Sleep Problems in Children

It is important to identify the sleep disorder underlying the problem, rather than treat symptomatically, as the choice of treatment depends on the cause of the problem. There are three basic types of sleep problem:

- Not sleeping enough (sleeplessness or insomnia).
- Sleeping too much (excessive sleepiness or hypersomnia).
- Episodic disturbances of behaviour related to sleep (parasomnias) - eg, night terrors, sleep-talking, sleepwalking. Nocturnal enuresis is regarded by researchers as a parasomnia and parents report that enuretic children are difficult to wake up. Sleep encephalograms in enuretic children are no different from dry children but it is thought that there is a higher arousal threshold to the stimuli of bladder distension and detrusor contraction in enuretic children.

Epidemiology

- Children's sleep problems are very common. At some stage about 40% of children have a sleep problem considered to be significant by their parents.
- Children with a chronic physical illness (eg, asthma), psychiatric disorder (eg, attention deficit hyperactivity disorder) or with a learning disability are particularly prone to problems with sleep.

Assessment

Sleep disorders are often not recognised by general practitioners. It is important to establish:

- The nature and development of the sleep problem.
- Whether the child's sleep environment and activities have any adverse affect on the child's sleep pattern. Assess the typical day and night routine, including evening activities leading up to bedtime, getting to sleep, disturbances during sleep, getting up and level of alertness and activities during the day. A sleep diary kept over about a two-week period can be very useful.

Polysomnography is considered the gold standard for children with sleep-related breathing disorders but are not useful for behavioural disorders. The multiple sleep latency test (time elapsed from the start of a daytime nap period to the first signs of sleep) can exclude conditions such as narcolepsy.

Sleeplessness in infants and toddlers

- This is the most common form of sleep problem.
- The management is dependent on the cause and is often straightforward if the underlying cause can be identified. The most effective way to prevent these problems is to introduce consistent routines in the first few months of life.
- Children should be encouraged from a very early age to fall asleep in their own bed without a parent being present. Although brief waking in the night can be normal at any age, it creates a problem if the child cannot go back to sleep without its parents. Children who are with their parents when they first go to sleep at night are much more likely to insist on them being present again when they wake during the night.
- Modification of the parental behaviour at the time the child is put to bed may be helpful. One study found that parental interventions which encouraged independence and self-soothing were associated with extended and more consolidated sleep compared to more active interactions.
- Medication may also have a detrimental effect on sleep apnoea. It is recognised that severe sleep disorders may require medication as well as behavioural treatment but the evidence base for the use of pharmacological agents in children is weak and is often extrapolated from adult trials.
The British National Formulary for Children (BNFC) lists chloral hydrate, sedative antihistamines and melatonin under its Hypnotics section. Chloral hydrate is now mainly used for sedation during diagnostic procedures. Sedating antihistamines may cause hangover symptoms during the day and withdrawal sleeplessness. Melatonin has been implicated in causing seizures but paradoxically has been found beneficial in treating sleep disorders in children with epilepsy. The BNFC recommended that it be prescribed in primary care only as part of a shared-care arrangement with a specialist. Consensus evidence-based guidelines are urgently needed. 

Behavioural methods to improve parents’ handling of bedtime and night-waking problems are very effective. Gradually changing children’s need for their parents’ presence at bedtime or during the night is usually effective if used consistently and with conviction. Behavioural methods may be of value. These include:

- **Positive routines** - a regular bedtime with a 20-minute winding down time. Move bedtime back 5 minutes per night until a reasonable time is established.
- **Extinction** - on hearing a child cry, go in and check the child is not unwell or needing a nappy change. Don’t pick up or feed the child. Leave.

The advice and support of a health visitor or, in the occasional severe or complex situation, a psychologist, are very important for any plan of management to be successful. Educational booklets and sleep programmes may also be helpful.

**Excessive sleepiness**

Excessive sleepiness is more common in adolescence and adult life but may also be seen in younger children. It may be caused by a variety of problems - eg, medication, sleep-disordered breathing associated with upper respiratory tract obstruction, obesity, anxiety and depression. It may be interpreted as laziness or boredom. It must be differentiated from fatigue or exhaustion.

At an early age, instead of sleepiness reducing the child’s activity levels, it may cause overactive and disruptive behaviour.

Management includes identifying and correcting any cause when possible and behavioural methods to improve the normal sleep routine.

**Parasomnias**

There are many types of parasomnia. They may be primary sleep phenomena or related to a physical or psychiatric disorder.

- Most resolve spontaneously with time and so explanation and reassurance are often appropriate.
- Measures to avoid accidental injury may be necessary, especially in the case of sleepwalking.
- When treatment is required, behavioural treatment methods are preferable and medication is a last resort. Management may also need to include treatment of any underlying physical or psychological disorder.

**Complications**

Sleep problems may lead to daytime problems such as poor memory and concentration, irritability, behavioural problems, aggression, emotional distress, depression and increased accident rates. It is claimed that teenagers need nine hours of sleep each night and suffer emotional problems and learning difficulties if they have less than this recommended amount of sleep.

There may be adverse effects on school performance, immune function and even growth.

There may also be effects on the family, such as parental ill health, reduced affection for the child, marital discord and adverse effect on a parent’s work ability.

**Further reading & references**

11. British National Formulary

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