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Intelligence and socioeconomic position in childhood in relation to frailty and cumulative allostatic load in later life: the Lothian Birth Cohort 1936

Catharine R Gale,¹,² Tom Booth,¹ John M Starr,¹,³ Ian J Deary¹

ABSTRACT

Background Information on childhood determinants of frailty or allostatic load in later life is sparse. We investigated whether lower intelligence and greater socioeconomic disadvantage in childhood increased the risk of frailty and higher allostatic load, and explored the mediating roles of adult socioeconomic position, educational attainment and health behaviours.

Methods Participants were 876 members of the Lothian Birth Cohort 1936 whose intelligence was assessed at age 11. At age 70, frailty was assessed using the Fried criteria. Measurements were made of fibrinogen, triglyceride, total and high-density lipoprotein cholesterol, albumin, glycated haemoglobin, C reactive protein, body mass index and blood pressure, from which an allostatic load score was calculated.

Results In sex-adjusted analyses, lower intelligence and lower social class in childhood were associated with an increased risk of frailty: relative risks (95% CIs) were 1.57 (1.21 to 2.03) for a SD decrease in intelligence and 1.48 (1.12 to 1.96) for a category decrease in social class. In the fully adjusted model, these associations ceased to be significant: relative risks were 1.13 (0.83 to 1.54) and 1.19 (0.86 to 1.61), respectively. Educational attainment had a significant mediating effect. Lower childhood intelligence in childhood, but not social class, was associated with higher allostatic load. The sex-adjusted coefficient for allostatic load for a SD decrease in intelligence was 0.10 (0.07 to 0.14). In the fully adjusted model, this association was attenuated but remained significant (0.05 (0.01 to 0.09).

Conclusions Further research will need to investigate the mechanisms whereby lower childhood intelligence is linked to higher allostatic load in later life.

INTRODUCTION

Frailty is a syndrome of decreased reserve and increased vulnerability to stressors due to age-related impairments in multiple, inter-related systems and a decline in the ability to maintain homeostasis which increases the risk of adverse outcomes.¹ ² The causes of frailty are likely to involve biological and psychosocial mechanisms.³ If frailty is a consequence of cumulative decline in multiple physiological systems,⁴ clues to its aetiology might come from studying determinants of frailty decades before its onset.

Evidence on childhood determinants of frailty is sparse. In Latin America, greater socioeconomic deprivation in childhood was associated with an increased likelihood of frailty.⁵ In France, poorer living standards in childhood were linked with greater frailty, but not independently of markers of socioeconomic position later in life.⁶ Whether childhood socioeconomic inequalities are predictive of frailty in other populations is unknown.

Another childhood factor that might influence frailty risk is intelligence. Higher childhood intelligence has been frequently associated with reduced mortality and morbidity in adult life.⁶ ⁷ These associations do not appear to be confounded by parental socioeconomic position,⁶ ⁷ though childhood intelligence might be acting as a proxy for other aspects of the early social environment not well captured by social class. Various, non-exclusive, mechanisms may underlie these associations, including disease prevention, healthier behaviour, adult socioeconomic advantage, reduced risk of mental disorder and ‘system integrity’—that is, a better functioning brain might indicate a body whose systems act more efficiently.⁸ ⁹ Some of these same mechanisms could link intelligence in childhood with risk of frailty in later life: several risk factors for frailty—such as smoking,¹⁰ obesity,¹¹ adult socioeconomic deprivation,¹² lower educational attainment—¹³—have been associated with lower childhood intelligence.¹⁴–¹⁷ Another possible pathway might be via stress regulation. Cognitive function is thought to influence stress perception,¹⁸ and the efficacy with which individuals cope with stressors, whether in childhood¹⁹ or later life.²⁰ This might affect health via neuroendocrine or other physiological mechanisms.²¹

Allostasis refers to the temporary adjustments that take place in physiological systems to maintain stability in the face of fluctuation in environmental demands.²² Such adaptations are protective in the short term, but in the long term, repeated episodes of allostasis together with inefficient activation or turning off of physiological responses means that the body experiences ‘wear and tear’ of all major regulatory systems which increases the risk of morbidity or death.²³ ²⁴ Allostatic load has been conceptualised as a measure of this cumulative biological dysregulation or wear and tear across regulatory systems.²³ ²⁴ The concept of allostatic load differs from that of frailty, in that it has been applied in studies of people from childhood upwards, rather than just in older populations, but it shares considerable theoretical overlap with frailty, in that cumulative decline in multiple physiological systems is thought to underlie the clinical presentation of this syndrome.²
There have been few investigations of the links between allo-
static load and frailty, but one longitudinal study found that 
higher allostatic load was associated with an increased risk of 
incident frailty, suggesting that dysregulation in multiple 
physiological systems may provide a biological warning of frailty.25 
Childhood circumstances or characteristics may have a long-
lasing influence on the regulation of physiological systems. In 
children, allostatic load increases with greater exposure to socio-
economic disadvantage.26 The impact on allostatic load of such 
exposure may still be apparent in adulthood.27 Prolonged expo-
sure to socioeconomic disadvantage later in life has also been 
linked with higher allostatic load.25 Lower intelligence in child-
hood has been linked with contributors to higher allostatic load 
in adult life, such as higher blood pressure,28 body mass index 
(BMI),29 and concentrations of triglycerides,29 glucose,29 
inflammatory and haemostatic factors.30 A recent study reported 
an association between lower childhood intelligence and higher 
allostatic load at age 73.31 Childhood intelligence may be linked 
to later life allostatic load via the same potential mechanisms 
specified above in the case of frailty.

We investigated the hypotheses that older people who as chil-
dren had lower intelligence or were exposed to greater socio-
economic disadvantage would be at greater risk of frailty and 
have higher allostatic load. We regarded adult social class, edu-
cational attainment and health behaviours as potential mediators 
of any association. Lower intelligence and socioeconomic disad-
avantage in childhood are consistently associated with lower edu-
cational attainment and socioeconomic disadvantage in adult 
life. Such an environment in adulthood increases the risk of frailty13 
and, perhaps partly due to its inherent stresses, allo-
static load.27 32 Lower intelligence and socioeconomic disadvan-
tage in childhood have been linked with poorer health behaviours in adult life.14 Potential mechanisms underlying 
these links may include lower educational attainment and 
poorer self-management of health risk.33 Health behaviours 
may contribute to allostatic load by altering its biomarkers, and 
there is some evidence that smoking and lack of physical activity 
increase the risk of frailty.10 34

METHODS
Participants
The Lothian Birth Cohort 1936 (LBC1936) was set up to study 
cognitive ageing in surviving members of the Scottish Mental 
Survey of 1947.35 In total 1091 community-dwelling people 
were recruited at a mean age of 70 years. Ethical approval was 
obtained from the Multi-Centre Ethics Committee for Scotland 
and Lothian Research Ethics Committee. The study conformed 
to the principles embodied in the Declaration of Helsinki.

Measures
Intelligence in childhood
Most children born in 1936 and attending school on 4 June 
1947 took the Moray House Test No 12, a test of general intel-
ligence, when they were aged about 11 as part of the Scottish 
Mental Survey. It was concurrently validated against the 
Terman-Merrill Revision of the Binet Scales.

Social class in childhood and adulthood
Participants provided information on their father’s occupation 
when they were aged 11 years. Occupations were classified into 
five social class categories: professional, managerial, skilled non-
manual, skilled manual, and semiskilled/unskilled. Own socio-
economic position was derived from participants’ (or their 
spouses’) highest reported occupation and classified into cat-
egories as described above.

Environmental deprivation in childhood
Participants provided information on living conditions at age 
11: the number of people living in their home, the number of 
rooms, the number of people who shared toilet facilities, and 
whether these were indoors or outdoors. We calculated number 
of persons per room, and separately standardised this and the 
two variables on toilet facilities. We formed a composite 
measure of environmental deprivation in childhood by summing 
these standardised variables.

Health behaviours
Participants provided information on alcohol intake in the past 
week, smoking history and physical activity. Physical activity was 
assessed on a six-point scale ranging from movement associated 
with necessary (household) chores to keep-fit/heavy exercise or 
competitive sport. We categorised alcohol intake in three 
groups: abstainers (no alcohol), or drinkers within or above sex-
specific recommended weekly limits (≤21 vs 22+ units for men; 
≤14 vs 15+ units for women).36

Educational attainment
Participants provided information on highest educational qualifi-
cation. This was categorised as: no qualifications, O level or 
equivalent, A level or equivalent, semiprofessional or profes-
sional qualifications, degree.

Frailty
Maximum handgrip strength was measured three times on each 
side using a dynamometer; the best of these measurements was 
used for analysis. BMI was calculated as weight (in kilograms)/ 
height (in metres)2. Gait speed was assessed by measuring time 
taken to walk 6 m at maximum speed. Participants were asked 
to indicate their usual level of physical activity on a six-point 
scale, ranging from ‘moving only in connection with necessary 
(household) chores’ to ‘keep-fit/heavy exercise or competitive 
sport several times a week’. Symptoms of depression were 
assessed using the depression subscale of the Hospital Anxiety 
and Scale (HADS-D).37 We used these data to derive indicators of 
frailty or prefrailty using the Fried criteria.1 Physical frailty is 
defined as the presence of three or more of: unintentional 
weight loss, weakness, self-reported exhaustion, slow walking 
speed and low physical activity. Prefrailty is defined as the pres-
ence of one or two of these criteria. We operationalised these 
criteria using definitions similar to those used in Fried’s original 
studies: weight loss was defined as current BMI <18.5 kg/m2; 
weakness was defined as maximum grip strength in the lowest 
20% of the distribution, taking account of sex and BMI; 
exhaustion was considered present if the participant responded 
positively to the HADS-D question ‘I feel as if I’m slowed 
down’; slow walking speed was defined as a walking speed in 
the lowest 20% of the distribution, taking account of sex and 
height; and low physical activity was defined as activity in the 
lowest sex-specific 20% of the distribution. To avoid the poten-
tial problem of spurious shared variance between our measures 
of frailty status and allostatic load, we omitted the component 
‘weight loss’ (defined here as a BMI <18.5 kg) when summing 
the number of frailty components that were present, on the 
grounds that BMI is a component of our allostatic load measure.

Allostatic load
We used data on nine biomarkers: fibrinogen, triglyceride, ratio of high density to total cholesterol, albumin, glycated haemoglobin, C reactive protein, BMI, and mean systolic blood pressure (SBP) and diastolic BP (DBP). Blood samples (non-fasting) were taken. SBP and DBP were calculated as the average of three sitting readings taken using an Omron 705IT monitor.

We derived an allostatic load score from the nine biomarkers by giving a score of one for each biomarker where participants were in the high-risk quartile of the distribution, and then summing those scores. Participants who reported taking medication for control of hypertension, diabetes or raised cholesterol were treated as if they were in the high-risk quartile of the distribution of the relevant biomarkers on the grounds that use of medication is an indicator of a history of poorer biological regulation.38

Statistical analysis
We used rank order correlations to examine associations between the characteristics of the sample and frailty status and cumulative allostatic load. Multinomial logistic regression was used to examine associations between intelligence or socioeconomic position in childhood and frailty status. Generalised linear models assuming a Poisson distribution were used to examine associations between childhood characteristics and allostatic load. We used Sobel-Goodman and boot-strapping tests to examine associations between childhood characteristics and allostatic load. Multinomial logistic regression was used to examine associations between intelligence or socioeconomic position in childhood and frailty status or allostatic load.

RESULTS
Table 1 shows the characteristics of the participants and the rank order correlation between those characteristics, and both frailty status and allostatic load at age 70 years. In total, 7% were frail and 47% were prefrail. There was a significant positive correlation between greater degree of frailty and allostatic load (p=0.248) (online supplementary table S1 shows how the distribution of each component of allostatic load varied by frailty status). In general, the correlations between the childhood and adult characteristics of the participants and these two health outcomes were similar. As children, people with a higher degree of frailty or higher allostatic load had a lower IQ and were less likely to have fathers in a professional or managerial occupation, though there were no associations between level of home environmental deprivation and either frailty status or allostatic load. As adults, people with a higher degree of frailty, or higher allostatic load, were less likely to have had a professional or managerial occupation, had lower educational attainment, were more likely to be former or current smokers, and drank less alcohol. Allostatic load was higher in those who were less active. There was no difference in sex distribution by frailty status, but women tended to have a lower allostatic load.

The relationships between IQ and indicators of socioeconomic circumstances in childhood and frailty status or allostatic load at age 70 did not differ between the sexes (p for interaction terms >0.5). Analyses were therefore carried out in men and women together, adjusting for sex.

Table 2 shows relative risk (RR) ratios for prefrailty and frailty.

Models 1–3 show estimates for childhood cognitive and social risk factors separately, adjusted for sex. Lower intelligence in childhood was associated with an increased risk of being either prefrail or frail. For a SD decrease in IQ, the RRs (95% CIs) were 1.25 (1.08 to 1.45) and 1.57 (1.21 to 2.03), respectively (model 1). Having a father in a lower social class in childhood was associated with an increased risk of frailty: for one category decrease in father’s social class, the RR (95% CI) of frailty was 1.48 (1.12 to 1.96) (model 2). People whose father

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD), median (IQR) or number (%)</th>
<th>Correlation with frailty status†</th>
<th>Correlation with allostatic load†</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQ at age 11 years, mean (SD)</td>
<td>100.9 (14.5)</td>
<td>−0.126***</td>
<td>−0.164***</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>443 (50.6)</td>
<td>−0.002</td>
<td>−0.071*</td>
</tr>
<tr>
<td>Father in professional/managerial social class, n (%)</td>
<td>229 (68.0)</td>
<td>0.097**</td>
<td>0.100**</td>
</tr>
<tr>
<td>Home environmental deprivation score at age 11 years</td>
<td>−0.16 (−0.38 to 0.15)</td>
<td>−0.028</td>
<td>0.009</td>
</tr>
<tr>
<td>Professional/managerial social class, n (%)</td>
<td>502 (57.1)</td>
<td>0.142***</td>
<td>0.149***</td>
</tr>
<tr>
<td>Has degree, n (%)</td>
<td>132 (15.1)</td>
<td>−0.161***</td>
<td>−0.181***</td>
</tr>
<tr>
<td>Allostatic load, median (IQR)</td>
<td>3 (2–5)</td>
<td>0.248***</td>
<td>0.248***</td>
</tr>
<tr>
<td>Frailty status, n (%)</td>
<td>404 (46.0)</td>
<td>0.079*</td>
<td>0.147***</td>
</tr>
<tr>
<td>Smoking status</td>
<td>410 (46.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>106 (12.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol units per week, n (%)</td>
<td></td>
<td>−0.074*</td>
<td>−0.070*</td>
</tr>
<tr>
<td>None</td>
<td>162 (18.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤21 (men)/≤14 (women)</td>
<td>562 (64.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥22 (men)/≥15 (women)</td>
<td>152 (17.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical activity, mean (SD)</td>
<td>2.97 (1.10)</td>
<td></td>
<td>−0.229***</td>
</tr>
</tbody>
</table>

†Rank order correlations with father’s or own social class or highest educational qualification were based on the 5-category version of these variables. As low physical activity is a component of frailty status we do not show the correlation between them.

***p<0.001, **p<0.01, *p<0.05.
had been in a lower social class also had a slightly increased risk of prefrailty, but this was not significant. There was no association between level of environmental deprivation in the home in childhood and risk of prefrailty or frailty (model 3). When childhood IQ and father’s social class were entered in a model together, childhood IQ remained a predictor of prefrailty and frailty, so it was no longer significant. There was no association between father’s social class and frailty status: 35% of the total effect was mediated through highest educational qualification (model 4). We then examined whether the associations between childhood IQ and father’s social class on frailty risk were accounted for by attained social class, highest educational qualification or the health behaviours, smoking and alcohol intake (model 5). The inclusion of these factors in the model attenuated the associations between childhood intelligence and frailty status: 35% of the total effect was mediated through highest educational qualification or the health behaviours, smoking and alcohol intake (model 5). The association between childhood IQ and allostatic load was attenuated by 0.10 (0.07 to 0.14). Having a father in a lower social class was associated with increased allostatic load, but there was no association between household deprivation in childhood and allostatic load. When childhood IQ and father’s social class were entered in a model together, childhood IQ remained a predictor of allostatic load, but the relation between father’s social class and allostatic load was no longer significant (model 4). We then examined whether the associations between childhood IQ and allostatic load were accounted for by attained social class, highest educational attainment or the health behaviours, smoking, alcohol intake and physical activity (model 5). The association between childhood IQ and allostatic load was attenuated by 0.10 (0.07 to 0.14). Having a father in a lower social class was associated with increased allostatic load, but there was no association between household deprivation in childhood and

### Table 2: Relative risk ratios for incident prefrailty or frailty according to intelligence and socioeconomic circumstances in childhood

<table>
<thead>
<tr>
<th>Model</th>
<th>Relative risk ratios (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prefrailty</td>
</tr>
<tr>
<td>1</td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td>2</td>
<td>Father’s social class</td>
</tr>
<tr>
<td>3</td>
<td>Environmental deprivation at age 11, per SD increase</td>
</tr>
<tr>
<td>4</td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td>5</td>
<td>Father’s social class</td>
</tr>
<tr>
<td></td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td></td>
<td>Father’s social class</td>
</tr>
<tr>
<td></td>
<td>Highest social class in adulthood</td>
</tr>
<tr>
<td></td>
<td>Highest educational qualification</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>1.0</td>
</tr>
<tr>
<td>Ex</td>
<td>1.32 (0.97 to 1.79)</td>
</tr>
<tr>
<td>Current</td>
<td>1.35 (0.84 to 2.15)</td>
</tr>
<tr>
<td>Units of alcohol per week</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1.0</td>
</tr>
<tr>
<td>≤21 (men)/≤14 (women)</td>
<td>0.77 (0.52 to 1.13)</td>
</tr>
<tr>
<td>≥22 (men)/≥15 (women)</td>
<td>0.74 (0.44 to 1.17)</td>
</tr>
</tbody>
</table>

***p<0.001, **p<0.01, *p<0.05.
†All models are adjusted for sex.

### Table 3: Coefficients (95% CIs) for allostatic load according to intelligence and socioeconomic circumstances in childhood

<table>
<thead>
<tr>
<th>Model</th>
<th>Coefficient (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td>2</td>
<td>Father’s social class</td>
</tr>
<tr>
<td>3</td>
<td>Environmental deprivation at age 11, per SD increase</td>
</tr>
<tr>
<td>4</td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td>5</td>
<td>Father’s social class</td>
</tr>
<tr>
<td></td>
<td>Intelligence at age 11, per SD decrease</td>
</tr>
<tr>
<td></td>
<td>Father’s social class</td>
</tr>
<tr>
<td></td>
<td>Highest social class in adulthood</td>
</tr>
<tr>
<td></td>
<td>Highest educational qualification</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>Reference</td>
</tr>
<tr>
<td>Ex</td>
<td>0.13 (0.05 to 0.21)**</td>
</tr>
<tr>
<td>Current</td>
<td>0.16 (0.05 to 0.27)***</td>
</tr>
<tr>
<td>Units of alcohol per week</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Reference</td>
</tr>
<tr>
<td>≤21 (men)/≤14 (women)</td>
<td>−0.13 (−0.22 to −0.03)***</td>
</tr>
<tr>
<td>≥22 (men)/≥15 (women)</td>
<td>−0.13 (−0.25 to −0.01)*</td>
</tr>
<tr>
<td>Physical activity</td>
<td>−0.11 (−0.14 to −0.07)***</td>
</tr>
</tbody>
</table>

***p<0.001, **p<0.01, *p<0.05.
†All models are adjusted for sex.
slightly attenuated by these adjustments but remained signifi-
cant. Having lower educational attainment, lower physical activ-
ity, ever smoking and not drinking alcohol were also
independently associated with increased allostatic load. Attained
social class was not associated with allostatic load.
Sobel-Goodman mediation tests showed that 29% of the total
effect of childhood IQ on allostatic load was mediated by educa-
tional attainment (p=0.01). Health behaviours and attained
social class had no significant mediating effects.

DISCUSSION
In this study, significant associations between lower intelligence
and greater socioeconomic disadvantage in childhood—as indi-
cated by father’s social class—and increased risk of frailty at age
70 were attenuated and no longer significant after adjustments
for the potential mediating factors, educational attainment,
attained social class and health behaviours in adulthood. Of
these, only educational attainment had a significant mediating
effect. Lower intelligence, but not father’s social class, remained
a significant predictor of greater allostatic load at age 70 in the
fully adjusted model; this was partially mediated through educa-
tional attainment.

Chronic stress in early life—such as that entailed by socio-
economic disadvantage—may contribute to accelerated biological
ageing.23 39 Here, we found that an association between lower
childhood social class and increased risk of frailty was mediated
through educational attainment. This is consistent with a study
where poorer childhood living standards were linked with greater
frailty, but not independently of markers of later life socio-
economic position.5 Childhood socioeconomic disadvantage may
also increase susceptibility to frailty via effects not examined
here, such as adult physical activity, obesity and cardiovascular
disease.10 34 40 We found little evidence in support of our
hypothesis that allostatic load would be higher in those exposed
to childhood socioeconomic disadvantage. Although allostatic
load was slightly higher in participants from lower childhood
social classes, this association was confounded by childhood intel-
ligence, and ceased to be significant after adjustment for this
factor. The weak association found here between allostatic load
and childhood social class is consistent with findings in a study of
cross sections where associations between life course socio-
economic position and allostatic load were only present in the
younger two cohorts.27 The fact that we found no associations
between our other measure of childhood socioeconomic circum-
stances—environmental deprivation in the home—and either
frailty or allostatic load may mean that our measure of environ-
mental deprivation provided a less accurate indicator of socio-
economic disadvantage than father’s social class.

Although we found an association between lower childhood
intelligence and risk of frailty in a model adjusted for the con-
founding effect of father’s social class, after further adjustment
for the potential mediators, the associations between childhood
IQ and frailty status were no longer significant. Several studies
have shown that frailty occurs more commonly in people of
lower socioeconomic status11 12 or educational attainment,13 and
there is evidence to link it with smoking.10 Here we found that
educational attainment was the only significant mediator of the
association between childhood IQ and frailty status. When inter-
preting this finding, it is important to bear in mind that child-
hood intelligence is a predictor of educational outcomes,15 that
are partly heritable, and that they are significantly correlated
genetically.14 42 The statistical mediation we find here might be
because the ‘influence’ of intelligence is mediated via education,
but it is also possible that education is a proxy for intelligence,
and that including it in the model is an overadjustment.

Our observation that older people with lower intelligence in
childhood have a higher allostatic load independent of child-
hood socioeconomic circumstances, is consistent with findings
that lower early life intelligence was associated with greater
physiological dysregulation in midlife.43 In this study, there was
no exploration of mediating factors. Here we found that the
association was partially mediated by educational attainment.
Intelligence is thought to play an important part in determining
what individuals perceive is stressful,16 and is also likely to influ-
ence their likelihood of exposure to stressful work or living
environment, and the efficacy with which they respond to
adversities.17 These factors may partly explain the link between
childhood IQ and later allostatic load.

The two outcomes in our study, frailty and allostatic load,
were significantly correlated with each other (r=0.248). The cross-sectional nature of this association makes it impossible to
determine whether higher allostatic load increases risk of frailty
—as has been demonstrated previously23—or reflects the
physiological dysregulation in multiple systems that is character-
istic of frailty.5 Only one other study has shown an association
between higher allostatic load and frailty, and that too was
cross-sectional.44

Our study has some weaknesses. Information on childhood
circumstances was obtained from the participants at age 70 so
may be less accurate than parent-derived information in child-
hood. When deriving the Fried frailty phenotype, we had no
data on unintentional weight loss. The original phenotype of
frailty studies1 used BMI <18.5 kg/m2 as a substitute indicator
of weight loss, but as BMI was part of our allostatic load

What is already known on this subject

- Frailty is a syndrome observed in older people whose core
  feature is increased vulnerability to stressors due to
dysregulation in multiple physiological systems.
- Allostatic load is a measure of multisystem physiological
dysregulation that reflects the effects of exposure to chronic
stress.
- Evidence on childhood determinants of frailty or allostatic
  load in later life frailty is sparse, but there are indications
  that greater socioeconomic disadvantage in childhood may
  increase the risk of frailty and lead to higher allostatic load.

What this study adds

- Associations between lower intelligence and greater
  socioeconomic disadvantage in childhood—as indexed by
  father’s social class—and increased risk of frailty at age
  70 years were attenuated and no longer significant after
  adjustment for potential mediating factors, in particular
  educational attainment.
- Lower intelligence, but not socioeconomic disadvantage, in
  childhood was also associated with higher allostatic load at
  age 70 years, and this persisted, though attenuated, after
  adjustment for potential mediating factors. Educational
  attainment partially mediated this association.
In this prospective study, significant associations between lower intelligence and greater socioeconomic disadvantage in childhood—as indexed by father’s social class—and increased risk of frailty at age 70 years were attenuated and ceased to be significant when adjusted for potential mediating factors. Both associations were mediated through educational attainment. Lower intelligence, but not social class in childhood, was associated with higher allostatic load, a correlate of frailty status, and this association, though attenuated, remained significant in the fully adjusted model. Part of this association was mediated through educational attainment. Further research will need to investigate the mechanisms whereby lower childhood intelligence is linked to greater physiological dysregulation in later life.

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Contributors
CRG, TB, JMS and UD conceived the study. CRG and TB analysed and interpreted the data. CRG drafted the manuscript. All authors contributed to the final version.

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Data sharing statement
Data are available upon request from the Lothian Birth Cohort 1936 Study. To request the data readers should contact the principal investigator, Ian Deary, who can be contacted at i.deary@ed.ac.uk.

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