



# Rates of breastfeeding and exposure to socio-economic adversity amongst children with intellectual disability



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## ABSTRACT

Children with intellectual disability are at increased risk of experiencing poor health relative to their typically developing peers. Previous research indicates that exposure to socio-economic disadvantage contributes towards this disparity but that additional factors (including parenting practices) may be involved in mediating/moderating pathways. This study examined duration of breastfeeding amongst children with and without intellectual disability by a secondary analysis of data from the UK Millennium Cohort Study. Children with intellectual disability were significantly less likely to have been ever breastfed; breastfed exclusively or at all at 3 months or breastfed at all at 6 months relative to children without intellectual disability. None of these differences remained significant when other psycho-social risk factors for reduced breastfeeding were controlled for. The study adds to both the sparse literature on breastfeeding practices amongst families of children with intellectual disability and research demonstrating relationships between socio-economic disadvantage and wellbeing for children with intellectual disability.

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## 1. Introduction

From early childhood and throughout the life course, people with intellectual disabilities experience poorer health and wellbeing relative to people without disabilities (Anderson et al., 2013; Emerson & Hatton, 2014; Haveman et al., 2010; NHS Health Scotland, 2004; Oeseburg, Dijkstra, Groothoff, Reijneveld, & Jansen, 2011; Ouellette-Kuntz, 2005). While part of this disparity relates to well established biological determinants of intellectual disability, exposure to childhood adversities (material or psychological hazards in early life) that are known risk factors for poorer physical and mental health in the general population (Marmot, 2005; Miller, Chen, & Parker, 2011; World Health Organization, 2008) appear to also play a role.

Indeed, it is known that children with mild to moderate intellectual disabilities (Emerson, 2012a, 2012b; Maulik, Mascarenhas, Mathers, Dua, & Saxena, 2011) and (to a lesser degree) children with severe to profound disabilities (Chapman, Scott, & Stanton-Chapman, 2008; Emerson, 2012a) are more likely than their non-disabled peers to be raised by a family of low socio-economic position and, as a consequence, be exposed to a range of environmental adversities associated with this (Emerson, 2013). They are also more likely than their non-disabled peers to be excluded from mainstream education and their local community and to face other adversities and negative life events such as exposure to violence and peer

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victimization (Department for Children Schools & Families, 2008; Department for Education, 2010; Hatton & Emerson, 2004; Sullivan & Knutson, 2000).

While relatively few studies have directly examined relationships between childhood adversity, health and wellbeing amongst people with intellectual disability, those that have (Emerson & Einfeld, 2010; Emerson & Hatton, 2007a, 2007b; Emerson, Einfeld, & Stancliffe, 2011; Emerson et al., 2014) suggest 20–50% of poorer physical and mental health outcomes for children with intellectual disabilities relative to their non-disabled peers can be accounted for by increased risk of exposure to socio-economic disadvantage alone. However, relatively little is known about the pathways that mediate the apparent link between exposure to socio-economic disadvantage and poorer health in children with intellectual disability.

Research in the general population, has increasingly focused on identifying the biological and psycho-social pathways that may mediate or moderate the link between exposure to socio-economic disadvantage and health (Emerson, 2013). One psycho-social pathway that appears particularly relevant to early development is the impact that exposure to socio-economic disadvantage may have on parenting behaviours and practices (Conger & Donnellan, 2007; Shonkoff, 2010; Shonkoff, Boyce, & McEwen, 2009). Other research has attempted to identify the range of protective factors that determine an individual's resilience (their potential to cope with or limit the negative influence of adverse experiences) (Luthar & Brown, 2007; Mohaupt, 2009; Rutten et al., 2013). To date however, little is known about exposure to variables that may influence resilience or support positive health and wellbeing outcomes among children within intellectual disability and further research in this area has been encouraged (Emerson, 2013; Emerson & Brigham, 2014).

The current study investigated breastfeeding in early childhood as one possible aspect of parenting that may partially mediate the link between exposure to socio-economic disadvantage and health amongst people with intellectual disabilities. Breastfeeding is a potentially important variable to consider since it is both amenable to intervention and has been associated with a range of benefits in the general population (Hetnzer, Razza, Malone, & Brooks-Gunn, 2009; Horta & Victora, 2013a, 2013b; Kaspiris, Griva, Zaphropoulou, Vasiliadis, & Sawidou, 2010; Kramer & Kakuma, 2004; Kramer et al., 2008). Specifically, research in this area has suggested that whether or not a child has ever been breastfed and total duration of time during which they were breastfed is negatively associated with risk of early childhood diarrhoea and respiratory tract infection (Horta & Victora, 2013b) and in later life the risk of obesity and diabetes (Horta & Victora, 2013a). Positive associations have also been reported between breastfeeding and the health and wellbeing of mothers (Gwinn, Lee, Rhodes, Layde, & Rubin, 1990; Hahn-Holbrook, Haselton, Schetter, & Glynn, 2013) and between breastfeeding, cognitive and motor development of children (Horta & Victora, 2013a; Quigley et al., 2012; Sacker, Quigley, & Kelly, 2006), though findings in this area are more variable (Holme, MacArthur, & Lancashire, 2009; Tozzi et al., 2012).

In light of this evidence, the World Health Organization recommends that all children should be exclusively breastfed for the first 6 months of life and should continue to receive breast milk in combination with other foods until 2 years old (World Health Organization, 2001) and the National Institute for Health and Clinical Excellence provides clear recommendations to support mothers to breastfeed in the postnatal period (Dyson et al., 2006; National Institute of Health & Clinical Excellence, 2006). A variety of factors are however known to reduce the likelihood of breastfeeding initiation and limit total breastfeeding duration (Dennis & McQueen, 2009; Hamlyn, Brooker, Oleinikova, & Wands, 2002; Kelly & Watt, 2005; Thailor & Mercer, 2009). These include socio-economic factors that as discussed may often reflect the circumstances of families who are raising a child with intellectual disabilities. The current study therefore compared the extent to which a cohort of children with intellectual disabilities were breastfed (both in terms of whether they were ever breastfed and duration of breastfeeding) relative to their non-disabled peers and the socio-economic factors that were associated with this.

## 2. Method

The study is based on secondary analysis of the first four waves of data collected by the UK's Millennium Cohort Study (MCS). MCS data are managed by the Centre for Longitudinal Studies at the University of London and are available to researchers registered with the Economic and Social Data Service ([www.esds.ac.uk](http://www.esds.ac.uk)) through its data archive ([www.data-archive.ac.uk](http://www.data-archive.ac.uk)). Full details of the design of MCS are available in a series of reports and technical papers (Hansen, 2012; Hansen, Jones, Joshi, & Budge, 2010; Johnson, 2009, 2012; Jones & Ketende, 2010; Plewis, 2007; Plewis & Ketende, 2006), key aspects of which are summarized below.

### 2.1. Sampling

Participant families were randomly selected from Child Benefit Records, a non means-tested welfare benefit available to all UK children at the time the cohort was established. Sampling was geographically clustered to include all four countries of the UK (England, Wales, Scotland, Northern Ireland), and disproportionately stratified to over-sample children from ethnic minority groups and disadvantaged communities (Plewis, 2007). Children and families were drawn from 398 randomly selected electoral wards in the UK. The first survey (MCS1) took place when children were 9 months old and included a total of 18,552 families. Children were followed up at ages three (MCS2; 15,590 families, 84% retention rate from MCS1), five (MCS3; 15,246 families, 82% retention rate from MCS1) and seven (MCS4; 13,857 families, 75% retention rate from MCS1). For each family, information was collected on the target child falling within the designated birth date window. For multiple births (e.g., twins, triplets) information was collected on all children. To avoid the statistical problems associated with the

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