

COMMENTARY

Challenges in managing sleep problems in young children

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Competing interests:

None declared

West J Med
2000;173:38

Ramchandani and colleagues have systematically reviewed trials of interventions for the 2 most common sleep concerns in children younger than 5 years: delayed sleep onset and problematic night waking. As the authors note, there is a relative paucity of well-controlled and methodologically sound studies of these interventions. This paucity reflects the difficulties in conducting this type of research, and it leads to difficulty in translating study results to the clinical setting.

Methodologic weaknesses in many of these studies include small sample size, the failure to include a control group, and reliance on subjective parental reporting to assess efficacy. In addition to these flaws in study design, a variety of other factors could have influenced treatment outcome, including individual differences in child temperament, educational level of the parent, and the presence or absence of marital difficulties. It is therefore not surprising that the more “generic” approaches, which failed to include a behavioral program tailored to the individual family or to address potential barriers to compliance with the treatment plan, were generally associated with worse clinical outcomes. In weighing the likelihood of success of any of the treatment methods discussed for an individual patient, the clinician must take these variables into account. In complex cases, referral to a sleep disorders center or a mental health professional is entirely justified.

The use of medication to treat childhood behavioral problems is highly controversial. This review addresses the use of sedative medication to treat sleep problems in young children, either alone or in combination with behavioral management. There is widespread concern that medication is being used inappropriately for treating a wide range of behavioral difficulties in young children. Anecdotal evidence suggests that both over-the-counter and prescription sedatives are commonly used for pediatric sleep problems in the United States, even in infants. For example, in a recent survey of pediatric practitioners in the northeastern United States, we found that over 20% of

the practitioners were at least occasionally recommending diphenhydramine (Benadryl) at bedtime as a treatment for night terrors, a practice not based on empirical evidence.¹ Clonidine, an alpha agonist with sedative properties, is used by child psychiatrists for treating delayed sleep onset in children, despite reports of potentially serious and even fatal cardiovascular side effects.²

Although the study by Ramchandani and colleagues suggests that the addition of sedative medication at the initiation of a behavioral treatment program might improve outcome, perhaps through improving parental compliance, they found little evidence supporting the use of medication as an isolated method of treatment, especially on a long-term basis. In addition, such treatment practices may implicitly encourage parents to seek out pharmacologic solutions for their child’s behavioral problems, instead of instituting a more labor-intensive but ultimately more successful behavior management program.

Finally, it is worth emphasizing that the definitions of sleep onset and night waking problems in young children are, to a certain extent, culturally determined. Our society places a high value on early acquisition of independent skills by children. This promotes the belief that “self-soothing” in infants is an important developmental milestone and that co-sleeping, or sleeping with a parent or sibling, is not an acceptable practice because it prevents the infant from becoming independent. Health care practitioners should be sensitive to potential cultural and individual family differences in the perception of sleep behaviors in children and take these into account in preventive and management strategies.

References

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