, this work examines practices that were stable and habituated parts of daily life prior to the misalignment (Canniford and Shankar 2013; Epp, Schau, and Price 2014; Phipps and Ozanne 2017; Seregina and Weijo 2017; Woermann and Rokka 2015). For these habituated practices, consumers rework elements in relation to their existing material configurations, entrenched meanings, and former competences. But newly adopted practices are inherently unstable (Phipps and Ozanne 2017) and lack a personal history of enactments that establish tightly held materials, meanings, and competences. Thus, these practices may reconfigure differently following a misalignment due to the absence of established routines to guide realignment attempts.

In our research, we focus on why consumers successfully habituate some newly adopted practices, but not others. Our findings reveal the "messiness of doing" that complicates consumers' plans: consumers might anticipate how practice elements will work together, but when they actually perform the practice, what they experience is often quite different as misalignments thwart practice enactments. We show that whether and how a practice habituates depends on realignment capabilities—the ability to envision potential relationships among practice elements—that consumers build when preparing to enact a practice. We use a longitudinal approach to track consumers as they attempt to habituate newly adopted practices related to becoming parents. We follow new parents through the planning and implementation phases of this endeavor. In doing so, we observe how parents build realignment capabilities through their planning efforts, what goes wrong when implementing practices, and how parents recover in these situations. We identify five misalignment response paths, differentiated by parents' realignment capabilities, that parents take when reconfiguring practices. Depending on the path taken, the practice either is abandoned, remains vulnerable, or habituates.

Our work contributes to consumer research in several ways. First, we introduce the *envisioned practice* (i.e., plans for enacting a practice) as a bridge between social and enacted practices, revealing the process of translation between these two practice levels. Second, we extend work on practice misalignments by outlining how reconfigurations occur for newly adopted practices. Here, we document the role of realignment capabilities in reconfiguration and describe how consumers build these capabilities through planning. In doing so, we show that *how* consumers plan for a practice is more important than *what* they actually plan to do. Finally, understanding the recovery processes for newly adopted practices contributes to consumers' well-being, as consumers strive to attain ontological security through the habituation of practices (Phipps and Ozanne 2017). This knowledge could aid in the development of interventions that encourage consumers to adopt new practices, such as those that promote healthy lifestyles.

Next, we outline the theoretical foundations that inform our research, describing practices, misalignments, and practice reconfigurations. We then discuss our context and methodology. Our findings describe how consumers draw on social practices to form envisioned practices and outline how consumers reconfigure practices after misalignments. We conclude with a discussion of our contributions.

THEORETICAL FOUNDATIONS

Practice Theories

Practice theories seek to understand the enactment of social life (Schatzki 1996). While various practice definitions exist, most theories converge on the idea that practices are "a routinized type of behavior which consists of several elements, interconnected to one another: forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge" (Reckwitz 2002, 249). At their origin, practice theories describe how society is produced and reproduced, focusing on how individuals create and live within their social worlds (Bourdieu 1977; Giddens 1984). Practice theories thus predominantly focus on the predictability and routinization of practices (Reckwitz 2002; Shove, Pantzar, and Watson 2012; Warde 2005), as repetition of practices provides individuals with a sense of ontological security: "stability is the emergent and always provisional outcome of successively faithful reproductions of practice" (Giddens 1984; Phipps and Ozanne 2017; Shove et al. 2012, 12).

Practices operate at two levels: practice-as-entity (or social practices) and practice-as-performance (or enacted practice) (Shove and Pantzar 2005; Shove et al. 2012). Social practices exist at a cultural level and provide scripts that individuals appropriate as they integrate practice elements into performances. In doing so, individuals are not just "users [of a practice] but [are] active and creative practitioners" who integrate practice elements (Reckwitz 2002; Shove and Pantzar 2005, 45). Practice elements include: (1) materials, such as things, bodies, technologies, and objects; (2) competences, such as skills, knowledge related to the practice, and techniques required to perform the practice; and (3) meanings, such as the symbolic ideas,

aspirations, and emotions associated with the practice (Shove et al. 2012).

Through the integration of elements, consumers produce individual enactments of social practices (Reckwitz 2002; Shove et al. 2012). This process, however, does not always result in a perfect match between the social and enacted practice; "persons in different situations do the same activity differently" as they adapt the social practice to their own circumstances (Warde 2005, 146). Ultimately, the habituation of practices occurs when all practice elements are aligned in "configurations that work" (Rip and Kemp 1998, 330; Shove et al. 2012). Maintaining practice stability, however, often requires significant effort, as elements do not always automatically work well together—"practices emerge, persist and disappear as links between their defining elements are made and broken" (Shove et al. 2012, 21). Understanding practice emergence and change thus requires "paying attention to the trajectories of elements, and to the making and breaking of links between them" (Shove et al. 2012, 22).

Practice Misalignments

Even though practice theories largely focus on the stability of practices—examining how links between elements are made and reproduced at a social level—disruption to routines can prompt changes in practice performance (Magaudda 2011; Reckwitz 2002; Shove et al. 2012; Warde 2005). Several dynamics can disrupt practices: technological changes, shifting cultural discourses, changes to practice participants and/or their interpretation of practice meanings, or changes to other practice elements (Epp et al. 2014; Reckwitz 2002; Shove et al. 2012; Warde 2005). When practices are disrupted, the links between elements break (Phipps and Ozanne 2017) and these "disruptions challenge practice routines and continuity" (Epp et al. 2014, 83).

When practice elements are misaligned, mismatches, contradictions, and tensions among elements threaten practice habituation (Epp et al. 2014; Shove et al. 2012). This destabilizes the practice such that it needs to be modified or the practice will dissipate (Canniford and Shankar 2013; Parmentier and Fischer 2015). Recent work has begun to explore what happens when elements of consumers' practices are misaligned (Arsel and Bean 2013; Canniford and Shankar 2013; Phipps and Ozanne 2017; Woermann and Rokka 2015). This research describes misalignments that arise from mismatches between practice elements, disruptions to those performing the practice, or clashes with intersecting practices. For example, Canniford and Shankar (2013) explain how the technological materials used by surfers do not always match the meanings associated with the practice. Epp et al. (2014) study disruptions to family practices that occur when members are geographically dispersed. Lastly, Seregina and Weijo (2017) show how the cosplay practice often clashes with practices in other life domains, such as work and family.

Reconfiguring enacted practices typically involves bringing practice elements back into alignment with one another (Arsel and Bean 2013; Canniford and Shankar 2013; Epp et al. 2014; Phipps and Ozanne 2017; Seregina and Weijo 2017; Woermann and Rokka 2015). Consumers do this in multiple ways. First, consumers use cultural scripts to guide their realignment attempts (Arsel and Bean 2013; Fischer, Otnes, and Tuncay 2007; Phipps and Ozanne 2017). Fischer et al. (2007), for example, outline how cultural discourses, such as scientific rationalism, dictate how consumers should progress through successive fertility treatments. Second, consumers introduce intersecting practices that help align disrupted practices (Canniford and Shankar 2013; Fischer et al. 2007; Phipps and Ozanne 2017). Surfers, for example, adopt purifying practices to address the misalignments they experience between nature and technology (Canniford and Shankar 2013). Third, consumers rework practice elements to bring about alignment (Epp et al. 2014; Fischer et al. 2007; McAlexander et al. 2014; Phipps and Ozanne 2017). The informants in Phipps and Ozanne (2017), for example, shifted their meanings of kitchen cleanliness to match their new material reality of not having enough water to wash dishes multiple times per day. Element reconfigurations are often facilitated by imaginative capacity that allows consumers "to creatively envision components interacting in a reassembly" (Epp et al. 2014, 88). Notably, in some situations, consumers are unable to realign practice elements and instead abandon the practice (Epp et al. 2014; McAlexander et al. 2014; Phipps and Ozanne 2017).

The practices studied in extant work, however, were well established and habituated. In these cases, consumers had a clear sense of what the practice was supposed to be, which provided them with a set of guidelines as to what they wanted to achieve with a reconfiguration (Canniford and Shankar 2013; Epp et al. 2014; Phipps and Ozanne 2017; Seregina and Weijo 2017; Woermann and Rokka 2015). For example, the families described in Epp et al. (2014) held clear blueprints for how their family dinners should unfold, the cosplay participants discussed in Seregina and Weijo (2017) understood the nuance of how to craft and showcase costumes, and residents documented in Phipps and Ozanne (2017) had entrenched water usage practices. After experiencing a misalignment, these consumers all attempted to reconfigure their practices in relation to its previous form: entrenched material configurations, meanings, and competences anchored their reconfiguration attempts. However, not all misaligned practices are stable and habituated; consumers often perform newly adopted practices that are unstable, have yet to be habituated, and lack personal blueprints for reconfiguration. Here, consumers have not yet fully integrated the practice into their lives, and misalignments pose a

significant threat to habituation. What happens when these newly adopted practices experience misalignments?

We know little about newly adopted practice misalignments. Phipps and Ozanne (2017, 19–20) note: "Little research examines the attunement of practices as they stabilize . . . but this may be a period when a new practice is most at risk of failing to be habituated. Research on attunement of practices might offer new insights for making more enduring changes to social practices." Warde (2005, 149) also emphasizes the need to study new practices and "how people come to an understanding of what is required by the practice and their role within it." Further, he asserts "that we might profitably examine in detail how understandings, procedures and values of engagement are each acquired and then adapted to performances" (139). Shove and Pantzar (2005) likewise note the challenge of moving from social to enacted practices, but we have limited understanding of what those challenges may be and how individuals recover.

We situate our work within these calls for additional research and understanding of newly adopted practices and examine whether and how newly adopted practices survive misalignments. Our research question asks, why do consumers successfully habituate some newly adopted practices after experiencing a misalignment, but not others?

METHOD

To address this question, we conducted a longitudinal study that followed new parents prior to the birth of their first child through the first eight months postpartum. When becoming parents, consumers integrate several parenting-related practices into their lives (Davies et al. 2010). Moreover, given the dynamic and unpredictable nature of life with a baby, many of these practices will not work out as intended; broken links are inevitable. Thus, this context allowed us to track habituation by observing the implementation and evolution of newly adopted practices and how consumers responded when these practices experienced misalignments.

Context: North American Parenting

We chose first-time parents in North America as our research context. When preparing for the birth of one's first child, expectant parents make multiple choices about which social practices to adopt, all of which are perceived to be vitally important (Miller 2014). Consumers also often have limited experience caring for a newborn and tend to be unfamiliar with the products surrounding parenting practices (Davies et al. 2010; Thomsen and Sørensen 2006). Further, given how quickly practices change with a baby, this context allows us to observe how practices enter a family, habituate, and in some cases, grow obsolete as the baby's needs change. Thus, we can observe practice trajectories, accounting for newly adopted practices and if and how they habituate. Appendix A lists the social practices adopted by our informants.

Within the North American parenting context, cultural discourses shape understandings of parenthood and associated practices (Fischer et al. 2007; Thompson 2005). These discourses are derived from an abundance of social, institutional, and marketplace sources that sometimes converge, but often compete (Davies et al. 2010; Huff and Cotte 2013; Keenan and Stapleton 2014; Prothero 2002). For example, research documents several broad discourses that purport to answer the questions of "how to be a good parent" and "what kinds of choices are right" (Epp and Thomas 2018). These include discourses about how to be a good mother (Afflerback et al. 2013; Davies et al. 2010; Fischer and Gainer 1993; Prothero 2002) and father (Coskuner-Balli and Thompson 2013), how and why parenthood should be pursued (Fischer et al. 2007), and what kind of birth experience is optimal (Thompson 2005). Underlying many of these discourses is an ideology of "intensive mothering" (Hays 1996).

Among middle-class North American families who increasingly delay having children until later in life (Mathews and Hamilton 2016), adherence to intensive mothering ideologies is pervasive (Hays 1996; Weinberger, Zavisca, and Silva 2017). Intensive mothering is a child-centered discourse that characterizes mothers as highly involved, emotionally engaged, financially committed, and expertly driven (Hays 1996) such that mothers are solely accountable for every aspect of their child's well-being, a fact that is especially challenging for employed and single mothers (Christopher 2012). Fathers also experience intensity, albeit perhaps not in the same way; still, prior literature supports the notion that the discourse extends to intensive parenting more broadly (Shirani, Henwood, and Coltart 2012, 34; Sullivan 2010).

Immersed in a culture of intensive parenting, parents feel enormous pressure to maximize the amount of time, energy, and money they spend on their children. Of note, industry reports show that baby- and child-specific products represent a $172 billion global industry ($15.4 billion in the United States) (Bell 2014; Euromonitor 2014). This pressure to maximize captures the ferocity of parenthood, where investment is constant and activity provision is endless (Weinberger et al. 2017). Although competing ideologies of parenthood exist, the ubiquity of intensive parenting pervades taken-for-granted institutional and cultural caregiving assumptions and directs moral judgments of parents' caregiving practices (Epp and Velagaleti 2014).

Intensive parenting gives rise to a number of related phenomena that affect parents' experiences as they adopt practices. First, and perhaps most notably, intensive parenting arose in the mid-1990s from embeddedness in what Beck (1992) refers to as a "risk society"—that is, "a society increasingly characterized by [both real and perceived]

risk [that] produces members increasingly preoccupied with safety" (Afflerback et al. 2013, 389). Within a parenting context, a risk reduction focus motivates consumers to adopt social practices that align with this view and necessitates planning in the form of research to develop competences related to safety for feeding practices, sleep practices, and other consumer products embedded within a range of parenting practices. Intensive parenting discourses, for example, draw out the long-term, irreversible implications of infant feeding choices, where breastfeeding is viewed as a moral imperative due to its cultural meanings associated with health benefits and good mothering (Afflerback et al. 2013). Thus, adopting particular social practices is viewed as consequential not only for child development, but also for parental identity.

Second, intensive parenting is entwined with a neoliberal ethos of personal moral responsibility where success is built through "planning and control of the many aspects of one's life" (Beck and Beck-Gernsheim 1995; Shirani et al. 2012, 26). Thus, where seeking expert advice was once key to developing risk reduction competences, ensuring safety, and demonstrating good parenting, consumers have moved away from expertise derived from institutionalized sources (e.g., education or occupation) to social sources (e.g., word of mouth and online popularity). This shift increases the amount of information available to consumers and makes it harder to discern the quality of information (Matchar 2013). Further complicating matters, many new parents often live far away from extended family members who would traditionally direct choices about caregiving practices (Epp and Velagaleti 2014). As a result, new parents face a plethora of options when it comes to social practices and no clear authority guiding them as to which practices they should adopt. Among middle-class North American parents, then, perhaps the most salient contemporary challenge is sifting through the abundance of information about the social practices of caregiving to determine what is "best" (Heffner 2013).

Finally, inherent in this sifting process, North American parents contend with constant comparisons and perceived, if not actual, moral judgments from others. While consumption often helps new parents transition into parenthood and redefine their identities (Fischer and Gainer 1993; Prothero 2002; Thomsen and Sørensen 2006), internal conflicts about choosing the best caregiving practices also reflect escalating expectations and competition among parents (Afflerback et al. 2013; Clarke 2007; Huff and Cotte 2013; Keenan and Stapleton 2014).

In sum, the North American parenting context is characterized by a discourse of intensive parenting where parents are actively engaged in planning and preparation both when becoming parents and also when raising children. In doing so, parents engage with social practices and carefully choose which practices to enact, selecting from an array of options across parenting domains (see appendix A), with each choice experienced as vitally important. This context thus allows us to observe the complexity inherent in the process of practice adoption and habituation.

Data Collection and Sample Description

We collected data via open-ended depth interviews at three time periods to reveal informants' perspectives of their experiences becoming parents (McCracken 1988). The first interview with expectant parents occurred two to three months before the birth of their child. While the families in our study varied in when they started planning to become parents (i.e., some tried to conceive for years, while others conceived unintentionally) and the parenting knowledge they had before becoming pregnant (i.e., some had extensive, and even professional, childcare experience, while others had limited experiences with children), it was during this time that they all started adding material elements to their plans, engaging more deeply with prenatal/parenting resources to establish competences and meanings (e.g., prenatal classes, hospital tours), and finalizing the practices they intended to adopt when the baby was born.

Using McCracken's (1988) funnel method, the interviews began with "grand tour" questions meant to uncover parents' family/relationship background, vison of parenthood, and preparations for parenthood (e.g., prenatal care, purchases, caregiving plans, and information sources considered). We followed these questions with detailed prompts related to the specific practices they intended to implement. For each practice, we explored what parents intended to do, how they decided to pursue that practice in that way, the research they did (if any) about the practice, and the actions taken to prepare for implementing the practice. These prompts were designed to elicit information about each practice's materials, competences, and meanings. We coupled depth interviews with home tours as an auto-driving technique (Heisley and Levy 1991) where we asked informants to show us the baby products they had acquired and any other preparations they had made (e.g., setting up the nursery). Thus, the first interview revealed the details of parents' plans related to a range of parenting practices.

We then conducted two follow-up interviews: the first took place two to three months after the child's birth and the second took place six to eight months after the birth. During these interviews, we tracked the practices discussed during the prior interview(s) by exploring what happened during implementation and eliciting their plans for that practice moving forward. We also discussed additional practices that the parents were currently implementing or planning to implement. We timed the follow-up interviews to correspond to critical points in the baby's development when parents implement practices and when new phases of consumption and parenting practices are adopted. Specifically, at two to

three months postpartum, parents implement immunization practices and new activities for the baby, and other practices become more complicated as parents transition their babies into childcare settings if returning to work. In addition, feeding and diapering practices are established, and parents have used many of the newborn products acquired for the child. At six to eight months postpartum, parents adopt another set of practices related to introducing solid foods and regulating sleep behaviors. Interviews lasted from one to two hours and were audio-recorded and transcribed (resulting in over 2,700 single-spaced pages of interview data).

In total, 25 families from two North American cities enrolled in this study, and 24 families completed all three phases (see table 1). The Tisdale family dropped out after the first phase, as their child was stillborn. We recruited informants through organizations and groups catering to expectant parents: prenatal classes, online message boards, baby stores, midwifery clinics, and hospitals. Data collection continued until we reached theoretical saturation (Creswell and Poth 2018). Informants were given a $100 token of appreciation for participating in the study ($50 at each of the first and third interviews). In all cases where two parents were part of the family, when possible, we interviewed parents jointly to allow for mutual reflection, negotiation of multiple accounts, and co-construction of data (Epp and Price 2011). Our informants were 24 to 39 years old, consistent with what would be expected given that the average age for having a first child is 26.3 in the US (Mathews and Hamilton 2016) and 28.5 in Canada (Statistics Canada 2014). We used theoretical sampling to capture a range of experiences, family types, backgrounds, socioeconomic status, and parenting approaches (Huberman and Miles 1994).

Further, despite the planning-centric nature of North American parenting, we did observe variation in our sample in terms of planning for specific practices. By using individual practices as our unit of analysis (Epp et al. 2014; Shove et al. 2012), we were able to explore a range of planning activities across practices, where parents planned extensively for some practices and not at all for others (either because they did not think to plan, they chose not to plan, or they were unable to plan for that practice), with varying levels in between.

Data Analysis

We focused our analysis on misalignments. Thus, we tracked families' practices over the course of the study, noting misalignments, and analyzed responses to these misalignments over time. In total, we tracked 161 individual practices (average = 6.7/family; range = 4–10) that correspond to five main categories of social practices (see appendix A): diapering (which includes practices for both cloth and disposable diapering), feeding (which includes practices related to both initial feeding and solid food feeding), sleeping (with practices related to where and how the baby sleeps), vaccines (with practices related to whether and how a child is vaccinated), and other parenting practices (such as comforting, bathing, baby wearing, and cleaning).

Many of these practices did not experience misalignments and parents successfully habituated them with relative ease. Just over half of the practices (89), however, experienced misalignments that derailed habituation (average = 3.7/family; range = 1–9). For these practices, we examined parents' planning processes and whether and how they recovered from the misalignment. Our approach relied on an iterative process moving between data and theory to uncover and refine emergent themes, triangulating interpretations across researchers who were both immersed in the context (Spiggle 1994; Thompson 1997).

FINDINGS OVERVIEW

Emergent from our analysis is a multistaged process whereby practices move from the level of social to envisioned to enacted, and finally to a reconfigured practice, where some newly adopted practices habituate and others do not (figure 1). First, parents engage in planning where they form envisioned practices that guide how they will care for their baby. In doing so, they draw on available social practices and choose which practices they wish to adopt. During planning, parents curate the materials, competences, and meanings associated with each practice and build realignment capabilities. We identified two key capabilities that influence how parents reconfigure practices after a misalignment: anticipation and integration (table 2 defines and presents examples of each, but we elaborate on the capabilities shortly).

Next, parents implement their envisioned practices. Many practices are enacted smoothly, but this is not the case for all—some practices experience misalignments. Parents respond to misalignments by finding ways to make practices work: they problem-solve, troubleshoot, and try to realign elements. This leads to reconfigured practices that ideally move toward stability, but may remain vulnerable. The process of moving from social to envisioned to enacted to reconfigured practices is ongoing as parents perpetually integrate practices into their lives.

Using figure 1 as an organizing framework, we next explain how parents form their envisioned practices by drawing on social practices and accumulating the necessary elements, while also building realignment capabilities through planning. We then describe how misalignments emerge between enacted practice elements (threatening habituation) and how parents' realignment capabilities shape

TABLE 1

INFORMANT CHARACTERISTICS

Family name[a]	Parents	Age	Occupation and education	Baby	Income	Marital status
Bell-Dickson	Elise	31	Bartender, some college	Daughter Jenny	$40–60K	Dating
	Chad	32	Taxi driver, some college			
Burke	Lori	33	Public health inspector, graduate degree	Daughter Mandy	$100–$125K	Married
	Ryan	31	Web coordinator, community college diploma			
Carlson	Ashley	32	Law student/musician, in graduate school	Son Gavin	$60–80K	Married
	Garett	39	Arts administrator/musician, undergraduate degree			
Carter	Emily	30	Trip design manager, graduate degree	Son Chase	$125–200K	Married
	Alex	32	Product manager, some graduate school			
Crane	Gail	38	Administrator, community college diploma	Son Bobby	$80–100K	Common-law
	Brent	39	Financial advisor, community college diploma			
Davies	Susan	32	Nanny/musician, graduate degree	Son Gibson	$40–60K	Married
	Randall	37	Theatre coordinator, some university			
Dover	Kathy	27	Registered nurse, undergraduate degree	Daughter Rose	Prefer to not answer	Single
Drummond	Mary	32	Cancer researcher, graduate degree	Daughter Lucy	$100–125K	Married
	Jake	35	Fundraiser, undergraduate degree			
Foster	Emma	34	Pharmacist, graduate degree	Daughter Kate	$125–200K	Married
	Jason	33	Lab manager, undergraduate degree			
Gentry	Haley	34	Alumni relations, undergraduate degree	Son Nate	$125–200K	Married
	Sam	34	Designer, undergraduate degree			
Hughes	Laura	32	Former journalist, undergraduate degree	Son Max	$200K+	Married
	Jeff	34	Dentist, graduate degree			
Jenkins	Steph	33	Graphic designer, community college diploma	Son Travis	$80–100K	Married
	David	24	Social worker, community college diploma			
Klein	Alice	28	Early childhood educator, community college diploma	Daughter Carla	$60–80K	Married
	Alan	28	Food and beverage director, community college diploma			
Larkin	Marcy	26	Physician's assistant, undergraduate degree	Daughter Kerry	$125–200K	Married
	Rex	30	Electrician, undergraduate graduate			
Mahoon	Hansa	30	Customer representative, undergraduate degree	Daughter Kalinda	$20–40K	Married
	Ashwin	33	Postdoctoral fellow, graduate degree			
Miller	Abby	33	Restaurant gen manager, some graduate school	Daughter Carrie	$40–60K	Married
	Jack	34	Chef, undergraduate degree			
Nelson	Olivia	33	Speech pathologist, graduate degree	Son Jon	$60–80K	Married
	Grant	33	Wildlife biologist, undergraduate degree			
Shelton	Shannon	28	Dietician, undergraduate degree	Daughter Lexi	$100–125K	Married
	Dwayne	30	Mechanic, community college diploma			
Simpson	Eva	26	Event services, community college diploma	Daughter Heather	$100–125K	Dating
	Patrick	27	Contractor, community college diploma			
Smith	Monica	30	Artist, some community college	Son Josh	$60–80K	Married
	James	32	Military, undergraduate degree			
Tallon	Cindy	27	Dental assistant, community college diploma	Daughter Hannah	$60–80K	Married
	Jason	26	Retail manager, high school			
Tanner	Jessica	29	Restaurant manager, undergraduate degree	Son Mark	$100–125K	Married
	Michael	31	Mortgage broker, undergraduate degree			
Taylor	Kayla	32	Clinical fellow, graduate degree	Daughter Ava	$125–200K	Married
	John	30	Business development, graduate degree			
Tisdale	Sally	37	Speech and language pathologist, graduate degree	Son Barry	$125–200K	Common-law
	Darren	38	GIS officer, undergraduate degree			
York	Evelyn	37	Accountant, graduate degree	Son Noah	$200K+	Married
	Andrew	36	Accountant, graduate degree			

[a]To protect anonymity, all names are pseudonyms and data are stored electronically in a password-protected folder per Institutional Review Board/Ethics Board guidelines and approvals.

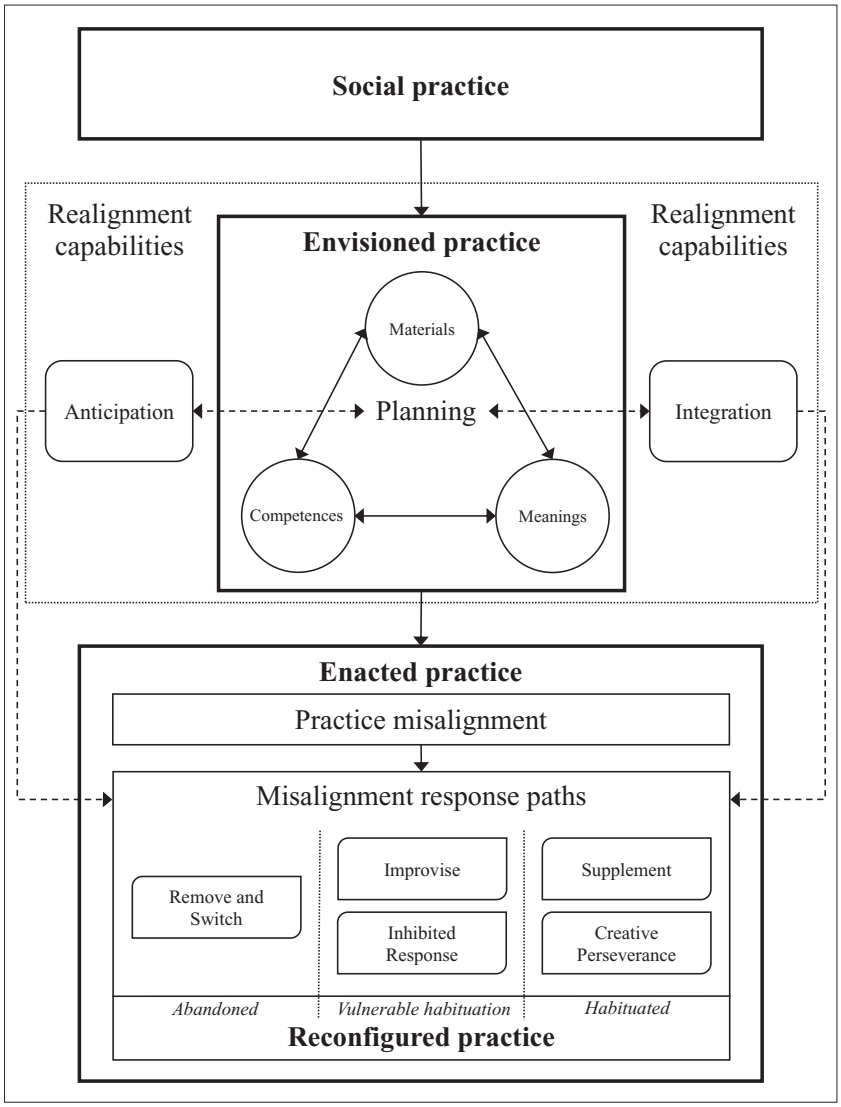
their responses to misalignments and result in a reconfigured practice that is either habituated, abandoned, or left in a state of vulnerable habituation where element misalignments persist. Throughout our findings, we highlight the relationships between social, envisioned, and enacted practices, and illuminate how this process can be messy; it is not always an easy translation between social and enacted practices.

ENVISIONED PRACTICE

Prior literature takes for granted that practitioners can seamlessly translate a social practice into an enacted practice (Reckwitz 2002; Schatzki 1996; Shove and Pantzar 2005; Shove et al. 2012). For newly adopted practices, however, problematizing this theoretical space—the movement from social to enacted—allows us to document the

FIGURE 1

FINDINGS OVERVIEW: PRACTICE MISALIGNMENTS AND RECONFIGURATION



work of integration. Our analysis reveals that an important additional step in the translation of social to enacted practices is the formation of an envisioned practice. In our context, parents' envisioned practices represent their plans for how they will care for their baby and operate as a bridge between social and enacted practices. Parents build envisioned practices by accumulating—to varying degrees—the sets of needed elements for each practice they intend to integrate in the future. In doing so, parents also build realignment capabilities that later guide them as they reconfigure practices after a misalignment. During this envisioned phase, practices are latent and anticipated, rather than enacted or performed, and represent what parents anticipate may happen in the future. Next, we briefly outline the elements of envisioned practices and describe realignment capabilities.

Envisioned Practice Elements

Each envisioned practice consists of the set of elements needed to enact a practice (materials, competences, and meanings). Consider, for example, the Klein family's

TABLE 2

REALIGNMENT CAPABILITIES

Capability	Definition	Examples			
Anticipation	Whether and how parents think about potential misalignments amongst practice elements	None	General	Specific	
		"We have a little co-sleeper. We'll have him in the bed and use a little co-sleeper and that will be good." (Susan Davies)	"My sister was not able to breastfeed longer than six months. . .I don't know what the reason was for that. Part of me is prepared for the fact that it may not go as I expect. I've heard a number of people really struggle at the beginning trying to get the hang of it." (Steph Jenkins)	"I thought [low supply] might be a problem before I had Nate. . .[because] of some medical stuff that the side effects were a decreased supply." (Haley Gentry)	
Integration	The range and diversity of practice elements that consumers view as complementary or incompatible, both within and across practices that could be used in a reconfiguration.	Restricted	Single Practice	Multiple Practice	Hybrid Practice
		"We will use the same brand that my sister uses, and she's using the Pampers Swaddlers. . .I'm quite happy to take her word on it, and I will likely use the same thing." (Evelyn York)	"We have a little basket, but it's beside our bed, that the baby can sleep in for a while. . .if the baby is really loud and snoring and is just awake, maybe we'll stick it in the other room. . .as opposed to [co-sleeping]. . .I don't think co-sleeping is for either of us." (Ashley Carlson)	"It's just easier to [use] disposable [diapers]. We might still [use cloth diapers], like once everything gets into the routine. . .But it's just initially, I think it's easier to have one less thing to worry about in the laundry and all that stuff. And see how everything goes. And if I feel like I want to switch, maybe do that later." (Marcy Larkin)	"[I will] ideally breastfeed, but I know there are a lot of challenges with it so I just hope it works well for me. Probably substitute with the formula if needed. I've looked into breast pumps and stuff, which are very costly, and I feel like there's a lot of work with them. . .I think it might just be easier to substitute formula when I'm away or what not." (Kathy Dover)

envisioned feeding practice. Using social practices related to breastfeeding and pumping breast milk as scripts, the Kleins built a plan for how to initially feed their baby. They purchased material elements, including an electric breast pump and glass bottles (because, according to Alice Klein, "I've done so much research on plastic and how it may say it's BPA-free, but there's still lots of chemicals that go into it, whereas with glass, you know you're safe"), and thought about the competences they needed to enact the practice, including utilizing their midwife to make sure, as Alice explains, "I'm breastfeeding properly and the baby's sucking and everything." These materials and competences match the meanings embedded in the practice as they align with the Kleins' aspirations for the practice (Alice: "[I plan to] breastfeed hopefully up to two years") and their commitment to following a strict Paleo diet that emphasizes unprocessed foods (Alice: "The founder of Paleo, Loren Cordain, talks about how plastic is really bad for you"). Notably, at this point in time, the Kleins' breastfeeding practice is yet to be enacted.

Realignment Capabilities

While building envisioned practices, parents also build realignment capabilities—their ability to envision potential relationships between practice elements. Unlike competences, which refer to knowing how to enact a practice, realignment capabilities represent a higher-order ability to respond to misalignments. How parents reconfigure and habituate a practice (or not) depends on the initial configuration of two realignment capabilities that capture parents' ability to anticipate potential misalignments between

practice elements and their ability to think about different ways to reconfigure practice elements. These capabilities represent particular considerations of the "breaking and making of links" between elements (see table 2). In general, parents develop a distinct combination of capabilities for each practice and both capabilities emerge through planning.

Anticipation Capability. First, anticipation capability refers to whether and how parents think about potential misalignments (i.e., "breaks") between practice elements when building their envisioned practices. Some parents did not anticipate any potential misalignments for a practice, others anticipated general misalignments (i.e., thinking that something may go wrong, but not being sure what that might be), and still others anticipated specific misalignments.

When parents did not anticipate any misalignments, they either actively avoided thinking about potential problems, like Steph Jenkins ("I don't like to get overexposed [to information about sleep problems] . . . I try to get the bare minimum so I don't get overwhelmed"), or they just expected their plans to unfold smoothly. As indicated in table 2, for example, the Davies family did not anticipate any misalignments for their sleep practice. Their initial plan was to use a cosleeper with the baby in bed with them. They assumed this would work ("we'll use a little cosleeper and that will be good") and did not consider that the practice might be disrupted.

In contrast, while the Jenkins and Davies families did not anticipate sleep misalignments, the Jenkins family did anticipate general breastfeeding misalignments (table 2). Steph notes, "Part of me is prepared for the fact that [breastfeeding] may not go as I expect." Steph is worried that breastfeeding may not work, but does not anticipate specific misalignments; she describes a general concern for an undefined future problem. Haley Gentry, on the other hand, anticipates a specific breastfeeding misalignment: low milk supply (table 2). Haley had a preexisting medical condition for which a potential side effect was low milk supply. When building their envisioned practice, the Gentrys directed their research efforts toward solving that problem should it arise, as Haley explains: "I did a lot of research before [the baby] was born and so there's actually a milk, it's a milk bank . . . where mothers in the community who have a ton of extra milk can just drop it off to these couple houses . . . and you can pick it up from their house."

By anticipating a specific misalignment, the Gentrys were able to think about how they might recruit additional practice elements to bring their breastfeeding practice into alignment.

Anticipating both general and specific misalignments enables parents to respond better to misalignments, as they are less likely to be surprised. When they do not anticipate misalignments, parents' ability to overcome challenges is constrained, and they struggle to generate solutions because they are blindsided by the misalignment. The Jenkins family, for instance, met their baby's four-month sleep regression—marked by multiple nighttime wakings—with almost complete inaction. Their uncertainty of how to resolve the issue, coupled with the limitations they placed on researching what could go wrong, led to inertia and a lack of resolution.

Parents build their anticipation capability as they contemplate potential misalignments. Exposure to others' failures, research that details the challenges of a practice, and exposure to institutional solutions for overcoming common problems (e.g., lactation specialists) highlight the range of setbacks that could derail a practice. Parents thus need to have access to information about the potential pitfalls of practices. This can be problematic, however, as society's protection of parenthood tends to mask its difficulty; parents enact cultural norms where they avoid talking about failure and espouse the instinctive nature of parenthood (Douglas and Michaels 2004; Thompson 2005). This stems, in part, from the culture of intensive parenting that leads to competition and moral judgments among parents (Epp and Thomas 2018; Shirani et al. 2012). Moreover, the decision to pursue one practice versus another is not always deliberate but can be an embodied, holistic experience of "fit" based on parents' social and historical background (Allen 2002), where parents choose a practice without questioning its appropriateness or considering possible misalignments. For example, Shannon Shelton did not consider doing anything other than breastfeeding; her breastfeeding decision was virtually automatic: "I'm planning to breastfeed . . . I always knew that I wanted to. And being a dietician . . . it's something that you pretty much have to buy into . . . of course it was an option for me [to not breastfeed], but I never really considered it to be an option, to be honest."

Such behaviors shroud the difficulties of being a new parent and can prevent the development of anticipation capability, making it harder for parents to reconfigure practices after a misalignment.

Integration Capability. The second capability, integration, refers to the range and diversity of practice elements that consumers view as complementary or incompatible, both within a single practice and across multiple practices. Integration capability emerges through planning as parents consider which assortment of elements should be included in an envisioned practice and contemplate which elements they could recruit should a misalignment occur. This capability captures if and how parents think about potential element rearrangements, and provides a reference to guide parents in their choices about what elements do and do not go together, how elements work together, and whether or not to allow certain elements into a practice.

How parents think about the assortment of elements that are, or could be, included in a practice is based on how they think about the boundaries placed around each of the social practices within a parenting domain (see appendix A). At a cultural level, social practices provide scripts that define the set of materials, competences, and meanings that constitute a particular practice (Schatzki 1996; Shove and Pantzar 2005). Across our dataset, however, we found that parents differed in how closely they adhered to these scripts when planning: some closely followed the scripts and placed firm boundaries around practices, viewing only one practice as viable; others viewed practices as bounded, but allowed for substitutability between practices; and still others viewed boundaries as porous, such that elements from across practices were viewed as compatible. These three ways of thinking about practice boundaries correspond to three types of integration capability: (1) single-practice integration, where parents view practices as being highly bounded and do not view practices as substitutable (e.g., formula feeding cannot substitute for breastfeeding); (2) multiple-practice integration, where parents view practices as highly bounded, but substitutable (e.g., formula feeding can substitute for breastfeeding); or (3) hybrid-practice integration, where parents view social practice boundaries as porous and think about how they might combine elements from across multiple practices (e.g., combining elements from both breastfeeding and formula feeding practices). Notably, parents do not always develop integration capabilities (see table 2). In these situations, parents do not think about the relationship between practice elements or how elements could be rearranged should a misalignment take place. This restricted integration capability emerges when parents' planning efforts are minimal or absent (e.g., Evelyn York just "use[d] the same brand that my sister uses"), such that they easily pick a social practice and merely follow the script when curating elements.

First, single-practice integration capability—where parents view only a single, bounded practice as viable—emerges when parents' planning efforts focus on a single social practice in a parenting domain. When planning, parents curate materials, competences, and meanings associated with only a single social practice and either do not consider alternative social practices or rule out alternative practices as nonviable. The Carlsons, for example, closely adhered to the social practice script for independent sleeping and were opposed to cosleeping (table 2). As such, they engaged in elaborate planning when building their envisioned practice, where they focused on accumulating elements to support independent sleeping (e.g., reading books on sleep training, buying a crib and sleep basket) and did not research other sleep practices.

With single-practice integration, parents' capability to envision how they could rework practice elements after a misalignment is constrained by the perceived boundaries of the practice on which they have been focused. By directing their planning efforts toward a single social practice in a domain, parents are exposed to a concentrated set of sources that present parenting practices in a particular way, as they view all other options as nonviable. For example, Susan Davies, who adhered to natural parenting approaches and held a bounded view of baby-led weaning feeding practices, relied on advice from a registered holistic nutritionist to guide her feeding practices: "So I went to [nutritionist's] class . . . I'm making bone broth for him . . . because that'll help lube him up [for constipation] and it's one of the healthiest things you can do for them . . . He has liver pâté. He sucked on a piece of moose . . . luckily I have her [the nutritionist] as a resource, and I see her three times a week."

By focusing on only a single social practice within a domain, parents often develop an elaborate envisioned script for a practice that includes different ways of arranging complementary elements, as was the case with the Davies' feeding practice. This elaborate script helps guide them through practice reconfigurations should a misalignment occur and is akin to the deep expertise consumers are able to artfully acquire as they become more engaged with a taste regime (Arsel and Bean 2013). Although deep expertise in a single practice can prove advantageous, it can also blind parents to other potential views of relationships among elements, much as discourses both enlighten and limit possibilities (Fischer et al. 2007).

The second type of integration capability emerges when parents consider multiple social practices to be viable options, but view these as either/or choices. For example, the Larkins, who viewed diapering practices as bounded, decided to use disposable diapers, but they left open the possibility of switching to cloth diapering in the future (table 2). Multiple-practice integration capability develops when parents plan for multiple social practices in a single domain—often because they are not sure which social practice they want to enact. In these cases, parents research multiple practices and draw on information from a range of social, marketplace, and institutional sources, many of which debate the merits of various practices (e.g., breast vs. formula feeding). The Tallons, for example, did extensive research on infant feeding practices to determine which was best for their family, as Cindy Tallon explains: "Until I actually got pregnant I never thought that I would be someone who'd wanna breastfeed . . . So then I actually started to look into it and I was like, I'm actually going to breastfeed. I'm going to give it a fair try, you know, and see if it works out. And then if it doesn't work we'll switch to formula . . . I've actually researched that and like read books and read online and talked to people."

The Tallons ultimately decided to breastfeed, but they were prepared to switch to formula feeding if necessary, indicating that they viewed multiple practices in this domain as viable. The key differentiator between multiple- and single-practice integration capability is that with the

former, parents view multiple practices as viable, whereas with the latter, only one practice is considered viable. Notably, with both single- and multiple-practice integration, planning is focused on the fluidity of elements *within* practices because parents view practices as bounded.

The third integration capability adopts a hybrid orientation to element fluidity where parents view practice boundaries as porous and are open to the movement of elements *across* practices. For example, Kathy Dover's feeding practice combines elements from both breastfeeding and formula feeding (table 2). Kathy does not adhere to the cultural boundaries placed around these two social practices and deviates from the proscribed scripts. Hybrid integration capability emerges from planning efforts where parents do not think in terms of social practice boundaries but instead think about the complementary ways they could combine elements from across social practices. Marcy Larkin, for example, described herself as "really quite open-minded, so I'm not really strongly one way or another with most things . . . I just try to find whatever solution makes sense to me and [with] what I'm most comfortable."

The degree to which information sources frame social practices as bounded versus porous, in part, influences whether parents view these practices as "either/or" options or whether they consider it appropriate to combine elements from across multiple social practices (Arsel and Bean 2013). Elise Bell-Dickson explains that her mother, for example, frames breastfeeding and formula feeding as mutually exclusive, where a new mother ideally breastfeeds for six weeks and then switches to formula feeding: "[My mother] was like, 'Well, that's ridiculous. You don't have to [breastfeed for a year]. Why would you do that? You can get formula for free from WIC [Women, Infants, and Children program].'" In contrast, Haley Gentry describes how promotional materials she received from a formula company framed breastfeeding and formula feeding as complementary: "They market it as a supplement . . . dads could feed at night, or something like that, or you know? . . . So it wasn't like, 'Use this, not your boob.' It wasn't that messaging. It was also more of just like talking up the good parts of the formula."

While message framing is an important influence on parents' integration capability, it is not the only influencer; embodied views, cultural discourses, and personal experiences all play a role in how, and the extent to which, parents plan and thus influence their integration capability.

Integration capability was important to our informants because it directed the range of element reconfigurations they entertained when they encountered a misalignment and framed how they thought about the assortment of materials, competences, or meanings they could enlist in a reconfiguration. In contrast to reconfigurations for established practices, where consumers focus on recreating entrenched meanings and material configurations (Epp et al. 2014), we find that for newly adopted practices, reconfigurations emerged from engagement in planning and are bounded by parents' integration capability. It is thus important to consider not only which practices a person chooses, but also the range of practices that they consider viable.

Overall, both anticipation and integration capability emerged as important for our informants' reconfiguration efforts. Anticipation capability heightens parents' sensitivity to potential misalignments, while integration capability characterizes the assortment of elements that parents are willing to deploy to bring a practice back into alignment. Both capabilities are built through parents' planning efforts, with differential planning approaches leading to the development of different anticipation and integration capabilities. These capabilities ultimately impact how parents view the creating and replacing of links between elements in a practice. We note, however, that capability building was not always seamless or easy for our informants. In many cases, parents faced constraints that inhibited their ability to build these capabilities.

Constraints to Building Capabilities

Several constraints inhibited parents' ability to build capabilities: a lack of access to resources, tradeoffs in effort devoted to different practices, and divergent planning approaches within a couple. First, circumstances limited some informants' access to the social, marketplace, and institutional resources needed to build capabilities. For example, Kathy Dover, a single mother, felt uncomfortable taking prenatal classes ("I find [prenatal classes] hard in this situation; I don't think I would enjoy it") and thus missed the typical corpus of information presented at these classes, which exposes potential misalignments and presents alternate practices or enactments. Kathy also lacked access to the social resources often developed as expectant parents form friendships through these classes. She further notes that many other resources failed to account for her situation as a single mother:

> I think that's [being single] one of the reasons I struggled with breastfeeding because I needed someone else to help me be able to breastfeed, and I couldn't do everything [the lactation consultant] needed me to do in order for it to work . . . just to hold [baby] and use a breast shield and . . . to use a syringe to express with that as well. Like, I don't have 10 hands and I don't have help at home. So it was a huge challenge . . . she was very pushy about what I needed to do, and not understanding [that] it's not realistic in my situation.

Kathy often felt like she was a single mother in a world that assumes two parents, which led to a sense of isolation

that constrained her planning efforts and resulting realignment capabilities.

The Bell-Dickson family also struggled to access resources when planning. Their limited financial means meant that many of their choices were made for them (e.g., which childbirth class to attend) because they relied on social assistance. Elise notes: "I used the girls [for information] in the aerobics class . . . We've talked a lot about, 'Did you buy this? How do you feel about this? What kind of car seat did you get?' That's been kind of helpful too, although [my friend] bought everything new when I got a lot of used stuff." Being unable to buy new products and engage in the same kind of research as expectant parents with more financial resources contributed to Elise feeling a loss of agency. After the first interview, Elise described how she wanted the ability to choose the car seat, stroller, and crib so she could research safety ratings and product features. When asked if she had any choices about the car seat, which she got through a special program, she said, "There was nothing. Yeah, just the one. I gave them $20 and they installed it. That was it." Elise's constrained marketplace options hampered capability building, much of which happens through marketplace engagement.

A second constraint to building capabilities highlights the tradeoffs parents make between practices when planning. Given the demands of intensive parenting (Afflerback et al. 2013), expectant parents often find it virtually impossible to dedicate sufficient planning resources to all the social practices they need to adopt. Thus, parents focus their planning resources on the practices that hold deeper meanings and play a central role in their views of parenthood (Phipps and Ozanne 2017; Searle 1995). Prioritizing some practices over others, and the corresponding differential planning approaches, accounts for why parents' capabilities vary for each practice.

The Smiths, for example, preferred cloth diapering but opted to prioritize breastfeeding instead, as Monica Smith describes: "Because we wanted so badly to breastfeed, and I know how stressful that can be, I thought if we do that and the cloth diapers at the same time, I'm not willing to put that kind of stress on my plate." The Smiths thus focused their planning on breastfeeding, anticipating specific misalignments (Monica: "There are many problems that come with [breastfeeding] and complications, stress . . . [potential] C-section [related issues] . . . breastfeeding in public") and building integration capabilities related to only the breastfeeding practice, as Monica explains: "It will be breastfeeding . . . I think because that's one of the things we really want to do, I'm going to do everything I can to make sure that that happens. So, unless there's something physically that I'm not aware of yet, that's the way it should be going."

While many parents, like the Smiths, wish they could engage in extensive planning for every parenting practice, this is not feasible. As a result, parents only engage in limited planning, or do not plan at all, for some practices. This restricts their capability building.

The last constraint to building capabilities occurs when members of a couple approach planning in different ways. Consider the Nelson family, where Grant opposed doing extensive research to learn about methods for soothing a baby to promote independent sleeping:

> I just don't want to be all textbook everything. We're going to figure out what our baby likes. I don't need to be shushing in his ear to get him to be quiet [a technique advocated in some parenting books]. We'll figure out something that he likes . . . if I sing to him or if I get out the guitar. If we show him a book or something . . . I'm just so sick of so many books and videos, I'm just done with it. I'm ready to have the baby and find out what works. I don't need everyone to tell me what's going to work because it's not going to. Every baby is different.

In contrast, Olivia Nelson embraced extensive research related to independent sleep strategies: "I want to have some strategies just to have up my sleeve for when it's, like, three in the morning and the baby won't stop crying. Like, 'Oh, my God, what can we do,' kind of thing. I want to have some idea of what we can try, so that's a little bit how [Grant and I] differ."

Olivia's closing comment draws attention to her husband's different approach to baby preparation. While both Olivia and Grant anticipated general misalignments related to independent sleeping, Olivia developed single-practice integration capability in contrast to Grant's restricted integration capability. Divergent capabilities can challenge habituation processes following a misalignment, as parents may hold conflicting views about how to reconfigure a practice. However, parents taking different, and even contradictory, routes to planning was rare in our data. More common was parents planning together or one person taking actions to prepare, and then sharing the knowledge and information with the other. In both those situations, what emerges is a set of capabilities for each practice that is consistent across parents.

In sum, parents build realignment capabilities—anticipation and integration—when building envisioned practices. These capabilities play a key role in whether and how practices habituate after misalignments. Neither capability in isolation dictates a particular outcome; it is the combination of capabilities that is implicated in misalignment responses. Parents build capabilities in relation to individual envisioned practices as they plan. While some parents build capabilities with ease, others face obstacles: family status and financial situations block access to resources, the necessity to make tradeoffs among practices forces parents to prioritize, and differential planning approaches within couples can lead to divergent capabilities. Next,

we detail how misalignments can thwart practice habitation.

PRACTICE MISALIGNMENTS: THE MESSINESS OF DOING

When moving from envisioned to enacted practices, links between practice elements often break or fail to materialize; what a person envisions does not always work as intended. Despite sometimes extensive planning—which gives parents a sense that they understand a social practice—parents lack the embedded knowledge and embodied skills that come only from performing a practice (Arsel and Bean 2013). That is, enactment complicates the envisioned practice such that social practices do not always easily translate into enacted practices. By examining the movement from envisioned to enacted practices, we capture how parents experience the messiness of doing: its emotionality, its unpredictability, and its vulnerability to the interference of others.

The Burke family, for example, struggled with diapering as they experienced a slew of misalignments between practice elements. The family planned to use cloth diapers for both environmental and health reasons, fearing the baby may have a latex allergy like her father, but encountered several other broken links among elements when enacting the practice, as Lori Burke explains:

> I hated them [cloth diapers] at first, but now love them . . . And she's super comfortable in them . . . They're a time commitment too. And one of them started leaking . . . We went away for Thanksgiving, and it was four days, and obviously we had to take disposables. She got open sores, and they took two weeks to heal [so we had to keep her in disposables because] barrier cream doesn't work with cloth diapers . . . And after learning that she had that latex sensitivity, I have to bring all these cloth diapers with me.

First, the anticipated latex allergy emerged. What they did not anticipate was the second misalignment: the cloth diapers leaking. The third misalignment occurred between the cloth diapers and the diaper creams needed to heal the allergic reaction, where the Burkes were either stuck using cloth diapers without the cream or disposable diapers with the cream, which would further expose the baby to latex. The Burkes' diapering practice was hijacked by broken links and unpredictable misalignments that challenged their envisioned practice and mandated practice reconfiguration. This example illustrates the messiness that emerges within practice enactments.

Interference from other caregivers, family members, or social networks also complicates enactment and incites misalignments. Such misalignments commonly occurred when others' enactments introduced contradictory or unwanted competences or meanings that disrupted parents' enacted practices. For example, the Fosters' sleep practice included several sleep aids and precise routines, including "cry it out" techniques, to promote independent sleeping for their daughter. The sleep practice, however, was knocked out of alignment when their daycare provider started using different sleep techniques. Emma Foster comments:

> We just let her cry . . . a little longer each night . . . a lot of times she'd fall asleep on her own . . . Once we started daycare, that's all gone to crap. She cannot fall asleep on her own anymore . . . I don't think they let them cry it out . . . when they start crying they have to pick them up . . . [Building a consistent practice is hard because] we're only with her for two days, whereas the daycare does it like five days. So I have two days in the weekend to try to figure it out.

As Emma describes, a common problem when caring for a baby is that multiple caregivers use different practices or enact the same practice differently (Epp and Velagaleti 2014). When divergent competences collide, as with the Fosters and their daycare provider, practice misalignments occur and habituation is threatened.

Parents' accounts of misalignments depict the emotionality and stress that result when practice enactments depart from what they envisioned. We find that parents measure failures against the social practice, informed by cultural ideals and pressures of what the practice should be and how it should work (Fischer et al. 2007). Consider Abby Miller's breastfeeding experience. From the start, Abby clearly intended to breastfeed, despite her anticipation of some general challenges: "I just pretty much want to breastfeed as long as I can . . . I mean, not everybody is able to do that and maybe I won't be able to, but I know that it forms a lot closer bond . . . some studies have shown the more loving, kind, considerate people are people that had breast milk." Later, the Millers' envisioned practice was complicated by Abby's work as a restaurant manager, where uninformed coworkers and the hectic pace thwarted her practice, as the couple explains:

> **Abby:** The first couple of days it was kind of annoying for them [coworkers] for me to go away [to pump breast milk] . . . Now, it's fine . . . It's just hard to get the time just because of how the restaurant business works and how little staff we have . . . I can't have somebody come in for half an hour . . . It just doesn't make sense for the business. It's just hard on me, though . . . I didn't want to supplement as much, so that was a little hard getting through that transition of "We're going to have to give her formula or she's going to starve or I can't go back to work."
>
> **Jack:** We tried to fight it for a while. When she first went back to work, those first couple of days, she needed to eat an hour before Abby's home from work and I didn't feed her, so we just struggled through that hour of screaming and yelling and trying anything we could do."

The Millers' emotional recollection points to the deeply held meanings they had related to breastfeeding and the material realities of Abby's work environment that prevented her from effectively producing and pumping breast milk. Evident in their story are the weight of the social practice and the sense of normative judgments, consistent with a culture of intensive parenting, that partially account for their reaction. The couple elaborates on this point:

> **Jack:** We wish we would have gone longer . . . It [the decision to stop breastfeeding] was kind of forced upon us . . . Pretty much, she just wasn't producing it . . . Abby was coming home from work just extremely stressed out—"I didn't get anything"—and then sitting there for an hour trying to get her to latch on and she just wasn't latching on. And so it was getting really stressful on her, and well, that's stupid, and let's just switch to formula now! I don't know why I had that preconceived notion. I guess because you hear so much, "breastfeed as long as you can" . . . so, in my mind I'd almost put it as, okay, formula is a bad thing, like we shouldn't do formula and stuff . . . I think I had built it up in my head as more of a negative thing than it was . . . I think we beat ourselves up a little too much trying too hard.
>
> **Abby:** I ended up in tears, really just trying so hard.

The Millers' account calls into question the smooth integration between social practice and enactment and draws attention to the many ways their envisioned practice was challenged. The messiness of doing highlights the relatively abstract nature of social practices. The social practice of breastfeeding, for example, is not constrained by the social practice of work, but these two collide in an enactment. Social practices do not have to account for misalignments and the messiness of doing, but enacted practices are embroiled in both.

Misalignments thus bring with them the emotional experience of broken links, subject to normative enactments of the social practice script, and parents find that as they enact practices, they must account for other people's opinions and interference. When misalignments occur, practices are threatened and parents try to reconfigure them, a process we turn to next.

MISALIGNMENT RESPONSE PATHS

We identify five paths that parents follow when reconfiguring practice elements after a misalignment. The path taken depends on parents' realignment capabilities. Notably, the type of practice does not determine which response path is taken; for example, most parents experienced breastfeeding misalignments, but these reconfigurations followed all five response paths (see appendix B). Table 3 describes each path and summarizes the relationship between parents' capabilities and each path. The paths mark movement, to varying degrees, away from the envisioned practice and result in reconfigured practices that are either abandoned (the envisioned practice is no longer performed), habituated (the envisioned practice is reconfigured and stable), or in a state of vulnerable habituation (misalignments persist, leaving the practice unstable).

Abandoned Practices

Remove and Switch. The Remove and Switch path results in a reconfiguration where the envisioned practice is abandoned. After a misalignment, parents remove the envisioned practice elements and replace them with a set of elements corresponding to an alternate practice. For this path, parents anticipate specific misalignments and plan for multiple practices. The Gentrys, for example, planned to use cloth diapers but also considered disposable diapering to be a viable option, even curating disposable diapers "just in case." This planning approach cultivated an integration capability where multiple practices each retained their own meanings, materials, and associated competences. The Gentrys also anticipated specific misalignments by thinking about the challenges they may encounter with cloth diapering, as the couple explains:

> **Sam:** Diapers was a tough one, too, trying to figure out cloth or disposable . . . We're going to give cloth a shot, but it's with a service so that we're not washing here . . .
>
> **Haley:** But we have disposables, too, upstairs.
>
> **Sam:** Right. We have no shortage of disposables . . .
>
> **Haley:** This [laundry] service . . . doesn't have a contract. You only have to do one month.
>
> **Sam:** If, after a month we say no, it's not for us, then no harm, no foul.

Within the first few weeks with their newborn, they did, in fact, experience a misalignment where the diapers did not work well for the baby. The couple describes several obstacles:

> **Haley:** No dice [on cloth diapers].
>
> **Sam:** We tried two. That's the end of the sentence. We tried two, the quantity of two . . . We had a blowout of one . . . The other one was primed for blowout. It was so fast to do disposables, and it's got the blue line.
>
> **Haley:** Pampers has the lock dry . . . it has a line that's yellow and it turns blue when it's wet.
>
> **Sam:** It's just so much easier. At that point, you just want to do whatever is easiest for you, because you're just looking for something to be easier and to make life smoother.

In addition to a lack of functionality, their laundry service turned out to be incompatible with their chosen diaper brand. Thus, the Gentrys abandoned the suite of products and services related to cloth diapering in favor of a new suite of products related to disposable diapering; they abandoned their envisioned practice for a new practice that progressed toward habituation.

TABLE 3

DESCRIPTION OF MISALIGNMENT RESPONSE PATHS

Path[a]	Description	Realignment capabilities		Habituation outcome
		Anticipation	Integration	
Remove and Switch	Parents remove elements related to the envisioned practice and replace them with a new set of elements corresponding to an alternate practice.	Specific misalignments	Multiple	Abandoned
Inhibited Response	Parents do not deviate from their envisioned practice, either by not recruiting new elements or not reconfiguring existing elements.	None	Restricted	Vulnerable Habituation
Improvise	Parents scramble in situ to generate a solution to an unforeseen misalignment among elements.	General misalignments	Single	Vulnerable Habituation
Supplement	Parents bring in elements from a new social practice to work in conjunction with their envisioned practice.	Specific misalignments	Hybrid	Habituated
Creative Perseverance	Parents creatively reconfigure and/or enlist new elements that support their envisioned practice.	Specific misalignments	Single	Habituated

[a]These are the five paths that emerged from our data analysis. We acknowledge there may be additional paths that result from different capability combinations in other contexts.

With Remove and Switch, multiple (vs. single or hybrid) integration capability affords parents the ability to switch to an alternate practice, but also inhibits their ability to think of ways to reconfigure elements that support the envisioned practice. Notably, even though the envisioned practice did not habituate with this path, parents still tended to view the outcome favorably, as it resulted in a stable practice, just not their envisioned one. Multiple-practice integration may help to alleviate the tensions consumers feel between conflicting discourses (Epp and Velagaleti 2014), which allows them to move more seamlessly between social practices.

Vulnerable Habituation

Inhibited Response. The first path leading to vulnerable habituation, where reconfigured practices remain misaligned, is Inhibited Response. This path arises from a lack of anticipation capability and restricted integration capability. With this capability combination, parents remain committed to their envisioned practice, but keep defaulting back to the practice in its misaligned form instead of making changes to resolve the misalignment.

The Davies, for example, were unable to reconfigure their sleep practice when their son refused to sleep anywhere other than on his mother. Susan and Randall intended for their baby to sleep independently but did not think through the details of how this could unfold when building their envisioned practice (Interviewer: "Did you guys discuss the options of having a cosleeper versus a bassinet? Susan: We'll see how it works and how much he wants to feed"). Moreover, given that Susan worked as a nanny ("I've been really lucky that I've had 20 years of working with kids"), she was confident in her views and did not anticipate misalignments ("I know exactly what's worked"). This resulted in limited anticipation and integration capabilities (see table 2) and made it hard for Susan and Randall to reconfigure their practice when, at 6.5 months old, the baby would not sleep independently. Susan describes:

> He has to fall asleep on me, nursing, and then I can't move or he wakes up screaming and it doesn't matter. Occasionally I can get away for like 15 minutes . . . last night Randall put him in the pram . . . and he slept for three and a half hours . . . That's the longest that he's ever been off of me his entire life. [Interviewer: Last time I was here, you talked about maybe moving him into his crib at some point]. Well, he hasn't been ready at all. Like it wouldn't have happened; it would've been a cry-it-out situation, and I'm not prepared to deal with that.

Rather than reconfiguring existing elements, or bringing in new competences (such as sleep training), the Davies succumbed to inertia and the problem persisted.

The Bell-Dicksons were similarly unwilling to change their sleep practice. They intended for their baby to sleep independently in a bassinet, but did not give it much thought when planning their envisioned practice (Elise: "I just decided . . . I don't know if we talked about it." Chad:

"I don't remember talking about it"). As a result, they developed neither anticipation nor integration capabilities for this practice. When the baby was born, they struggled with sleep and quickly fell into a pattern of cosleeping. Elise notes, "We're currently trying to work her out of cosleeping, which was probably a poor choice on my behalf." Despite being unhappy with cosleeping, neither Elise nor Chad tried to reconfigure the practice. In fact, Elise purposefully avoided seeking out resources that could help her reconfigure the practice:

> This is something I don't really want to put out there. Does that make sense? I'm a little bit ashamed of letting her cosleep because people talk about how unsafe it is . . . Rather than ask for advice [from a mothers' Facebook forum] I just left [the forum] . . . [and] every time [we went for a checkup with the doctor] they have a series of questions they ask you. How many pees? How many poops? Where is she sleeping? I would just kind of say, "She sleeps in the bassinet," which is a lie . . . I'm lying to my pediatrician.

Even though Elise was unhappy with the state of their sleep practice, she, like the Davies, succumbed to inertia and was unable to make changes to her practice, and even went to the lengths of lying to her doctor to avoid confronting the misalignment.

Across our dataset, many families fell into this situation where problems persisted due to an Inhibited Response path. Driven by restricted levels across both capabilities, parents were unable or unwilling to change their practices. This path was challenging for parents, as they continuously struggled to solve problems in the same way while achieving little in terms of results. This lack of progress weighed on parents and made many day-to-day tasks (e.g., feeding, sleeping, personal time) a constant source of frustration. Moreover, this path may incite further instability, as it can lead to tensions between parents and other members of their care team, deceit, and, in some cases, guilt. Similar to the masking practices described by Canniford and Shankar (2013), this response path results in a practice that may temporarily stabilize but is unlikely to lead to long-term habituation, as the underlying misalignments remain unresolved.

Improvise. The Improvise path also leads to vulnerable habituation. Here, parents think about the possibility of things going wrong but do not consider specific problems they may encounter—that is, they anticipate general misalignments—and focus their integration capability on reworking elements within a single social practice. After a misalignment, parents improvise: they generate a solution to the unforeseen misalignment in situ and try to salvage their envisioned practice by incorporating new elements through a series of trials. In many cases, parents reluctantly integrate elements from other social practices, even if they did not initially think these practices were viable. For example, the Burkes planned to breastfeed and assumed they would be able to do so:

> **Lori:** It was a no brainer, like formula wasn't even part of an option . . . I'm definitely going to try breastfeeding, and I feel pretty good about it because of the support we have between the midwives and the doulas. So I think it's going to be positive—that's kind of the only thought in my head right now is breastfeeding. I really don't want to formula feed at all.
>
> **Ryan:** We work at Public Health too, so I personally know a ton of people at Public Health that would help . . . so I figure if we have even the slightest problem, we have probably 12 different people to pull from to get some solid, tested advice.

The Burkes anticipated general misalignments and were prepared to call on experts (e.g., midwives, colleagues) to help them build competences should the need arise. When the baby was born, her mouth was too small to breastfeed properly. Lori explains:

> I've been a pumper this whole time, I still am. So I'm doing what I can. But breastfeeding just didn't go at all . . . I went to Public Health too, and talked to the lactation consultants. And the midwives were good. And it was apparently not the technique, it was just she didn't have a wide grip, a wide mouth at all . . . the midwives were worried about her getting dehydrated. So we had to do the formula right from the beginning . . . And it was just awful. I cursed my head off. And I didn't curse at all during labor. So it was excruciating and I had a few breakdowns, and I just thought there's no way . . . I can never keep up with her so I definitely, I don't know the ratios, maybe 60 or 70% breast milk and then the rest formula. It's always a bit of a top up . . . So never what you expect or plan.

Improvising is often a scramble—the Burkes did not anticipate the specific misalignment, so they relentlessly drew on their available resources (e.g., lactation consultants) to build new competences to resolve the problem. After lots of trial and error, the Burkes eventually settled on a stable feeding practice where they combined pumping breast milk with feeding formula, but they were never fully content with the reconfiguration, as the meanings and emotions associated with the practice remained misaligned and were far removed from their envisioned practice.

The Nelsons also followed the Improvise path when they experienced a sleep-related misalignment. Recall that Grant and Olivia approached planning differently and amassed different integration capabilities related to independent sleeping. When their baby started waking frequently in the night, the Nelsons scrambled to solve the misalignment. While neither parent anticipated this specific issue (they built only general anticipation capability), Olivia built integration capabilities to promote independent sleeping that supported improvisation:

> **Grant:** At first he was sleeping like through the night. And then [at three months] it got really bad where you're just up three or four times at night . . . and then we would get up

and bounce him for a long time and then Olivia started nursing him and we knew that was the only way to soothe him. We knew we didn't want to go down that road . . .

Olivia: So . . . We tried it [cry-it-out sleep training], [but] I would [only] be able to last 10, 15 minutes tops, and then I was like, "Okay, I'm done."

Grant: There were definitely some conflicts over that. Every night he cried and then we'd sit in bed and talk about it for, you know, the whole 20 minutes like, "No, don't go there." And then like every night and before we go to bed, "Okay, let's get a strategy." And every night she has this strategy that she wanted to do, and then it would just break down instantly . . . And then she would try to do that and I'd be like, "No, I know you can't do that." So what's the next strategy you read about? . . . And then eventually after we left him for five or 10 minutes, he fell back asleep . . . and then he started making it until like 3:30 . . . And Olivia was like, "You know what? I'm just going to feed him."

Olivia: So I'm just going to do what my gut tells me to do . . . I'm just going to go feed him.

Grant: And it just eventually got later and later and . . . Olivia would feed him and go back to bed . . . it started being 5:30, and once in a while 6:00, which is what we wanted him to get to.

Using Olivia's integration capability, the Nelsons stumbled upon a workable reconfiguration after scrambling to find a solution. While Grant was supportive of Olivia's efforts, he was not able to bring any new competences to bear on the problem, placing the full burden on Olivia. This made the reconfiguration process difficult and straining for the family.

Across our dataset, the Improvise path resulted in solutions to misalignments, but parents were often dissatisfied as they viewed it as a "make do" solution instead of a carefully thought-out plan of action. Here, parents ended up adopting a practice that they never wanted or intended to enact. This contrasts with the Remove and Switch path, where parents change practices but move toward a practice that they already viewed as a potentiality. With the Improvise path, the combination of anticipating only general misalignments and focusing on a single practice means that parents are not in a position where they can easily curate elements to support their envisioned practice. This results in reconfigurations that are more uncertain and vulnerable. This vulnerability places families in a state of ontological insecurity (Phipps and Ozanne 2017) where they feel uneasy and experience the ad hoc solutions as less than ideal.

Habituation

In two paths, Supplement and Creative Perseverance, parents are able to realign all elements and habituate the envisioned practice. Both paths lead to stable outcomes that our informants experience as positive and stem from parents anticipating specific misalignments, but the two paths differ in terms of integration capability. This pattern illustrates a central characteristic of capabilities: capabilities work in combination, not independently, such that positive outcomes accrue from a range of capability combinations. As described below, for example, the flexibility of hybrid-practice integration does not necessarily garner better outcomes than those that accrue from single-practice integration capability.

Supplement. The first habituated path, Supplement, emerges when parents anticipate specific misalignments and are open to combining elements from across practices (hybrid integration). With this path, parents bring in new elements—often appropriating elements from a different social practice—and add them to their practice, without removing existing elements. Common examples include adding disposable diapers to overcome cloth diaper misalignments and adding formula to a baby's diet when faced with breastfeeding challenges. The Carlsons, for example, added disposable diapers to their cloth diapering practice after they experienced several misalignments, including travel plans that complicated cloth diapering and a thrush-based diaper rash. Prior to these disruptions, the Carlsons built hybrid integration capability where they planned to use cloth diapers but "did purchase some disposable diapers" (Ashley) and specific anticipation capability where they thought through potential misalignments, such as problems related to the fit of the diaper and interactions between the diaper and the baby's skin. After experiencing cloth diapering misalignments, the Carlsons added disposable diapers to their diapering practice, pulling in meanings, materials, and competences from this alternate social practice. Ashley notes, "I use [cloth diapers]. Garett doesn't use them . . . [we're about 50–50]."

Likewise, the Simpsons initially planned to exclusively breastfeed, but after experiencing misalignments, they reconfigured their feeding practice to include breastfeeding, pumping breast milk, and formula feeding, as Eva describes: "She breastfeeds when she gets up, and then, in three-hour increments . . . [until] around 5:30, and then she'll have her bath, and then she has her two formula bottles . . . And I pump at 9 . . . and then I store the milk . . . so [dad] can give her a breast milk bottle."

The Simpsons' reconfiguration was enabled by their specific anticipation capability, where they thought about various breastfeeding challenges (Eva: "[I want to] make sure the milk comes in . . . or just people saying they just can't breastfeed. They've tried to exclusively pump and [my friend] said it was exhausting to be pumping for every time the baby needed to eat"), and hybrid integration capability, where they were open to combing elements from across social practices (Eva: "[Receiving free formula samples]

kind of works out actually. If I do need to formula feed, I'd rather try the samples before I go and buy them").

With the Supplement path, parents expand their repertoire of elements, giving them greater flexibility moving forward. While parents sometimes struggled with initiating this path when it moved them away from their envisioned practice (e.g., adding formula when breastfeeding was initially preferred), overall they were satisfied with the reconfiguration, as it still included the elements of their envisioned practice. This ability to reconfigure in a way that is consistent with the envisioned practice is driven by integration capabilities that facilitate merging old and new elements via a hybrid approach (in contrast to Remove and Switch, where the bounded view of multiple practices results in abandoning the initial plan).

Creative Perseverance. The final habituation path, Creative Perseverance, occurs when parents reconfigure existing, or enlist new, elements that support their envisioned practice. In these cases, parents anticipate specific misalignments and their integration capability focuses on a single practice. Examples from our data include integrating donor breast milk into feeding practices (Gentrys), using biodegradable disposable diapers (Burkes), and scalding breast milk to reduce excess lipase, an enzyme that makes milk taste sour (Nelsons). The manner in which parents focus their reconfiguration around a particular social practice is consistent with the informants in Fischer et al. (2007), who persisted toward their goals while staying within a culturally pervasive discourse.

The Taylors exemplify Creative Perseverance. During pregnancy, they decided Kayla would breastfeed and pump breast milk, and they were committed to using only organic products. Their desire to eliminate plastics in their envisioned practice prompted the Taylors to consider a range of solutions for breast milk storage and bottles. They built specific anticipation and single-practice integration capabilities through extensive research:

> **Kayla:** We're trying to get rid of a lot of plastics . . . So, initially we had all glass bottles on our registry, and we wanted to only store breast milk in glass . . . then we got input from John's sister that glass is so heavy . . . and then what if it breaks?
>
> **John:** And plus [with] the glass bottle the nipple is smaller . . . with a larger nipple you're less likely to have a colicky baby. So then it's like, "Well, is that a tradeoff? We like the glass because of the toxicity aspect, but then we like the plastic bottles because they have a more ergonomic, supposedly better [nipple]."
>
> **Kayla:** Yeah, so we decided, "Well, maybe we won't go with glass" . . . And so then we researched more on the Baby Lab [website] and found these silicone bottles . . . And stainless steel bottles, and so we decided to go with the silicone because the stainless steel you couldn't see how much milk had been drank unless you unscrew the whole thing . . . And then related to that was, "Well, what are we going to store the breast milk in?" It kind of defeats the purpose if we feed the baby in a silicone bottle but it's been stored in a plastic bag in the freezer for a couple months . . . so we eventually, and this is actually information that we got at our child birth class too . . . One of the best materials to store breast milk in is glass. So then we decided, "Well, we're using jars for all these other things, is there a jar system that we could use?" So we ended up getting four-ounce canning jars, but we learned that the lids have BPA in them, so then we researched, "Are there replacement lids?" . . . Now we have glass jars.
>
> **John:** Glass jars with replacement BPA-free plastic lids with the original metal collars . . . . [and] silicone baby bottles.

The Taylors built an elaborate, organic system for breast milk storage and feeding. But, when implementing this system after the baby's birth, the couple quickly realized it was not viable:

> **Kayla:** I'm not using the glass storage containers, because we had 12 of those, and I've gone through 98 bags of storage. I burned through 12 pretty fast. [I said to myself] "This is not going to work."
>
> **John:** Also, it's mechanically easier with the bags to defrost them . . .
>
> **Kayla:** [We looked at two brands of storage bags], they're both BPA-free and healthy, but the one that we went with, they're biodegradable, so we decided to go with that one.

This creative reconfiguration (storage bags instead of glass bottles) allowed the Taylors to maintain alignment with their envisioned practice.

With Creative Perseverance, parents reconfigure their envisioned practice and achieve habituation by curating complementary elements that align with their preferred social practice. These solutions are often difficult to implement, but parents are content with the reconfiguration because it allows them to retain their envisioned practice, even though they may be enacting it using a different configuration of elements (Magaudda 2011). This contentment contrasts with instances when practices followed the Inhibited Response path, where, without the benefit of realignment capabilities, attempts to adhere narrowly to the envisioned practice resulted in vulnerable practices where parents still struggled to fully resolve the misalignment.

In summary, our analysis reveals a multistage process whereby consumers reconfigure newly adopted practices that experience a misalignment. We show how consumers form an envisioned practice, informed by social practices, by curating practice materials, meanings, and competences through planning. In the process, parents also build realignment capabilities related to anticipating misalignments and envisioning alternate configurations for practice elements. When misalignments do thwart the implementation of the

envisioned practice, parents follow five misalignment response paths, differentiated by their initial capability configuration, that result in practices that are either abandoned, habituated, or in a state of vulnerable habituation.

DISCUSSION

In our work, we describe consumers' experiences integrating social practices into their lives and show that this process is often complex: understanding a practice and successfully enacting a practice are not the same. When newly adopted practices experience misalignments, consumers' reconfiguration attempts drive whether and how the practice will ultimately habituate. Our findings explain why, after a misalignment, consumers are able to habituate some newly adopted practices but not others. We highlight the role of two realignment capabilities in this process to show that *how* you make plans may ultimately matter more than *what* you actually plan to do. Both capabilities, differentially and in combination, shape how consumers respond to misalignments, which, in turn, impacts whether and how habituation occurs.

Our findings contribute broadly to practice theories. Prior research explores social practices (Shove and Pantzar 2005; Shove et al. 2012) and enacted practices (Phipps and Ozanne 2017; Woermann and Rokka 2015), but the link between these is undertheorized. We introduce the envisioned practice, as distinct from either social or enacted practices, as a bridge between the two levels of a practice. The envisioned practice reveals the work of translation and captures how planning in specific ways links social practices with the habituation outcomes of enacted practices: we show that "doing" a practice starts with planning an envisioned practice.

Practice habituation occurs in three different scenarios: (1) the habituation of a practice that does not experience a misalignment, (2) the rehabituation of an established practice that experiences a misalignment, and (3) the habituation of a newly adopted practice that experiences a misalignment. The first scenario, habituation without misalignments, is the prototypical practice replication story where routinized practices stabilize over time (Reckwitz 2002; Warde 2005). Misalignments, however, complicate the other two scenarios where habituation requires the realignment of practice elements. Extant work examines the realignment of established practices (Epp et al. 2014; Phipps and Ozanne 2017; Woermann and Rokka 2015), while we focus on how this occurs for newly adopted practices.

For established practices, the material configurations, meanings, and competences that guide reconfigurations are entrenched. In contrast, with newly adopted practices, elements and enactments are still fluid. This means that the capabilities that drive reconfigurations, and how those capabilities emerge, differ for established and new practices. For established practices, the capabilities implicated in reconfigurations depend on prior enactments (Epp et al. 2014). In the absence of such prior enactments, we find that the capabilities for newly adopted practices are anchored in envisioned practices. In other words, the capabilities driving established practice reconfigurations are derived from prior practice performances, while the capabilities driving new practice reconfigurations are built during the envisioned practice planning phase. More broadly, we show that capabilities are central to practice habituation, and that the process of building an envisioned practice is central to linking social practices and stable enactments.

Our work also uncovers the range of possible outcomes for newly adopted practices that experience misalignments, and highlights that multiple paths can lead to positive outcomes—parents were happy with the stability afforded by both habituation and abandonment outcomes. Vulnerable habitation, however, was problematic, as misalignments remained and left parents in a state of ontological insecurity (Phipps and Ozanne 2017). In this regard, our work complements Phipps and Ozanne (2017) but also offers a direct extension. We show that ontological insecurity does not result from just material constraints; the configuration of capabilities also contributes to stability such that the same material constraints (e.g., breastfeeding misalignments) can lead to different habituation outcomes depending on capability configurations (appendix B). Our findings indicate that consumers could avoid vulnerable habituation by cultivating particular capabilities while planning. Material constraints are thus only part of the reason why consumers are sometimes unable to habituate disrupted practices: anticipation and integration capability also contribute to how consumers resolve misalignments.

Uncovering the role of realignment capabilities provides an additional layer of understanding to what prior research tells us about practice reconfigurations. By shifting the focus from material elements to capability configurations, we gain a deeper understanding of how and why consumers reconfigure in the ways they do. Integration capability offers insights into why, for example, some of Phipps and Ozanne's (2017) informants abandoned their gardens, while others adopted new gardening practices in response to drought: those who abandoned the practice were likely constrained by their exclusive focus on a single practice, while those holding multiple- or hybrid-practice integration capability were better able to adapt. Further, our findings could extend Arsel and Bean's (2013) work by explaining likely response paths if newly adopted social practices experience misalignments. Taste regimes bound social practice enactments and foster single-practice integration capability that prompts consumers to improvise or follow a creative perseverance path. Encouraging consumers to

anticipate specific misalignments would help steer them toward the creative perseverance path and thus habituation.

Both of the capabilities highlighted in our work play an important role in the habituation of newly adopted practices after a misalignment. First, anticipation capability—whether and how consumers think about potential misalignments—reveals that for all misalignment response paths that resulted in a stable outcome (i.e., practice abandoned or habituated) parents thought about the specific links that could break within a practice. When parents failed to consider specific misalignments, they were unable to successfully reconfigure, which left habituation vulnerable.

Second, we note the importance of integration capability. This capability reflects how consumers think about the compatibility and substitutability of practice elements. This is similar to Epp et al.'s (2014) conceptualization of imaginative capacity, but it also accounts for consumers' consideration of social practice boundaries. Our analysis shows that for practices to habituate, specific anticipation capability must be combined with either hybrid- or single-practice integration capability, as these both facilitate reconfigurations that retain some or all of the envisioned practice's elements. In the absence of hybrid- or single-practice integration capability, parents either abandoned practices or failed to recruit sufficient elements to achieve habituation.

The various types of integration capability reflect the diversity in consumers' openness to different social practices. Integration capability thus plays a nuanced role in practice habituation. Conventional wisdom, as well as scholarly work, concludes that openness to hybrid practices should better prepare consumers for misalignments; flexibility is key (Olson 2011). Our analysis, however, shows that the role of integration capability in the habituation of newly adopted practices depends on how it interacts with anticipation capability. When coupled with anticipating specific misalignments, we see multiple-, hybrid-, and single-practice integration capability all leading to stable outcomes, but in different ways. Multiple-practice integration capability allows consumers to pivot toward a different social practice (e.g., abandon cloth diapering and adopt disposables); hybrid-integration capability facilitates the merging of elements from across social practices (e.g., combine cloth and disposable diapering); and single-practice integration capability incites the building of elaborate plans that support the envisioned practice in a reconfiguration (e.g., focus deeply on cloth diapering only).

The range of paths that practices can take during reconfigurations also reveals boundaries around the role of commitment in the habituation process (Bagozzi and Dholakia 1999; Mann, de Ridder, and Fujita 2013). We show that habituation stems not just from practice commitment, but also from realignment capabilities that account for the messiness of doing. Across our data, we observed families that were equally committed to a practice, but some were able to achieve habituation while others were not. For example, the Burkes and Gentrys were both highly committed to breastfeeding, but only the Gentrys were able to achieve habituation. Commitment to a practice is thus not enough: how one plans—and the corresponding reconfiguration capabilities—matters for whether and how a practice habituates after a misalignment.

Our findings emerged from a context with several important characteristics: consumers simultaneously adopted several related practices; complex cultural discourses governed these practices; and consumers engaged with a range of sources when preparing for the practices. We propose that our findings should apply to other contexts that share these characteristics, such as consumers taking on a new hobby (e.g., triathlon training), adopting a new pet (e.g., getting a puppy), transitioning to a new life phase (e.g., living alone for the first time), adopting new lifestyles (e.g., becoming vegan), or starting a new career (e.g., shifting careers).

Consider, for example, the increasing number of millennials who are adopting farming as a leisure pursuit (Charles 2011; Musk 2017). First, this entails simultaneously adopting multiple practices related to land maintenance, planting, fertilizing, harvesting, and distributing crops. Second, there are multiple social practices, many of which are linked to cultural discourses that could be used to accomplish each of these tasks. Local and sustainable food movements, for instance, are characterized by discourses describing different farming practices (e.g., organic or chemical) and educating consumers about the sources and circumstances of food production (Press et al. 2014; Thompson and Coskuner-Balli 2007). Finally, when preparing to implement farming practices, millennials work with community members, government agencies, local food systems, and a range of other sources to build the plan for their new endeavor. With a plan in place, millennials implement these practices, many of which will undoubtedly experience misalignments, be it crop loss due to weather or pests, challenges of spoilage, or equipment failures. Whether these farming practices habituate or not will depend on the capabilities millennials develop when planning.

To prepare for these misalignments, millennials should focus their planning efforts to enhance capability building. For instance, millennials could learn about different farming approaches to build hybrid or multiple integration capability or dive deeply into a single practice (e.g., organic approaches) while also thinking about the ways their plans could be derailed. Millennials should also consider the dynamic nature of reconfigurations—at any point in time, shifts in practice elements may result in new misalignments. This example of millennial farmers illustrates the importance of building capabilities that help overcome misalignments to establish a set of habituated practices. In

short, consumers should strive for capability accumulation when planning, as the right capability configuration can help them overcome misalignments.

Our findings have important implications for consumers, marketers, institutional service providers, and public policy makers. Consumers frequently adopt new practices that face misalignments. Encouraging consumers to build capabilities, and providing them with the resources needed to do so, can help them overcome misalignments. Consumers, for example, could benefit from cultural templates that provide scripts for how they might respond to misalignments. These templates can help motivate capability building by highlighting potential pitfalls and inciting integration capability. Likewise, marketers, institutional service providers, and public policy makers also need to be cognizant of how consumers respond to misalignments, including doing things like lying to doctors to preserve a practice. Better understandings of the social practices and the perceptions of social practice boundaries that inform consumers' capabilities and envisioned practices could help marketers, service providers, and public policy makers better support consumers as they adopt new practices.

In our context, parents built capabilities by drawing on the collective wisdom of those who have ventured into parenthood before them through books, blogs, parent groups, the marketplace, and parenting/childbirth courses. Many of our informants were able to easily access these resources when building their envisioned practices, but informants who did not fit the culturally normative view of "new parents" (i.e., two parents with sufficient financial resources) struggled to access some of these resources. While they did acquire the material elements needed to care for their child, the process through which they attained these elements did not always facilitate easy capability development. This is concerning, given that many new parents do not fit the traditional mold. For example, approximately 40% and 30% of babies in the US and Canada are born to single mothers, respectively (Martin et al. 2018; Statistics Canada 2018). Marketers, service providers, and policy makers need to recognize that consumers with differing needs (e.g., low income, single parent, adoptive parents, and teenage mothers) may struggle to access resources that match their particular situation and, thus, face obstacles to capability building. To illustrate, adoptive parents may not attend doctors' appointments or childbirth courses that foreshadow potential misalignments and detail childcare approaches. Providing services that account for parents' unique and varied circumstances would improve consumer well-being.

The insights from our research, however, are bounded by the nature of our research context. North American parenting is dominated by the intensive parenting discourse that promotes planning. While our dataset does include variability in planning at the practice level, including some practices where parents did not plan at all, future research should explore the role of planning in cultures where intensive parenting is not the norm. Moreover, even within North America, there are situations where planning is not always possible or desired, such as when babies are born extremely premature, when women do not know they are pregnant, or when families are hesitant to plan due to previous pregnancy loss. Without the benefit of planning an envisioned practice and building capabilities, how do these parents habituate practices after misalignments? Future research should also explore how those with limited access to traditional planning resources navigate practice reconfigurations. While our findings speak to the necessity of a broader range of resources to meet the needs of a heterogeneous population, we describe only one of what are likely many mechanisms that influence practice habituation. Explicitly exploring a more heterogeneous population may reveal additional mechanisms.

In closing, our work describes why consumers successfully habituate some newly adopted practices but not others. We document the challenges associated with translating social practices into enacted practices and describe how planning builds capabilities that help consumers navigate practice reconfigurations. Armed with the knowledge that capabilities are central to reconfigurations, consumers, marketers, and public policy makers can help move desirable practices toward habitation. Our analysis reveals which capabilities matter most in the habituation process and how important it is to build capabilities when planning.

DATA COLLECTION INFORMATION

Both authors collected data for this study via in-depth interviews. These interviews took place from May 2013 to July 2014. The first author conducted interviews in Kingston, Ontario, and the second author conducted interviews in Madison, Wisconsin. Informants were interviewed on three separate occasions and given $100 as a token of appreciation for participating in the study. Both authors analyzed the data.

APPENDIX A

PRACTICES THAT EXPERIENCED MISALIGNMENTS ACROSS FAMILIES

Broad domain	Diapering		Feeding					Sleeping					Vaccines			Other			
Subdomain	N/A		Initial feeding			Solid food feeding		Sleep location		Sleep duration	Sleep scheduling		N/A			N/A			
Social practice	Cloth diapering	Disposable diapering	Breastfeeding	Formula feeding	Pumping breast milk	Spoon feeding purees	Baby-led weaning	Independent sleeping	Cosleeping	Continuous sleeping	Routinized sleeping	Unstructured sleeping	Immunizing	Not immunizing	Selective immunizing	Comforting/ soothing	Bathing	Baby wearing	Cleaning
Jenkins	X									X									
Gentry	X		X							X	X								
Bell-Dickson			X					X	X										
Fosters	X	X	X			X		X		X	X								
Burke	X	X	X																
Carters	X		X							X						X			
Davies	X		X			X		X											
Carlson	X		X					X											
Miller			X																
Tanner			X																
Tallon	X		X					X										X	
Nelson	X		X					X		X									
Klein			X							X			X			X			
Taylor	X		X																X
Hughes			X			X		X		X									
Smith			X																
Simpsons		X	X	X						X									
Shelton			X																
Dover			X		X														
Drummond			X	X	X					X									
Larkin			X				X										X		
York			X		X			X		X									
Crane			X	X						X									
Mahoon			X					X	X										

NOTE.—Families often experienced more than one misalignment within a practice.

APPENDIX B

EXAMPLE MISALIGNMENT RESPONSES FOR THE BREASTFEEDING PRACTICE

Family	Misalignment description	Response path	Response description
Hughes	Laura's milk supply was low.	Remove and Switch	Switched from breastfeeding to formula feeding.
Bell-Dickson	Elise's milk was slow to come in, so family and doctors recommended supplementing with formula.	Inhibited Response	Elise and Chad did not do anything to change feeding habits. They waited it out and hoped the situation would improve on its own.
Burke	The baby's mouth was too small, making breastfeeding impossible.	Improvise	Lori and Ryan scrambled to pull in whatever resources they could to support breastfeeding, but ultimately had to resort to pumping breast milk and supplementing with formula.
Crane	Gail's milk supply was low.	Supplement	Supplemented breastfeeding and pumping breast milk with formula to compensate for low supply of breast milk.
Gentry	Haley's milk supply was low.	Creative Perseverance	Avoided giving baby formula by using donated breast milk. Milk was initially procured through an informal local organization. Haley then made arrangements with another mother who donated breast milk on a long-term basis.

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