Importance: Sleep is vital to children’s biopsychosocial development. Inadequate sleep quantity and quality is a public health concern with an array of detrimental health outcomes. Portable mobile and media devices have become a ubiquitous part of children’s lives and may affect their sleep duration and quality.

Objective: To conduct a systematic review and meta-analysis to examine whether there is an association between portable screen-based media device (eg, cell phones and tablet devices) access or use in the sleep environment and sleep outcomes.

Data Sources: A search strategy consisting of gray literature and 24 Medical Subject Headings was developed in Ovid MEDLINE and adapted for other databases between January 1, 2011, and June 15, 2015. Searches of the published literature were conducted across 12 databases. No language restriction was applied.

Study Selection: The analysis included randomized clinical trials, cohort studies, and cross-sectional study designs. Inclusion criteria were studies of school-age children between 6 and 19 years. Exclusion criteria were studies of stationary exposures, such as televisions or desktop or personal computers, or studies investigating electromagnetic radiation.

Data Extraction and Synthesis: Of 467 studies identified, 20 cross-sectional studies were assessed for methodological quality. Two reviewers independently extracted data.

Main Outcomes and Measures: The primary outcomes were inadequate sleep quantity, poor sleep quality, and excessive daytime sleepiness, studied according to an a priori protocol.

Results: Twenty studies were included, and their quality was assessed. The studies involved 125,198 children (mean [SD] age, 14.5 [2.2] years; 50.1% male). There was a strong and consistent association between bedtime media device use and inadequate sleep quantity (odds ratio [OR], 2.17; 95% CI, 1.42-3.32) \( (P < .001, I^2 = 90\%) \), poor sleep quality (OR, 1.46; 95% CI, 1.14-1.88) \( (P = .003, I^2 = 76\%) \), and excessive daytime sleepiness (OR, 2.72; 95% CI, 1.32-5.61) \( (P = .007, I^2 = 50\%) \). In addition, children who had access to (but did not use) media devices at night were more likely to have inadequate sleep quantity (OR, 1.79; 95% CI, 1.39-2.31) \( (P < .001, I^2 = 64\%) \), poor sleep quality (OR, 1.53; 95% CI, 1.11-2.10) \( (P = .009, I^2 = 74\%) \), and excessive daytime sleepiness (OR, 2.27; 95% CI, 1.54-3.35) \( (P < .001, I^2 = 24\%) \).

Conclusions and Relevance: To date, this study is the first systematic review and meta-analysis of the association of access to and the use of media devices with sleep outcomes. Bedtime access to and use of a media device were significantly associated with the following: inadequate sleep quantity, poor sleep quality, and excessive daytime sleepiness. An integrated approach among teachers, health care professionals, and parents is required to minimize device access at bedtime, and future research is needed to evaluate the influence of the devices on sleep hygiene and outcomes.

Published online October 31, 2016.

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Sleep is crucial to the development of physically and psychologically healthy children. Sleep disturbance in childhood is known to lead to adverse physical and mental health consequences. Short- and long-term detrimental health outcomes include poor diet, sedentary behavior, obesity, reduced immunity, stunted growth, mental health issues (eg, depression and suicidal tendencies), and substance abuse.1,3

Despite its importance to health, insufficient sleep and resultant daytime sleepiness are prevalent among the pediatric population and increase throughout adolescence.4,5 In the United States, 75% of those 17 to 18 years old report insufficient sleep, which is consistent with the findings in other developed countries.6 The American Academy of Pediatrics has highlighted factors, including electronic media device use, early school start times, and increase in caffeine consumption, that contribute substantially to this trend of insufficient and deteriorating sleep in the pediatric population.4,5

Studies7,8 during the past decade have demonstrated that the use of conventional electronic devices, such as televisions, gaming consoles, and computers, negatively affects sleep. Newer portable mobile and media devices, including smartphones and tablet devices with broader capabilities (eg, internet and social networking), provide a different type of exposure because they allow real-time interaction and therefore continuous stimulation for children, unlike older stationary devices.3 Herein, these newer portable screen-based mobile and media devices are termed media devices.

The presence of media devices is almost ubiquitous among children: 72% of all children and 89% of adolescents have at least 1 device in their sleep environment, with most used near bedtime.3,6 Such devices are hypothesized to adversely affect sleep through various pathways.7,8 First, they may negatively influence sleep by directly displacing, delaying, or interrupting sleep time. Second, the content can be psychologically stimulating, and, third, the light emitted from devices affects circadian timing, physiological sleep, and alertness.9 However, the association between media device use and poor sleep outcomes has been underexplored because the speed at which these devices have been developed has outpaced research capabilities.8,9 A previous literature review8 reported a suspected association between screen time and poor sleep outcomes and stimulated debate to assess the quality of evidence and quantify the magnitude of the potential relationship.7 To our knowledge, we present the first systematic review to quantify the influence of media device use on sleep outcomes in a meta-analysis.

Methods

Study Selection
This study was conducted following Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines10 and was performed according to an a priori protocol. All experimental and observational study designs, in any language, published between January 1, 2011, and June 15, 2015, were included. The time frame was selected to reflect the interactive nature of media devices now used. The inclusion criteria were studies of children and adolescents of school age between 6 and 19 years. The exclusion criteria were studies of stationary exposures, such as televisions or desktop or personal computers, or studies investigating electromagnetic radiation.

Data Sources and Search Strategy
A search strategy consisting of 24 Medical Subject Headings (MeSH) and non-MeSH terms was developed in Ovid MEDLINE and adapted for other databases (eTable 1 in the Supplement). On June 15, 2015, searches of the published literature were conducted across 12 databases, including the British Education Index, Cumulative Index to Nursing and Allied Health database, Cochrane Library, Educational Resources Information Center, International Biography of Social Sciences, Ovid MEDLINE (EMBASE, MEDLINE, and PsycINFO), PubMed, Science Direct, Scopus, and Web of Science. The gray literature was searched using the OpenGrey online database. Bibliographies of included studies and conference abstracts were hand searched, and authors of included studies were contacted to identify any ongoing or unpublished studies.

Device Exposure Categories and Sleep Outcomes
Cohorts of children with access to media devices less than 3 times a week were combined with children who had no media device access and were categorized as having no access to a media device. Children with bedtime access to a media device at least 3 times a week were categorized as having access to a media device. Children who used media devices around bedtime were categorized as those who used a media device. Outcomes were the proportion of children who experienced inadequate sleep quantity (defined as <10 hours of daily sleep for children and <9 hours of daily sleep for adolescents11,12), poor sleep quality (defined as frequent difficulty in sleep initiation or sleep maintenance or nonrefreshing sleep13), and excessive daytime sleepiness (defined as poor daytime functioning as a result of both sleep quantity and quality14).

Study Screening and Quality Assessment
Titles and abstracts identified from searches were screened for relevance, and duplicates were excluded. The full texts of all relevant articles were retrieved, and their eligibility for inclusion was assessed. Two reviewers (D.B. and M.S.P.) independently assessed the methodological quality of all full-text articles, and discrepancies were resolved by a third reviewer (B.C.). The quality assessment tool consisted of 13 domains that...
analyses.19 All meta-analysis data were presented as OR with 95% CIs. Statistical heterogeneity was assessed using the I² statistic. Heterogeneity exceeding 85% was explored using subgroup analysis.  

### Data Synthesis

If study designs, populations, interventions, and outcomes were deemed to be clinically homogeneous, the data were pooled in a random-effects meta-analysis using the Mantel-Haenszel method.17,18 If dichotomous data were not available but study analyses were reported, the analysis data were pooled with the dichotomous data using a generalized inverse variance approach.19 If IPD were available and considered to have external validity, a logistic regression model was fitted, accounting for the study as the random effect, and adjusted for participant age.20

### Assessment of Subgroups and Statistical Heterogeneity

Statistical heterogeneity was assessed using the I² statistic. Heterogeneity exceeding 85% was explored using subgroup analyses.19 All meta-analysis data were presented as OR with the associated 95% CIs, P values, and I² summary data. Pre-specified subgroups to explore heterogeneity included quality assessment (high-quality vs unclear and low-quality studies), age of children (6-11, 12-15, and 16-18 years), and type of media device (cell phone vs tablet).

### Results

#### Identified Studies and Quality Assessment

A total of 467 studies were identified, and 69 full texts were reviewed, leading to 49 being excluded (Figure 1). Of 20 studies involving 125,198 children (mean [SD] age, 14.5 [2.2] years; range, 6-18 years; 50.1% male) that were assessed for methodological quality, 17 were included, with 3 excluded because of poor methods conduct or reporting21-23 (eTable 2 in the Supplement). Two studies13,24 were of good quality, 6 studies13,25-29 were of low quality, and 9 studies30-38 were of unclear quality (eTable 2 in the Supplement).

#### Characteristics of Included Studies

Included studies were conducted in Europe (n = 7),13,24,27,28,30,31,35,36,38 North America (n = 4),3,25,26,31 Asia (n = 3),24,36,37 and Australasia (n = 3),30,32,34 (eTable 3 in the Supplement). Six studies13,24,26,27,30,33 assessed the association between media device use and sleep during weekday periods only. Five studies13,25,28,32,34 assessed sleep separately on weekdays and weekends, and 6 studies30,31,35-38 aggregated weekly data.

#### Media Device Exposure Categories

Media device investigations were categorized into 2 exposure groups, namely, studies3,13,24,27,28,30-33,35,37,38 that reported bedtime media device use and studies3,25-27,31,32,33 that described children who had access to (but did not use) media devices at night. One study36 presented data on the use of media devices throughout the entire day, which is not reported herein. Individual study results grouped by device exposure category are listed in eTable 4 in the Supplement.

#### Bedtime Media Device Use Compared With Not Having Access to a Device

We identified 12 studies that investigated the use of media devices near bedtime (eTable 4 in the Supplement). Eight studies reported that bedtime media device use was significantly associated with inadequate sleep quantity (P < .05). Seven of the studies reported an association between bedtime media device use and poor sleep quality (P < .05), and 1 study35 reported that bedtime media device use was associated with improved sleep quality. Four studies that presented data on excessive daytime sleepiness demonstrated statistically significant results (P < .05).

#### Inadequate Sleep Quantity

In 7 studies,3,13,27,30,32,35 the prevalences of inadequate sleep quantity among the 2 groups were 45.4% (children having bedtime media device use) and 31.5% (children not having access to a device). The pooled OR was 2.17 (95% CI, 1.42-3.32) (P < .001, I² = 90%) (Figure 2). The large heterogeneity was due to the study by Chahal et al,31 which recruited only 10-year-old and 11-year-old children. After that study was excluded, the OR was 2.52 (95% CI, 1.79-3.55) (P < .001, I² = 72%). Two studies3-27 were included in an IPD meta-analysis, and the age-adjusted OR (aOR) was 3.06 (95% CI, 2.01-4.70) (P < .001).

#### Poor Sleep Quality

Five studies3,13,27,30,32,35 reported dichotomous data on poor sleep quality, and the prevalences of poor sleep quality among the 2 groups were 52.1% (children having bedtime media device use) and 34.4% (children not having access to a device). Two additional studies27,28 reported the OR from a logistic regression. The pooled OR was 1.46 (95% CI, 1.14-1.88) (P = .003, I² = 76%) (Figure 3). There was an increased odds of poor sleep quality in those who used a media device near bedtime. The IPD meta-analysis aOR was 1.92 (95% CI, 1.27-2.90) (P = .002) from 2 studies.3,27
**Excessive Daytime Sleepiness**

Two studies\(^3,32\) reported dichotomous data on excess daytime sleepiness, and the prevalences were 21.3% (children having bedtime media device use) and 6.7% (children not having access to a device). The pooled OR was 2.72 (95% CI, 1.32-5.61) \((P = .007, I^2 = 50\%)\) (eFigure 1 in the Supplement). There

**Figure 1. PRISMA Flowchart of the Searched, Identified, and Included Studies**

799 Records identified through database searching

4 Additional records identified

Hand searching

Contacting experts

279 Records after 188 duplicates removed

109 Records after 170 irrelevant articles screened out

9 Conference abstracts awaiting publication

31 Records excluded based on abstract

69 Full-text articles retrieved and assessed for eligibility

49 Full-text articles excluded

20 Full-text articles assessed for methodological quality

3 Articles excluded owing to methodological flaws\(^a\)

17 Included studies

11 Studies included in meta-analysis

PRISMA indicates Preferred Reporting Items for Systematic Reviews and Meta-analyses.

\(^a\)Some studies satisfied more than 1 criteria.

\(^b\)Further details are listed in eTable 1 in the Supplement.
was an increased odds of excessive daytime sleepiness among children who used a media device near bedtime.

**Having Access to a Media Device Compared With Not Having Access to a Device**

Most studies reported statistically significant evidence of an association between the presence of a media device in the sleep environment near bedtime and inadequate sleep quantity (6 of 7 studies), poor sleep quality (4 of 6 studies), and excessive daytime sleepiness (3 of 4 studies). These results are summarized in eTable 4 in the *Supplement.*

**Inadequate Sleep Quantity**

There were data from 6 studies4,25-27,31,32,35 that investigated inadequate sleep quantity, and the prevalences were 41.0% (children having access to a bedtime media device) and 31.5% (children not having access to a device). The OR was 1.79 (95% CI, 1.39-2.31) (P = .001, $I^2 = 64\%$) (Figure 4). There was an increased odds of inadequate sleep quantity among children who had access to a media device near bedtime. The IPD meta-analysis aOR was 1.88 (95% CI, 1.46-2.42) (P < .001) from 2 studies.3,27

**Poor Sleep Quality**

Dichotomous data were available from 4 studies3,25,27,32 that investigated poor sleep quality, and the prevalences were 44% (children having access to a bedtime media device) and 32.4% (children not having access to a device). The OR was extracted from 2 studies.26,35 The pooled OR for poor sleep quality was 1.53 (95% CI, 1.11-2.10) (P = .009, $I^2 = 74\%$) (eFigure 2 in the *Supplement*). There was an increased odds of poor sleep quality in children who had access to a media device in the sleep environment near bedtime.

**Excessive Daytime Sleepiness**

Dichotomous data were available from 3 studies3,25,32 that investigated excessive daytime sleepiness, and the prevalences were 13.2% (children having access to a bedtime media device) and 4.9% (children not having access to a device). The OR was extracted from an additional study.35 The pooled OR for excessive daytime sleepiness was 2.27 (95% CI, 1.54-3.35) (P < .001, $I^2 = 24\%$) (eFigure 3 in the *Supplement*). There was an increased odds of excessive daytime sleepiness in children who had access to a media device in the sleep environment near bedtime.

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**Figure 3. Children With Poor Sleep Quality**

<table>
<thead>
<tr>
<th>Source</th>
<th>Log Odds Ratio</th>
<th>SE</th>
<th>Device Users Near Bedtime, Total No.</th>
<th>No Access to a Device, Total No.</th>
<th>Odds Ratio (95% CI)</th>
<th>Reduction in Odds</th>
<th>Increase in Odds</th>
<th>Weight, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arora et al,32 2014</td>
<td>0.157</td>
<td>0.150</td>
<td>440 298</td>
<td>1.17 (0.87-1.57)</td>
<td></td>
<td>19.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gamble et al,32 2014</td>
<td>0.703</td>
<td>0.125</td>
<td>555 629</td>
<td>2.02 (1.58-2.58)</td>
<td></td>
<td>20.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gradisar et al,3 2013</td>
<td>1.319</td>
<td>0.462</td>
<td>181 24</td>
<td>3.74 (1.51-9.24)</td>
<td></td>
<td>5.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysing et al,33 2015</td>
<td>0.392</td>
<td>0.065</td>
<td>0 0</td>
<td>1.48 (1.30-1.68)</td>
<td></td>
<td>24.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jiang et al,34 2015</td>
<td>0.329</td>
<td>0.094</td>
<td>0 0</td>
<td>1.39 (1.16-1.67)</td>
<td></td>
<td>22.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kubiszewski et al,35 2013</td>
<td>-1.470</td>
<td>0.546</td>
<td>141 43</td>
<td>0.23 (0.08-0.67)</td>
<td></td>
<td>4.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lemola et al,27 2015</td>
<td>1.008</td>
<td>0.867</td>
<td>180 182</td>
<td>2.74 (0.50-15.00)</td>
<td></td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total events</td>
<td></td>
<td></td>
<td>1497 1176</td>
<td>1.46 (1.14-1.88)</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity: $t^2 = 0.06; 
\chi^2 = 25.30; P < .001; I^2 = 76\%$

Test for overall effect: $z = 2.98; P = .003$

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**Figure 4. Alternate Comparison of Children With Inadequate Sleep Quantity**

<table>
<thead>
<tr>
<th>Source</th>
<th>Access to a Device</th>
<th>No Access to a Device</th>
<th>Odds Ratio (95% CI)</th>
<th>Reduction in Odds</th>
<th>Increase in Odds</th>
<th>Weight, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buxton et al,25 2015</td>
<td>108</td>
<td>238</td>
<td>289 865</td>
<td>1.66 (1.24-2.22)</td>
<td></td>
<td>21.6</td>
</tr>
<tr>
<td>Chahal et al,31 2013</td>
<td>229</td>
<td>577</td>
<td>888 2819</td>
<td>1.43 (1.19-1.72)</td>
<td></td>
<td>26.0</td>
</tr>
<tr>
<td>Gamble et al,32 2014</td>
<td>376</td>
<td>884</td>
<td>81 300</td>
<td>2.00 (1.50-2.67)</td>
<td></td>
<td>21.7</td>
</tr>
<tr>
<td>Gradisar et al,3 2013</td>
<td>45</td>
<td>61</td>
<td>52 92</td>
<td>2.16 (1.07-4.37)</td>
<td></td>
<td>9.1</td>
</tr>
<tr>
<td>Kubiszewski et al,35 2013</td>
<td>55</td>
<td>221</td>
<td>24 111</td>
<td>1.20 (0.70-2.07)</td>
<td></td>
<td>12.6</td>
</tr>
<tr>
<td>Lemola et al,27 2015</td>
<td>118</td>
<td>287</td>
<td>10 75</td>
<td>4.54 (2.24-9.19)</td>
<td></td>
<td>9.0</td>
</tr>
<tr>
<td>Total events</td>
<td>931</td>
<td>2268</td>
<td>1344 4262</td>
<td>1.79 (1.39-2.31)</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Heterogeneity: $t^2 = 0.06; 
\chi^2 = 13.77; P = .02; I^2 = 64\%$

Test for overall effect: $z = 4.51; P < .001$

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We compared children having access to a media device with children not having access to a device.

We compared children having bedtime media device use with children not having access to a device. The number of participants was not provided by Hysing et al33 or Jiang et al34; only the results from the statistical analysis were reported.
Subgroup Analyses
There were no subgroup associations found owing to the quality of included studies or type of media device. Similarly, there was no subgroup association for the age of the children, although most were between 10 and 18 years old.

GRADE Assessment
The GRADE assessment of included studies was low because of their nonrandomized nature. The assessment of the findings was upgraded owing to the large effect sizes found but was downgraded because of the substantial heterogeneity. Therefore, the level of evidence is low, meaning that the results may change on publication of further evidence.

Discussion
Summary of the Findings
To our knowledge, this study is the first systematic review and meta-analysis to quantify the association of media device access and use with children's sleep. We found that bedtime device use was associated with an increase in the odds of inadequate sleep quantity, poor sleep quality, and excessive daytime sleepiness. Media device presence in the bedroom (even without use) was also associated with an increased odds of detrimental sleep outcomes.

This study is the first systematic review and meta-analysis to date to include a robust quality assessment that quantified the association of media device access and use with poor sleep outcomes.8 Our study provides supporting evidence for an interaction between media device use and psychophysiological arousal as a key mechanism of effect.33 Our findings support recommendations that interventions should be developed and evaluated to reduce media device access and use at bedtime. Specifically, we support age-specific guidance for media device access and use33 and parent-led initiatives to reduce device access and use in collaboration with teachers and health care professionals.39

These findings support current clinical opinion that media device access and use result in poor sleep outcomes. The limitations of research in this area include measurement error of self-reported data, difficulty in ascertaining causality, isolation of the influences of specific exposures, technological devices outpacing research, and weaknesses inherent to observational study designs. Substantial heterogeneity was found in many of the meta-analyses and is likely a reflection of the included nonrandomized studies. Therefore, a degree of caution is needed when interpreting these findings.

Implications for Policy and Practice
The deleterious association between screen-based media use and sleep in children and adolescents is a major public health concern. Given the evolving technological landscape and the replacement of textbooks with media devices in schools, screen-based media device access and use are likely to rise. It is imperative that teachers, health care professionals, parents, and children are educated about the damaging influence of device use on sleep. Policy-led population-level health promotion to not stigmatize individual children but guide communities to promote the importance of sleep hygiene is needed. In addition, we encourage screening of children during routine clinical visits (by health visitors, school nurses, or family physicians) to identify those with inadequate sleep to explore device use as a potential cause and target sleep hygiene promotion.

Implications for Research
Multidisciplinary interventions to improve sleep hygiene have been investigated40,41; however, pragmatic studies are needed to understand the mechanism of action and causal pathway between device use and sleep using objective data collection methods. Interventions could be delivered by family physicians as a part of routine care for those seen with health concerns and by teachers who introduce devices into education.41 Device technologists should investigate software and parent-led interventions, such as automatic time switches to restrict access to media devices near bedtime. Interventions and policies must be developed, evaluated, and implemented at the population level to raise awareness of the potential health hazard to improve sleep hygiene through an integrated approach involving teachers, health care professionals, and parents.

Conclusions
Media device access and use at bedtime are significantly associated with detrimental sleep outcomes and lead to poor health outcomes. We recommend that interventions to minimize device access and use need to be developed and evaluated. Interventions should include a multidisciplinary approach from teachers and health care professionals to empower parents to minimize the deleterious influence on child health.
Use of Screen-Based Media Devices and Sleep Outcomes

Conflict of Interest Disclosures: None reported.

Funding/Support: This research is funded in part by grant 5R13HD073352 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (Dr Hale).

Role of the Funder/Sponsor: The funding source had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

REFERENCES