SLEEP TERRORS AND NIGHTMARE DISORDER

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INTRODUCTION

- Sleep plays a vital and often underestimated role in the growth and development of children.
- Sleep problems have a high prevalence:
  - 40% of teens have sleep related problems.
  - 25% to 50% of preschoolers.
INTRODUCTION

• They are often a clue to underlying emotional, interactional, or family problems that deserve attention and may be the aspect of the child’s functioning that the family is most open to address.
The clinician may want to ask some “trigger” questions to determine related family/environmental factors:

- At what age did the problem begin
- What else was happening at that time
- How much of a problem is it
- What factors are associated with it worsening or getting better
- who are the family members most affected
- What have others told you about this sleep problem
The ability to sleep throughout the night usually does not develop until 3 to 6 months of age.

Insufficient sleep and poor sleep quality may manifest as changes in

- Mood
- Behavior
- Memory
- Attention
COMMON PARASOMNIAS OF CHILDHOOD

- Night terrors
- Nightmares
- Parasomnias are undesirable physical events that occur during entry into sleep, within sleep, or during arousal from sleep
NIGHT TERRORS

• Arousals from deep (slow wave) sleep, usually in the first one third of the night and come with intense fear

• Activates the autonomic system and causes
  • Tachycardia
  • Tachypnea
  • Flushing of the skin
  • Diaphoresis
  • Increased muscle tone
NIGHT TERRORS

• Episodes usually start 1 to 3 hours after falling asleep
• Each episode lasts 5 to 20 minutes and ends of its own accord with the child falling asleep
• They tend to occur in bouts of up to 20 per night for several weeks, then disappear, only to recur several weeks later
The child is found sitting up in the bed unresponsive; if awakened, the child is confused and disoriented.

Vocalizations occurs frequently.

Amnesia is usually present.
PREVALENCE

- 1% to 6.5% in early childhood
- 2.5% from the age of 15 years onward
- Seen within in 4 to 12 years of age
- Genetics may play a role: parents usually suffered from night terrors
Night terrors are usually diagnosed based on history. Differentials to exclude include obstructive sleep apnea, restless legs syndrome/periodic limb movement syndrome, or seizures. No need for a sleep study, although it could be helpful in distinguishing night terrors from nocturnal complex partial seizures. It could also rule out OSA in a snoring child. OSA can lead to recurrent arousals and shifts in sleep stage and may be associated with increased night terrors.
MANAGEMENT

• Management of night terrors is focused primarily on parental reassurance and education
• Parents should be informed of the essentially self limited natures of these episodes
• Most children stop having them after puberty
• Scheduled awakening may be considered for the children who is having nightly episodes and wake the child to the point of arousal 15 to 30 minutes before that time.
• This can be done for 2 to 4 weeks until the episodes stop occurring and can be repeated if the episodes start again.
MANAGEMENT

• The bladder should be emptied routinely at bedtime and the environment kept dark and quiet.

• A 30 to 60 minutes afternoon nap can also reduce stage IV sleep, thereby decreasing episodes.
MANAGEMENT

• Short acting benzodiazepines may be considered only if the episodes are severe and excessively violent and place him or her at high risk of injury
• Treatment for 3 to 6 months or until the episodes stop occurring
• Benzodiazepines should be slowly tapered because abrupt discontinuation results in slow-wave sleep rebound and return of nocturnal episodes
NIGHTMARES

• Characterized by disturbing dreams that usually occur in rapid eye movement (REM) sleep and result in awakening
• There is significant anxiety after awakening and difficulty returning to sleep
• Common in younger children, who cannot distinguish between dreams and reality
PREVALENCE

- 10 to 50% of children between 3 to 5 years of age
- Peaks around age 6 to 10
- During this stage children have vivid imaginations
- Can be precipitated by stress or traumatic events
- Associated with
  - Sleep deprivation
  - Anxiety disorders
  - Medications: antidepressants, antihypertensive agents, and dopamine agonists
They deserve brief comforting, preferably in the child’s bed.

Children who have chronic nightmares have been shown to improve with targeted relaxation exercises and stories in which a child masters a situation.

Children can prepare to have good dreams through rehearsing and imaging pleasant thoughts.
MANAGEMENT

• Pediatricians should assess both the chronicity and severity of nightmares because unusual severity has been related to psychopathology.

• Nightmares can be distinguished from night terrors by their occurrence in the latter half of the night, when REM sleep predominates.

• Unlike night terrors, return to sleep is significantly delayed.
MANAGEMENT

- Maintaining good sleep hygiene
- Limiting exposure to frightening or overstimulating television shows and movies
- Children may respond well to parental reassurance or use of security objects such as blankets
- Night light might be helpful
- Referral to a developmental-behavioral pediatrician should be considered if the child is excessively disturbed by these events
• Severe nightmares may respond to bedtime diphenhydramine, trazadone, or cyproheptadine, although counseling is mandatory if the condition is of this severity.
NIGHTMARES MAY SIGNAL A CHILD IS BEING BULLIED

• Stress/trauma from being bullied can lead to increased risk of sleep arousal problems, such as nightmares or night terrors

• Pediatricians should consider peer bullying as a potential precursor of nightmares or night terrors
RESOURCES

- Nightmares may signal a child is being bullies. Aap news room article