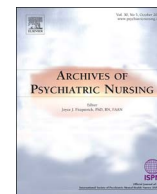




Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu

Cosleeping and Behavioral Sleep Problems in School-aged Children with Neurodevelopmental and Mental Health Disorders

María-Felisa Bastida-Pozuelo^a, Lisa J. Meltzer^b, María-Montserrat Sánchez-Ortuño^{c,*}

^a Child and Youth Mental Health Day Center, Murcia, Spain

^b Division of Pediatric Behavioral Health, National Jewish Health, Denver, CO, USA

^c School of Nursing, University of Murcia, Spain

ARTICLE INFO

Keywords:

Cosleeping
Children
Mental health disorders
Sleep disorders

ABSTRACT

The aim of this study was to explore the presence of sleep-related complaints and their relationship to cosleeping in a sample of 57 children with mental health disorders. Information about the practice of cosleeping was collected through an interview and behavioral sleep problems were evaluated with a subset of items from the Spanish version of the Pediatric Sleep Questionnaire (PSQ). Controlling for age, cosleepers scored higher on insomnia, daytime sleepiness and poor sleep scheduling, compared to solitary sleepers. Therefore, mental health professionals should explore the child's sleep environment and, when necessary, use appropriate interventions to address such problems.

Introduction

Cosleeping is defined as the practice in which parents and children sleep together in body contact throughout the night or part of it (Cortesi, Giannotti, Sebastiani, Vagnoni, & Marioni, 2008). The practice of cosleeping can be intentional or reactive. “Intentional cosleeping” refers to parents/caregivers who plan to bed share and do so from early infancy onward. Parents may bed-share with the child intentionally due to cultural beliefs, breastfeeding facilitation, parent ideology, parents own sleep experiences, convenience, anxiety, child safety, parent and child emotional needs, better infant sleep, unavailability of other beds, enjoyment, physical proximity to the infant, and better caregiving (Mileva-Seitz, Bakermans-Kranenburg, Battaini, & Luijk, 2016). On the other hand, cosleeping is “reactive” when the parent starts to bring the child to bed after the age of about one year in response to problematic circumstances, typically poor child sleep patterns (Ramos, 2003; Santos et al., 2017).

The overall prevalence of cosleeping is difficult to determine. In general, surveys tend to underestimate their magnitude as parents often hide cosleeping because they fear being judged by health care providers. A general population study of children aged 6–14 years conducted in Spain indicated that 75 to 85% of children fall asleep in bed with their parents at least one day a week (Pin, Cubel, Martin, Roselló, & Morell, 2011). Of note, cosleeping rates differ substantially across cultures and at different time periods. For instance, the prevalence in the first 4 years of life has been reported to be between 6% and 70%, yet in

school-aged children it is less common, with prevalence rates ranging from 4% to 23% (Jenni, Fuhrer, Iglowstein, Molinari, & Largo, 2005). Furthermore, cosleeping appears to be less prevalent in cultures that value autonomy and individualism, as it is the case for most western or developed countries, potentially due to the parents' desire to instill early independence in their children by encouraging sleeping alone (Luijk et al., 2013).

Among the most widely reported factors associated with a greater prevalence of cosleeping in infants are socioeconomic factors like lower family income, lower maternal age, lower maternal education, and nonwhite ethnicity (Fu, Colson, Corwin, & Moon, 2008; Willinger, Ko, Hoffman, Kessler, & Corvin, 2010). For example, the US and UK literature suggests that cosleeping rates are greater in nonwhite ethnicities (Fu et al., 2008). Nonetheless, in some western and typically non-cosleeping nations, an increase in cosleeping over recent decades has been reported; with an increase from 6% to 13% between 1993 and 2000 in the United States, and similar increases in Northern European countries such as the Netherlands and Norway (Willinger et al., 2010). An increase in breastfeeding practices has been hypothesized to be linked to an increase in the frequency of cosleeping (Mileva-Seitz et al., 2016). Indeed, cosleeping and breastfeeding are positively related. This component may be a bidirectional and mutually reinforcing relationship with cosleeping both facilitating breastfeeding and being facilitated by a mother's desire to continue breastfeeding while minimizing the sleep deprivation imposed by frequent night awakenings (Peters, Lusher, Banbury, & Chandler, 2016).

* Corresponding author at: School of Nursing, Campus de Espinardo, 30100 Murcia, Spain.
E-mail address: montses@um.es (M.-M. Sánchez-Ortuño).

<https://doi.org/10.1016/j.apnu.2018.02.002>

Received 24 October 2017; Received in revised form 7 February 2018; Accepted 11 February 2018
0883-9417/ © 2018 Elsevier Inc. All rights reserved.

Whether cosleeping should be recommended or discouraged is a hotly debated topic, especially for younger children (Mileva-Seitz et al., 2016). In this regard, the American Academy of Pediatrics (AAP) updated 2016 recommendations for a Safe Infant Sleeping Environment (American Academy of Pediatrics, 2016) include roomsharing, but not bedsharing, preferably until the baby turns 1 year, but at least for the first six months.

Fewer studies have considered cosleeping in older children, with one large cross-sectional study reporting an association between sleep problems and cosleeping; although the direction or causality could not be determined (Jenni et al., 2005). Despite the limited literature in this area, some people assume that parents who bedshare or cosleep may create sleep problems in their children. Yet parents who bedshare might choose this practice in response to pre-existing sleep problems. However, there is no evidence indicating that cosleeping is a successful approach to treat sleep problems in children. Either way, in general, it is suggested that cosleeping may not be a healthy sleep-related practice in older children.

Sleep problems are particularly prevalent among children with mental health disorders. For example, prevalence rates of sleep difficulties in children with neurodevelopmental disabilities (e.g., autism spectrum disorders, ASD) or mental health disorders (e.g., anxiety disorders) may be as high as 75–80%, with sleep problems enduring over time (Alfano & Gamble, 2009; Jan et al., 2010). The most common sleep complaints in these children include difficulty falling/staying asleep, frequent nighttime awakenings, restless sleep, irregular sleep-wake patterns, and bedtime resistance (Alfano & Gamble, 2009).

If sleep problems trigger cosleeping, one would assume that the practice of cosleeping may be higher in children with mental health disorders. However, the literature on cosleeping and sleep problems in children with mental health issues is scarce. Liu, Hubbard, Fabes, and Adam (2006) examined sleep patterns, sleep problems, and their correlates in children with ASD showing that cosleeping is common in children with ASD, and these children experience a number of sleep issues. These findings suggest that sleep problems are important to explore among children with mental health issues, since it has been demonstrated that untreated sleep disturbances produce symptoms such as emotional lability, irritability, low tolerance to frustration, behavioral disorders and aggressiveness that affect the daytime functioning of these children and complicate their management (Cohen, Conduit, Lockley, Rajaratnam, & Comish, 2014; Idiazábal-Aletxa & Aliagas-Martínez, 2009; Jan et al., 2010). Children who have ASD and sleep problems are prone to more severe comorbid behavioral disturbances compared with children without sleep disturbances. In addition, it has been shown that treating insomnia in children who have neurodevelopmental disorders may improve problematic daytime behaviors. (Malow, Byars, Johnson, et al., 2012)

Therefore, it is important for clinicians working with children who have mental health disorders, including pediatric mental health nurses, pediatricians, child psychologists, and psychiatrists, to evaluate for sleep problems, examine sleep patterns, and identify any modifiable sleep behaviors, such as cosleeping. Thus, the aim of this study is to explore the relationship between the practice of cosleeping and behavioral sleep problems in school-aged children with mental health disorders.

Method

Subjects

Data for this study were provided by parents of children with diagnosed mental health disorders attending the San Andrés Child and Adolescent Mental Health Clinic of the Spanish National Health Service, located in the city of Murcia, Spain, during the period January–February 2016. Data are from the baseline assessment of a pilot study examining the effects of providing a one-session sleep

Table 1

Diagnoses among children attending the mental health clinic according to the ICD-10 (1992) (N = 57).

Diagnosis	n (%)
F84 Pervasive developmental disorders	37 (64.91)
F98.9 Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	7 (12.28)
F90 Hyperkinetic disorders	3 (5.2)
F80 Specific developmental disorders of speech and language	2 (3.5)
F43.2 Adjustment disorders	2 (3.5)
F94 Disorders of social functioning with onset specific to childhood and adolescence	2 (3.5)
F98.2 Feeding disorder of infancy and childhood	1 (1.75)
F71 Moderate mental retardation	1 (1.75)
Z-62 Problems related to parenting	1 (1.75)
F38 Mood (affective) disorders	1 (1.75)

education group to parents whose children were initiating a social skills group intervention. Although the social skills group participants were primarily children with pervasive developmental disorder (PDD), the group also included children with other mental health diagnoses. Prior to initiating the social skills group, parents/caregivers were screened by a pediatric mental health nurse, who asked about their children's sleep environment and provided a self-administered sleep questionnaire that was used to ascertain sleep-related variables in their children. Inclusion criteria included child age between 6 and 16 years, the diagnosis of at least one neurodevelopmental or mental health disorder, and presence of a parent or guardian able to provide the requested information. There were no inclusion or exclusion criteria based on a child's reported sleep complaints, sleep disorders, or use of sleep medications. Parents of 57 consecutive children attending the clinic during the two-month pilot study agreed to participate. Written authorization and ethics approval to use these data were obtained from the Director of the Health Area in which the clinic is located. Children's mean age was 10 years and the majority were male (80.7%) The list of mental health diagnoses, according to the ICD 10, is displayed in Table 1. Only two children had more than one mental health diagnosis. In these cases, we included only the primary diagnosis.

Measures

Cosleeping

For this study, cosleeping was defined as parent/caregivers and child sleeping in body contact with each other for all or part of the night (Cortesi et al., 2008). As part of the initial structured interview with the pediatric mental health nurse, parents were asked whether they, or another person living at home, practiced cosleeping with their child and, if so, how often. The parents/caregivers were asked how many nights in a typical week their child coslept with them or another parent/caregiver in the house. Subsequently, children were divided into 3 groups: Solitary Sleepers (0 nights per week); Occasional cosleepers (up to 2 nights per week); and Regular cosleepers (3 or more nights per week).

Behavioral sleep-related problems

Behavioral sleep-related problems, such as insomnia symptoms, daytime sleepiness, sleep scheduling issues and nightmares, were assessed with items from the Spanish version of the Pediatric Sleep Questionnaire (PSQ) (Tomás-Vila, Miralles, & Beseler, 2007). The Spanish version of the PSQ consists of 71 questions for which the respondent must circle "Yes", "No", or "Don't Know", and several open-ended questions on demographics, sleep schedules, and medications. Questions are designed to be short and simple and it requires about 20 min to be completed. For the present study, we only used a subset of questions from the PSQ and combined those to derive three different index scores: Insomnia (including six items), Daytime Sleepiness

Download English Version:

<https://daneshyari.com/en/article/6786785>

Download Persian Version:

<https://daneshyari.com/article/6786785>

[Daneshyari.com](https://daneshyari.com)