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Mothers' perceived physical health during early and middle childhood: Relations with child developmental delay and behavior problems

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ABSTRACT

The self-perceived physical health of mothers raising children with developmental delay (DD; $N = 116$) or typical development (TD; $N = 129$) was examined across child ages 3–9 years, revealing three main findings. First, mothers of children with DD experienced poorer self-rated physical health than mothers of children with TD at each age. Latent growth curve analyses indicated that mothers in the DD group experienced poorer health from age 3 but that the two groups showed similar growth across ages 3–9 years. Second, cross-lagged panel analyses supported a child-driven pathway in early childhood (ages 3–5) by which early mother-reported child behavior problems predicted poorer maternal health over time, while the reversed, health-driven path was not supported. Third, this cross-lagged path was significantly stronger in the DD group, indicating that behavior problems more strongly impact mothers' health when children have developmental delay than when children have typical development. The health disparity between mothers of children with DD vs. TD stabilized by child age 5 and persisted across early and middle childhood. Early interventions ought to focus on mothers' well-being, both psychological and physical, in addition to child functioning.

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1. Introduction

Mothers of children with developmental delay (DD) experience poorer *psychological* well-being compared to other mothers (Baker et al., 2003; Hauser-Cram, Warfield, Shonkoff, & Krauss, 2001); however, little is known about these mothers' *physical* well-being. The present study examines associations between child DD, child behavior problems, and mothers' perceived physical health across early and middle childhood.

1.1. Psychological well-being among mothers of children with DD

Parents of children with DD face increased stress, depression, and other negative psychological outcomes relative to parents of children with typical development (TD; e.g. Baker, Blacher, Crnic, & Edelbrock, 2002; Olsson & Hwang, 2001). At the same time, individual and contextual factors, such as child adaptive functioning (Boyce, Behl, Mortensen, & Akers, 1991), parents' social support (Manuel, Naughton, Balkrishnan, Smith, & Koman, 2003), and quality of support services (Mitchell &

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Hauser-Cram, 2008), contribute to variability in parent well-being, and many parents experience marked resilience in the face of child DD or behavior problems (Broberg, Blacher, & Emerson, 2009; Gerstein, Crnic, Blacher, & Baker, 2009).

Children and adults with intellectual disability (ID) have three to four times the rates of psychological disorder as their peers with typical cognitive development (e.g. Dekker, Koot, van der Ende, & Verhulst, 2002), a discrepancy that emerges as early as age 3 in the form of elevated rates of behavior problems (Baker et al., 2002). Researchers have repeatedly found that the presence of child DD itself does not account for poorer maternal well-being; rather, it is this increased child psychopathology that negatively affects maternal well-being (e.g. Baker et al., 2003; Peters-Scheffer, Didden, & Korzilius, 2012). Lower socio-economic resources and social capital also exacerbate the poorer well-being of parents of children with DD (Emerson, 2003) in ways that may worsen over time as child-related stressors and limitations take a cumulative toll on family resources (Emerson, Hatton, Llewellyn, Blacher, & Graham, 2006).

1.2. Physical health among mothers of children with DD

In the limited research that has focused on the impact of raising a child with DD on mothers' physical health, mothers of children with DD have reported lower physical health relative to fathers of children with DD and mothers and fathers of children with TD (Olsson & Hwang, 2008). More broadly, raising a child with a chronic health condition or disability has been associated with cellular aging (Epel et al., 2004) and cortisol dysregulation (Seltzer et al., 2010), factors that are in turn linked to immune suppression and cardiovascular disease (Djuric et al., 2008). Among older mothers of adult children with DD, the physical health risks are well-documented, and include greater reported somatic symptoms (e.g. headaches, backaches, trouble sleeping, joint stiffness) (Ha, Hong, Seltzer, & Greenberg, 2008) and arthritis-related limitations (Magaña & Smith, 2006) than parents of offspring with TD. In fact, while differences in psychological health attenuate over time, health differences persist at later ages (Ha et al., 2008).

Stressors associated with child disability and behavior problems may negatively affect mothers' physical well-being in a delayed, cumulative fashion (see Taylor, Repetti, & Seeman, 1997 for a review of chronic stress and health), as the effects of stress on physical health often emerge approximately two years after the stressor itself (McEwen, 2000). Indeed, in previous work with the present sample, child DD at age three predicted poorer perceived maternal health two years later (Eisenhower, Baker, & Blacher, 2009). As with psychological well-being, the effects on physical well-being may be accounted for by the heightened child behavior problems among children with DD, rather than by the DD itself (Eisenhower et al., 2009). In the present study we examine contributions of child developmental status (DD vs. TD), behavior problems, and their interaction in predicting maternal health over time from child age 3–9 years.

1.3. Health changes over time for mothers of children with and without DD

We examine trajectories of mothers' health as children enter formal schooling and continue through elementary school. Challenges facing families during these years include new school demands, emerging relationships with teachers and peers, and children's increased independence from parents (Rimm-Kaufman & Pianta, 2000). The transition to school may be particularly stressful for families of children with DD as they seek and manage services to address children's special education needs (McIntyre, Blacher, & Baker, 2006).

Reciprocal associations between child characteristics and parental well-being over time are well-established (Gross, Shaw, Moilanen, Dishion, & Wilson, 2008; Sameroff, 2009), including links between child behavior problems and parenting stress across early childhood (Baker et al., 2002) and middle childhood (Neece, Green, & Baker, 2012). However, unlike the association with parent stress, the association with parent health may be more unidirectional and driven by child characteristics. In the current paper, we examine trajectories of maternal health to determine whether mothers of preschool- and school-age children with DD experience poorer physical health across child ages 3–9 years than mothers of children with TD. We also examine whether child behavior problems predict maternal health, both independently and in interaction with child developmental delay, and whether this association is transactional over time vs. unidirectional. Given that effects of chronic stress on health are often delayed and cumulative, we examine these relations longitudinally, applying cross-lagged panel analysis in order to shed light on causal processes (Kline, 2010).

2. Materials and methods

2.1. Participants

Participants were 245 children (59.2% boys) and families who enrolled in the Collaborative Family Study at either age 3 ($N = 225$) or age 5 ($N = 20$). Based at three universities (Pennsylvania State University, University of California Los Angeles, and University of California Riverside), the study included samples drawn from Central Pennsylvania (24%) and Southern California (76%). Families were assessed annually at child ages 3 through 9 years. Children were classified as having developmental delay (DD; $N = 116$) or typical development (TD; $N = 129$). Families of children with DD were recruited through regional agencies that provided diagnostic and intervention services for individuals with developmental disabilities. Selection criteria for the DD group were that the child (a) score 40–84 on a test of developmental functioning; (b) be ambulatory; and (c) not be diagnosed with autism. Families of children with typical development (TD) were recruited

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