Growing Up in Ireland
National Longitudinal Study of Children

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THE INFANTS AND THEIR FAMILIES

INFANT COHORT

EXECUTIVE SUMMARY

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A project of the scale and complexity of ***Growing Up in Ireland*** would not be possible without the assistance and commitment of a large number of people, groups, bodies and organisations, all of whom we wish to thank, on behalf of the ***Growing Up in Ireland*** Management Group and Study Team.

First, we wish to acknowledge the funding of the project by the Department of Health and Children, through the Office of the Minister for Children and Youth Affairs, in association with the Department of Social Protection and the Central Statistics Office.

Thanks are due to members of the Inter-Departmental Steering Group (formerly chaired by Ms Sylda Langford and currently chaired by Dr Mary Doyle, Director General of the Office of the Minister for Children and Youth Affairs {OMCYA}). Thanks are also due to the members of the Inter-Departmental Project Team (chaired by Dr Sinead Hanafin, Head of Research, Department of Health and Children). Ms Anne-Marie Brooks and Mr Tim Heneghan from the OMCYA were also extremely supportive and helpful in the execution of the project.

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We are very grateful to the members of the Scientific and Policy Advisory Committee (SPAC) who provided many fresh perspectives in numerous areas.

The Research Ethics Committee (REC) has provided rigorous ethical assessment of all aspects of ***Growing Up in Ireland***. This has involved their critical review of often voluminous documentation at each stage of the project, requiring an extraordinary level of commitment, time and input from its members.

The 84 children who sit on the Children's Advisory Forum (CAF) have provided very important help in developing questionnaires and testing schemes for the Child Cohort.

Staff and colleagues in both the ESRI and Trinity College provided assistance in many ways, as did the members of the Advisory Panels of Experts who made a particularly important contribution to instrument development and project design throughout.

A range of stakeholder groups gave generously of their time, assistance and support, particularly during planning and design phases.

The energy and dedication of our staff in implementing ***Growing Up in Ireland*** have been tremendous since the inception of the project.

The final (and biggest) word of thanks goes, of course, to more than 11,000 families of nine-month-old infants who participated in the Infant Cohort of the Study. ***Growing Up in Ireland*** would simply not have been possible without the time and assistance they so readily and generously provided to us.

James Williams, ESRI **Sheila Greene, TCD**

MINISTER'S FOREWORD

As Minister for Children and Youth Affairs, it gives me great pleasure to publish *'The Infants and their Families'.* This is the second formal publication from ***Growing Up in Ireland*** – the National Longitudinal Study of Children.

Growing Up in Ireland is one of the largest and most complex studies that has ever been undertaken in Ireland. By tracking the development of two cohorts of young children for at least seven years (approximately 11,100 infants and 8,500 nine-year old children), this Study aims to '*examine the factors which contribute to or undermine the wellbeing of children in contemporary Irish families, and, through this, contribute to the setting of effective and responsive policies relating to children and to the design of services for children and their families'.*

Growing Up in Ireland is funded by the Office of the Minister for Children and Youth Affairs in association with the Department of Social Protection and the Central Statistics Office. This Study was commissioned as part of a wider National Children's Research Programme, which was set up to progress Goal Two of the National Children's Strategy (2000):

> *Children's lives will be better understood; their lives will benefit from evaluation, research and information on their needs, rights and the effectiveness of services.*

Since the inception of the National Children's Research Programme, a solid evidence base on children's lives has been established. I am confident that the findings emerging from this publication will add greatly to this evidence base and will also prove to be of enormous benefit to both policymakers and practitioners in the valuable work they undertake to improve the lives of children in Ireland.

I would like to thank Professor James Williams of the Economic and Social Research Institute and Professor Sheila Greene of the Children's Research Centre at Trinity College Dublin, their research team and their team of fieldworkers who are carrying out this Study. Most importantly, I would also like to thank the 11,100 families and carers who have generously given up their valuable time to participate.

Barry Andrews, T.D.
Minister for Children and Youth Affairs

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1. INTRODUCTION

Growing Up in Ireland tracks the development of two groups of children – an Infant Cohort (at nine months) and a Child Cohort (at nine years). The current report presents the first summary of the chartacteristics and circumstances of nine-month-olds in Ireland today.

The principal objective of ***Growing Up in Ireland*** is to describe the lives of children and, in particular, to establish what is typical and normal as well as what is atypical and problematic. The Study focuses on a broad range of child outcomes. In so doing, it will facilitate comparison with findings from similar studies of children elsewhere, as well as establishing norms for Ireland. Being longitudinal in nature, the Study will also address developmental trajectories over time and explore the factors that most affect those trajectories and the life chances of children as they grow from nine months to early childhood (in the case of the Infant Cohort).

2. CONCEPTUAL FRAMEWORK

The conceptual framework adopted by ***Growing Up in Ireland*** emphasises children's connectedness to the world within which they live. It sees the child's world as being made up of a multilayered set of interconnecting environmental systems, all of which influence the developing child to greater or lesser degrees. Parents (and family members such as siblings and grandparents, if they are present) are the most influential part of the ecology in early child development as are, for example, childcare and pre-school arrangements. Outside the immediate family surroundings the child is influenced by (and influences) other important relationships, such as those in the community/neighbourhood and, later in the child's life, school. The reciprocal relationships between home, wider family, community/neighbourhood and school have a bearing on the child's development, as do the institutional structures of government policy in areas such as education, health and social welfare, as well as the less formal social norms within the child's local neighbourhood or community.

3. DATA AND METHODOLOGY

The Infant Cohort of ***Growing Up in Ireland*** is based on a nationally representative sample of 11,100 families and their nine-month-old child. The sample was randomly selected from the Child Benefit Register which is maintained by the Department of Social Protection. The response rate for the survey was 65% of all families selected or 69% of those who were successfully contacted by an interviewer.

The Child Benefit Register contained a total of 73,662 infants who were nine months of age, 51.8% of whom were boys. All children included in the Study were born between December 2007 and May 2008.

4. CHARACTERISTICS OF INFANTS AND THEIR FAMILIES

4.1 FAMILY TYPE

Growing Up in Ireland shows that 14% of infants lived in lone-parent families: 6% in lone-parent families with one child under 18 years and 8% in larger lone-parent families. The majority of nine-month-olds (86%) lived in two-parent families: 33% in two-parent families with one child and 53% in two-parent families with two or more children – Figure 1.

Figure 1: Family type and size of households in which infants lived

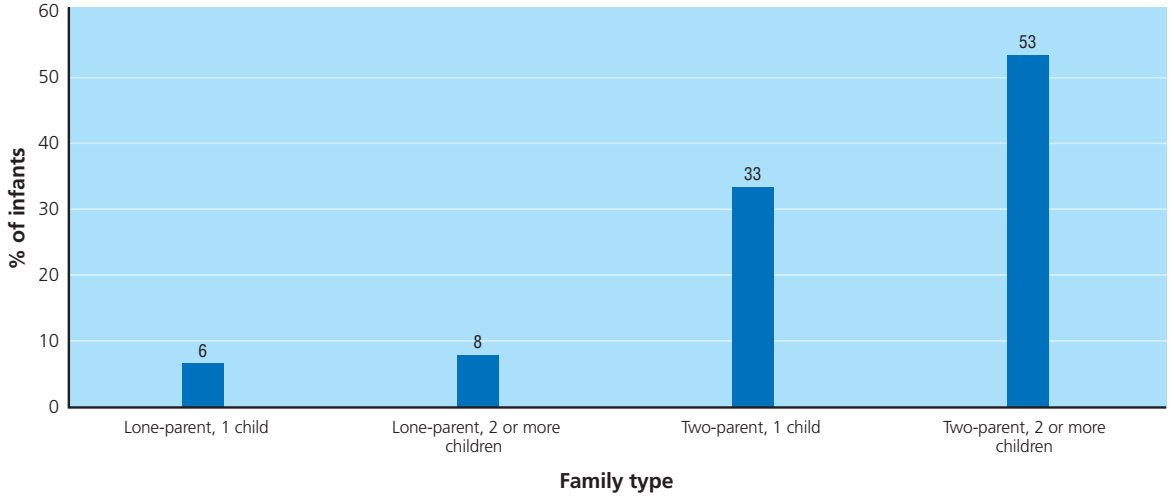
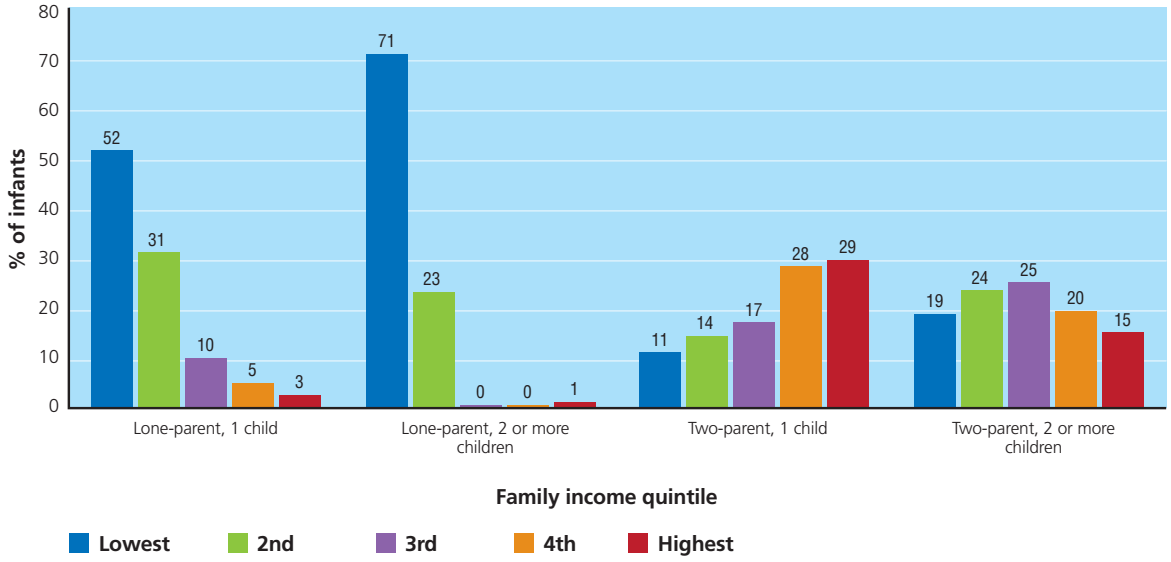


Figure 2 shows that lone-parent families were much more likely to be in the lowest income groups, especially larger lone-parent families; 71% of lone parents with two or more children and 52% of those with one child were in the lowest income category. This compares with 19% of larger two-parent families and 11% of smaller two-parent families.

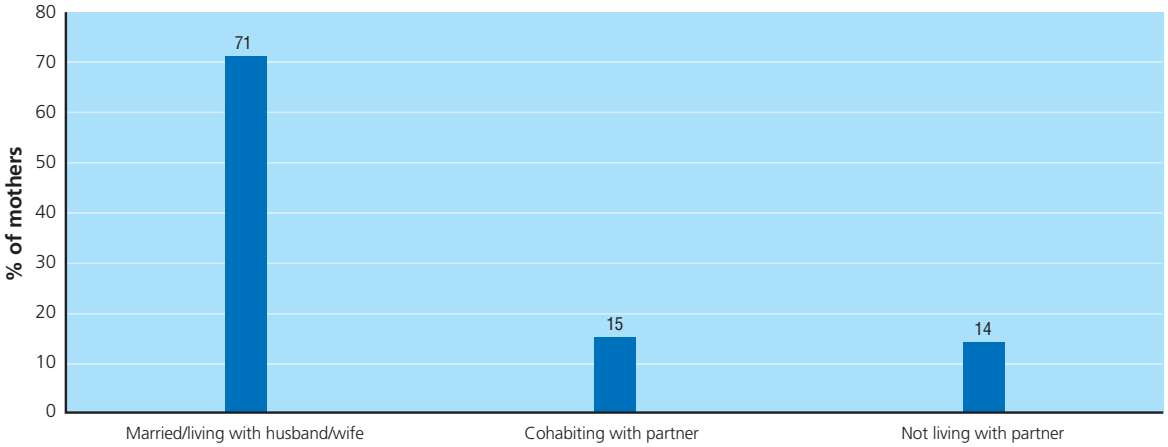
Figure 2: Family type classified by family equivalised income quintile



4.2 MARITAL STATUS

Figure 3 shows the marital status of the infants' mothers at the time of interview. The majority of mothers (71%) were married and living with their spouse, indicating that the traditional family unit headed by a husband and wife is still the single most common structure for infants in Ireland today. The remainder were fairly evenly split between those who were cohabiting with a partner (15%) and those who were living alone without a resident partner (14%).

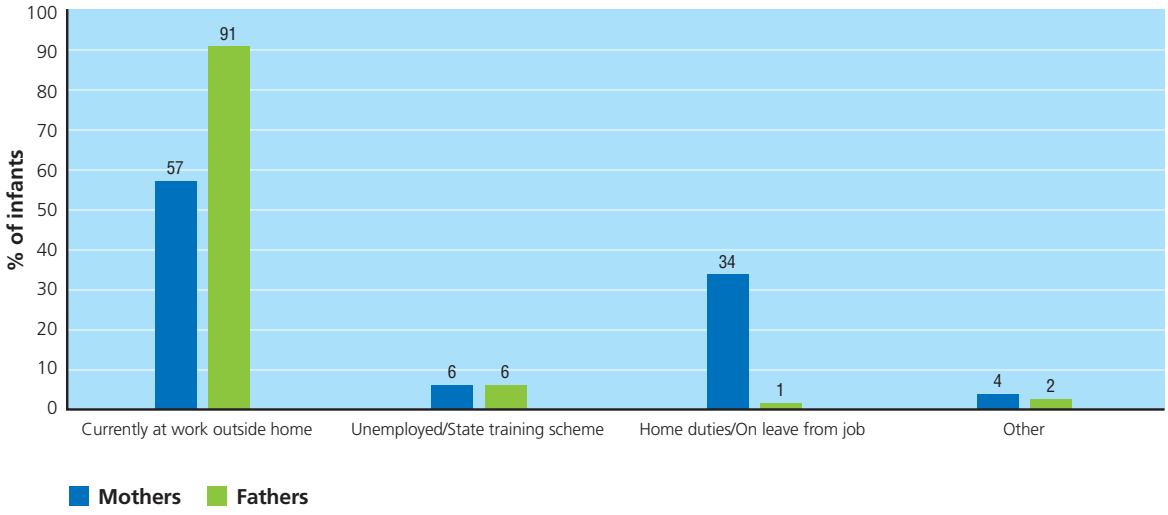
Figure 3: Marital status of nine-month-olds' mothers



4.3 ECONOMIC STATUS

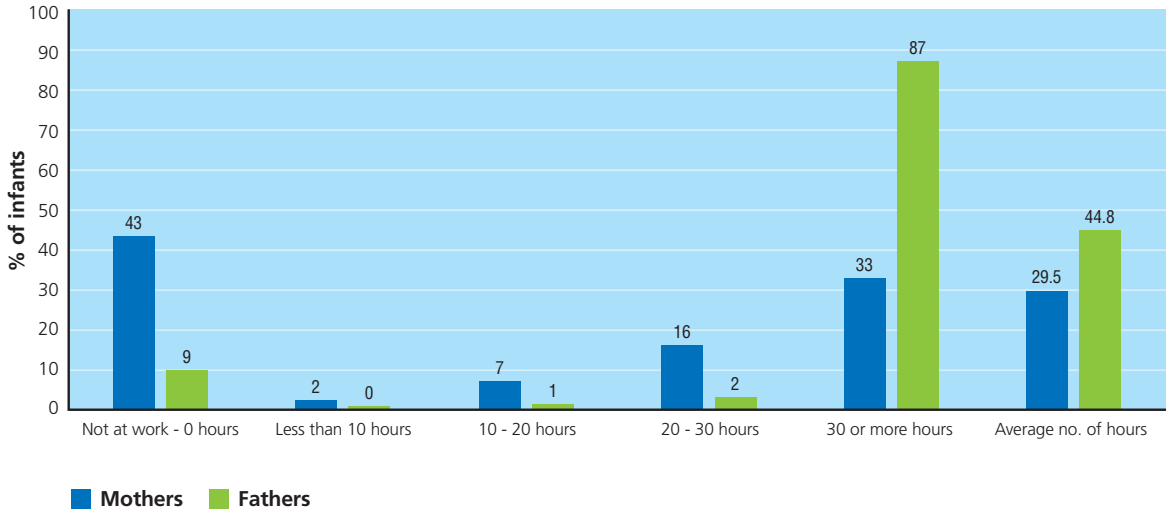
Figure 4 shows that, when asked how they would best describe themselves with regard to employment, almost 57% of mothers and 91% of fathers classified themselves as being principally employed outside the home, while 34% of mothers classified themselves as being involved in 'home duties'. In contrast, only 1.2% of fathers classified themselves in that category.

Figure 4: Principal economic status of mothers and fathers



The number of hours spent in paid employment outside the home will potentially affect, for example, the length of time the infant spends in parental and non-parental childcare, as well as factors such as parental stress and parental work-life balance. Figure 5 shows the breakdown of hours worked in paid employment outside the home by both mothers and fathers. Fathers were more likely to have recorded working longer hours than mothers – just under 45 hours compared to 30 hours respectively. The majority of fathers (87%) reported that they worked 30 or more hours per week in paid employment outside the home compared to one-third (33%) of mothers.

Figure 5: Number of hours worked by mothers and fathers in paid employment



4.4 CITIZENSHIP AND COUNTRY OF BIRTH

A total of 81% of the mothers of infants and 82% of resident fathers were citizens of Ireland. Just over 73% of mothers and 76% of fathers were born in Ireland. Mothers and fathers not born in Ireland are most likely to have been born in Britain, Other Western Europe, Eastern Europe and Africa (Table 1).

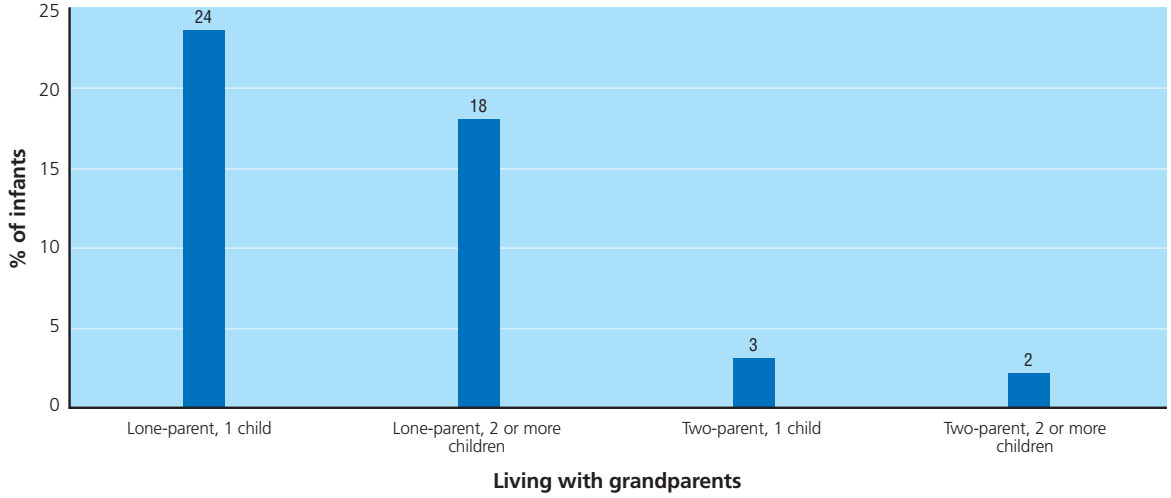
Table 1: Country of birth of mothers and fathers of infants

Country of birth	Mother %	Father %
Ireland	73.5	76.1
Britain	6.5	6.8
Other Western Europe	7.2	6.4
Eastern Europe	4.2	3.1
Africa	3.3	2.8
Rest of World	5.2	4.8
Total	**100.0**	**100.0**

4.5 LIVING WITH GRANDPARENTS

Overall, 5% of infants lived in households in which there was a resident grandparent. This percentage varied greatly across family types. Infants in lone-parent families were much more likely to live with a grandparent than those in two-parent families – Figure 6.

Figure 6: Percentage of infants living with grandparents classified by family type

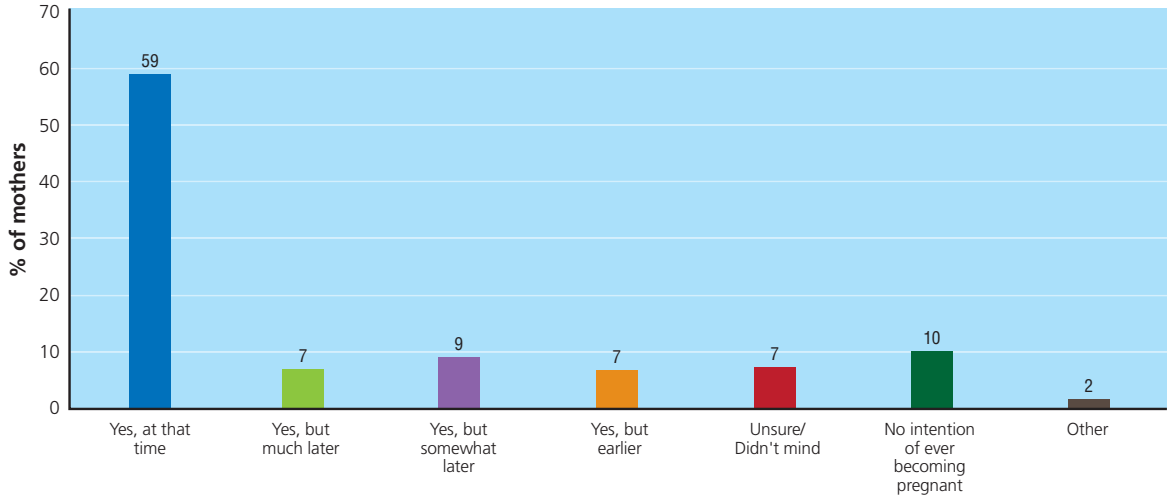


5. PREGNANCY AND BIRTH

5.1 INTENTION TO GET PREGNANT

Over half of mothers (59%) reported that they had intended to become pregnant when they did with the Study Child; 23% had intended to become pregnant at some other time, and 7% were unsure or didn't mind. A total of 10% reported that when they became pregnant they had no intention of ever becoming pregnant (Figure 7).

Figure 7: Intentions regarding pregnancy with the Study Infant



5.2 PROVISION OF ANTENATAL CARE

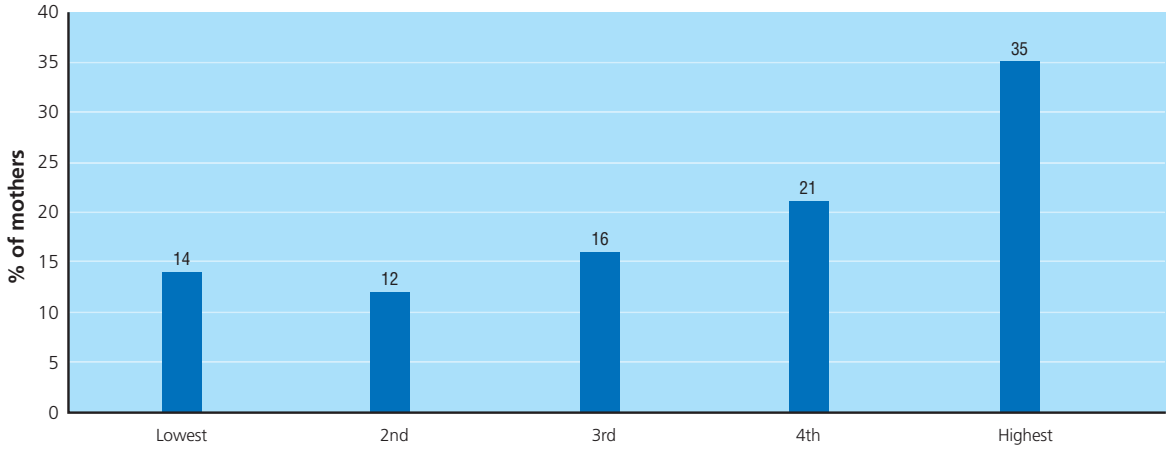
On becoming aware of her pregnancy, the mother's first antenatal appointment was usually with her family doctor (67%), at an average of 9.1 weeks into the pregnancy. Single mothers had their first antenatal appointment later than mothers in two-parent families with a similar number of children, as shown in Table 2.

Table 2: Number of weeks' pregnancy when mother had her first antenatal appointment classified by family type

Family Type	Mean weeks
Lone-parent, 1 child	10.3
Lone-parent, 2 or more children	10.3
Two-parent, 1 child	8.5
Two-parent, 2 or more children	9.3

The most common form of antenatal care during the pregnancy was shared care between a GP and another professional (78%); 19% of mothers had antenatal care provided only by a private consultant (12%) or by a hospital clinic (7%). Figure 8 shows that mothers in the highest income quintile were much more likely to have had care provided only by a private consultant or hospital clinic (35%) than any of the other income groups.

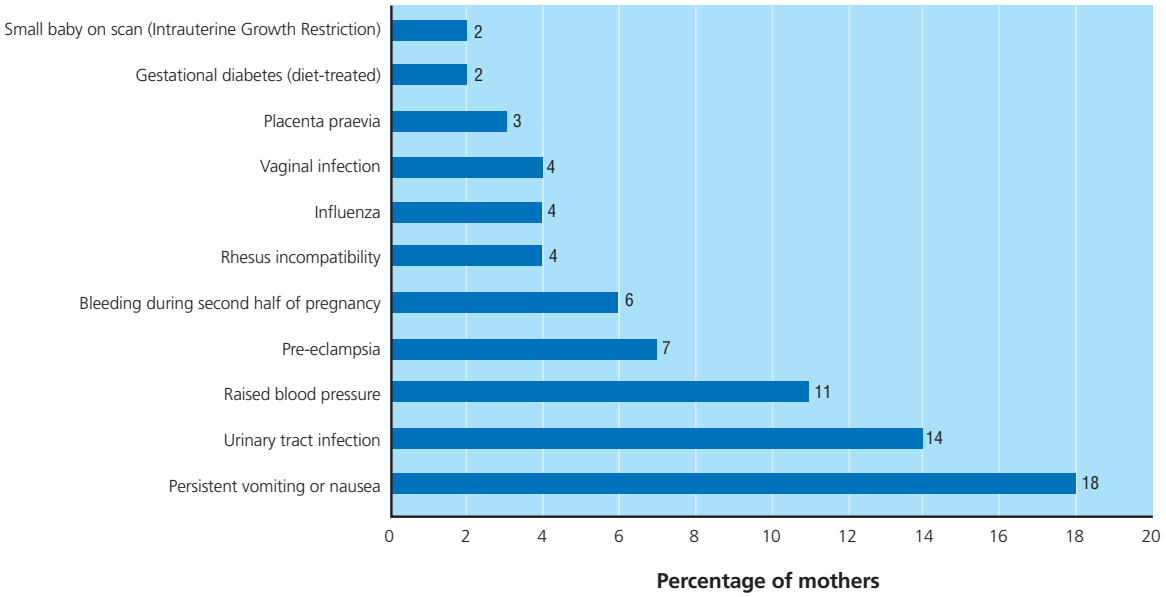
Figure 8: Use of private consultant or hospital clinic only for antenatal care classified by income



5.3 COMPLICATIONS IN PREGNANCY

Complications in pregnancy were relatively common. Just over half of all mothers (54%) reported at least one complication such as those listed in Figure 9. The most frequently reported pregnancy complications were persistent vomiting and nausea (18% of all mothers) and urinary tract infection (14% of all mothers).

Figure 9: Incidence of pregnancy complications



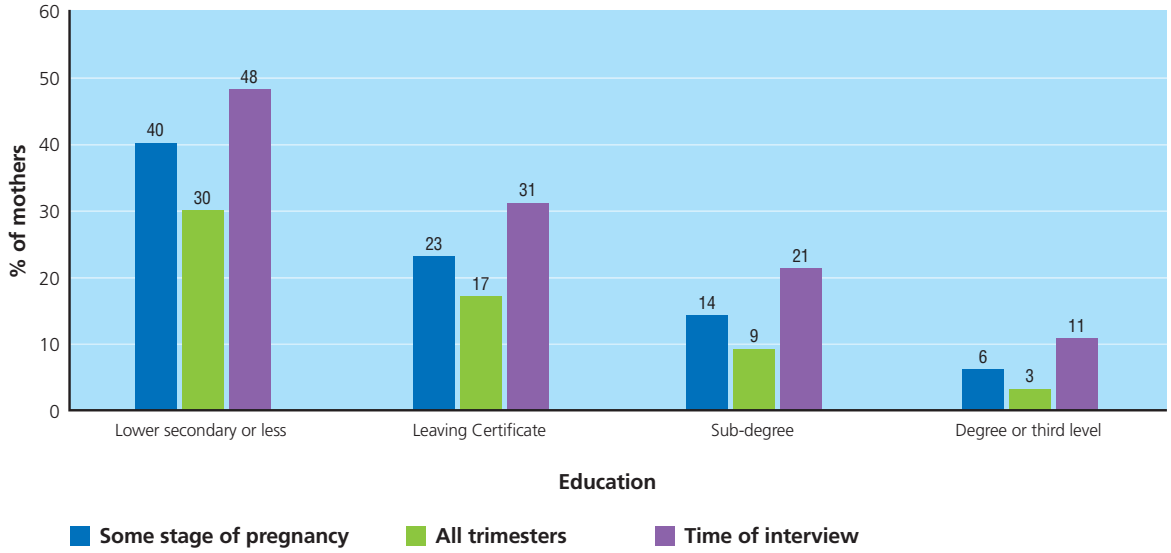
5.4 SMOKING AND DRINKING IN PREGNANCY

Most mothers refrained from smoking or drinking during their pregnancies. The data suggests that smokers may find it more difficult to give up cigarettes than drinkers find it to abstain from alcohol.

5.4.1 Smoking

In ***Growing Up in Ireland***, 18% of mothers said they had smoked at least at some stage during their pregnancy and 13% (in total) smoked in all three trimesters. Mothers born in Ireland had higher rates of smoking in pregnancy (20%) than those born in other countries (13%). Mothers with lower levels of education were the most likely to have smoked at some stage in pregnancy. For example, 40% of mothers who left education at lower secondary level or less reported that they smoked at some stage in pregnancy. This compares with 6% among graduates – Figure 10.

Figure 10: Smoking (a) at any stage in pregnancy, (b) in all three trimesters, and (c) at time of interview when infant was aged nine months



Note: Mothers who smoked in all trimesters are a subset of those who smoked at any stage

While mothers from lower educational groups were more likely to be smokers anyway (Figure 10), it appears that even among fellow smokers they were also less likely to have avoided cigarettes in pregnancy. Table 3 shows that, of mothers who were smoking at the time of interview (when their infant was aged nine months), 78% of those in the lowest educational categories had also smoked at some stage in their pregnancy and 62% had smoked in all three trimesters. In contrast, only 38% of the highest-educated smokers had smoked at any stage in pregnancy and just 24% had smoked in all three trimesters.

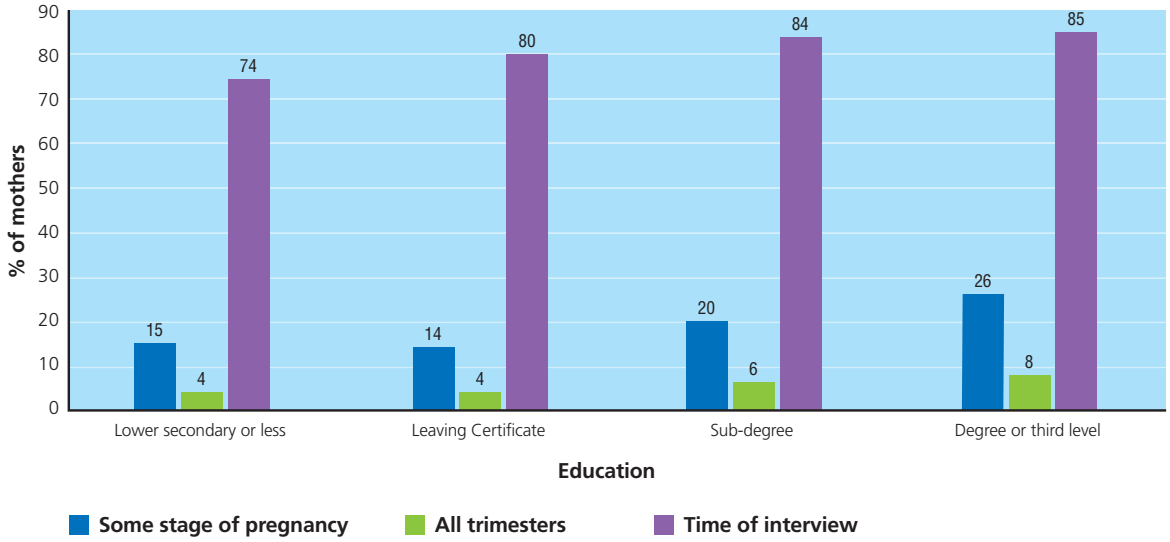
Table 3: Percentage of mothers smoking at time of interview who also smoked at some stage of pregnancy and who smoked in all three trimesters classified by maternal education

Mother's education	Mothers smoking at time of interview (current smokers) %	Current smokers who smoked at some stage during pregnancy %	Current smokers who smoked in all three trimesters %
Lower secondary or less	48	78	62
Leaving Cert	31	65	50
Sub-degree	21	55	40
Degree	11	38	24

5.4.2 Drinking alcohol

In ***Growing Up in Ireland***, 20% of mothers had consumed alcohol at some stage in the pregnancy but only 6% (in total) had taken alcohol in all three trimesters. The trends for the consumption of alcohol in relation to socio-demographic variables differ from those observed for smoking. Drinking alcohol at some stage in pregnancy was, for example, highest for mothers with degree-level education (26%). Figure 11 shows that mothers with the highest education were more likely to drink at any stage of pregnancy, in all three trimesters, and at the time of interview than their peers with the lowest education.

Figure 11: Drinking alcohol (a) at any stage in pregnancy, (b) in all three trimesters, and (c) at time of interview when infant was aged nine months



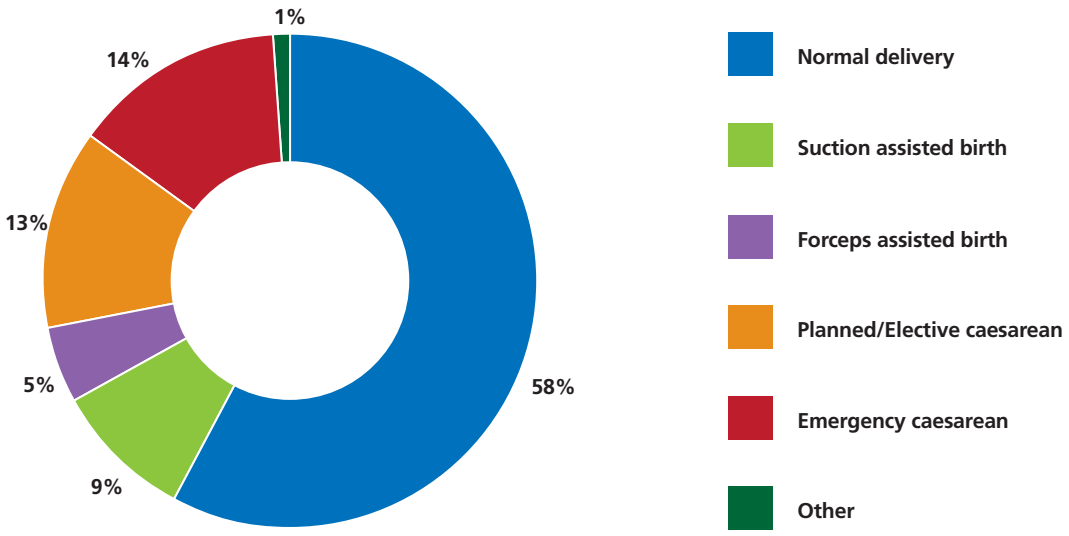
Note: Mothers who drank in all trimesters are a subset of those who drank at any stage

5.5 BIRTH AND DELIVERY

The majority of ***Growing Up in Ireland*** infants were born on time (82%), which is between 37 and 41 weeks' gestation. A small percentage of infants (1%) were born very early at 32 weeks or earlier, and an additional 5% were born between 37 and 41 weeks. Of the 12% of late births, the vast majority were in the 42nd week. Nearly all infants were born in hospital (98%). Only 1% were born in a planned home birth (the remainder were mostly unplanned home births or births on the way to hospital).

While Figure 12 shows that a majority of infants (58%) were born in a normal vaginal delivery, a substantial minority of mothers (41%) experienced some medical assistance in giving birth, such as the use of forceps or caesarean section.

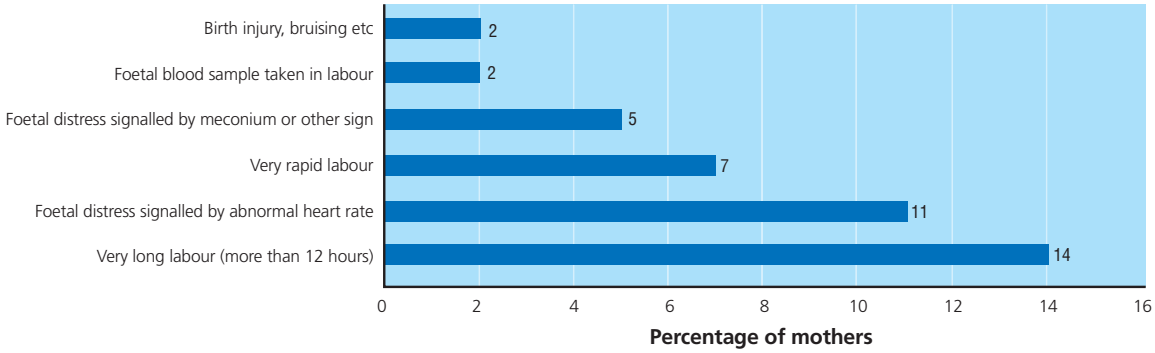
Figure 12: Final delivery method



5.6 BIRTH COMPLICATIONS

A majority of mothers (62%) reported no complications during the birth. The most commonly reported complication was a very long labour (exceeding 12 hours) which was experienced by 14% of all mothers – Figure 13. The next most frequent complication was foetal distress as indicated by an abnormal heart rate (11%).

Figure 13: Birth complications (as a percentage of all births)



5.7 BIRTH WEIGHT

The average infant weighed 3.47 kgs at birth according to mother's report. Boys weighed slightly more at birth than girls (mean of 3.53 kgs versus 3.40 kgs). Mothers with the least education gave birth to infants that were lighter (3.37 kgs) than infants born to more highly educated mothers (for example, 3.52 kgs for graduate mothers).

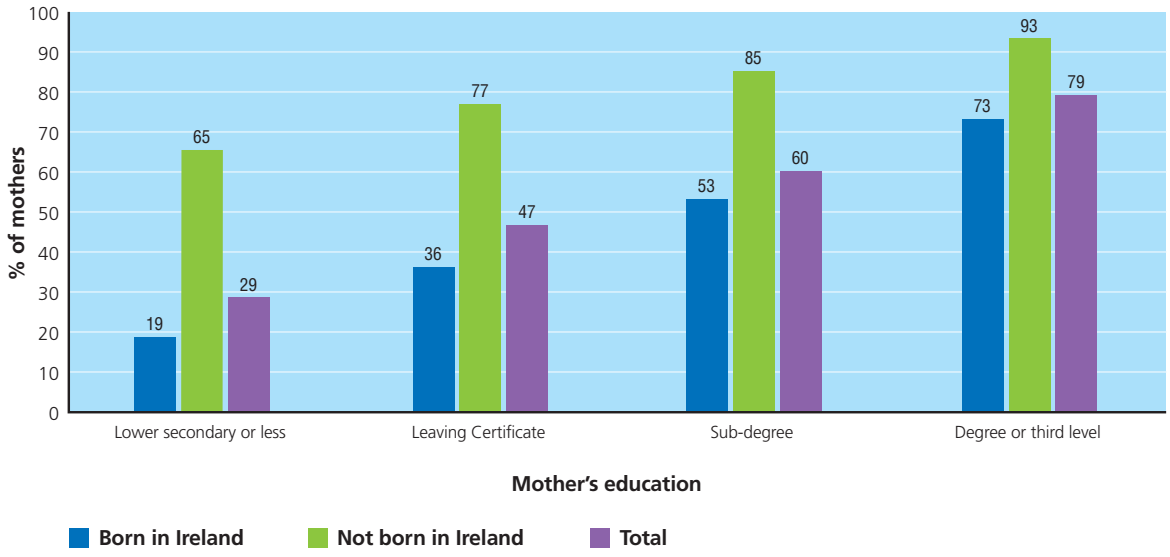
Just over 5% of ***Growing Up in Ireland*** infants were classified as low birth weight (defined as less than 2.5 kgs).

5.8 BREASTFEEDING

A total of 57% of infants in ***Growing Up in Ireland*** were ever breastfed and 49% (in total) were still being breastfed by the time they left hospital. By the time of interview at age nine months, the mean duration of breastfeeding, for those who had ever breastfed but had since stopped, was 12 weeks and ranged between just one day and nine months. At the time of interview, 9% of infants were still being partially breastfed, and an additional 2% were still being exclusively breastfed.

Mothers who were not born in Ireland (who made up 27% of all mothers) were much more likely to breastfeed their infants than Irish-born mothers: 83% compared to 48%. For both Irish-born and non-Irish-born mothers, breastfeeding was less likely among those with the lowest education, as shown in Figure 14.

Figure 14: Ever breastfed classified by mother's education and whether or not she was born in Ireland

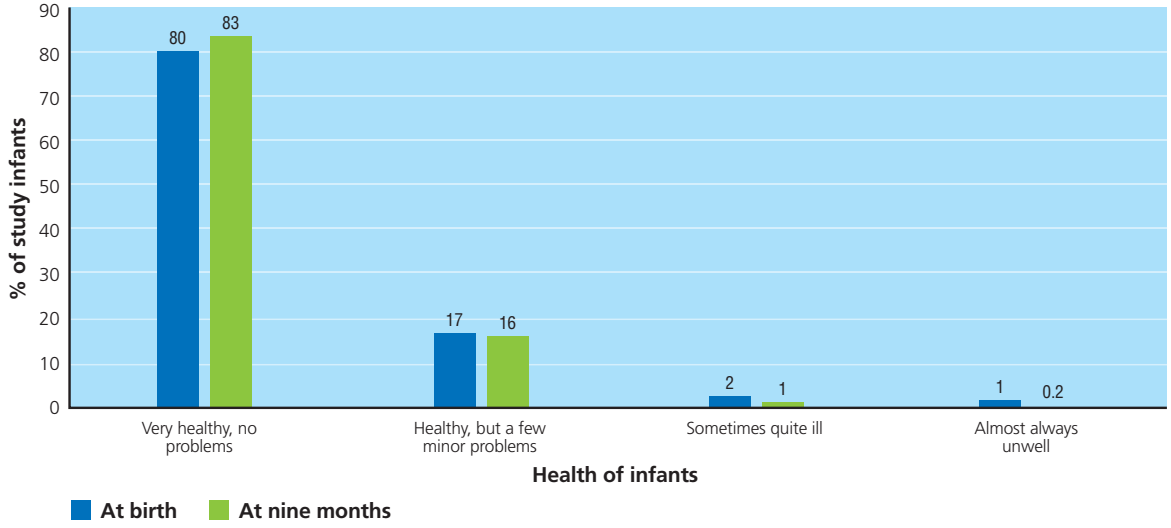


6. CHILD'S HEALTH

6.1 MOTHER'S PERCEPTION OF INFANT'S HEALTH AT BIRTH AND AT NINE MONTHS

Mothers were asked to rate their infant's health at birth and also at the time of interview as: *very healthy with no problems; healthy but with a few minor problems; sometimes quite ill;* or *almost always unwell.* Most mothers reported their infant's health at birth to be either *very healthy* (80%) or *healthy with a few minor problems* (17%) (Figure 15). Similarly high levels of good health were reported for the infants at nine months – 83% *very healthy* and 16% *healthy with a few minor problems.*

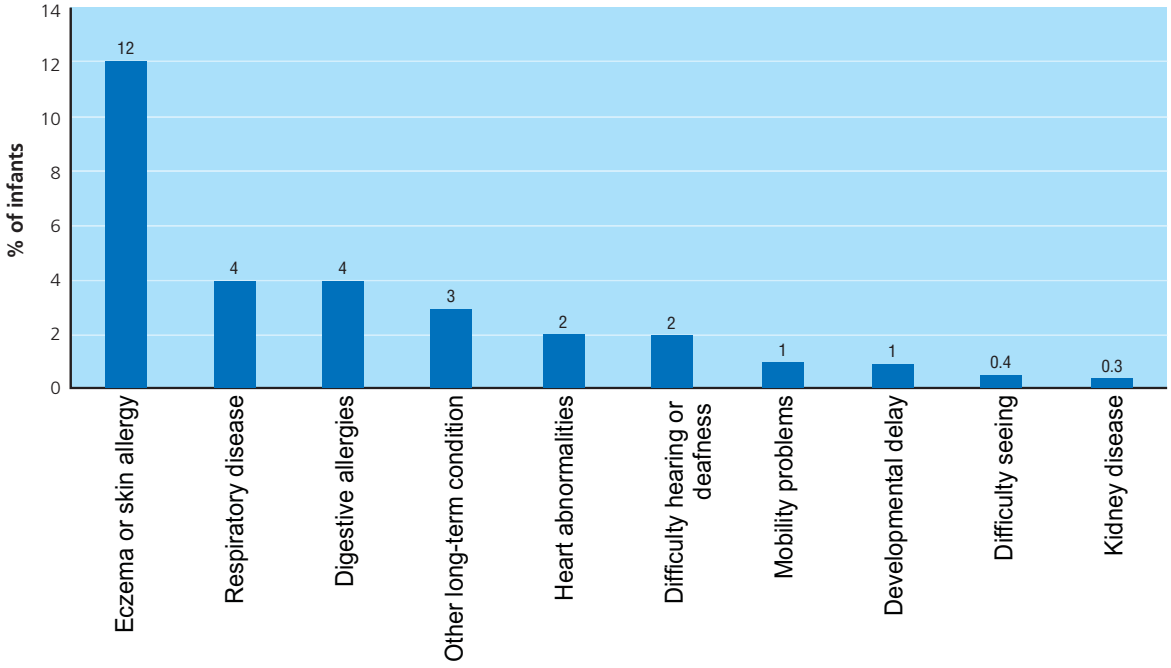
Figure 15: Mother's perception of infant's health at birth and at nine months



6.2 INFANT ILLNESS AND DISABILITY

Mothers were asked to record whether or not their infant had ever received a medical diagnosis of any illness from a pre-coded list. Just under one-quarter (24%) of infants were reported as having had at least one of the listed illnesses at some time. By far the most common illness among infants in ***Growing Up in Ireland*** was eczema or skin allergy (12% of Study children). This was followed by respiratory disease including asthma (4%), digestive allergies (4%) and other long-term conditions (3%). The 10 most common illnesses for infants as reported by their mother are shown in Figure 16.

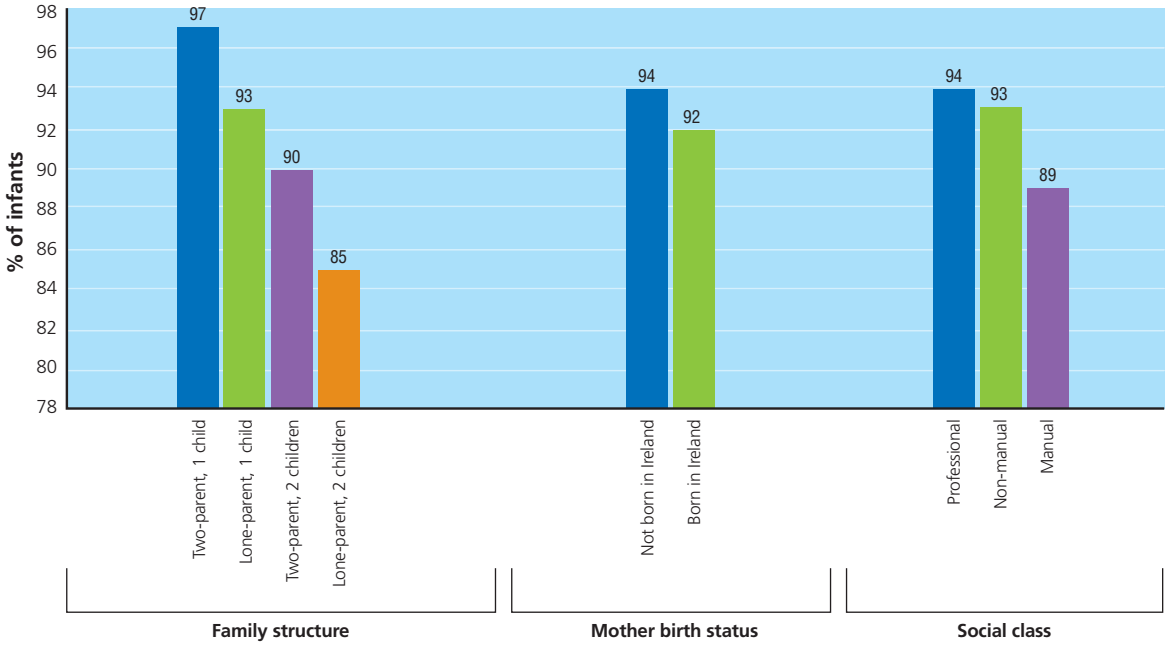
Figure 16: Most common illnesses for infants as reported by mothers



6.3 IMMUNISATION

Almost all nine-month-old infants had had their first six-week check-up (99%) and subsequent vaccinations at two (99%) and four (98%) months of age. The uptake of vaccinations for infants at six months was lower, however, at 92%. Vaccination uptake at six months varied significantly by family structure, social class and whether or not the infant's mother was Irish-born (Figure 17).

Figure 17: Percentage of infants who had received their six-month vaccination classified by family structure, whether or not mother was born in Ireland and family social class



7. INFANTS' ROUTINES AND DEVELOPMENTAL STATUS

7.1 SLEEP

By the age of nine months, ***Growing Up in Ireland*** infants were typically getting 10.5 hours of sleep per night, although the majority were still waking at night, at least *occasionally*. The most popular time for infants to go to sleep for the night was 8pm (25%), and for waking up it was 7am (28%). Table 4 summarises the pattern for going to bed and getting up.

Table 4: Distribution of usual times for infants to get up and go to sleep for the night

Getting up		Going to sleep	
7am or earlier	43%	7pm or earlier	13%
Between 7.01am and 9am	53%	Between 7.01pm and 9pm	71%
After 9am	4%	After 9pm	16%

The infant's sleeping pattern (or habits) was a *large* or *moderate* problem for 11% of parents and a *small* problem for a further 19%. Of those mothers who reported sleep patterns to be a problem, 12% had consulted a doctor or pharmacist about it.

Just over half of ***Growing Up in Ireland*** infants (52%) slept in their parents' room. Most of the remainder slept in a room on their own (42%). The vast majority spent most of the night in their own bed or cot (87%), while 11% usually slept in their parents' bed.

Current advice to parents is to put infants to sleep on their backs (supine position), as this position is associated with a lower risk of Sudden Infant Death Syndrome. A majority of mothers in ***Growing Up in Ireland*** (76%) normally put their baby down to sleep on his/her back. More Irish-born mothers used the supine position (81%) than mothers born in other countries (61%).

7.2 SOLID FOOD

Nearly all infants (98%) were taking solid food on a regular basis by the age of nine months. The mean age for starting solids was 19 weeks.

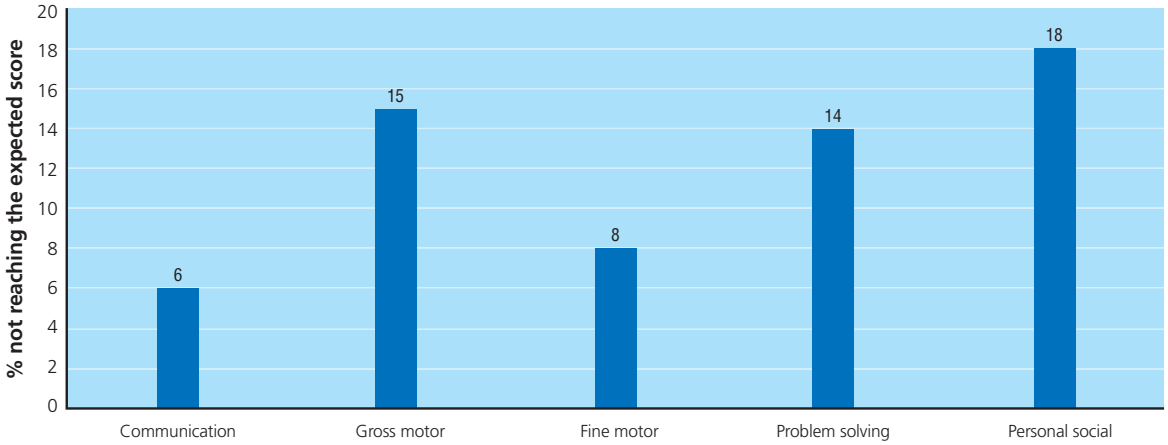
7.3 DEVELOPMENTAL STATUS

The infant's developmental status was reported by mothers using the Ages and Stages Questionnaire.[1] This measures whether or not the child has reached various milestones under the headings of:

- **Communications** – showing some understanding of basic commands from parents and making their first efforts to engage in communications
- **Gross motor** – being able to stand up, sit up and move around with support
- **Fine motor** – being able to use fingers and thumbs to manipulate small objects
- **Problem solving** – showing curiosity in and some rudimentary understanding of how the world around them works
- **Personal social** – being able to perform some basic self-care tasks such as feeding and showing cooperation when, for example, being dressed

Infants are given scores based on how many milestones they have achieved. Figure 18 shows the percentage of nine-month-olds who failed to reach the target score for each skill expected of infants aged 10 months.[2]

Figure 18: Percentage of infants failing to meet the target score expected of 10-month olds for individual developmental areas measured by the ASQ



[1] This is a standardised measure of development.
[2] The ASQ 2, as used in ***Growing Up in Ireland***, is divided into two-monthly interval questionnaires at the infant stage. The 10-month questionnaire was used for reference in ***Growing Up in Ireland***, as infants had already passed their nine-month birthday.

Personal-social skills had the highest failure rate; 18% of infants had not reached the expected target score. In contrast, communication was the area in which infants were doing best – only 6% failed to reach the target score.

A total of 14% of infants failed to reach the target score on two or more skills, possibly indicating a risk of a more general developmental delay. Some groups of infants were more likely to 'fail' two or more skills than others – boys (16%) were more likely than girls (13%); infants who had a low birth weight (27%) compared to those who had normal birth weight (14%); and twins or triplets (35%) compared to single-birth infants (14%).

8. CHILDCARE

8.1 PARENTAL AND NON-PARENTAL CARE

A total of 38% of infants were in some form of regular non-parental childcare. Table 5 summarises details on the main type of childcare used.

Table 5: Main type of childcare used

Main type of childcare used	% of infants
Parental care	62
A relative in your home	6
A non-relative in your home	3
A relative in their home	10
A non-relative in their home	8
Centre-based caregiver	11
Total	**100**

After parental care, the most common form of childcare used with infants involved a relative – 10% in the relative's home, 6% in the infant's home. Non-relatives provided childcare in respect of 11% of infants, while centre-based care accounted for the same percentage of children. Table 6 shows that grandparents are the main source of non-parental care, accounting for the care of some 12% of infants.

Table 6: Breakdown of main type of childcare provision to the Study Child

		%
	Parental care	62
Relative	Grandparent of Study Child	12
	Aunt/uncle of Study Child	3
	Other relative of Study Child	1
Non-relative	Au pair/nanny	1
	Friend	2
	Neighbour	1
	Registered childminder	2
	Unregistered childminder	5
Centre-based	Work-based creche	1
	Other creche/nursery/Montessori/playschool	10
	Total	100

8.2 DURATION AND COST OF NON-PARENTAL CHILDCARE

Across all main types of non-parental care, infants spent an average of 25 hours per week in childcare at an average cost of just over €5.14 per hour among those in some form of paid childcare. Table 7 shows the average number of hours spent and cost per hour for each of the main types. Hourly cost went from a low of €4.30 for paid relatives to €5.48 for centre-based caregivers.

Table 7: Hours, cost and age of baby classified by main type of non-parental childcare used

	Mean hours per week	Mean cost per hour	Mean age of infant when main childcare arrangement started
	Hours	€	Months
Unpaid relative	19.4	n.a.	5.8
Paid relative	26.3	4.30	6.7
Childminder/aupair/nanny	24.7	5.34	6.5
Centre-based caregiver	29.2	5.48	6.9
Total	**25.1**	**5.14**	**6.5**

8.3 IMPACT OF CHILDCARE NEEDS ON OTHER ASPECTS OF MOTHER'S LIFE

Mothers were asked to record whether or not difficulties in arranging childcare had any effect on other work or non-work aspects of their life. Table 8 shows, for example, that 31% of mothers recorded that difficulties in arranging childcare had prevented them from engaging in social activities; 21% reported that such difficulties had restricted the hours they could work or study.

Table 8: Percentage of mothers who reported that difficulties in arranging childcare had affected various aspects of their lives.[3]

Pre-specified area affected by difficulty in arranging childcare	%
No effect on any of pre-specified areas	47
Prevented you looking for a job	8
Made you turn down or leave a job	7
Stopped you from taking some study or training	8
Made you leave a study or training course	3
Restricted the hours you could work or study	21
Prevented you from engaging in social activities	31
Other (please specify)	2

[3] Note that the figures add to more than 100% as mothers could tick as many options as applied.

9. PARENTING AND SUPPORT

9.1 INTRODUCTION

The family is often regarded as being the primary and most fundamental social system influencing a child's development and learning. Within the family, parents typically have a central role in influencing the nature and the quality of their children's lives.

9.2 PARENT-CHILD ATTACHMENT

Attachment represents the deep and enduring bond between children and their parents. It provides the early foundation for a child's sense of security and is seen as a key contributor to socio-emotional growth and development in the infant to toddler period.

The Quality of Attachment subscale from the Maternal Postnatal Attachment Scale was administered to mothers to assess their emotional attachment to the child.[4] It includes questions about how mothers feel in their interactions with the infant in a parenting role (competent, tense, patient) as well as their feelings towards the infant (pride, affection, enjoyment). These items were used to calculate a total Quality of Attachment score.

Mothers tended to rate all items very positively, although it may be of interest to note that 24% felt "slightly guilty that I am not more involved" and a further 7% felt moderately or very guilty about their level of involvement. While 78% "almost never" felt tense and anxious when with the Study Infant, 21% reported feeling this way "occasionally". Overall, however, very high levels of attachment were reported. The mean score was 42.5 out of a possible 45.

Fathers were asked to complete a shorter set of questions about their attachment to the infant.[5] Again, overall attachment levels were very high, with a mean score of 24.1 out of a possible 25. Little differentiation was evident across the socio-demographic groupings.

9.3 PARENTAL STRESS

Parental stress was measured using the Parental Stress Scale (Berry and Jones, 1995).[6] Parents were asked to record their level of disagreement or otherwise with each of 18 questions which make up the scale.

In general, both parents reported reasonably low levels of stress on the total stress score: mothers scored a mean of 32.2 and fathers a mean of 30.8 (out of a maximum of 90). Stress levels of both parents were related to income and other measures of advantage/disadvantage, being higher for more disadvantaged groups. In addition, stress among mothers was related to family type, being higher in single- than two-parent families.

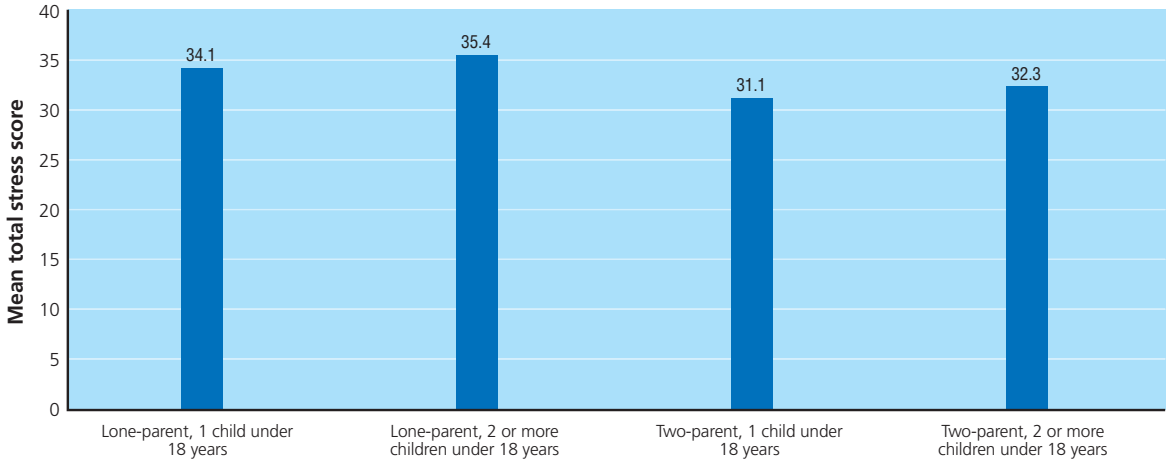
Further, mothers with two or more children (in both single-parent and two-parent families) had higher levels of stress than those with one child. Mothers in two-parent families with one child had a mean total stress score of 31.1 and those with two or more children had a score of 32.2. This score rose to 34.1 for lone parents with one child and rose again to 35.4 for those with two or more children (Figure 19).

[4] The nine-item Quality of Attachment subscale from the Maternal Postnatal Attachment Scale (Condon & Corkindale, 1998). Condon, J.T. and Corkindale, C.J. (1998). The assessment of parent-to-infant attachment: Development of a self-report questionnaire instrument. *Journal of Reproductive & Infant Psychology*, 16, 1, 57-76.

[5] The five-item Quality of Attachment subscale from the Paternal Postnatal Attachment Scale (Condon & Corkindale, 2008). Condon, J.T., Corkindale, C.J., & Boyce, P. (2008). Assessment of postnatal paternal-infant attachment: Development of a questionnaire instrument. *Journal of Reproductive and Infant Psychology*, 26, 3, 195-210.

[6] Berry, J.O. & Jones, W.N. (1995). The Parental Stress Scale: Initial Psychometric Evidence. *Journal of Social and Personal Relationships,* Vol 12, No. 3, 463-472

Figure 19: Mother's total parental stress score classified by family type



9.4 FATHERS' PARENTING ROLE

Fathers were asked to rate the three most important things that they, as parents, did for their children from a list of six pre-coded options, as outlined in Table 9. "Showing my child love and affection" was considered by fathers to be the most important thing they could do for their child – 69% ranked this as their first priority. Ensuring the protection and safety of the infant was perceived to be the next most important, albeit considerably some way behind, being ranked as the top priority by 22% of fathers. Taking time to play with the Study Infant was also ranked as an important activity (22% said it was the second most important thing and 25% ranked it third).

Table 9: Father's report of the most important things for him to do for his (nine-month-old) child

Most important thing to do for infant	Most Important	2nd most Important	3rd most Important
Showing my child love and affection	69	19	6
Taking time to play with my child	3	22	25
Taking care of my child financially	3	10	19
Giving my child moral and ethical guidance	2	9	14
Making sure my child is safe and protected	22	34	20
Teaching my child and encouraging his or her curiosity	1	6	16

9.5 PARENTING SUPPORT AND CONTACT WITH GRANDPARENTS

Given the significance of the parenting role for the child's development, it is important that parents receive adequate support to carry it out, especially in the transition to parenthood and early infancy (Crnic, Greenberg, Ragozin, Robinson & Basham, 1983).[7]

9.5.1 Perceived support available in bringing up a child

Mothers were asked how they felt about the amount of support or help they got from family or friends living outside their household. In general, perceived levels of supports were high. A total of 72% of mothers said they *got enough help*, 10% that they *did not get enough help* and 5% that they *got no help at all.* Additionally, 6% of mothers said they *did not need any help* and 8% that their family were not living in the country (and therefore were unavailable to provide support).

[7] Crnic, K.A., Greenberg, M.T., Ragozin, A.S., M.N. & Basham, R.B. (1983). Effects of stress and social support on mothers and premature and full term infants. *Child Development*, 54, 209-217

9.5.2 Contact with and support received from infant's grandparents

Grandparents play an important role in children's lives, often providing informal childcare and babysitting while parents return to work outside the home (Hayes & Bradley, 2007).[8] High levels of contact with grandparents were reported in the ***Growing Up in Ireland*** study: 89% of mothers reported being in regular contact with the Study Infant's grandparents. Only 2% were not in regular contact and 1% reported that all grandparents were deceased. A further 8% reported that all the infant's grandparents lived abroad.

Grandparents can potentially offer a range of different types of support. Table 10 indicates that grandparents were most likely to babysit (33% said *weekly or more often*), take the infant out (24%) and help around the house (18%). Grandparents were least likely to help out financially (72% *never* did) and have the infant to stay overnight (62% *never* did). Lone-parent families typically reported much higher levels of support from grandparents, especially in terms of "having the baby to stay overnight" and "helping out financially".

Table 10: Mother's report of support from grandparents

How often do infant's grandparents … ?	Never	Sometimes	Weekly or more
Babysit	19	48	33
Have infant to stay overnight	62	32	6
Take infant out	46	30	24
Buy toys or clothes for infant	4	81	15
Help you around the house	56	26	18
Help you out financially	71	26	3

10. MOTHER'S EMPLOYMENT STATUS

The employment status of both mothers and fathers has a major impact on family life, including influencing attachment, time spent with the child, non-parental childcare, and so on.

10.1 EMPLOYMENT STATUS BEFORE THE BIRTH

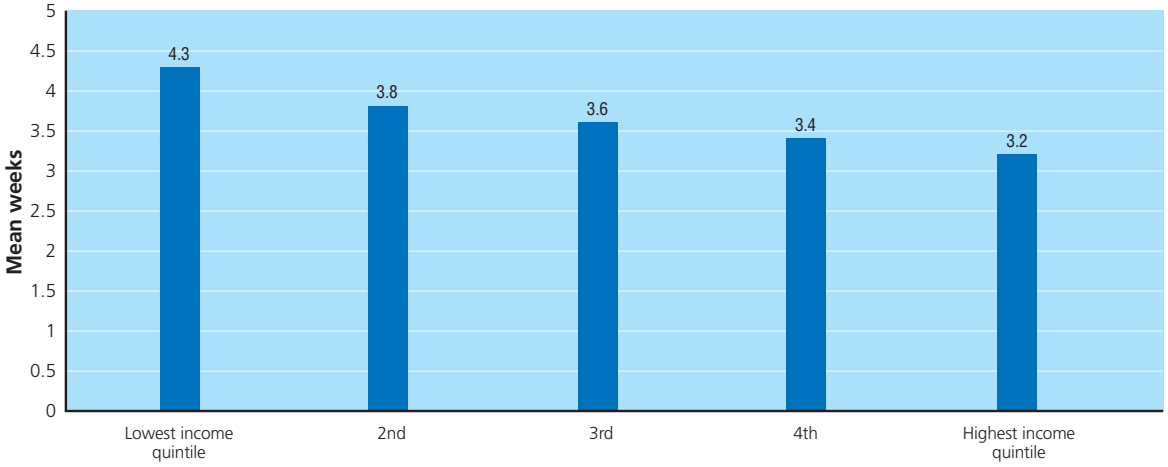
Over three-quarters (76%) of mothers of infants had been working before they became pregnant – 53% full-time and 23% part-time, although this varied substantially with the birth order of children. Mothers of a first-born child were much more likely to have worked outside the home before the birth (75% full-time and 11% part-time) than, for example, those with their fourth-born child (19% full-time and 35% part-time).

10.2 MATERNITY LEAVE

Mothers who were working outside the home before the birth stopped, on average, 3.6 weeks before the child was born. This was strongly related to family income quintile. Figure 20 shows that mothers in the highest income quintile continued working closer to the birth of the infant. Mothers in the lowest income quintile stopped working on average 4.3 weeks before the birth compared to only 3.2 weeks for those in the highest income group.

[8] Hayes, N. & Bradley, S. (2007). The child care question. In B. Fanning & M. Rush (eds.), *Care and Social Change in the Irish Welfare Economy*. Dublin: UCD Press

Figure 20: Mother's report of when she stopped working before the infant's birth, classified by family income quintile



10.3 EMPLOYMENT STATUS AFTER THE BIRTH AND FUTURE WORK INTENTIONS

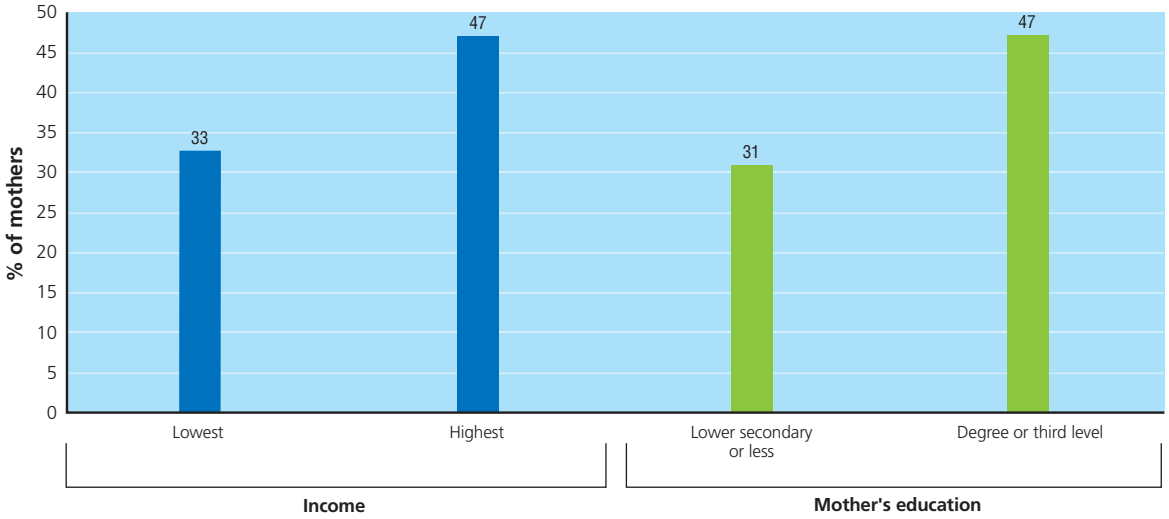
Of those mothers who were working outside the home before the birth, 56% had returned to work by the time the infant was nine months old – 30% full-time and 26% part-time. On average, mothers returned to work when the infant was 6.7 months old. The Study indicates a strong relationship between maternal education and the timing of a mother's return to work outside the home after the birth. More highly educated mothers generally returned to work when the infant was somewhat older. For example, mothers who left education at lower secondary or less returned to work on average when the infant was 5.9 months old, compared with seven months among graduate mothers.

10.4 WORK-LIFE BALANCE

Although the majority of mothers working outside the home felt that their work had not negatively affected their home life, a substantial minority felt that it had. A total of 37% agreed *(strongly agreed* or *agreed)* that they had missed out on family activities which they would have liked to have taken part in, while 30% agreed that their family time was less enjoyable and more pressured as a result of work responsibilities outside the home.

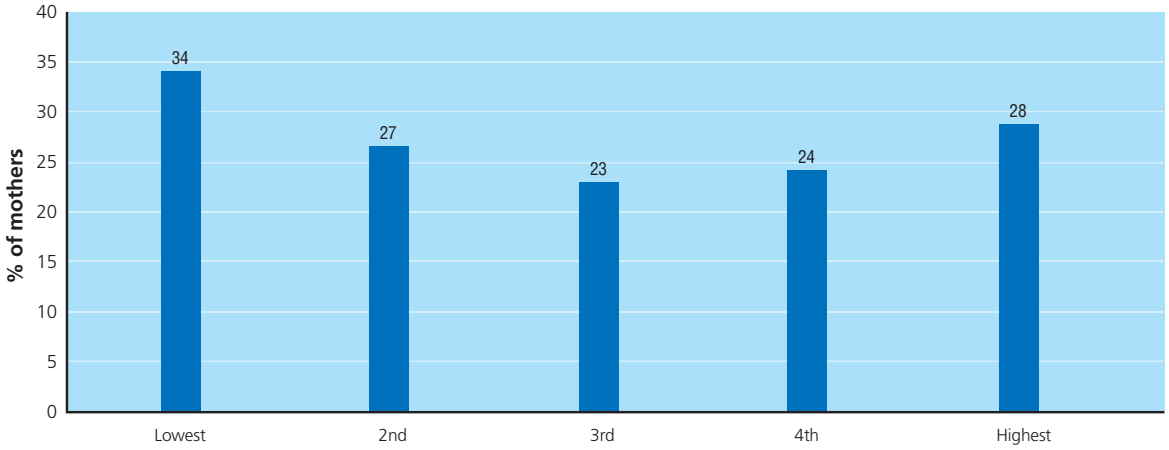
The mother's report on work-life balance/imbalance was clearly related to family income and educational attainment. Figure 21 shows that the percentage who reported that work outside the home had negatively affected family life increased with family income. One-third of mothers (33%) from the lowest family income group reported that they had missed out on home or family activities compared to almost half of mothers (47%) in the highest income quintile. The same trend was apparent with educational attainment.

Figure 21: Mother's report of having missed out on home or family activities, classified by family income quintile and mother's highest level of educational attainment



Overall, mothers of infants were less likely to feel that their family life negatively affected their work life than *vice versa*. A quarter of mothers (25%) agreed that they had to turn down work activities or opportunities they would have preferred to have taken on, and 26% agreed that the time they spent working was less enjoyable and more pressured because of family commitments. Figure 22 shows that those in the lowest income quintile were significantly more likely to have reported having had to turn down work activities (34%) than their counterparts in other income groups – varying from 23% to 28%.

Figure 22: Mother's report of having to turn down work activities or opportunities as a result of family responsibilities, classified by family income quintile



11 NEIGHBOURHOOD

Neighbourhood and community will directly affect the child through their physical conditions, perceived safety and availability of services. Indirect outcomes for the child may result from the impact of the local community on family functioning and parental style. For example, living in a neighbourhood which is perceived by parents to be dangerous may result in changes in parenting style as they attempt to keep their children from falling under undesirable influences.

11.1 QUALITY OF THE NEIGHBOURHOOD ENVIRONMENT

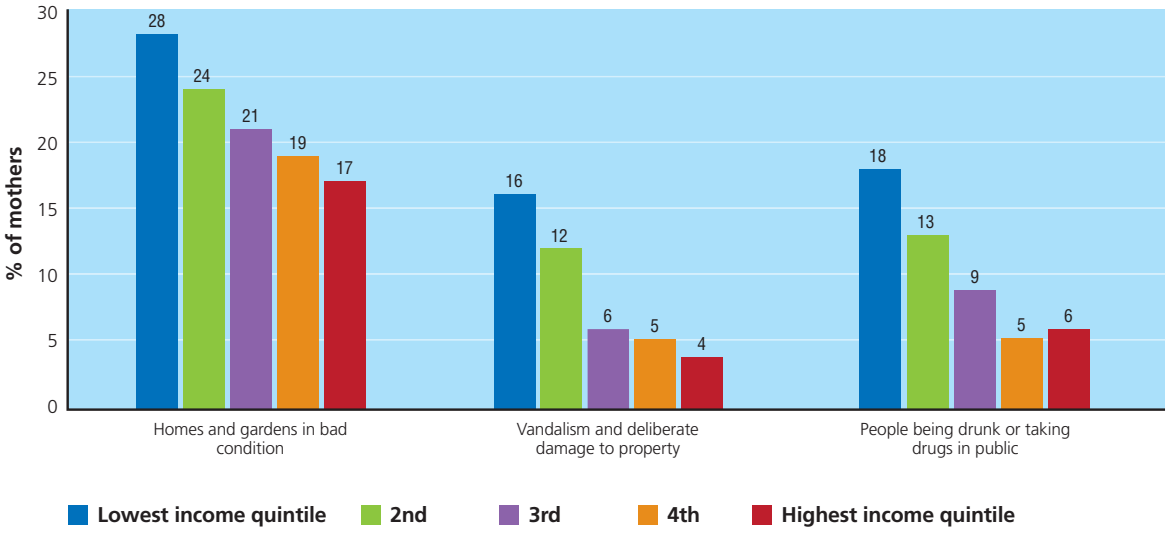
Mothers were asked to rate four items relating to the quality of the neighbourhood in which they lived on a four-point scale from *very common* to *not at all common*. These were:

1. Rubbish and litter lying about
2. Homes and gardens in bad condition
3. Vandalism and deliberate damage to property
4. People being drunk or taking drugs in public.

"Rubbish and litter lying about" appeared to be the most pervasive problem; mothers of 22% of infants reported this as being *very common* or *fairly common* in their local area. This was followed by "vandalism and deliberate damage to property" (11%) and "people being drunk or taking drugs in public" (11%). "Homes and gardens in bad condition" was the least common problem, cited by 9%.

Figure 23 indicates that there was a strong statistical relationship between family income and the last three of the neighbourhood characteristics in question.[9] A total of 28% of mothers in the lowest income group agreed that "homes and gardens being in bad condition" was very or fairly common. This compares with 17% among graduate mothers. These differences were also evident in respect of "vandalism and deliberate damage to property" (16% compared to 4%) and for "people being drunk or taking drugs in public" (18% compared to 6%).

Figure 23: Percentage of mothers rating a number of physical conditions as 'very common' or 'fairly common' classified by family income quintile



[9] As there was no relationship between the perceived prevalence of "rubbish and litter lying about" and family income, this is not shown in Figure 23.

11.2 PERCEIVED SAFETY OF THE NEIGHBOURHOOD

Mothers were asked three questions in relation to their perception of the safety of their local area using a four-point scale from *strongly agree* to *strongly disagree*. The items were:

1. It is safe to walk alone in this area after dark
2. It is safe for children to play outside during the day in this area
3. There are safe parks, playgrounds and play spaces in this area.

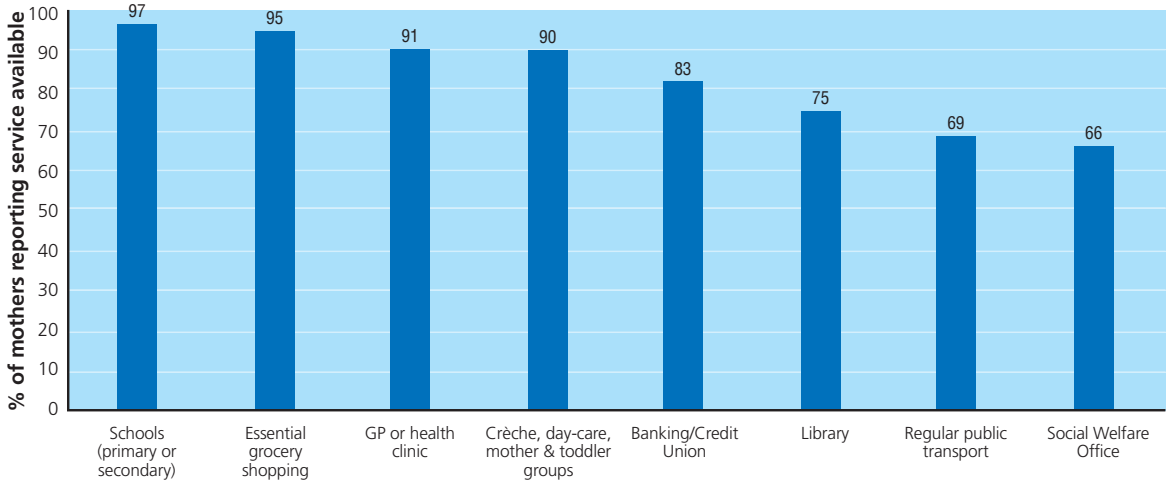
Most agreed that it was safe for children to play outside during the day (86%). Three-quarters (75%) agreed that it was safe to walk alone after dark and 66% agreed that there were safe parks, playgrounds and play spaces in their local area.

11.3 SERVICES IN THE COMMUNITY

Access to community and neighbourhood resources such as medical facilities, schools, parks, public transport, banking facilities, and so on can have an impact on infant and family outcomes and wellbeing (Garbarino & Kostelny, 1993).[10] The availability of eight specific services was considered.

As is clear from Figure 24, most services were reported as being accessible by the majority of mothers. Almost all mothers (97%) reported that schools were available in the local area. Essential grocery shopping, GP or health clinic, crèche, daycare, mother and toddler groups, and banking/credit unions were also reported as being available to large majorities of infants (95%, 91%, 90% and 83% respectively). Libraries, regular public transport, and Social Welfare offices were reported as being available to between approximately two-thirds and three-quarters of mothers of infants (75%, 69% and 66% respectively).

Figure 24: Percentage of mothers recording that specified services were available in their local area



12. SUMMARY

This report summarises a broad range of outcomes, characteristics and attributes of the infant at nine months of age. In general, infants in Ireland have quite positive outcomes, though there is evidence of social gradients in many areas. Many of these variations illustrate areas in which the main policy challenges of the future lie, to ensure that all children in Ireland have as positive a childhood as possible. This descriptive report provides only an initial look at the lives of infants. The wealth of information collected in ***Growing Up in Ireland*** will allow much more intensive, multivariate analysis to be undertaken to tease out the critical factors related to child outcomes and development.

[10] Gabarino, U. & Kostelny, K. (1993). Neighbourhood and community influences on parenting. In Luster, T. & Okagaki, L. (eds.) *Parenting: An Ecological Perspective* (pp. 203 - 226). Hillsdale, NJ: Laurance Erlbaum Associates.

Growing Up in Ireland
National Longitudinal Study of Children

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