

# BMJ Open

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Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2014-005517
Article Type:	Research
Date Submitted by the Author:	21-Apr-2014
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<b>Primary Subject Heading</b>:	Epidemiology
Secondary Subject Heading:	Epidemiology, Mental health, Public health
Keywords:	EPIDEMIOLOGY, MENTAL HEALTH, PAEDIATRICS

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# Prevalence and Correlates of Sleep Disturbance and Depression Among Chinese Adolescents

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**Keywords:** Prevalence, Sleep disturbance, depression, risk factors, Chinese adolescents

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**Word count:** 3,310

**Strengths and limitations of this study:**

There has been a lack of epidemiological research about both sleep disturbance and depressive mood among Chinese adolescents

The results of the study show the prevalence of students' reported poor sleep quality is more prevalent than the prevalence of depression reported in China.

There is an association between sleep disturbance and depression.

The study demonstrates that an adolescent's family, school, and psychosocial factors influence their sleep qualities and depressive mood.

The sample size limits the conclusions that can be drawn from the multivariate analysis; however, this was a secondary objective of the study.

1  
2  
3 **ABSTRACT**

4 **Study objective:** To investigate the prevalence and the risk factors of sleep disturbance and depression  
5 among Chinese adolescents, and to examine the association of the two problems.  
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8 **Design:** Cross sectional survey research  
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10 **Participants:** A total of 3,485 school students in junior high school and senior high school from the  
11 sampled schools in Guangdong, and a stratified cluster random sampling strategy was used to select the  
12 schools.  
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15 **Main outcome measures:** A self-administered questionnaire was used. *The Pittsburgh sleep quality*  
16 *index (PSQI)* was used to assess sleep quality, and *the Center for Epidemiology Scale for Depression*  
17 *(CES-D)* was used to identify whether individuals had a depressive mood.  
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20 **Results:** In total, the mean PSQI global score was 8.69 ( $\pm$  2.40) points, and 43.6% of the total sample  
21 was thought to have poor sleep quality (collectively known as sleep disturbance). The mean CES-D  
22 score of students was 15.23 ( $\pm$  9.36) points, and 6.7% of the students had depression according the  
23 CES-D. Additionally, the results revealed that the girls, the 14-18 year age group, and the older than 19  
24 years age group were all more likely to suffer from sleep disturbance, and the students who had  
25 depression were 3.17 times more likely to suffer from sleep disturbance than those who did not have  
26 the depression. Factors that were determined to be both correlated with sleep disturbance and  
27 depression having a poor relationship with teachers, feeling lonely, suicide-ideation, running away  
28 from home.  
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31 **Conclusion:** Sleep disturbance was determined to be more prevalent among Chinese adolescents than  
32 having depression. School factors, family factors, and psychosocial adjustment were both correlated  
33 with sleep disturbance and depression, and there was an association between the students with sleep  
34 disturbances and depression.  
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## 1 INTRODUCTION

2 Sleep plays very important roles in the development of adolescents; it not only impacts physical  
3 growth, behavior, and emotional development but it also affects learning and attention.[1] Adolescence  
4 is a period of immense behavioral, psychological and social changes and challenges. Sleep is essential,  
5 accounting for approximately 40% of a child's typical day.[2] Previous studies have estimated that a  
6 large amount (estimated prevalence of 25%-40%) of adolescents have sleep problems.[3] In Western  
7 countries, estimates of the prevalence of sleep problems for adolescents range from 11% to 30%.[4] It  
8 is well known that poor sleep quality (collectively known as sleep disturbance) in the teenage years has  
9 adverse effects on developmental processes, psychosocial function, and general ability. For example,  
10 insomnia is a disease characterized by poor sleep quality; epidemiology studies have indicated that  
11 insomnia is linked to behavioral and emotional problems, such as depression and poor social  
12 competence.[5] Prospective studies have found that adolescents with insomnia are more likely to  
13 develop and maintain depression than are adolescents without insomnia.[6] In addition, the sleep  
14 problems of adolescents are not only influenced by biological and psychological factors but also by  
15 cultural and social factors.[7] People suffering from sleep disturbances have lower self-rated health,  
16 more physical and mental health complaints, such as depression, and more absences from school or  
17 work due to sickness.[8] Previous studies have differing results about the sleep disturbances between  
18 the two genders,[9] and a study in Taiwan reported that women scored 1.25 points higher than men on  
19 the insomnia inventory.[10] In a study by Liu, the prevalence of sleep disturbance varies with age and  
20 grade level among adolescents, and adolescents from incomplete families were more likely to have  
21 poorer sleep quality when compared with their peers.[11] In addition, a school environment is very  
22 important for the sleep quality and mental status of adolescents.[12] It has been reported that the  
23 prevalence of sleep problems in children and adolescents with depression ranges from 66% to 90%.[3]  
24 Recently, many researchers reported that sleep disturbance can be a sign of depression, and depression  
25 can likewise be a sign of sleep disturbance.[13] It has also been reported that sleep disturbance and  
26 depressed are closely related, and insufficient sleep may result in depression.[14]

27 Although we concluded that sleep quality and mental health are universal phenomenon, it is clear  
28 that sleep behavior and mental problems in adolescents vary according to ethnic and socio-cultural  
29 backgrounds.[15] Thus, different cultural backgrounds and genetic characteristics may result in  
30 different sleep/mental problems among adolescents. Previous studies about sleep quality and

1 depression have rarely focused on adolescents in mainland China; it is unknown whether sleep  
2 disturbances and depression and their correlates occur in Chinese adolescents as they do in Western  
3 adolescents. Therefore, we conducted this cross-sectional study in China to investigate the sleep quality  
4 and depression of adolescents, to estimate the prevalence of sleep disturbance and depression, and to  
5 examine the relationship between potentially influential factors and their involvement in sleep  
6 disturbance and depression

## 7 8 **METHODS**

### 9 **Study design and participants**

10 A cross-sectional study was conducted and based on a province-wide sample to investigate the sleep  
11 quality and depression of adolescents, to estimate the prevalence of sleep disturbance and depression,  
12 and to examine the relationship between potentially influential factors and their involvement in sleep  
13 quality and depression. The participants were middle school students from Guangdong, China.  
14 Guangdong is known as an immigrant province, with more than half of the population migrating from  
15 other provinces; therefore, the sample from Guangdong has a certain degree of representativeness. The  
16 schools were divided into three categories: junior high schools, senior high schools, and vocational  
17 schools. A stratified cluster random sampling method was used to randomly select participants among  
18 the three types of schools. Six junior high schools, four senior high schools, and two vocational schools  
19 were selected. Next, two classes were randomly selected from each grade in these schools. All  
20 available students within the grade were surveyed; those not surveyed were absent or refused to  
21 participate and consisted of less than 1% of the student population. All the participants were fully  
22 informed of the purpose of the survey and were invited to participate voluntarily. Written consent  
23 letters were obtained from the school, each participating student and one of the student's parents. A  
24 rigorously anonymous method for collection of the self-report questionnaires was guaranteed. The  
25 questionnaires were administered by research assistants in the classrooms without the presence of the  
26 teachers. It is important to stress that the questions of this questionnaire were based on an instrument  
27 proposed by the WHO and adapted to the realities of China, and the findings of a number of  
28 investigations indicate that such data can be extremely useful.[16-18]

### 29 30 **Measures**

### 1 **Independent variable**

2 Socio-demographic variables: Age, grade, gender and so on.

3 Family factors: Living arrangement, family economic status, family relationship, and parental caring.

4 Living arrangements were assessed by asking who lived in the student's primary home. Family  
5 economic status was measured by asking the student's perception of their family's current economic  
6 status (rated from below average to above average). Family relationships were assessed by asking the  
7 students, with the responses coded on a 3-point scale ranging from below average to above average.

8 Parental caring was assessed by asking, "Are you satisfied with the love you receive from your father,  
9 mother, or both of them, based on a 4-point scale from dissatisfaction to satisfaction?"

10 School factors: Classmate relations and teacher-classmate relations were also assessed based on the  
11 student's self-rating about their relationships with classmates and teachers, ranging from poor to good.

12 Academic achievements were captured by a single item asking about a personal appraisal of students'  
13 performances relative to that of their classmates (responses were coded as "above average", "average",  
14 and "below average").

15 Psychosocial adjustment: Feeling lonely was assessed by asking, "During the past 12 months, how  
16 often did you feel lonely per week?" Response options ranged from 1 (never) to 4 (over 4 days).

17 Suicide-ideation status was based on whether a participant had endorsed thoughts of suicide over the  
18 past year. Suicide-attempt status was based on attempts made over the past year, with 1 or more  
19 attempts indicating endorsement. A student's attempt to hurt themselves was assessed by asking,

20 "During the past 12 months, did you ever hurt yourself on purpose?" Responses were categorized into  
21 4 groups: never, considered, planned, and attempted. Running away from home was assessed by asking,

22 "During the past 12 months, did you run away from home without your parents' permission for more  
23 than 24 hours?" Response options were 1) never, 2) considered, 3) attempted, or 4) have run away from  
24 home one time or more.

25

### 26 **Dependent variables**

27 We used the *Pittsburgh sleep quality index (PSQI)* to assess sleep quality and disturbances over a  
28 1-month time interval; the sum of the scores for these seven components yields one global score with a  
29 range of 0-21 points in which higher scores indicate worse sleep quality.[17] The Chinese version of  
30 this test, which has been shown to be valid and reliable, is also commonly used. In China, a PSQI

1 global score of above 7 points indicates poor sleep quality collectively known as *sleep disturbance*; a  
2 higher score indicates a greater reduction in sleep quality.[19]

3 Depression is one type of common mental disorders;[20] in our study, *the Center for Epidemiology*  
4 *Scale for Depression (CES-D)* was used to identify whether individuals had a depressive mood. The  
5 respondents were asked to rate the frequency, over the past week, of 20 symptoms of depression by  
6 choosing one of four response options ranging from “rarely or none of the time” to “most or all of the  
7 time”. [21] The scores range from 0 to 60, with a score greater than 28 indicating “Depression”. For the  
8 CES-D survey, those who failed to answer at least 17 of the 20 items were discarded.

### 10 **Statistical analysis**

11 All data were entered by two investigators independently using EpiData 3.1, and the statistical  
12 analyses were conducted using SPSS 21.0 and SAS 9.2. Descriptive analyses were used to describe  
13 demographic characteristics and the prevalence of sleep disturbances and depression among  
14 adolescents. Categorical and continuous data were reported in the form of proportions and means (SD).  
15 Chi-squared tests were used to test the difference between the categorical variables referred to above.  
16 Multivariate logistic regression models included the significant variables that had been tested by  
17 univariate analyses or that have been widely reported in the literature; these were used to screen for the  
18 risk factors for sleep disturbance/ depression according to the odds ratios (ORs) and 95% confidence  
19 intervals (95% CIs). An  $OR > 1$  with a  $P < 0.05$  was reported as a risk factor. Considering that our study  
20 using a multi-stage sampling, students were grouped into classes; therefore, differences might not  
21 segregate independently. Thus, a multi-level analysis was performed to select possible factors that  
22 might influence students’ sleep disturbances and depression. The CLMMIX procedure in SAS was used  
23 to fit the two-level logistic regression mixed models in which classes were treated as clusters. All  
24 statistical tests were two-sided with a  $P$  value less than 0.05 considered significant.

## 26 **RESULTS**

### 27 **Demographic information**

28 A total of 3,485 participants were involved in this analysis. *Table 1* provides the basic demographic  
29 information for the sample involved in this study. The proportion of male students was 53.9%, and the  
30 male-to-female ratio was approximately 1.2:1. The students ranged in age from 9 to 21 years old, and

1 the mean age of the students was 15.7 ( $\pm 1.90$ ) years; the most common age group was 14-18 years old.  
2 The junior group of students represented 49.8% of the sample, while the senior group of students  
3 comprised 50.2% of the sample. Regarding the family factors, a total of 88.9% of students lived with  
4 both biological parents, whereas 4.6% lived in single-parent families. A total of 15.4% of students  
5 thought of their family relationships as average, and 77.1% of students were satisfied with both of their  
6 parents' love. A subset of students (29.9%) reported that their current economic status was above  
7 average, whereas 9.4% reported that their economic status was below average. Regarding school  
8 factors, 29.1% of the students appraised themselves as average in their academic achievement, while  
9 28.7% of students rated themselves as below average. Additionally, 42.9% of the students thought their  
10 academic pressure was above average. A total of 7.5% of participants reported poor relationships with  
11 their teachers, and 4.1% had poor relations with their classmates. Regarding the psychosocial factors,  
12 13.8% of students felt lonely more than 4 days per week. A total of 3.5% of students often had  
13 suicide-ideation, and 1.9% of students had attempted suicide often. In addition, 2.8% of participants  
14 often hurt themselves on purpose, and 3.7% of participants had run away from home more than once.

#### 16 **Univariate Analysis for Sleep disturbance and Depression**

17 According to the PSQI, the mean PSQI global score was 8.69 ( $\pm 2.40$ ) points, and 43.6% of the total  
18 sample was thought to have sleep disturbances (had a global score higher than 8 points). In addition,  
19 6.7% of the students had depression, according the CES-D. The mean CES-D score of students was  
20 15.23 ( $\pm 9.36$ ) points. As shown in *Table 2*, without adjustment for other variables, sleep disturbances  
21 and depression groups were correlated with gender, family economic status, family relationships,  
22 parental caring, academic pressure, relationships with teachers or classmates, feeling lonely,  
23 suicide-ideation, suicide-attempt, hurting themselves on purpose, and running away from home. Only  
24 age, grade, and depression were significantly correlated with having a sleep disturbance, while only  
25 living arrangements and sleep disturbances were significantly correlated with depression.

#### 27 **Multilevel Logistic Regression Analysis: Sleep disturbance**

28 The final logistic regression model for sleep disturbance is presented in *Table 3*. Eight of the original  
29 variables remained in the final model: gender, age, habit of sleep duration after lunch, family  
30 relationships, relationships with teachers, feeling lonely, suicide-ideation, running away from home,



1 and depression. The results revealed that the girls, the 14-18 year age group, and the older than 19  
2 years age group were all more likely to suffer from sleep disturbance. Taking frequent or occasional  
3 naps after lunch was a risk factor for sleep disturbance compared with the group that rarely or never  
4 had the habit of sleep duration after lunch. Students with average family relationships (OR=1.34, 95%  
5 CI=1.08-1.67) and below average family relationships (OR=1.27, 95% CI=0.90-1.81) had a higher  
6 probability of sleep disturbance. Likewise, students with average or poor relationships with teachers  
7 were more troubled with sleep disturbances. In addition, students feeling lonely 1-4 days a week  
8 (OR=1.69, 95% CI=1.38-2.07) or over 4 days a week (OR=3.30, 95% CI=2.42-4.50) had a higher  
9 probability of sleep disturbances. Having occasional or frequent suicide-ideations were risk factors for  
10 sleep disturbance, and students who considered running away from home (OR=1.43, 95%  
11 CI=1.19-1.73) and attempted running away from home (OR=2.38, 95% CI=1.23-4.62) were also risk  
12 factors for sleep disturbance compared to students who had never considered running away from home.  
13 Finally, students who had depression were 3.17 times more likely to suffer from sleep disturbance than  
14 those who did not have the depression.

15

### 16 **Multilevel Logistic Regression Analysis: Depression**

17 The final model for depression in *Table 4* showed many correlations. Having average relationships  
18 with teachers (OR=3.10, 95% CI=1.83-5.25) or poor relationships with teachers (OR=1.55, 95%  
19 CI=1.11-2.16) were risk factors for having depression. Students who felt lonely 1-4 days a week  
20 (OR=1.77, 95% CI=1.01-3.08) and over 4 days a week (OR=3.83, 95% CI=2.10-7.00) also had a  
21 higher probability of having depression. Likewise, students occasionally or sometimes having  
22 suicide-ideation had a higher probability of having depression. Considering running away from home  
23 (OR=2.91, 95% CI=1.99-4.25), planning to run away from home (OR=3.71, 95% CI=1.98-6.93), and  
24 attempting to run away from home (OR=4.63, 95% CI=2.48-8.63) were also risk factors for depression  
25 compared to students who never considered running away from home. Students with sleep disturbances  
26 were also more likely to have depression (OR=3.35, 95% CI=2.31-4.87).

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28

### 29 **DISCUSSION**

30 Similar studies have already reported that the prevalence of sleep problems in children and

1 adolescents ranges from 66% to 90%.[22] In this study, the prevalence of adolescents with sleep  
2 disturbances was 43.6%. A report from China in 2000 revealed that 16.9% of the sample was troubled  
3 with insomnia symptoms,[23] while a report from China in 1987 revealed that the prevalence was  
4 14.9%.[24] This study agrees with the results from a Western report in which 43.0% of children  
5 experienced a sleep problem.[25] Therefore, the considerable variation in the prevalence of sleep  
6 disturbances may due to the different time periods, different target populations, and different  
7 methodological definitions of sleep disturbances, and now poor sleep quality is a prevalent public  
8 health problem among Chinese adolescents.

9 Our results indicated that the proportion of male and female adolescents with a sleep disturbance was  
10 21.8% respectively; and the girls were all more likely to suffer from sleep disturbance, and these results  
11 agreed with the previous study from Anhui province in China.[14] Additionally, the previous study  
12 from Hong Kong had reported that the prevalence of sleep disturbances among females was higher, [9]  
13 and most of the studies from other countries also found that girls were more likely to report sleep  
14 disturbances than boys.[26-28] In this study, the 14-18 year olds and the senior grade group were the  
15 groups most commonly associated with sleep disturbance, which was in line with a previous study  
16 from China that reported that older age or higher grade level was associated with more sleep  
17 problems.[23] Additionally, multivariate logistic regression analyses performed to control for  
18 confounding factors and to determine the main correlates of sleep disturbance finally presented that  
19 family relationships, relationships with teachers, feeling lonely, suicide-ideation, running away from  
20 home, and depression were correlated with sleep disturbance; in particular, students with the adverse  
21 events of the above factors had a higher probability of suffering from sleep disturbance. These findings  
22 are in accordance with the results of many previous studies; for example, a study from Shandong  
23 province of China in 2000 also reflected that poor marital relations of parents, poor family economic  
24 status, poor child-parent and peer relations, poor school achievement and social competence were the  
25 risk factors for sleep problems.[23] Therefore, we find that adolescents' sleep problems are correlated  
26 with multiple family, school and psychosocial factors; thus, we should focus on these factors to reduce  
27 the prevalence of adolescents with sleep disturbances.

28 In this study, we found that the prevalence of students having depression was 6.7%; similarly, an  
29 Australia study reported that the prevalence was 8.0%.[19] As previously reported, adolescent  
30 depression is a prevalent and disabling condition resulting in emotional suffering and sleep dysfunction;

1 therefore, it is important for us to focus on this problem.[3] Our study reported that the prevalence of  
2 depression among females was not much higher than among males, but a previous study reported  
3 prevalence rates of emotional problems to be higher in boys than in girls.[29] These differences may  
4 due to emotional problems, including depression and others. The results of our multivariate logistic  
5 regression were that average or below average relationships with classmates, feeling lonely more than 1  
6 day per week, having suicide-ideations, considering or attempting to run away from home, and having  
7 sleep disturbances were risk factors for having depression. A previous study reported that the point  
8 prevalence of major depression was 8.4%, and the effects of age, socioeconomic status, and  
9 psychosocial status yielded significant odds ratios for Chinese group depression.[30] Thus, we  
10 observed that depression can lead to sleep disturbances, and vice versa.

11 There are several limitations to the current study. First, although the sample size was large, the  
12 sample was drawn from a rural prefecture of mainland China; therefore, further studies are required to  
13 generalize the results to all Chinese children. Secondly, the questionnaires did not include items that  
14 could address students with sleep-related breathing problems, and some psychological diseases, such as  
15 attention-deficit hyperactivity disorder (ADHD). Thirdly, it should be noted that the present results that  
16 were based on a structured self-rating questionnaire were cross-sectional and retrospective; although  
17 self-reporting is a common and accepted method, we could not completely rule out the possibility of  
18 recall bias. To minimize subjectivity, students were provided with a detailed definition of the  
19 information about *the PSQI* and *the CES-D*.

20 Our study presents the prevalence and relevant risk factors for sleep disturbances and depression  
21 among youth in China; further research is warranted. Although there were some limitations to this  
22 study, the results were similar to the previous study about adolescents' sleep qualities and depression.  
23 In summary, an adolescent's family, school, and psychosocial factors influence their sleep quality and  
24 depressive mood. The prevalence of sleep disturbance observed in this study suggests the importance  
25 of research on preventive interventions targeting sleep quality among Chinese students, and effective  
26 preventive measures require full consideration of the social and environmental factors, and we should  
27 focus on the high-risk population whose family factors, school factors, and psychosocial adjustments  
28 are negative.

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1    **Ethical statement**

2        This study received approval from the Sun Yat-Sen University School of Public Health Institutional  
3    Review Board. The participants were fully informed of the purpose of the study and were invited to  
4    participate voluntarily. Written letters of consent were obtained from the schools of the participating  
5    students and either of the student's parents.

6  
7    **Contributors**

8    GL and LCY searched the literature, conceived the study, designed the study analysed the data,  
9    interpreted the results, and draft the report. DJX and HY organized the study, collected the data and  
10    analysed the data. DXQ, HJW, HGL, GX collected the data, interpreted the results, and obtained  
11    funding.

12  
13    **Acknowledgments:** We gratefully acknowledge the contribution of the Guangdong Education Bureau  
14    and its participating schools. We would like to thank the local health professionals, principals and  
15    teachers of participating schools. We express great thanks to all participants of our study.

16  
17    **Funding Source:** This study was supported by Guangdong Food and Drug Administration. The  
18    funders had no role in study design, data collection and analysis, decision to publish, or preparation of  
19    the manuscript.

20  
21    **Conflict of Interest:** The authors have declared that no competing interests exist.

22  
23    **Financial Disclosure:** The authors have no financial relationships relevant to this article to disclose.

## References:

- 1     1   Anders TF, Eiben LA. Pediatric sleep disorders: a review of the past 10 years. *J Am Acad Child*  
2     3     *Adolesc Psychiatry* 1997;**36**:9-20.
- 3     2   Owens J. Classification and epidemiology of childhood sleep disorders. *Prim Care*  
4     5     2008;**35**:533-46.
- 6     3   Ivanenko A, Crabtree VM, Gozal D. Sleep and depression in children and adolescents. *Sleep Med*  
7     8     *Rev* 2005;**9**:115-29.
- 9     4   Lazaratou H, Dikeos DG, Anagnostopoulos DC, *et al.*. Sleep problems in adolescence. A study of  
10    11   senior high school students in Greece. *Eur Child Adolesc Psychiatry* 2005;**14**:237-43.
- 12   5   Taylor DJ, Lichstein KL, Durrence HH. Insomnia as a health risk factor. *Behav Sleep Med*  
13   14   2003;**1**:227-47.
- 15   6   Roane BM, Taylor DJ. Adolescent insomnia as a risk factor for early adult depression and  
16   17   substance abuse. *Sleep* 2008;**31**:1351-6.
- 18   7   Stores G. Children's sleep disorders: modern approaches, developmental effects, and children at  
19   20   special risk. *Dev Med Child Neurol* 1999;**41**:568-73.
- 21   8   Pigeon WR, Cerulli C, Richards H, *et al.*. Sleep disturbances and their association with mental  
22   23   health among women exposed to intimate partner violence. *J Womens Health (Larchmt)*  
24   25   2011;**20**:1923-9.
- 26   9   Chung KF, Cheung MM. Sleep-wake patterns and sleep disturbance among Hong Kong Chinese  
27   28   adolescents. *Sleep* 2008;**31**:185-94.
- 29   10   Chen YY, Kawachi I, Subramanian SV, *et al.*. Can social factors explain sex differences in  
30   31   insomnia? Findings from a national survey in Taiwan. *J Epidemiol Community Health*

- 1 2005;**59**:488-94.
- 2 11 Liu X, Zhao Z, Jia C, *et al.*. Sleep patterns and problems among chinese adolescents. *Pediatrics*
- 3 2008;**121**:1165-73.
- 4 12 Li SH, Shen XM, Jin XM, *et al.*. [Sleep habits and sleep disturbance in school-age children of
- 5 China]. *Zhonghua Er Ke Za Zhi* 2008;**46**:185-9.
- 6 13 Roehr B. American Psychiatric Association explains DSM-5. *BMJ* 2013;**346**:f3591.
- 7 14 Xu Z, Su H, Zou Y, *et al.*. Sleep quality of Chinese adolescents: distribution and its associated
- 8 factors. *J Paediatr Child Health* 2012;**48**:138-45.
- 9 15 Rona RJ, Li L, Gulliford MC, *et al.*. Disturbed sleep: effects of sociocultural factors and illness.
- 10 *Arch Dis Child* 1998;**78**:20-5.
- 11 16 Crockett LJ, Beal SJ. The life course in the making: gender and the development of adolescents'
- 12 expected timing of adult role transitions. *Dev Psychol* 2012;**48**:1727-38.
- 13 17 Buysse DJ, Reynolds CR, Monk TH, *et al.*. The Pittsburgh Sleep Quality Index: a new instrument
- 14 for psychiatric practice and research. *Psychiatry Res* 1989;**28**:193-213.
- 15 18 Wang M, Armour C, Wu Y, *et al.*. Factor structure of the CES-D and measurement invariance
- 16 across gender in Mainland Chinese adolescents. *J Clin Psychol* 2013;**69**:966-79.
- 17 19 Tsai PS, Wang SY, Wang MY, *et al.*. Psychometric evaluation of the Chinese version of the
- 18 Pittsburgh Sleep Quality Index (CPSQI) in primary insomnia and control subjects. *Qual Life Res*
- 19 2005;**14**:1943-52.
- 20 20 Lee LC, Halpern CT, Hertz-Picciotto I, *et al.*. Child care and social support modify the
- 21 association between maternal depressive symptoms and early childhood behaviour problems: a US
- 22 national study. *J Epidemiol Community Health* 2006;**60**:305-10.

- 1  
2  
3  
4 1 21 Myers JK, Weissman MM. Use of a self-report symptom scale to detect depression in a  
5  
6 2 community sample. *Am J Psychiatry* 1980;**137**:1081-4.  
7  
8  
9 3 22 Meltzer LJ, Avis KT, Biggs S, *et al.*. The Children's Report of Sleep Patterns (CRSP): a  
10  
11 4 self-report measure of sleep for school-aged children. *J Clin Sleep Med* 2013;**9**:235-45.  
12  
13 5 23 Liu X, Uchiyama M, Okawa M, *et al.*. Prevalence and correlates of self-reported sleep problems  
14  
15 6 among Chinese adolescents. *Sleep* 2000;**23**:27-34.  
16  
17 7 24 Yang L, Zuo C, Eaton LF. Research note: sleep problems of normal Chinese adolescents. *J Child*  
18  
19 8 *Psychol Psychiatry* 1987;**28**:167-72.  
20  
21 9 25 Kahn M, Sheppes G, Sadeh A. Sleep and emotions: Bidirectional links and underlying  
22  
23 10 mechanisms. *Int J Psychophysiol* 2013;**89**:218-28.  
24  
25 11 26 Ohayon MM, Roberts RE, Zulley J, *et al.*. Prevalence and patterns of problematic sleep among  
26  
27 12 older adolescents. *J Am Acad Child Adolesc Psychiatry* 2000;**39**:1549-56.  
28  
29 13 27 Abdel-Khalek AM. Prevalence of reported insomnia and its consequences in a survey of 5,044  
30  
31 14 adolescents in Kuwait. *Sleep* 2004;**27**:726-31.  
32  
33 15 28 Ohida T, Osaki Y, Doi Y, *et al.*. An epidemiologic study of self-reported sleep problems among  
34  
35 16 Japanese adolescents. *Sleep* 2004;**27**:978-85.  
36  
37 17 29 Liu X, Kurita H, Guo C, *et al.*. Prevalence and risk factors of behavioral and emotional problems  
38  
39 18 among Chinese children aged 6 through 11 years. *J Am Acad Child Adolesc Psychiatry*  
40  
41 19 1999;**38**:708-15.  
42  
43 20 30 Roberts RE, Roberts CR, Chen YR. Ethnocultural differences in prevalence of adolescent  
44  
45 21 depression. *Am J Community Psychol* 1997;**25**:95-110.  
46  
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Table 1. Demographic characteristics of the Total Sample.

Variables	Numbers (%)
<b>Total</b>	3485 (100.0)
<b>Gender</b>	
Male	1877 (53.9)
Female	1608 (46.1)
<b>Age (years)</b>	
9-13	507 (14.5)
14-18	2734 (78.5)
≥19	244 (7.0)
<b>Grade</b>	
Junior	1734 (49.8)
Senior	1751 (50.2)
<b>Living arrangement</b>	
Two biological parents	3099 (88.9)
Only father or mother	160 (4.6)
Others	226 (6.5)
<b>Family economic status</b>	
Good	1041 (29.9)
Average	2116 (60.7)
Bad	328 (9.4)
<b>Family relationship</b>	
Above average	2740 (78.6)
Average	536 (15.4)
Below average	209 (6.0)
<b>Parental caring</b>	
Satisfied with father or mother	598 (17.2)
Satisfied with both of them	2686 (77.1)
Dissatisfied with both of them	201 (5.7)
<b>Academic achievement</b>	
Above average	1473 (42.3)
Average	1013 (29.1)
Below average	999 (28.7)
<b>Academic pressure</b>	
Above average	1497 (42.9)
Average	1487 (42.7)
Below average	501 (14.4)
<b>Relationship with teachers</b>	
Good	1681 (48.2)
Average	1542 (44.2)
Poor	262 (7.5)



**Table 1. Demographic characteristics of the Total Sample (continued).**

<b>Variables</b>	<b>Numbers (%)</b>
<b>Relationship with classmates</b>	
Good	2413 (69.2)
Average	931 (26.7)
Poor	141 (4.1)
<b>Feel lonely</b>	
Less than 1 Day/Week	1825 (52.4)
1 to 4 Days/Week	1178 (33.8)
More than 4 Days/Week	482 (13.8)
<b>Suicide-ideation</b>	
Never	2822 (81.0)
Occasionally (1-2 times/year)	439 (12.6)
Sometimes (3-6 times/year)	105 (3.0)
Often ( over 6 times/year)	119 (3.5)
<b>Suicide-attempt</b>	
Never	3292 (94.5)
Occasionally (1-2 times/year)	88 (2.5)
Sometimes (3-6 times/year)	39 (1.2)
Often ( over 6 times/year)	66 (1.9)
<b>Hurt themselves on purpose</b>	
Never	2996 (86.0)
Occasionally (1-2 times/year)	291 (8.4)
Sometimes (3-6 times/year)	99 (2.8)
Often ( over 6 times/year)	99 (2.8)
<b>Running away from home</b>	
Never	2447 (70.2)
Considered	873 (25.1)
Planned	57 (1.6)
Attempted	108 (3.1)

Table 2. Univariate chi-square analysis for sleep disturbance and depression, n (%).

Variables	Total	Sleep disturbance	Depression
<b>Total</b>	3485 (100.0)	1519 (43.6)	232 (6.7)
<b>Gender #</b>			
Male	1877 (53.9)	759 (21.8)	110 (3.2)
Female	1608 (46.1)	760 (21.8)	122 (3.5)
<b>Age (years) *</b>			
9-13	507 (14.5)	146 (4.2)	28 (0.8)
14-18	2734 (78.7)	1247 (35.8)	180 (5.2)
≥19	235 (6.7)	126 (3.6)	24 (0.7)
<b>Grade *</b>			
Junior	1734 (49.8)	664 (19.1)	114 (3.3)
Senior	1751 (50.2)	855 (24.5)	118 (3.4)
<b>Living arrangement **</b>			
Two biological parents	3099 (88.9)	1341 (38.5)	191 (5.5)
Only father or mother	60 (4.6)	82 (2.4)	16 (0.5)
Others	26 (6.5)	96 (2.7)	25 (0.7)
<b>Family economic status #</b>			
Good	1041 (29.9)	406 (11.8)	54 (1.5)
Average	2116 (60.7)	932 (26.8)	133 (3.8)
Bad	328 (9.4)	181 (5.0)	45 (1.3)
<b>Family relationship #</b>			
Above average	2740 (78.6)	1106 (31.8)	136 (3.9)
Average	536 (15.4)	282 (8.1)	49 (1.4)
Below average	209 (6.0)	131 (3.7)	47 (1.3)
<b>Parental caring #</b>			
Satisfied with father or mother	598 (17.2)	295 (8.5)	63 (1.8)
Satisfied with both of them	2686 (77.1)	1103 (31.6)	137 (4.0)
Dissatisfied with both of them	201 (5.7)	121 (3.5)	32 (0.9)
<b>Academic achievement **</b>			
Above average	1473 (42.3)	612 (17.6)	95 (2.7)
Average	1013 (29.1)	430 (12.3)	60 (1.7)
Below average	999 (28.7)	477 (13.7)	77 (2.3)
<b>Academic pressure #</b>			
Above average	1497 (42.9)	811 (23.3)	153 (4.4)
Average	1487 (42.7)	545 (15.7)	56 (1.6)
Below average	501 (14.4)	163 (4.7)	23 (0.7)
<b>Relationship with teachers #</b>			
Good	1681 (48.2)	616 (17.7)	79 (2.3)
Average	1542 (44.2)	756 (21.7)	109 (3.1)
Poor	262 (7.5)	147 (4.2)	44 (1.3)

**Table 2. Univariate Chi-square analysis for sleep disturbance and depression mood, n (%) (continued).**

<b>Relationship with classmates #</b>			
Good	2413 (69.2)	974 (28.0)	103 (3.0)
Average	931 (26.7)	468 (13.4)	90 (2.6)
Poor	141 (4.1)	77 (2.2)	39 (1.1)
<b>Feel lonely #</b>			
Less than 1 Day/Week	1825 (52.4)	614 (17.6)	35 (1.0)
1 to 4 Days/Week	1178 (33.8)	620 (17.8)	107 (3.1)
More than 4 Days/Week	482 (13.8)	285 (8.2)	90 (2.6)
<b>Suicide-ideation #</b>			
Never	2822 (81.0)	1112 (31.9)	94 (2.7)
Occasionally (1-2 times/year)	439 (12.6)	271 (7.8)	83 (2.4)
Sometimes (3-6 times/year)	105 (3.0)	66 (1.9)	21 (0.6)
Often ( over 6 times/year)	119 (3.5)	70 (2.0)	34 (1.0)
<b>Suicide-attempt #</b>			
Never	3292 (94.5)	1407 (40.4)	190 (5.5)
Occasionally (1-2 times/year)	88 (2.5)	58 (1.7)	23 (0.7)
Sometimes (3-6 times/year)	39 (1.2)	30 (0.8)	3 (0.1)
Often ( over 6 times/year)	66 (1.9)	24 (0.7)	16 (0.5)
<b>Hurt themselves on purpose #</b>			
Never	2996 (86.0)	1251 (35.9)	159 (4.6)
Occasionally (1-2 times/year)	291 (8.4)	165 (4.7)	44 (1.3)
Sometimes (3-6 times/year)	99 (2.8)	54 (1.5)	14 (0.4)
Often ( over 6 times/year)	99 (2.8)	49 (1.4)	15 (0.4)
<b>Running away from home #</b>			
Never	2447 (70.2)	924 (26.5)	87 (2.5)
Considered	873 (25.1)	495 (14.2)	117 (3.4)
Planned	57 (1.6)	42 (1.2)	10 (0.3)
Attempted	108 (3.1)	58 (1.7)	18 (0.5)
<b>Depression mood *</b>			
Yes	232 (6.7)	183 (5.3)	-
No	3253 (93.3)	1336 (38.3)	-
<b>Sleep disturbance **</b>			
Yes	1519 (43.6)	-	183 (5.3)
No	1966 (56.4)	-	49 (1.4)

#: According to the Chi-square test without adjust other variables,  $P < 0.05$  both in Sleep disturbance and Depression group.

\*:  $P < 0.05$ , only in Sleep disturbance group.

\*\* :  $P < 0.05$ , only in Depression mood group.

Table 3. Adjusted OR (95% CI) for Sleep disturbance by multi-level logistic regression.

Covariates	Adjusted OR (95% CI)	P-value
<b>Age (years)</b>		
9-13	1.00 (reference)	-
14-18	2.09 (1.66-2.63)	<.001
≥19	2.80 (1.92-4.07)	<.001
<b>Gender</b>		
Male	1.00 (reference)	-
Female	1.29 (1.11-1.50)	0.001
<b>Habit of sleep duration after lunch</b>		
Never	1.00 (reference)	-
Occasionally (1-4 times/week)	1.64 (1.22-2.19)	0.001
Often (over 4 times/week)	1.73 (1.29-2.34)	<.001
<b>Family relationship</b>		
Above average	1.00 (reference)	-
Average	1.31 (1.06-1.62)	0.012
Below average	1.27 (0.90-1.81)	0.178
<b>Relationship with teachers</b>		
Good	1.00 (reference)	-
Average	1.84 (1.32-2.56)	<.001
Poor	1.41 (1.21-1.65)	<.001
<b>Feel lonely</b>		
Less than 1 Day/Week	1.00 (reference)	-
1 to 4 Days/Week	1.69 (1.38-2.07)	<.001
More than 4 Days/Week	3.30 (2.42-4.50)	<.001
<b>Suicide-ideation</b>		
Never	1.00 (reference)	-
Occasionally (1-2 times/year)	1.39 (1.09-1.77)	0.008
Sometimes (3-6 times/year)	1.77 (1.01-3.12)	0.048
Often ( over 6 times/year)	0.95 (0.55-1.63)	0.852
<b>Running away from home</b>		
Never	1.00 (reference)	-
Considered	1.43 (1.19-1.73)	<.001
Planned	1.63 (0.86-3.09)	0.135
Attempted	2.38 (1.23-4.62)	0.010
<b>Depression mood</b>		
No	1.00 (reference)	-
Yes	3.17 (2.18-4.62)	<.001

NOTE: Adjusted OR means odds ration adjusted by student's age in the total sample because age a confounding for screening risk factors for adolescents sleep disturbances; 95% CI=95% confident interval.

Table 4. Adjusted OR (95% CI) for Depression mood by multi-level logistic regression.

Covariates	Adjusted OR (95% CI)	P-value
<b>Age (years)</b>		
9-13	1.00 (reference)	-
14-18	1.16 (0.76-1.79)	0.486
≥19	1.86 (0.99-3.49)	0.054
<b>Relationship with classmates</b>		
Good	1.00 (reference)	-
Average	3.10 (1.83-5.25)	<.001
Poor	1.55 (1.11-2.16)	0.010
<b>Feel lonely</b>		
Less than 1 Day/Week	1.00 (reference)	-
1 to 4 Days/Week	1.77 (1.01-3.08)	0.045
More than 4 Days/Week	3.83 (2.10-7.00)	<.001
<b>Suicide-ideation</b>		
Never	1.00 (reference)	-
Occasionally (1-2 times/year)	2.91 (1.99-4.25)	<.001
Sometimes (3-6 times/year)	3.71 (1.98-6.93)	<.001
Often ( over 6 times/year)	4.62 (2.48-8.63)	<.001
<b>Running away from home</b>		
Never	1.00 (reference)	-
Considered	2.91 (1.99-4.25)	<.001
Planned	3.71 (1.98-6.93)	<.001
Attempted	4.63 (2.48-8.63)	<.001
<b>Sleep disturbance</b>		
No	1.00 (reference)	-
Yes	3.35 (2.31-4.87)	<.001

NOTE: Adjusted OR means a student's age was adjusted for in the total sample because age was a confounding for screening risk factors for depression mood among adolescents; 95% CI=95% confident interval.

## STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation
<b>Title and abstract</b>	1	(a) Indicate the study's design with a commonly used term in the title or the abstract (b) Provide in the abstract an informative and balanced summary of what was done and what was found
<b>Introduction</b>		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
<b>Methods</b>		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants (b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding (b) Describe any methods used to examine subgroups and interactions (c) Explain how missing data were addressed (d) <i>Cohort study</i> —If applicable, explain how loss to follow-up was addressed <i>Case-control study</i> —If applicable, explain how matching of cases and controls was addressed <i>Cross-sectional study</i> —If applicable, describe analytical methods taking account of sampling strategy (e) Describe any sensitivity analyses

Continued on next page

**Results**

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage (c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders (b) Indicate number of participants with missing data for each variable of interest (c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time <i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure <i>Cross-sectional study</i> —Report numbers of outcome events or summary measures
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included (b) Report category boundaries when continuous variables were categorized (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses

**Discussion**

Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results

**Other information**

Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based
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\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).

# BMJ Open

## Prevalence and Correlates of Sleep Disturbance and Depressive symptoms Among Chinese Adolescents: a cross-sectional survey study

Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2014-005517.R1
Article Type:	Research
Date Submitted by the Author:	01-Jul-2014
Complete List of Authors:	Lan, Guo; Sun Yat-sen University, School of public health, Department of Medical Statistics and Epidemiology Jianxiong, Deng; Guangdong Food and Drug Administration, Centre for ADR monitoring of Guangdong Yuan, He; Sun Yat-sen University, Department of Medical Statistics and Epidemiology Xueqing, Deng; Sun Yat-sen University, Department of Medical Statistics and Epidemiology Jinghui, Huang; Guangdong Food and Drug Administration, Centre for ADR monitoring of Guangdong Guoliang, Huang; Guangdong Food and Drug Administration, Centre for ADR monitoring of Guangdong Xue, Gao; Sun Yat-sen University, Department of Medical Statistics and Epidemiology Lu, CiYong; Sun Yat-sen University, School of public health, Department of Medical Statistics and Epidemiology
<b>Primary Subject Heading</b>:	Epidemiology
Secondary Subject Heading:	Epidemiology, Mental health, Public health
Keywords:	EPIDEMIOLOGY, MENTAL HEALTH, PAEDIATRICS

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4 1 **Prevalence and Correlates of Sleep Disturbance and**  
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6 2 **Depressive symptoms Among Chinese Adolescents: a**  
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13 5 Lan Guo <sup>1#</sup>, Jianxiong Deng <sup>2#</sup>, Yuan He <sup>1#</sup>, Xueqing Deng <sup>1</sup>, Jinghui Huang <sup>2</sup>, Guoliang Huang <sup>2</sup>,  
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30 14 **Keywords:** Prevalence, Sleep disturbance, depressive symptoms, risk factors, Chinese adolescents  
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47 23 **Word count:** 3,780  
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3 **ABSTRACT**

4 **Study objective:** To investigate the prevalence and the correlates of sleep disturbance  
5 and depressive symptoms among Chinese adolescents and to examine the association  
6 between the two problems.  
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8 **Design:** Cross-sectional survey.

9 **Participants:** A total of 3,186 school students in grades 7-12 were sampled from the  
10 schools in Guangdong. A stratified-cluster random-sampling strategy was used to  
11 select the schools.  
12

13 **Main outcome measures:** A self-administered questionnaire was used. The  
14 *Pittsburgh Sleep Quality index (PSQI)* was used to assess the occurrence of sleep  
15 disturbance, and the *Center for Epidemiology Scale for Depression (CES-D)* was used  
16 to identify whether individuals had depressive symptoms.  
17

18 **Results:** The mean PSQI global score was 8.7 ( $\pm$  2.4) points, and 39.6% of the total  
19 sample had sleep disturbance. The mean CES-D score of students was 15.2 ( $\pm$  9.4)  
20 points, and 6.4% of the students had depressive symptoms. Additionally, girls and  
21 older adolescents were more likely to suffer from sleep disturbance, and the students  
22 who had depressive symptoms were 2.47 (95% CI=1.61-3.79) times more likely to  
23 suffer from sleep disturbance. Factors that were correlated with both sleep disturbance  
24 and depressive symptoms were having a poor relationship with teachers, feeling  
25 lonely, suicide ideation, and having run away from home.

26 **Conclusion:** Sleep disturbance was determined to be more prevalent among Chinese  
27 adolescents with depressive symptoms. Sleep disturbance and depressive symptoms  
28 were associated with each other, while school factors, family factors, and  
29 psychosocial adjustment were comprehensively correlated with both.  
30

31 **Strengths and limitations of this study:**

32 There has been a lack of epidemiological research about both sleep disturbance and depressive  
33 symptoms among Chinese adolescents.  
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35 The results of the study show that sleep disturbance is more prevalent among Chinese adolescents  
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1 who have depressive symptoms.

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3 There is a link between sleep disturbance and depressive symptoms

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6 The study demonstrates that an adolescent’s demographic, family, school, and psychosocial factors  
7 influence sleep disturbance and depressive symptoms.

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9 The sample size limits the conclusions that can be drawn from the multivariate analysis; however,  
10 quantifying correlates of sleep disturbance and depressive symptoms was a secondary objective of  
11 the study.

12

For peer review only

## 1 INTRODUCTION

2 Adolescence is often described as occurring between 13 and 18 years of age, which is  
3 roughly the period of high school for much of the world. <sup>1</sup> Sleep plays a very  
4 important role in the development of adolescents; it not only impacts physical growth  
5 and behavior, but it also affects mental health status. <sup>2</sup> Studies in Western countries  
6 have estimated that a large proportion (25%-40%) of adolescents have sleep  
7 disturbance, <sup>3-5</sup> and a report from China in 2000 revealed that 16.9% of the sample  
8 was troubled with sleep disturbance. <sup>6</sup> In total, adolescents' sleep disturbance has been  
9 a major international public health problem, and China is no exception, although the  
10 prevalence of Chinese adolescents with sleep disturbance has been a little lower than  
11 Western countries.

12 Depressive symptoms are a type of mental disorder, and the link between sleep  
13 disturbance and depressive symptoms in adulthood is well established. <sup>7</sup> For instance,  
14 women suffering from sleep disturbances have lower self-rated health and more  
15 physical and mental health complaints, such as depressive symptoms. <sup>8</sup> In contrast, a  
16 limited number of studies (especially epidemiological studies) have addressed the link  
17 between sleep disturbance and depressive symptoms among adolescents, and the link  
18 is not uniform. One study in the US has found that adolescents with sleep disturbance  
19 are more likely to develop and maintain depressive symptoms than are adolescents  
20 without sleep disturbance, <sup>9</sup> but one study found that there did not appear to be a  
21 strong association between sleep disturbance and depressive symptoms in adolescents.  
22 <sup>10</sup> Additionally, many researchers in US have reported that sleep disturbance can be a  
23 sign of depressive symptoms, and depressive symptoms can likewise be a sign of  
24 sleep disturbance. <sup>11</sup> Xu's research in China also demonstrated that sleep disturbance  
25 and depressive symptoms are closely related, and insufficient sleep may result in  
26 depressive symptoms. <sup>12</sup> The recent increase in interest in the link between sleep  
27 disturbance and depressive symptoms in adolescents is warranted.

28 Sleep disturbance and depressive symptoms among adolescents are not only  
29 influenced by each other but also by demographics, family, school and social factors.

30 <sup>13</sup> Several variables have been associated with sleep disturbance and depressive

1 symptoms. Previous studies have differing results about the characteristics of sleep  
2 disturbances between the two genders. Boys in Hong Kong were more likely to be  
3 troubled by sleep disturbance than girls,<sup>14</sup> but most of the studies from other  
4 countries found that girls were more likely to report sleep disturbances than boys.<sup>15 16</sup>  
5 Such inconsistencies may be attributed to differences in the sample and place, which  
6 suggested further research with larger samples is warranted. Additionally, Liu's study  
7 in China indicated that the prevalence of sleep disturbance varies with age and grade  
8 level among adolescents, and adolescents from incomplete families were more likely  
9 to have sleep disturbance compared with their peers.<sup>17</sup> Furthermore, parents' sleep  
10 patterns and psychological functionality was associated with adolescents' sleep in Iran.  
11<sup>18</sup> In addition, the school environment is important for the sleep quality and mental  
12 status of adolescents.<sup>19</sup> Li's research has demonstrated that poor classmate relation  
13 predicted a high level of sleep disturbance and depressive symptoms among Chinese  
14 adolescents. One striking difference between Chinese and US adolescents is the  
15 salience of school and academic achievements relative to other concerns, and Chinese  
16 adolescents care more about academic achievements.<sup>20</sup> Overall, although we  
17 conclude that sleep disturbance and depressive symptoms are universal phenomenon  
18 among adolescents, it is clear that there are cultural variations in their prevalence and  
19 the way that sleep disturbance or depressive symptoms relate to other factors.<sup>21</sup> Most  
20 previous studies, however, have been carried out in Western or developed countries,  
21 and only a handful of studies have been conducted in developing countries. There is  
22 also a paucity of studies on family status (i.e., living arrangement, family economic  
23 status), school dynamics (i.e., relationships with classmates or teachers), and personal  
24 psychosocial adjustment (i.e., feeling lonely, attempting suicide) in the Chinese  
25 cultural context. Therefore, we conducted this large-scale cross-sectional study in  
26 China to estimate the prevalence of sleep disturbance and depressive symptoms; to  
27 comprehensively examine the potentially contributing factors to sleep disturbance and  
28 depressive symptoms among demographics, school, family, and psychosocial health;  
29 and to discuss the link between sleep disturbance and depressive symptoms.

30 The following three hypotheses were formulated. First, following the results of

1 previous studies,<sup>6 19</sup> we hypothesized that sleep disturbance or depressive symptoms  
2 are a major public health problem nationwide among Chinese adolescents. Second,  
3 consistent with previous findings,<sup>15 18-20</sup> we expected that demographics, family,  
4 school, and psychosocial factors would be related to sleep disturbance or depressive  
5 symptoms among Chinese adolescents. Third, in line with prior research linking sleep  
6 disturbance and depressive symptoms,<sup>9 12</sup> we expected sleep disturbance to be a risk  
7 factor for depressive symptoms among Chinese adolescents, and vice versa.

## 10 **METHODS**

### 11 **Study design and participants**

12 This cross-sectional study was based on a province-wide sample to estimate the  
13 prevalence of sleep disturbance and depressive symptoms and to examine the  
14 relationship between potentially influential factors and their involvement in sleep  
15 disturbance and depressive symptoms among Chinese adolescents. The participants  
16 were high school students from Guangdong, China. Guangdong is known as an  
17 immigrant province, with more than half of the population migrating from other  
18 provinces; therefore, the sample from Guangdong has a certain degree of  
19 representativeness. First, the schools were divided into three categories: junior high  
20 schools (grades 7-9), senior high schools (grades 10-12), and vocational schools  
21 (grades 7-12). A stratified-cluster random-sampling method was used to randomly  
22 select participants among the three types of schools. Six junior high schools, four  
23 senior high schools, and two vocational schools were selected. Next, two classes were  
24 randomly selected from each grade in these schools. All available students within the  
25 grade were surveyed; those not surveyed were absent or refused to participate and  
26 consisted of less than 1% of the student population. All the participants were fully  
27 informed of the purpose of the survey and were invited to participate voluntarily.  
28 Written consent letters were obtained from the school, each participating student and  
29 one of the student's parents. A rigorously anonymous method for collection of the  
30 self-report questionnaires was guaranteed. The questionnaires were administered by

1 research assistants in the classrooms without the presence of the teachers. It is  
2 important to stress that we used a self-designed questionnaire whose questions were  
3 based on an instrument proposed by the WHO and adapted to the realities of China,  
4 and the findings of a number of investigations indicate that such data can be  
5 extremely useful.<sup>1 22</sup>

## 6 7 **Measures**

### 8 **Independent variables**

9 Socio-demographic variables: Age, grade, gender.

10 Family factors: Living arrangement, family economic status, family relationship, and  
11 parental caring. Living arrangements were assessed by asking who lived in the  
12 student's primary home. Family economic status was measured by asking the  
13 student's perception of their family's current economic status (rated from below  
14 average to above average). Family relationships were assessed by asking the students,  
15 with the responses coded on a 3-point scale ranging from below average to above  
16 average. Parental caring was assessed by asking, "Are you satisfied with the love you  
17 receive from your father, mother, or both of them, based on a 4-point scale from  
18 dissatisfaction to satisfaction?"

19 School factors: Classmate relations and teacher-classmate relations were also assessed  
20 based on the student's self-rating about their relationships with classmates and  
21 teachers, ranging from poor to good. Academic achievements and academic pressure  
22 were captured by a single item asking about a personal appraisal of students'  
23 performances or pressure relative to that of their classmates (responses were coded as  
24 "above average", "average", and "below average").

25 Psychosocial adjustment: Feeling lonely was assessed by asking, "During the past 12  
26 months, how often did you feel lonely per week?" Response options ranged from 1  
27 (never) to 4 (over 4 days). Suicide-ideation status was based on whether a participant  
28 had endorsed thoughts of suicide over the past year. Suicide-attempt status was based  
29 on attempts made over the past year, with 1 or more attempts indicating endorsement.

30 A student's attempt to hurt themselves was assessed by asking, "During the past 12

1 months, did you ever hurt yourself on purpose?" Responses were categorized into 4  
2 groups: never, considered, planned, and attempted. Running away from home was  
3 assessed by asking, "During the past 12 months, did you run away from home without  
4 your parents' permission for more than 24 hours?" Response options were 1) never, 2)  
5 considered, 3) attempted, or 4) have run away from home one time or more. Habits of  
6 sleeping after lunch were assessed based on the student's self-rating about their habit,  
7 ranging from poor to good.

### 8 9 **Dependent variables**

10 We used the *Chinese Pittsburgh Sleep Quality Index (CPSQI)* to assess sleep quality  
11 and disturbances over a 1-month time interval; the sum of the scores for these seven  
12 components yields one global score with a range of 0-21 points in which higher scores  
13 indicate worse sleep quality.<sup>22 23</sup> The CPSQI was translated into Mandarin Chinese to  
14 better correspond to the meaning of the original items in PSQI, and it is valid, reliable,  
15 and commonly used. In China, a PSQI global score of above 7 points indicates poor  
16 sleep quality collectively known as *sleep disturbance*; a higher score indicates a  
17 greater reduction in sleep quality.<sup>22</sup>

18 The *Center for Epidemiology Scale for Depression (CES-D)* in Chinese was used to  
19 identify whether individuals had depressive symptoms. The respondents were asked  
20 to rate the frequency, over the past week, of 20 depressive symptoms by choosing one  
21 of four response options ranging from "rarely or none of the time" to "most or all of  
22 the time".<sup>24</sup> The Chinese version of this scale has been validated,<sup>25-27</sup> and extensively  
23 utilized in Chinese studies.<sup>28</sup> The score ranges from 0 to 60, and the original  
24 recommended cut-off point for having depressive symptoms was 16 points  
25 (corresponding to the 80<sup>th</sup> percentiles) by the founder of the CES-D in 1977.<sup>29</sup> We  
26 adopted the 80th percentile as the cut-off (a score greater than 28 indicating "having  
27 depressive symptoms"), and the area under the ROC curve was 0.78. For the CES-D  
28 survey, those who failed to answer at least 17 of the 20 items were discarded.

### 29 30 **Statistical analysis**



1 All data were entered by two investigators independently using EpiData 3.1, and the  
2 statistical analyses were conducted using SPSS 21.0 and SAS 9.2. Descriptive  
3 analyses were used to describe demographic characteristics and the prevalence of  
4 sleep disturbances and depressive symptoms among adolescents. Categorical and  
5 continuous data were reported in the form of proportions and means (SD).  
6 Chi-squared tests were used to test the difference between the categorical variables  
7 referred to above. Multivariate logistic regression models included the significant  
8 variables that had been tested by univariate analyses or that have been widely reported  
9 in the literature; these were used to screen for the risk factors for sleep  
10 disturbance/depressive symptoms according to the odds ratios (ORs) and 95%  
11 confidence intervals (95% CIs). An  $OR > 1$  with  $P < 0.05$  was reported as a risk factor.  
12 Considering that our study used a multi-stage sampling, students were grouped into  
13 classes; therefore, differences might not segregate independently. Thus, multi-level  
14 analyses (the generalized linear mixed effects models adopting the GLMMIX  
15 procedure in SAS) in which classes were treated as clusters were adopted in the  
16 multivariate logistic regression analyses. All statistical tests were two-sided, with a  $P$   
17 value less than 0.05 considered significant.

## 18 19 20 **RESULTS**

21 There were 3,508 students invited to participate, and 3,485 students' questionnaires  
22 were completed and qualified for our survey; the response rate was 95.2%. After  
23 excluding students who were not 13 to 18 years old, we analyzed 3,186 students' data.

### 24 25 **Demographic information**

26 A total of 3,186 participants were involved in this analysis. *Table 1* provides the basic  
27 demographic information for the sample involved in this study. The proportion of  
28 boys was 53.4%, and the male-to-female ratio was approximately 1.2:1. The students  
29 ranged in age from 13 to 18 years old, and the mean age of the students was 15.6  
30 ( $\pm 1.6$ ) years. The students who never slept after lunch accounted for 9.7%. The grade

1 7-9 group of students represented 52.9% of the sample. Regarding the family factors,  
2 a total of 89.0% of students lived with both biological parents, whereas 4.7% lived in  
3 single-parent families. A total of 15.8% of students thought of their family  
4 relationships as average, and 77.6% of students were satisfied with both of their  
5 parents' love. A subset of students (30.6%) reported that their current economic status  
6 was above average, whereas 8.4% reported that their economic status was below  
7 average. Regarding school factors, 28.0% of students rated their academic  
8 achievement as below average, and 42.2% of the students thought their academic  
9 pressure was above average. A total of 7.1% of participants reported poor  
10 relationships with their teachers, and 3.8% had poor relations with their classmates.  
11 Regarding the psychosocial factors, 11.9% of students felt lonely more than 4 days  
12 per week. A total of 4.1% of students often had suicide ideation, and 1.2% of students  
13 had attempted suicide often. In addition, 1.5% of participants often hurt themselves on  
14 purpose, and 1.9% of participants had run away from home more than once.

15

### 16 **Univariate Analysis for Sleep disturbance and Depressive symptoms**

17 The mean PSQI global score was 8.7 ( $\pm$  2.4) points ( 8.6 ( $\pm$ 2.5) points among boys,  
18 8.6 ( $\pm$ 2.4) points among girls), and 39.6% of the total sample was classified as having  
19 sleep disturbances (global score higher than 8 points). In addition, 6.4% of the  
20 students had depressive symptoms, according the CES-D. The mean CES-D score of  
21 students was 15.2 ( $\pm$  9.4) points (14.6 ( $\pm$ 9.1) points among boys, 15.6 ( $\pm$ 8.8) points  
22 among girls). There were no gender differences in the PSQI global scores or the  
23 CES-D scores. ( $P>0.05$ )

24 As shown in *Table 2*, without adjustment for other variables, sleep disturbances and  
25 depressive groups were correlated with gender, family economic status, family  
26 relationships, parental caring, academic pressure, relationships with classmates,  
27 feeling lonely, suicide ideation, suicide attempts, hurting themselves on purpose, and  
28 having run away from home. Only age, grade, relationship with teachers, and having  
29 depressive symptoms were significantly correlated with having a sleep disturbance,  
30 while only living arrangements and having sleep disturbances were significantly

1 correlated with having depressive symptoms.

### 3 **Multilevel Logistic Regression Analysis: Sleep disturbance**

4 The final logistic regression model for sleep disturbance is presented in *Table 3*. Ten  
5 of the original variables remained in the final model: gender, age, habit of sleeping  
6 after lunch, family relationships, academic pressure, relationships with teachers,  
7 feeling lonely, suicide ideation, running away from home, and depressive symptoms.  
8 The results revealed that the girls, the 15-16-year age group, and the 17-18-year age  
9 group were all more likely to suffer from sleep disturbance. Taking occasional naps  
10 after lunch was a risk factor for sleep disturbance compared with the group that never  
11 napped after lunch (adjusted OR=1.68, 95% CI=1.27-2.22). Adolescents with  
12 below-average family relationships (AOR=1.54, 95% CI=1.06-2.26) had a slightly  
13 higher probability of sleep disturbance. Likewise, students with poor relationships  
14 with teachers (AOR=1.26, 95% CI=1.19-1.77) were more troubled with sleep  
15 disturbances. In addition, students feeling lonely 1-4 days a week (AOR=1.64, 95%  
16 CI=1.39-1.94) or over 4 days a week (AOR=2.22, 95% CI=1.70-2.89) had a higher  
17 probability of sleep disturbances compared those never feeling lonely. Having suicide  
18 ideations occasionally or sometimes was a risk factor for sleep disturbance, and  
19 students who considered running away from home (AOR=1.76, 95% CI=1.46-2.13)  
20 or attempted running away from home (OR=2.59, 95% CI=1.38-4.88) were also more  
21 likely to have a sleep disturbance compared to students who had never considered  
22 running away from home. Finally, students who had depressive symptoms were 2.47  
23 (95% CI=1.61-3.79) times more likely to suffer from sleep disturbance than those  
24 who did not. Notably, students with average academic pressure (AOR=0.80, 95%  
25 CI=0.65-0.99) or below-average academic pressure (AOR=0.41, 95% CI=0.33-0.51)  
26 compared with the above-average academic pressure group were less likely to be  
27 troubled by sleep disturbance.

### 29 **Multilevel Logistic Regression Analysis: Depressive symptoms**

30 The final model for depressive symptoms in *Table 4* showed many correlations.

1 Adolescents with a below-average family relationship (AOR=1.97, 95% CI=1.24-3.15)  
2 were more likely to have depressive symptoms. Having average relationships with  
3 classmates (AOR=2.82, 95% CI=1.62-4.90) or poor relationships with classmates  
4 (AOR=1.60, 95% CI=1.14-2.25) was a risk factor for having depressive symptoms.  
5 Students who felt lonely 1 to 4 days a week (AOR=2.67, 95% CI=1.75-4.07) or over 4  
6 days a week (AOR=4.24, 95% CI=2.65-6.80) also had a higher probability of having  
7 depressive symptoms. Likewise, students occasionally, sometimes or often having  
8 suicide ideation had a higher probability of having depressive symptoms. Considering  
9 running away from home (AOR=1.71, 95% CI=1.20-2.44) was also a risk factor for  
10 depressive symptoms compared to students who never considered running away from  
11 home. Students with sleep disturbance were also more likely to have depressive  
12 symptoms (AOR=2.52, 95% CI=1.64-3.86).

## 15 DISCUSSION

16 In this study, we found that sleep disturbance was not rare among Chinese adolescents,  
17 with a prevalence of 39.6%. Similar studies have reported that the prevalence of sleep  
18 disturbance in children and adolescents ranges from 66% to 90%.<sup>30</sup> A report from  
19 China in 2000 revealed that 16.9% of the sample was troubled with sleep disturbance,  
20<sup>6</sup> while a report from China in 1987 reported a prevalence of 14.9%.<sup>31</sup> This study also  
21 agrees with the results from a Western report in which 43.0% of children experienced  
22 sleep disturbance.<sup>32</sup> The considerable variation in the prevalence of sleep  
23 disturbances may be due to the different time periods, different target populations, and  
24 different methodological definitions of sleep disturbances. Adolescent sleep  
25 disturbance has been recognized as a major international public health problem, and  
26 China is no exception, although the prevalence of Chinese adolescents with sleep  
27 disturbance was a little lower than Western countries.

28 In addition, our results indicate that girls were more likely to suffer from sleep  
29 disturbance, which agrees with the previous study from Anhui province and Hong  
30 Kong in China.<sup>12 14</sup> In this study, older age was more associated with sleep

1 disturbance compared with the younger group, which is in line with a previous study  
2 from China that reported that older age was associated with more sleep problems.<sup>6</sup>

3 Additionally, multivariate logistic regression analyses performed to control for  
4 confounding factors and to determine the main correlates of sleep disturbance showed  
5 that poor family relationships, poor relationships with teachers, feeling lonely, suicide  
6 ideation, running away from home, and depressive symptoms were correlated with  
7 sleep disturbance. These findings are in accordance with the results of many previous  
8 studies. For example, a study from Shandong province of China in 2000 also reported  
9 that poor marital relations of parents, poor family economic status, poor child-parent  
10 and peer relations, poor school achievement and social competence were risk factors  
11 for sleep problems,<sup>6</sup> and a study in Switzerland also documented the relationship  
12 between sleep disturbance in adolescents and family functioning and demonstrated  
13 that the mother's and adolescent children's sleep and well-being are particularly  
14 strongly correlated with each other.<sup>33</sup> Furthermore, prior studies also demonstrated  
15 that suicide completers had higher rates of overall sleep disturbance among  
16 adolescents,<sup>34</sup> and running away from home was as common as suicide completion  
17 among adolescents with depressive symptoms.<sup>35</sup> Notably, our results also indicate  
18 that students with average or below-average academic pressure compared with  
19 above-average academic pressure were less likely to be troubled by sleep disturbance.  
20 This indicates that academic pressure is an important type of stress that affects sleep,  
21 and other studies have provided evidence that stress is associated with sleep  
22 disturbance.<sup>36</sup>

23 Consistent with our expectation, adolescents who had depressive symptoms were at  
24 a higher risk for sleep disturbance. Xu has detected an association between sleep  
25 disturbance and depressive symptoms among Chinese adolescents.<sup>12</sup> We found that  
26 sleep disturbance was common among adolescents in China, and an adolescent's  
27 family, school, and psychosocial factors have influences on sleep disturbance. Thus,  
28 educational campaigns directed at families and schools are needed to improve  
29 awareness of the adverse consequence of sleep disturbance.

30 In this study, the prevalence of students with depressive symptoms was 6.4%,

1 slightly lower than the 8.0% reported in an Australian study.<sup>37</sup> Depressive symptoms  
2 are a prevalent and disabling condition among adolescents that results in emotional  
3 suffering and sleep disturbance; therefore, it is important for us to focus on this  
4 problem.<sup>38</sup> Our study reports that the prevalence of depressive symptoms among girls  
5 was not much higher than among boys, but a previous study reported prevalence rates  
6 of emotional problems to be higher in boys than in girls.<sup>39</sup> These differences may due  
7 to emotional problems, including depressive symptoms and others. Additionally, our  
8 multivariate logistic regression showed that below-average family relationship,  
9 average or below-average relationships with classmates, emotional problems  
10 (including feeling lonely more than 1 day per week, having suicide ideations,  
11 considering running away from home), and having sleep disturbance was a risk factor  
12 for having depressive symptoms. Given that depressive symptoms are a type of  
13 emotional problem,<sup>40</sup> it is not surprising that our results indicate a link between sleep  
14 disturbance and emotional problems. Consistent with the third hypothesis, our results  
15 clearly showed a link between sleep disturbance and depressive symptoms. However,  
16 the direction of the link was difficult to determine due to the nature of this  
17 cross-sectional study; they might mutually reinforce each other, thereby formulating a  
18 vicious circle.

19 Given adolescents' vulnerability to both sleep disturbance and depressive  
20 symptoms, we conducted this large-scale study aimed to investigate the prevalence  
21 and correlates of both problems in Chinese adolescents. To date, no research has  
22 expressly considered comprehensively the correlates of sleep disturbance and  
23 depressive symptoms among demographics, school, family, and psychosocial domains  
24 in this population. Additionally, it must be stressed that there are several limitations to  
25 the current large-scale study. First, the data are cross-sectional, so no causal inference  
26 can be made regarding the observed relationships between sleep disturbance and  
27 depressive symptoms, and the common-method variance interpretation for the  
28 findings might apply. Second, the questionnaires did not include items that could  
29 address students with sleep-related breathing problems or psychological diseases such  
30 as attention-deficit hyperactivity disorder (ADHD). Third, it should be noted that the

1 present results that were based on a structured self-rating questionnaire were  
2 cross-sectional and retrospective; although self-reporting is a common and accepted  
3 method, we could not completely rule out the possibility of recall bias. To minimize  
4 incorrect or unavailable data given by students who did not fully understand the  
5 contents of the PSQI and the CES-D, we have provided a detailed explanation of the  
6 *PSQI* and *CES-D*.

7 In conclusion, the prevalence and correlates of sleep disturbances and depressive  
8 symptoms among adolescents in China are high, and further research into their causes,  
9 effects, and remedies is warranted. The prevalence of sleep disturbance observed in  
10 this study suggests the importance of research on preventive interventions targeting  
11 sleep quality among Chinese students. Effective preventive measures require full  
12 consideration of the social and environmental factors. We should focus on the  
13 high-risk population whose family factors, school factors, and psychosocial  
14 adjustments are negative.

### 17 **Contributors**

18 GL and LCY searched the literature, conceived the study, designed the study, analyzed  
19 the data, interpreted the results, and drafted the report. DJX and HY organized the  
20 study, collected the data and analyzed the data. DXQ, HJW, HGL, GX collected the  
21 data, interpreted the results, and obtained funding.

23 **Acknowledgments:** We gratefully acknowledge the contribution of the Guangdong  
24 Education Bureau and its participating schools. We would like to thank the local  
25 health professionals, principals and teachers of participating schools. We express great  
26 thanks to all participants of our study.

28 **Funding Source:** This study was supported by the Guangdong Food and Drug  
29 Administration. The funders had no role in the study design, data collection or  
30 analysis, decision to publish, or preparation of the manuscript.

1

2 **Conflict of Interest:** The authors have declared that no competing interests exist.

3

4 **Financial Disclosure:** The authors have no financial relationships relevant to this  
5 article to disclose.

6

7 **Data sharing:** No additional data available.

For peer review only



## References:

1. Crockett LJ, Beal SJ. The life course in the making: gender and the development of adolescents' expected timing of adult role transitions. *Dev Psychol* 2012;48(6):1727-38.
2. Anders TF, Eiben LA. Pediatric sleep disorders: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 1997;36(1):9-20.
3. Lazaratou H, Dikeos DG, Anagnostopoulos DC, et al. Sleep problems in adolescence. A study of senior high school students in Greece. *Eur Child Adolesc Psychiatry* 2005;14(4):237-43.
4. Bailly D, Bailly-Lambin I, Querleu D, et al. [Sleep in adolescents and its disorders. A survey in schools]. *Encephale* 2004;30(4):352-9.
5. Garcia-Jimenez MA, Salcedo-Aguilar F, Rodriguez-Almonacid FM, et al. [The prevalence of sleep disorders among adolescents in Cuenca, Spain]. *Rev Neurol* 2004;39(1):18-24.
6. Liu X, Uchiyama M, Okawa M, et al. Prevalence and correlates of self-reported sleep problems among Chinese adolescents. *Sleep* 2000;23(1):27-34.
7. Association. AP. *Diagnostic and statistical manual of mental disorders DSM IV. Washington, DC: American Psychiatric Association;1994.*
8. Pigeon WR, Cerulli C, Richards H, et al. Sleep disturbances and their association with mental health among women exposed to intimate partner violence. *J Womens Health (Larchmt)* 2011;20(12):1923-9.
9. Roane BM, Taylor DJ. Adolescent insomnia as a risk factor for early adult depression and substance abuse. *Sleep* 2008;31(10):1351-6.
10. Alfano CA, Zakem AH, Costa NM, et al. Sleep problems and their relation to cognitive factors, anxiety, and depressive symptoms in children and adolescents. *Depress Anxiety* 2009;26(6):503-12.
11. Roehr B. American Psychiatric Association explains DSM-5. *BMJ* 2013;346:f3591.
12. Xu Z, Su H, Zou Y, et al. Sleep quality of Chinese adolescents: distribution and its associated factors. *J Paediatr Child Health* 2012;48(2):138-45.
13. Stores G. Children's sleep disorders: modern approaches, developmental effects, and children at special risk. *Dev Med Child Neurol* 1999;41(8):568-73.
14. Chung KF, Cheung MM. Sleep-wake patterns and sleep disturbance among Hong Kong Chinese adolescents. *Sleep* 2008;31(2):185-94.
15. Abdel-Khalek AM. Prevalence of reported insomnia and its consequences in a survey of 5,044 adolescents in Kuwait. *Sleep* 2004;27(4):726-31.
16. Ohida T, Osaki Y, Doi Y, et al. An epidemiologic study of self-reported sleep problems among Japanese adolescents. *Sleep* 2004;27(5):978-85.
17. Liu X, Zhao Z, Jia C, et al. Sleep patterns and problems among Chinese adolescents. *Pediatrics* 2008;121(6):1165-73.
18. Bajoghli H, Alipouri A, Holsboer-Trachsler E, et al. Sleep patterns and psychological functioning in families in northeastern Iran; evidence for similarities between adolescent children and their parents. *J Adolesc* 2013;36(6):1103-13.
19. Li SH, Shen XM, Jin XM, et al. [Sleep habits and sleep disturbance in school-age children of China]. *Zhonghua Er Ke Za Zhi* 2008;46(3):185-9.
20. Gong J, Li Y, Xg C, et al. [A baseline survey on the association of smoking onset and life events on adolescents in Wuhan, China]. *Zhonghua Liu Xing Bing Xue Za Zhi* 2004;25(2):142-5.

- 1  
2  
3 21. Rona RJ, Li L, Gulliford MC, et al. Disturbed sleep: effects of sociocultural factors and illness.  
4 *Arch Dis Child* 1998;78(1):20-5.  
5  
6 22. Tsai PS, Wang SY, Wang MY, et al. Psychometric evaluation of the Chinese version of the  
7 Pittsburgh Sleep Quality Index (CPSQI) in primary insomnia and control subjects. *Qual Life Res*  
8 2005;14(8):1943-52.  
9  
10 23. Buysse DJ, Reynolds CR, Monk TH, et al. The Pittsburgh Sleep Quality Index: a new instrument  
11 for psychiatric practice and research. *Psychiatry Res* 1989;28(2):193-213.  
12  
13 24. Myers JK, Weissman MM. Use of a self-report symptom scale to detect depression in a community  
14 sample. *Am J Psychiatry* 1980;137(9):1081-4.  
15  
16 25. Cheng CP, Yen CF, Ko CH, et al. Factor structure of the Center for Epidemiologic Studies  
17 Depression Scale in Taiwanese adolescents. *Compr Psychiatry* 2012;53(3):299-307.  
18  
19 26. Lee SW, Stewart SM, Byrne BM, et al. Factor structure of the Center for Epidemiological Studies  
20 Depression Scale in Hong Kong adolescents. *J Pers Assess* 2008;90(2):175-84.  
21  
22 27. Zhang Jie WZFG. Development of the Chinese age norms of CES-D in urban area. *Chinese Mental*  
23 *Health Journal. (In Chinese)*. 2010(02):139-143.  
24  
25 28. Yen S, Robins CJ, Lin N. A cross-cultural comparison of depressive symptom manifestation: China  
26 and the United States. *J Consult Clin Psychol* 2000;68(6):993-9.  
27  
28 29. Radloff LS, editor *The CES-D scale: A self-report depression scale for research in the general*  
29 *populations.*, 1977.  
30  
31 30. Meltzer LJ, Avis KT, Biggs S, et al. The Children's Report of Sleep Patterns (CRSP): a self-report  
32 measure of sleep for school-aged children. *J Clin Sleep Med* 2013;9(3):235-45.  
33  
34 31. Yang L, Zuo C, Eaton LF. Research note: sleep problems of normal Chinese adolescents. *J Child*  
35 *Psychol Psychiatry* 1987;28(1):167-72.  
36  
37 32. Kahn M, Sheppes G, Sadeh A. Sleep and emotions: Bidirectional links and underlying mechanisms.  
38 *Int J Psychophysiol* 2013;89(2):218-28.  
39  
40 33. Kalak N, Gerber M, Kirov R, et al. The relation of objective sleep patterns, depressive symptoms,  
41 and sleep disturbances in adolescent children and their parents: a sleep-EEG study with 47 families. *J*  
42 *Psychiatr Res* 2012;46(10):1374-82.  
43  
44 34. Goldstein TR, Bridge JA, Brent DA. Sleep disturbance preceding completed suicide in adolescents.  
45 *J Consult Clin Psychol* 2008;76(1):84-91.  
46  
47 35. Tucker JS, Edelen MO, Ellickson PL, et al. Running away from home: a longitudinal study of  
48 adolescent risk factors and young adult outcomes. *J Youth Adolesc* 2011;40(5):507-18.  
49  
50 36. Byars KC, Yeomans-Maldonado G, Noll JG. Parental functioning and pediatric sleep disturbance:  
51 an examination of factors associated with parenting stress in children clinically referred for evaluation  
52 of insomnia. *Sleep Med* 2011;12(9):898-905.  
53  
54 37. Tsai PS, Wang SY, Wang MY, et al. Psychometric evaluation of the Chinese version of the  
55 Pittsburgh Sleep Quality Index (CPSQI) in primary insomnia and control subjects. *Qual Life Res*  
56 2005;14(8):1943-52.  
57  
58 38. Ivanenko A, Crabtree VM, Gozal D. Sleep and depression in children and adolescents. *Sleep Med*  
59 *Rev* 2005;9(2):115-29.  
60  
61 39. Liu X, Kurita H, Guo C, et al. Prevalence and risk factors of behavioral and emotional problems  
62 among Chinese children aged 6 through 11 years. *J Am Acad Child Adolesc Psychiatry*  
63 1999;38(6):708-15.  
64  
65 40. Siegel JM, Platt JJ, Peizer SB. Emotional and social real-life problem-solving thinking in

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1 adolescent and adult psychiatric patients. *J Clin Psychol* 1976;32(2):230-2.  
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For peer review only

Table 1. Demographic characteristics of the total sample.

Variable	Number (%)
<b>Total</b>	3186 (100.0)
<b>Gender</b>	
Male	1700 (53.4)
Female	1486 (46.6)
<b>Age (years)</b>	
13-14	420 (13.2)
15-16	1687 (53.0)
17-18	1079 (33.9)
<b>Grade</b>	
7 <sup>th</sup> -9 <sup>th</sup>	1686 (52.9)
10 <sup>th</sup> -12 <sup>th</sup>	1500 (47.1)
<b>Living arrangement</b>	
Two biological parents	2836 (89.0)
Only father or mother	149 (4.7)
Others	201 (6.3)
<b>Family economic status</b>	
Above average	975(30.6)
Average	1942 (61.0)
Below average	269(8.4)
<b>Family relationship</b>	
Above average	2501 (78.5)
Average	502 (15.8)
Below average	183 (5.7)
<b>Parental caring</b>	
Satisfied with father or mother	545 (17.1)
Satisfied with both of them	2471 (77.6)
Dissatisfied with both of them	170 (5.3)
<b>Academic achievement</b>	
Above average	1361 (42.7)
Average	932 (29.3)
Below average	893 (28.0)
<b>Academic pressure</b>	
Above average	1344 (42.2)
Average	1376 (43.2)
Below average	466 (14.4)
<b>Relationship with teachers</b>	
Good	1552 (48.7)
Average	1408 (44.2)
Poor	226 (7.1)

**Table 1. Demographic characteristics of the total sample (continued).**

Variable	Number (%)
<b>Relationship with classmates</b>	
Good	2220 (69.7)
Average	846 (26.6)
Poor	120 (3.8)
<b>Feel lonely</b>	
Less than 1 day/week	1733 (54.4)
1 to 4 days/week	1073 (33.7)
More than 4 days/week	380 (11.9)
<b>Suicide ideation</b>	
Never	2589 (81.3)
Occasionally (1-2 times/year)	391 (12.3)
Sometimes (3-6 times/year)	75 (2.4)
Often (over 6 times/year)	131 (4.1)
<b>Suicide attempt</b>	
Never	3083 (95.8)
Occasionally (1-2 times/year)	81 (2.5)
Sometimes (3-6 times/year)	14(0.4)
Often (over 6 times/year)	38 (1.2)
<b>Hurt themselves on purpose</b>	
Never	2807 (88.1)
Occasionally (1-2 times/year)	269 (8.4)
Sometimes (3-6 times/year)	61 (1.9)
Often (over 6 times/year)	49 (1.5)
<b>Running away from home</b>	
Never	2262 (71.0)
Considered	815 (25.6)
Planned	48 (1.5)
Attempted	61 (1.9)
<b>Habit of sleeping after lunch</b>	
Never	308 (9.7)
Occasionally (1-4 times/week)	1598 (50.2)
Often (over 4 times/week)	1280 (40.2)

Table 2. Univariate chi-square analysis for sleep disturbance and depressive symptoms, n (%).

Variable	Total	With sleep disturbance	With depressive symptoms
<b>Total</b>	3186 (100.0)	1261 (100.0)	205 (100.0)
<b>Gender #</b>			
Male	1700 (53.4)	729 (57.8)	92 (44.9)
Female	1486 (46.6)	532 (42.2)	113 (55.1)
<b>Age (years) *</b>			
13-14	420 (13.2)	240 (19.0)	22 (10.7)
15-16	1687 (53.0)	667 (52.9)	111 (54.1)
17-18	1079 (33.9)	354 (28.1)	72 (35.1)
<b>Grade *</b>			
7 <sup>th</sup> -9 <sup>th</sup>	1686 (52.9)	740 (58.7)	108 (52.7)
10 <sup>th</sup> -12 <sup>th</sup>	1500 (47.1)	521(41.3)	97 (47.3)
<b>Living arrangement **</b>			
Two biological parents	2836 (89.0)	1125(89.2)	169 (82.4)
Only father or mother	149 (4.7)	51 (4.0)	16 (7.8)
Others	201 (6.3)	85 (6.7)	20 (9.8)
<b>Family economic status #</b>			
Above average	975(30.6)	437 (34.7)	45 (22.0)
Average	1942 (61.0)	738 (58.5)	127 (62.0)
Below average	269(8.4)	86 (6.8)	33 (16.1)
<b>Family relationship #</b>			
Above average	2501 (78.5)	1063 (84.3)	115 (56.1)
Average	502 (15.8)	155 (12.3)	46 (22.4)
Below average	183 (5.7)	43 (3.4)	44 (21.5)
<b>Parental caring #</b>			
Satisfied with father or mother	545 (17.1)	184 (14.6)	58 (28.3)
Satisfied with both of them	2471 (77.6)	1029 (81.6)	118 (57.6)
Dissatisfied with both of them	170 (5.3)	48 (3.8)	29 (14.1)
<b>Academic achievement</b>			
Above average	1361 (42.7)	558 (44.3)	84 (41.0)
Average	932 (29.3)	362 (28.7)	59 (28.8)
Below average	893 (28.0)	341 (27.0)	62 (30.2)
<b>Academic pressure #</b>			
Above average	1344 (42.2)	399 (31.6)	137 (66.8)
Average	1376 (43.2)	625 (49.6)	49 (23.9)
Below average	466 (14.4)	237 (18.8)	19 (9.3)
<b>Relationship with teachers *</b>			
Good	1552 (48.7)	694 (55.0)	69 (33.7)
Average	1408 (44.2)	493 (39.1)	95 (46.3)
Poor	226 (7.1)	74 (5.9)	41 (20.0)

**Table 2. Univariate chi-square analysis for sleep disturbance and depressive symptoms, n (%) (continued).**

<b>Relationship with classmates #</b>			
Good	2220 (69.7)	928 (73.6)	94 (45.9)
Average	846 (26.6)	289 (22.9)	79 (38.5)
Poor	120 (3.8)	44 (3.5)	32 (15.6)
<b>Feel lonely #</b>			
Less than 1 day/week	1733 (54.4)	830 (65.8)	34 (16.6)
1 to 4 days/week	1073 (33.7)	335 (26.6)	98 (47.8)
More than 4 days/week	380 (11.9)	96 (7.6)	73 (35.6)
<b>Suicide ideation #</b>			
Never	2589 (81.3)	1108(87.9)	88 (42.9)
Occasionally (1-2 times/year)	391 (12.3)	88 (7.0)	68 (33.2)
Sometimes (3-6 times/year)	75 (2.4)	12 (1.0)	18 (8.8)
Often (over 6 times/year)	131 (4.1)	53 (4.2)	31 (15.1)
<b>Suicide attempt #</b>			
Never	3083 (95.8)	1223 (97.0)	169 (82.4)
Occasionally (1-2 times/year)	81 (2.5)	17 (1.3)	20 (9.8)
Sometimes (3-6 times/year)	14(0.4)	4 (0.3)	3 (1.5)
Often (over 6 times/year)	38 (1.2)	17 (1.3)	13 (6.3)
<b>Hurt themselves on purpose #</b>			
Never	2807 (88.1)	1147 (91.0)	140 (68.3)
Occasionally (1-2 times/year)	269 (8.4)	78 (6.2)	43 (21.0)
Sometimes (3-6 times/year)	61 (1.9)	20 (1.6)	7 (3.4)
Often (over 6 times/year)	49 (1.5)	16 (1.3)	15 (7.3)
<b>Running away from home #</b>			
Never	2262 (71.0)	1006 (79.8)	79 (38.5)
Considered	815 (25.6)	226 (17.9)	103 (50.2)
Planned	48 (1.5)	14 (1.1)	6 (2.9)
Attempted	61 (1.9)	15 (1.2)	17 (8.3)
<b>Depressive symptoms *</b>			
Yes	205 (6.4)	29 (2.3)	-
No	2981 (93.6)	1232 (97.7)	-
<b>Sleep disturbance **</b>			
Yes	1261 (39.6)	-	29 (14.1)
No	1925(60.4)	-	176 (85.9)

#: According to the chi-square test, without adjusting for other variables,  $P < 0.05$  in both the sleep disturbance group and the depressive symptoms group.

\*:  $P < 0.05$ , only in the sleep disturbance group.

\*\* :  $P < 0.05$ , only in the depressive symptoms group.

Table 3. Adjusted OR (95% CI) for sleep disturbance by multi-level logistic regression.

Covariate	Adjusted OR (95% CI)	P-value
<b>Age (years)</b>		
13-14	1.00 (reference)	
15-16	2.40 (1.87-3.08)	<.001
17-18	1.36 (1.15-1.62)	<.001
<b>Gender</b>		
Male	1.00 (reference)	
Female	1.27 (1.08-1.48)	0.003
<b>Habit of sleeping after lunch</b>		
Never	1.00 (reference)	
Occasionally (1-4 times/week)	1.68 (1.27-2.22)	<.001
Often (over 4 times/week)	1.05 (0.89-1.23)	0.590
<b>Family relationship</b>		
Above average	1.00 (reference)	
Average	1.08(0.71-1.64)	0.723
Below average	1.54 (1.06-2.26)	0.025
<b>Academic pressure #</b>		
Above average	1.00 (reference)	
Average	0.80 (0.65-0.99)	<.001
Below average	0.41 (0.33-0.51)	<.001
<b>Relationship with teachers</b>		
Good	1.00 (reference)	
Average	0.79 (0.57-1.11)	0.174
Poor	1.26 (1.19-1.77)	<.001
<b>Feel lonely</b>		
Less than 1 day/week	1.00 (reference)	
1 to 4 days/week	1.64 (1.39-1.94)	<.001
More than 4 days/week	2.22 (1.70-2.89)	<.001
<b>Suicide ideation</b>		
Never	1.00 (reference)	
Occasionally (1-2 times/year)	1.78 (1.36-2.34)	<.001
Sometimes (3-6 times/year)	2.37 (1.25-4.54)	0.009
Often (over 6 times/year)	0.80 (0.54-1.20)	0.280
<b>Running away from home</b>		
Never	1.00 (reference)	
Considered	1.76 (1.46-2.13)	<.001
Planned	1.42 (0.74-2.73)	0.298
Attempted	2.59 (1.38-4.88)	0.003
<b>Depressive symptoms</b>		
No	1.00 (reference)	
Yes	2.47 (1.61-3.79)	<.001

NOTE: Adjusted OR means odds ratio adjusted by multivariate analysis for screening risk factors for adolescents with sleep disturbance; 95% CI=95% confident interval.



Table 4. Adjusted OR (95% CI) for depressive symptoms by multi-level logistic regression.

Covariate	Adjusted OR (95% CI)	P-value
<b>Family relationship</b>		
Above average	1.00 (reference)	
Average	1.22 (0.82-1.81)	0.329
Below average	1.97 (1.24-3.15)	0.004
<b>Relationship with classmates</b>		
Good	1.00 (reference)	
Average	2.82 (1.62-4.90)	<.001
Poor	1.60 (1.14-2.25)	0.007
<b>Feel lonely</b>		
Less than 1 day/week	1.00 (reference)	
1 to 4 days/week	2.67 (1.75-4.07)	<.001
More than 4 days/week	4.24 (2.65-6.80)	<.001
<b>Suicide ideation</b>		
Never	1.00 (reference)	
Occasionally (1-2 times/year)	2.72 (1.85-3.98)	<.001
Sometimes (3-6 times/year)	2.77 (1.46-5.26)	0.002
Often (over 6 times/year)	3.38 (1.89-6.04)	<.001
<b>Running away from home</b>		
Never	1.00 (reference)	
Considered	1.71 (1.20-2.44)	0.003
Planned	1.08 (0.40-2.90)	0.885
Attempted	1.42 (0.65-3.10)	0.386
<b>Sleep disturbance</b>		
No	1.00 (reference)	
Yes	2.52 (1.64-3.86)	<.001

NOTE: Adjusted OR means odds ratio adjusted by multivariate analysis for screening risk factors for adolescents showing depressive symptoms; 95% CI=95% confident interval.

1                   **Prevalence and Correlates of Sleep Disturbance and**  
2                   **Depressive symptoms Among Chinese Adolescents: a**  
3                   **cross-sectional survey study**

4  
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15  
16   **Keywords:** Prevalence, Sleep disturbance, depressive symptoms, correlates, risk  
17   factors, Chinese adolescents

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26   **Word count:** 3,780

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28   **Strengths and limitations of this study:**

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1 There has been a lack of epidemiological research about both sleep disturbance and  
2 depressive symptoms among Chinese adolescents.

3  
4 The results of the study show that sleep disturbance is more prevalent among Chinese  
5 adolescents who have depressive symptoms.

6  
7 There is a link between sleep disturbance and ~~depressive symptoms~~ depression.

8  
9 The study demonstrates that an adolescent's demographic, family, school, and  
10 psychosocial factors influence sleep disturbance and depressive symptoms.

11  
12 The sample size limits the conclusions that can be drawn from the multivariate  
13 analysis; however, quantifying correlates of sleep disturbance and depressive  
14 symptoms was a secondary objective of the study.

1     **ABSTRACT**

2     **Study objective:** To investigate the prevalence and the correlates of sleep disturbance  
3     and depressive symptoms among Chinese adolescents and to examine the association  
4     between the two problems.

5     **Design:** Cross-sectional survey research.

6     **Participants:** A total of 3,186 school students in grades 7-12 were sampled from the  
7     schools in Guangdong. A stratified-cluster random-sampling strategy was used to  
8     select the schools.

9     **Main outcome measures:** A self-administered questionnaire was used. The  
10     *Pittsburgh Sleep Quality index (PSQI)* was used to assess the occurrence of sleep  
11     disturbance, and the *Center for Epidemiology Scale for Depression (CES-D)* was used  
12     to identify whether individuals had depressive symptoms.

13     **Results:** The mean PSQI global score was 8.7 ( $\pm$  2.4) points, and 39.6% of the total  
14     sample had sleep disturbance. The mean CES-D score of students was 15.2 ( $\pm$  9.4)  
15     points, and 6.4% of the students had depressive symptoms. Additionally, girls and  
16     older adolescents were more likely to suffer from sleep disturbance, and the students  
17     who had depressive symptoms were 2.47 (95% CI=1.61-3.79) times more likely to  
18     suffer from sleep disturbance. Factors that were correlated with both sleep disturbance  
19     and depressive symptoms were having a poor relationship with teachers, feeling  
20     lonely, suicide ideation, and having run away from home.

21     **Conclusion:** Sleep disturbance was determined to be more prevalent among Chinese  
22     adolescents with depressive symptoms. Sleep disturbance and depressive symptoms  
23     were associated with each other, while school factors, family factors, and  
24     psychosocial adjustment were comprehensively correlated with both.

25

## 1 INTRODUCTION

2 Adolescence is often described as occurring between 13 and 18 years of age, which is  
3 roughly the period of high school for much of the world.<sup>1</sup> Sleep plays a very  
4 important role in the development of adolescents; it not only impacts physical growth  
5 and behavior, but it also affects mental health status.<sup>2</sup> Studies in Western countries  
6 have estimated that a large proportion (25%-40%) of adolescents have sleep  
7 disturbance,<sup>3-5</sup> and a report from China in 2000 revealed that 16.9% of the sample  
8 was troubled with sleep disturbance.<sup>6</sup> In total, adolescents' sleep disturbance has been  
9 a major international public health problem, and China is no exception, although the  
10 prevalence of Chinese adolescents with sleep disturbance has been a little lower than  
11 Western countries.

12 Depressive symptoms are a type of mental disorder, and the link between sleep  
13 disturbance and depressive symptoms in adulthood is well established.<sup>7</sup> For instance,  
14 women suffering from sleep disturbances have lower self-rated health and more  
15 physical and mental health complaints, such as depressive symptoms.<sup>8</sup> In contrast, a  
16 limited number of studies (especially epidemiological studies) have addressed the link  
17 between sleep disturbance and depressive symptoms among adolescents, and the link  
18 is not uniform. One study in the US has found that adolescents with sleep disturbance  
19 are more likely to develop and maintain depressive symptoms than are adolescents  
20 without sleep disturbance,<sup>9</sup> but one study found that there did not appear to be a  
21 strong association between sleep disturbance and depressive symptoms in adolescents.  
22<sup>10</sup> Additionally, many researchers in US have reported that sleep disturbance can be a  
23 sign of depressive symptoms, and depressive symptoms can likewise be a sign of  
24 sleep disturbance.<sup>11</sup> Xu's research in China also demonstrated that sleep disturbance  
25 and depressive symptoms are closely related, and insufficient sleep may result in  
26 depressive symptoms.<sup>12</sup> The recent increase in interest in the link between sleep  
27 disturbance and depressive symptoms in adolescents is warranted.

28 Sleep disturbance and depressive symptoms among adolescents are not only  
29 influenced by each other but also by demographics, family, school and social factors.

30<sup>13</sup> Several variables have been associated with sleep disturbance and depressive

1 symptoms. Previous studies have differing results about the characteristics of sleep  
2 disturbances between the two genders. Boys in Hong Kong were more likely to be  
3 troubled by sleep disturbance than girls,<sup>14</sup> but most of the studies from other  
4 countries found that girls were more likely to report sleep disturbances than boys.<sup>15 16</sup>

5 Such inconsistencies may be attributed to differences in the sample and place, which  
6 suggested further research with larger samples is warranted. Additionally, Liu's study  
7 in China indicated that the prevalence of sleep disturbance varies with age and grade  
8 level among adolescents, and adolescents from incomplete families were more likely  
9 to have sleep disturbance compared with their peers.<sup>17</sup> Furthermore, parents' sleep  
10 patterns and psychological functionality was associated with adolescents' sleep in Iran.

11 <sup>18</sup> In addition, the school environment is important for the sleep quality and mental  
12 status of adolescents.<sup>19</sup> Li's research has demonstrated that poor classmate relation  
13 predicted a high level of sleep disturbance and depressive symptoms among Chinese  
14 adolescents. One striking difference between Chinese and US adolescents is the  
15 salience of school and academic achievements relative to other concerns, and Chinese  
16 adolescents care more about academic achievements.<sup>20</sup> Overall, although we  
17 conclude that sleep disturbance and depressive symptoms are universal phenomenon  
18 among adolescents, it is clear that there are cultural variations in their prevalence and  
19 the way that sleep disturbance or depressive symptoms relate to other factors.<sup>21</sup> Most

20 previous studies, however, have been carried out in Western or developed countries,  
21 and only a handful of studies have been conducted in developing countries. There is  
22 also a paucity of studies on family status (i.e., living arrangement, family economic  
23 status), school dynamics (i.e., relationships with classmates or teachers), and personal  
24 psychosocial adjustment (i.e., feeling lonely, attempting suicide) in the Chinese  
25 cultural context. Therefore, we conducted this large-scale cross-sectional study in  
26 China to estimate the prevalence of sleep disturbance and depressive symptoms; to  
27 comprehensively examine the potentially contributing factors to sleep disturbance and  
28 depressive symptoms among demographics, school, family, and psychosocial health;  
29 and to discuss the link between sleep disturbance and depressive symptoms.

30 The following three hypotheses were formulated. First, following the results of

1 previous studies,<sup>6 19</sup> we hypothesized that sleep disturbance or depressive symptoms  
2 are a major public health problem nationwide among Chinese adolescents. Second,  
3 consistent with previous findings,<sup>15 18-20</sup> we expected that demographics, family,  
4 school, and psychosocial factors would be related to sleep disturbance or depressive  
5 symptoms among Chinese adolescents. Third, in line with prior research linking sleep  
6 disturbance and depressive symptoms,<sup>9 12</sup> we expected sleep disturbance to be a risk  
7 factor for depressive symptoms among Chinese adolescents, and vice versa.

## 9 METHODS

### 10 Study design and participants

11 ~~This A~~ cross-sectional study was ~~conducted and~~ based on a province-wide sample to  
12 ~~investigate~~ estimate the prevalence of sleep disturbance and depressive symptoms and  
13 to examine the relationship between potentially influential factors and their  
14 involvement in sleep disturbance and depressive symptoms among Chinese  
15 adolescents. The participants were ~~middle school students~~ high school students from  
16 Guangdong, China. Guangdong is known as an immigrant province, with more than  
17 half of the population migrating from other provinces; therefore, the sample from  
18 Guangdong has a certain degree of representativeness. First, the schools were divided  
19 into three categories: junior high schools (grades 7-9), senior high schools (grades  
20 10-12), and vocational schools (grades 7-12). A stratified-cluster random-sampling  
21 method was used to randomly select participants among the three types of schools.  
22 Six junior high schools, four senior high schools, and two vocational schools were  
23 selected. Next, two classes were randomly selected from each grade in these schools.  
24 All available students within the grade were surveyed; those not surveyed were absent  
25 or refused to participate and consisted of less than 1% of the student population. All  
26 the participants were fully informed of the purpose of the survey and were invited to  
27 participate voluntarily. ~~Written consent letters were obtained from the school, each~~  
28 ~~participating student and one of the student's parents.~~ A rigorously anonymous  
29 method for collection of the self-report questionnaires was guaranteed. The  
30 questionnaires were administered by research assistants in the classrooms without the

1 presence of the teachers. It is important to stress that we used a self-designed  
2 questionnaire whose questions were based on an instrument proposed by the WHO  
3 and adapted to the realities of China, and the findings of a number of investigations  
4 indicate that such data can be extremely useful.<sup>1 22</sup>

## 6 Measures

### 7 Independent variables

8 Socio-demographic variables: Age, grade, gender ~~and so on~~.

9 Family factors: Living arrangement, family economic status, family relationship, and  
10 parental caring. Living arrangements were assessed by asking who lived in the  
11 student's primary home. Family economic status was measured by asking the  
12 student's perception of their family's current economic status (rated from below  
13 average to above average). Family relationships were assessed by asking the students,  
14 with the responses coded on a 3-point scale ranging from below average to above  
15 average. Parental caring was assessed by asking, "Are you satisfied with the love you  
16 receive from your father, mother, or both of them, based on a 4-point scale from  
17 dissatisfaction to satisfaction?"

18 School factors: Classmate relations and teacher-classmate relations were also assessed  
19 based on the student's self-rating about their relationships with classmates and  
20 teachers, ranging from poor to good. Academic achievements and academic pressure  
21 were captured by a single item asking about a personal appraisal of students'  
22 performances or pressure relative to that of their classmates (responses were coded as  
23 "above average", "average", and "below average").

24 Psychosocial adjustment: Feeling lonely was assessed by asking, "During the past 12  
25 months, how often did you feel lonely per week?" Response options ranged from 1  
26 (never) to 4 (over 4 days). Suicide-ideation status was based on whether a participant  
27 had endorsed thoughts of suicide over the past year. Suicide-attempt status was based  
28 on attempts made over the past year, with 1 or more attempts indicating endorsement.  
29 A student's attempt to hurt themselves was assessed by asking, "During the past 12  
30 months, did you ever hurt yourself on purpose?" Responses were categorized into 4



1 groups: never, considered, planned, and attempted. Running away from home was  
2 assessed by asking, “During the past 12 months, did you run away from home without  
3 your parents’ permission for more than 24 hours?” Response options were 1) never, 2)  
4 considered, 3) attempted, or 4) have run away from home one time or more. Habits of  
5 sleeping after lunch were assessed based on the student’s self-rating about their habit,  
6 ranging from poor to good.

### 7 **Dependent variables**

8 We used the *Chinese Pittsburgh Sleep Quality Index (CPSQI)* to assess sleep quality  
9 and disturbances over a 1-month time interval; the sum of the scores for these seven  
10 components yields one global score with a range of 0-21 points in which higher scores  
11 indicate worse sleep quality.<sup>22 23</sup> The CPSQI was translated into Mandarin Chinese to  
12 better correspond to the meaning of the original items in PSQI, and it is valid, reliable,  
13 and commonly used. In China, a PSQI global score of above 7 points indicates poor  
14 sleep quality collectively known as *sleep disturbance*; a higher score indicates a  
15 greater reduction in sleep quality.<sup>22</sup>

16 The *Center for Epidemiology Scale for Depression (CES-D)* in Chinese was used to  
17 identify whether individuals had depressive symptoms. The respondents were asked  
18 to rate the frequency, over the past week, of 20 ~~depressive symptoms symptoms of~~  
19 ~~depression~~ by choosing one of four response options ranging from “rarely or none of  
20 the time” to “most or all of the time”.<sup>24</sup> The Chinese version of this scale has been  
21 validated,<sup>25-27</sup> and extensively utilized in Chinese studies.<sup>28</sup> The score ranges from 0  
22 to 60, and the original recommended cut-off point for having depressive symptoms  
23 was 16 points (corresponding to the 80<sup>th</sup> percentiles) by the founder of the CES-D in  
24 1977.<sup>29</sup> We adopted the 80th percentile as the cut-off (a score greater than 28  
25 indicating “having depressive symptoms”), and the area under the ROC curve was  
26 0.78. For the CES-D survey, those who failed to answer at least 17 of the 20 items  
27 were discarded.

### 28 **Statistical analysis**

1 All data were entered by two investigators independently using EpiData 3.1, and the  
2 statistical analyses were conducted using SPSS 21.0 and SAS 9.2. Descriptive  
3 analyses were used to describe demographic characteristics and the prevalence of  
4 sleep disturbances and depressive symptoms among adolescents. Categorical and  
5 continuous data were reported in the form of proportions and means (SD).  
6 Chi-squared tests were used to test the difference between the categorical variables  
7 referred to above. Multivariate logistic regression models included the significant  
8 variables that had been tested by univariate analyses or that have been widely reported  
9 in the literature; these were used to screen for the risk factors for sleep  
10 disturbance/depressive symptoms according to the odds ratios (ORs) and 95%  
11 confidence intervals (95% CIs). An  $OR > 1$  with  $P < 0.05$  was reported as a risk factor.  
12 Considering that our study used a multi-stage sampling, students were grouped into  
13 classes; therefore, differences might not segregate independently. Thus, multi-level  
14 analyses (the generalized linear mixed effects models adopting the GLMMIX  
15 procedure in SAS) in which classes were treated as clusters were adopted in the  
16 multivariate logistic regression analyses. All statistical tests were two-sided, with a  $P$   
17 value less than 0.05 considered significant.

## 19 RESULTS

20 There were 3,508 students invited to participate, and 3,485 students' questionnaires  
21 were completed and qualified for our survey; the response rate was 95.2%. After  
22 excluding students who were not 13 to 18 years old, we analyzed 3,186 students' data.

### 24 Demographic information

25 A total of 3,186 participants were involved in this analysis. *Table 1* provides the basic  
26 demographic information for the sample involved in this study. The proportion of  
27 boys was 53.4%, and the male-to-female ratio was approximately 1.2:1. The students  
28 ranged in age from 13 to 18 years old, and the mean age of the students was 15.6  
29 ( $\pm 1.6$ ) years. The students who never slept after lunch accounted for 9.7%. The grade  
30 7-9 group of students represented 52.9% of the sample. Regarding the family factors,

1 a total of 89.0% of students lived with both biological parents, whereas 4.7% lived in  
2 single-parent families. A total of 15.8% of students thought of their family  
3 relationships as average, and 77.6% of students were satisfied with both of their  
4 parents' love. A subset of students (30.6%) reported that their current economic status  
5 was above average, whereas 8.4% reported that their economic status was below  
6 average. Regarding school factors, 28.0% of students rated their academic  
7 achievement as below average, and 42.2% of the students thought their academic  
8 pressure was above average. A total of 7.1% of participants reported poor  
9 relationships with their teachers, and 3.8% had poor relations with their classmates.  
10 Regarding the psychosocial factors, 11.9% of students felt lonely more than 4 days  
11 per week. A total of 4.1% of students often had suicide ideation, and 1.2% of students  
12 had attempted suicide often. In addition, 1.5% of participants often hurt themselves on  
13 purpose, and 1.9% of participants had run away from home more than once.

#### 15 **Univariate Analysis for Sleep disturbance and Depressive symptoms**

16 The mean PSQI global score was 8.7 ( $\pm$  2.4) points (8.6 ( $\pm$ 2.5) points among boys,  
17 8.6 ( $\pm$ 2.4) points among girls), and 39.6% of the total sample was classified as having  
18 sleep disturbances (global score higher than 8 points). In addition, 6.4% of the  
19 students had ~~depressive symptoms~~ depression, according the CES-D. The mean  
20 CES-D score of students was 15.2 ( $\pm$  9.4) points (14.6 ( $\pm$ 9.1) points among boys, 15.6  
21 ( $\pm$ 8.8) points among girls). There were no gender differences in the PSQI global  
22 scores or the CES-D scores. ( $P$ >0.05)

23 As shown in *Table 2*, without adjustment for other variables, sleep disturbances and  
24 depressive groups were correlated with gender, family economic status, family  
25 relationships, parental caring, academic pressure, relationships with classmates,  
26 feeling lonely, suicide ideation, suicide attempts, hurting themselves on purpose, and  
27 having run away from home. Only age, grade, relationship with teachers, and having  
28 depressive symptoms were significantly correlated with having a sleep disturbance,  
29 while only living arrangements and having sleep disturbances were significantly  
30 correlated with having depressive symptoms.

## Multilevel Logistic Regression Analysis: Sleep disturbance

The final logistic regression model for sleep disturbance is presented in *Table 3*. Ten of the original variables remained in the final model: gender, age, habit of sleeping after lunch, family relationships, academic pressure, relationships with teachers, feeling lonely, suicide ideation, running away from home, and depressive symptoms. The results revealed that the girls, the 15-16-year age group, and the 17-18-year age group were all more likely to suffer from sleep disturbance. Taking occasional naps after lunch was a risk factor for sleep disturbance compared with the group that never napped after lunch (adjusted OR=1.68, 95% CI=1.27-2.22). Adolescents with below-average family relationships (AOR=1.54, 95% CI=1.06-2.26) had a slightly higher probability of sleep disturbance. Likewise, students with poor relationships with teachers (AOR=1.26, 95% CI=1.19-1.77) were more troubled with sleep disturbances. In addition, students feeling lonely 1-4 days a week (AOR=1.64, 95% CI=1.39-1.94) or over 4 days a week (AOR=2.22, 95% CI=1.70-2.89) had a higher probability of sleep disturbances compared those never feeling lonely. Having suicide ideations occasionally or sometimes was a risk factor for sleep disturbance, and students who considered running away from home (AOR=1.76, 95% CI=1.46-2.13) or attempted running away from home (OR=2.59, 95% CI=1.38-4.88) were also more likely to have a sleep disturbance compared to students who had never considered running away from home. Finally, students who had depressive symptoms were 2.47 (95% CI=1.61-3.79) times more likely to suffer from sleep disturbance than those who did not. Notably, students with average academic pressure (AOR=0.80, 95% CI=0.65-0.99) or below-average academic pressure (AOR=0.41, 95% CI=0.33-0.51) compared with the above-average academic pressure group were less likely to be troubled by sleep disturbance.

## Multilevel Logistic Regression Analysis: Depressive symptoms

The final model for depressive symptoms in *Table 4* showed many correlations. Adolescents with a below-average family relationship (AOR=1.97, 95% CI=1.24-3.15)

1 were more likely to have depressive symptoms. Having average relationships with  
2 classmates (AOR=2.82, 95% CI=1.62-4.90) or poor relationships with classmates  
3 (AOR=1.60, 95% CI=1.14-2.25) was a risk factor for having depressive symptoms.  
4 Students who felt lonely 1 to 4 days a week (AOR=2.67, 95% CI=1.75-4.07) or over 4  
5 days a week (AOR=4.24, 95% CI=2.65-6.80) also had a higher probability of having  
6 depressive symptoms. Likewise, students occasionally, sometimes or often having  
7 suicide ideation had a higher probability of having depressive symptoms. Considering  
8 running away from home (AOR=1.71, 95% CI=1.20-2.44) was also a risk factor for  
9 depressive symptoms compared to students who never considered running away from  
10 home. Students with sleep disturbance were also more likely to have depressive  
11 symptoms (AOR=2.52, 95% CI=1.64-3.86).

## 12 13 DISCUSSION

14 In this study, we found that sleep disturbance was not rare among Chinese adolescents,  
15 with a prevalence of 39.6%. Similar studies have ~~already~~ reported that the prevalence  
16 of sleep ~~problems~~ disturbance in children and adolescents ranges from 66% to 90%.<sup>30</sup>  
17 A report from China in 2000 revealed that 16.9% of the sample was troubled with  
18 sleep disturbance,<sup>6</sup> while a report from China in 1987 reported a prevalence of 14.9%.  
19 <sup>31</sup> This study also agrees with the results from a Western report in which 43.0% of  
20 children experienced sleep disturbance.<sup>32</sup> The considerable variation in the  
21 prevalence of sleep disturbances may be due to the different time periods, different  
22 target populations, and different methodological definitions of sleep disturbances.  
23 Adolescent sleep disturbance has been recognized as a major international public  
24 health problem, and China is no exception, although the prevalence of Chinese  
25 adolescents with sleep disturbance was a little lower than Western countries.

26 In addition, ~~o~~ Our results indicate that girls were more likely to suffer from sleep  
27 disturbance, which agrees with the previous study from Anhui province and Hong  
28 Kong in China.<sup>12 14</sup> In this study, older age was more associated with sleep  
29 disturbance compared with the younger group, which is in line with a previous study  
30 from China that reported that older age was associated with more sleep problems.<sup>6</sup>

1 Additionally, multivariate logistic regression analyses performed to control for  
2 confounding factors and to determine the main correlates of sleep disturbance showed  
3 that poor family relationships, poor relationships with teachers, feeling lonely, suicide  
4 ideation, running away from home, and depressive symptoms were correlated with  
5 sleep disturbance. These findings are in accordance with the results of many previous  
6 studies. For example, a study from Shandong province of China in 2000 also reported  
7 that poor marital relations of parents, poor family economic status, poor child-parent  
8 and peer relations, poor school achievement and social competence were risk factors  
9 for sleep problems,<sup>6</sup> and a study in Switzerland also documented the relationship  
10 between sleep disturbance in adolescents and family functioning and demonstrated  
11 that the mother's and adolescent children's sleep and well-being are particularly  
12 strongly correlated with each other.<sup>33</sup> Furthermore, prior studies also demonstrated  
13 that suicide completers had higher rates of overall sleep disturbance among  
14 adolescents,<sup>34</sup> and running away from home was as common as suicide completion  
15 among adolescents with depressive symptoms.<sup>35</sup> Notably, our results also indicate  
16 that students with average or below-average academic pressure compared with  
17 above-average academic pressure were less likely to be troubled by sleep disturbance.  
18 This indicates that academic pressure is an important type of stress that affects sleep,  
19 and other studies have provided evidence that stress is associated with sleep  
20 disturbance.<sup>36</sup>

21 Consistent with our expectation, adolescents who had depressive symptoms were at  
22 a higher risk for sleep disturbance. Xu has detected an association between sleep  
23 disturbance and depressive symptoms among Chinese adolescents.<sup>12</sup> We found that  
24 sleep disturbance was common among adolescents in China, and an adolescent's  
25 family, school, and psychosocial factors have influences on sleep disturbance. Thus,  
26 educational campaigns directed at families and schools are needed to improve  
27 awareness of the adverse consequence of sleep disturbance.

28 In this study, the prevalence of students with depressive symptoms was 6.4%,  
29 slightly lower than the 8.0% reported in an Australian study.<sup>37</sup> Depressive symptoms  
30 are a prevalent and disabling condition among adolescents that results in emotional

1 suffering and sleep disturbance; therefore, it is important for us to focus on this  
2 problem.<sup>38</sup> Our study reports that the prevalence of depressive symptoms among  
3 girls was not much higher than among boys, but a previous study reported prevalence  
4 rates of emotional problems to be higher in boys than in girls.<sup>39</sup> These differences  
5 may due to emotional problems, including depressive symptoms and others.  
6 Additionally, our multivariate logistic regression showed that below-average family  
7 relationship, average or below-average relationships with classmates, emotional  
8 problems (including feeling lonely more than 1 day per week, having suicide  
9 ideations, considering running away from home), and having sleep disturbance was a  
10 risk factor for having depressive symptoms. Given that depressive symptoms are a  
11 type of emotional problem,<sup>40</sup> it is not surprising that our results indicate a link  
12 between sleep disturbance and emotional problems. Consistent with the third  
13 hypothesis, our results clearly showed a link between sleep disturbance and  
14 depressive symptoms. However, the direction of the link was difficult to determine  
15 due to the nature of this cross-sectional study; they might mutually reinforce each  
16 other, thereby formulating a vicious circle.

17 Given adolescents' vulnerability to both sleep disturbance and depressive  
18 symptoms, we conducted this large-scale study aimed to investigate the prevalence  
19 and correlates of both problems in Chinese adolescents. To date, no research has  
20 expressly considered comprehensively the correlates of sleep disturbance and  
21 depressive symptoms among demographics, school, family, and psychosocial domains  
22 in this population. Additionally, it must be stressed that there are several limitations to  
23 the current large-scale study. First, the data are cross-sectional, so no causal inference  
24 can be made regarding the observed relationships between sleep disturbance and  
25 depressive symptoms, and the common-method variance interpretation for the  
26 findings might apply. Second, the questionnaires did not include items that could  
27 address students with sleep-related breathing problems or psychological diseases such  
28 as attention-deficit hyperactivity disorder (ADHD). Third, it should be noted that the  
29 present results that were based on a structured self-rating questionnaire were  
30 cross-sectional and retrospective; although self-reporting is a common and accepted

1 method, we could not completely rule out the possibility of recall bias. To minimize  
2 incorrect or unavailable data given by students who did not fully understand the  
3 contents of the PSQI and the CES-D, we have provided a detailed explanation of the  
4 *PSQI* and *CES-D*.

5 In conclusion, the prevalence and correlates of sleep disturbances and depressive  
6 symptoms among adolescents in China are high, and further research into their causes,  
7 effects, and remedies is warranted. The prevalence of sleep disturbance observed in  
8 this study suggests the importance of research on preventive interventions targeting  
9 sleep quality among Chinese students. Effective preventive measures require full  
10 consideration of the social and environmental factors. We should focus on the  
11 high-risk population whose family factors, school factors, and psychosocial  
12 adjustments are negative.

#### 15 **Contributors**

16 GL and LCY searched the literature, conceived the study, designed the study, analyzed  
17 the data, interpreted the results, and drafted the report. DJX and HY organized the  
18 study, collected the data and analyzed the data. DXQ, HJW, HGL, GX collected the  
19 data, interpreted the results, and obtained funding.

21 **Acknowledgments:** We gratefully acknowledge the contribution of the Guangdong  
22 Education Bureau and its participating schools. We would like to thank the local  
23 health professionals, principals and teachers of participating schools. We express great  
24 thanks to all participants of our study.

26 **Funding Source:** This study was supported by the Guangdong Food and Drug  
27 Administration. The funders had no role in the study design, data collection or  
28 analysis, decision to publish, or preparation of the manuscript.

30 **Conflict of Interest:** The authors have declared that no competing interests exist.



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**Financial Disclosure:** The authors have no financial relationships relevant to this article to disclose.

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**References:**

1. Crockett LJ, Beal SJ. The life course in the making: gender and the development of adolescents' expected timing of adult role transitions. *Dev Psychol* 2012;48(6):1727-38.
2. Anders TF, Eiben LA. Pediatric sleep disorders: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 1997;36(1):9-20.
3. Lazaratou H, Dikeos DG, Anagnostopoulos DC, Sbokou O, Soldatos CR. Sleep problems in adolescence. A study of senior high school students in Greece. *Eur Child Adolesc Psychiatry* 2005;14(4):237-43.
4. Bailly D, Bailly-Lambin I, Querleu D, Beuscart R, Collinet C. [Sleep in adolescents and its disorders. A survey in schools]. *Encephale* 2004;30(4):352-9.
5. Garcia-Jimenez MA, Salcedo-Aguilar F, Rodriguez-Almonacid FM, Redondo-Martinez MP, Monterde-Aznar ML, Marcos-Navarro AI, et al. [The prevalence of sleep disorders among adolescents in Cuenca, Spain]. *Rev Neurol* 2004;39(1):18-24.
6. Liu X, Uchiyama M, Okawa M, Kurita H. Prevalence and correlates of self-reported sleep problems among Chinese adolescents. *Sleep* 2000;23(1):27-34.
7. Association. AP. *Diagnostic and statistical manual of mental disorders DSM IV*. Washington, DC: American Psychiatric Association;1994.
8. Pigeon WR, Cerulli C, Richards H, He H, Perlis M, Caine E. Sleep disturbances and their association with mental health among women exposed to intimate partner violence. *J Womens Health (Larchmt)* 2011;20(12):1923-9.
9. Roane BM, Taylor DJ. Adolescent insomnia as a risk factor for early adult depression and substance abuse. *Sleep* 2008;31(10):1351-6.
10. Alfano CA, Zakem AH, Costa NM, Taylor LK, Weems CF. Sleep problems and their relation to cognitive factors, anxiety, and depressive symptoms in children and adolescents. *Depress Anxiety* 2009;26(6):503-12.
11. Roehr B. American Psychiatric Association explains DSM-5. *BMJ* 2013;346:f3591.
12. Xu Z, Su H, Zou Y, Chen J, Wu J, Chang W. Sleep quality of Chinese adolescents: distribution and its associated factors. *J Paediatr Child Health* 2012;48(2):138-45.
13. Stores G. Children's sleep disorders: modern approaches, developmental effects, and children at special risk. *Dev Med Child Neurol* 1999;41(8):568-73.
14. Chung KF, Cheung MM. Sleep-wake patterns and sleep disturbance among Hong Kong Chinese adolescents. *Sleep* 2008;31(2):185-94.
15. Abdel-Khalek AM. Prevalence of reported insomnia and its consequences in a survey of 5,044 adolescents in Kuwait. *Sleep* 2004;27(4):726-31.
16. Ohida T, Osaki Y, Doi Y, Tanihata T, Minowa M, Suzuki K, et al. An epidemiologic study of self-reported sleep problems among Japanese adolescents. *Sleep* 2004;27(5):978-85.
17. Liu X, Zhao Z, Jia C, Buysse DJ. Sleep patterns and problems among Chinese adolescents. *Pediatrics* 2008;121(6):1165-73.
18. Bajoghli H, Alipouri A, Holsboer-Trachsler E, Brand S. Sleep patterns and psychological functioning in families in northeastern Iran; evidence for similarities between adolescent children and their parents. *J Adolesc* 2013;36(6):1103-13.
19. Li SH, Shen XM, Jin XM, Yan CH, Wu SH, Jiang F, et al. [Sleep habits and sleep disturbance in school-age children of China]. *Zhonghua Er Ke Za Zhi* 2008;46(3):185-9.

- 1  
2  
3 20. Gong J, Li Y, Xg C, Ca J. [A baseline survey on the association of smoking onset and life  
4 events on adolescents in Wuhan, China]. *Zhonghua Liu Xing Bing Xue Za Zhi* 2004;25(2):142-5.  
5  
6 21. Rona RJ, Li L, Gulliford MC, Chinn S. Disturbed sleep: effects of sociocultural factors and  
7 illness. *Arch Dis Child* 1998;78(1):20-5.  
8  
9 22. Tsai PS, Wang SY, Wang MY, Su CT, Yang TT, Huang CJ, et al. Psychometric evaluation of  
10 the Chinese version of the Pittsburgh Sleep Quality Index (CPSQI) in primary insomnia and  
11 control subjects. *Qual Life Res* 2005;14(8):1943-52.  
12  
13 23. Buysse DJ, Reynolds CR, Monk TH, Berman SR, Kupfer DJ. The Pittsburgh Sleep Quality  
14 Index: a new instrument for psychiatric practice and research. *Psychiatry Res* 1989;28(2):193-213.  
15  
16 24. Myers JK, Weissman MM. Use of a self-report symptom scale to detect depression in a  
17 community sample. *Am J Psychiatry* 1980;137(9):1081-4.  
18  
19 25. Cheng CP, Yen CF, Ko CH, Yen JY. Factor structure of the Center for Epidemiologic Studies  
20 Depression Scale in Taiwanese adolescents. *Compr Psychiatry* 2012;53(3):299-307.  
21  
22 26. Lee SW, Stewart SM, Byrne BM, Wong JP, Ho SY, Lee PW, et al. Factor structure of the  
23 Center for Epidemiological Studies Depression Scale in Hong Kong adolescents. *J Pers Assess*  
24 2008;90(2):175-84.  
25  
26 27. Zhang Jie WZFG. Development of the Chinese age norms of CES-D in urban area. *Chinese*  
27 *Mental Health Journal. (In Chinese)*. 2010(02):139-143.  
28  
29 28. Yen S, Robins CJ, Lin N. A cross-cultural comparison of depressive symptom manifestation:  
30 China and the United States. *J Consult Clin Psychol* 2000;68(6):993-9.  
31  
32 29. Radloff LS, editor *The CES-D scale: A self-report depression scale for research in the general*  
33 *populations.*, 1977.  
34  
35 30. Meltzer LJ, Avis KT, Biggs S, Reynolds AC, Crabtree VM, Bevans KB. The Children's  
36 Report of Sleep Patterns (CRSP): a self-report measure of sleep for school-aged children. *J Clin*  
37 *Sleep Med* 2013;9(3):235-45.  
38  
39 31. Yang L, Zuo C, Eaton LF. Research note: sleep problems of normal Chinese adolescents. *J*  
40 *Child Psychol Psychiatry* 1987;28(1):167-72.  
41  
42 32. Kahn M, Sheppes G, Sadeh A. Sleep and emotions: Bidirectional links and underlying  
43 mechanisms. *Int J Psychophysiol* 2013;89(2):218-28.  
44  
45 33. Kalak N, Gerber M, Kirov R, Mikoteit T, Puhse U, Holsboer-Trachsler E, et al. The relation of  
46 objective sleep patterns, depressive symptoms, and sleep disturbances in adolescent children and  
47 their parents: a sleep-EEG study with 47 families. *J Psychiatr Res* 2012;46(10):1374-82.  
48  
49 34. Goldstein TR, Bridge JA, Brent DA. Sleep disturbance preceding completed suicide in  
50 adolescents. *J Consult Clin Psychol* 2008;76(1):84-91.  
51  
52 35. Tucker JS, Edelen MO, Ellickson PL, Klein DJ. Running away from home: a longitudinal  
53 study of adolescent risk factors and young adult outcomes. *J Youth Adolesc* 2011;40(5):507-18.  
54  
55 36. Byars KC, Yeomans-Maldonado G, Noll JG. Parental functioning and pediatric sleep  
56 disturbance: an examination of factors associated with parenting stress in children clinically  
57 referred for evaluation of insomnia. *Sleep Med* 2011;12(9):898-905.  
58  
59 37. Tsai PS, Wang SY, Wang MY, Su CT, Yang TT, Huang CJ, et al. Psychometric evaluation of  
60 the Chinese version of the Pittsburgh Sleep Quality Index (CPSQI) in primary insomnia and  
control subjects. *Qual Life Res* 2005;14(8):1943-52.  
38. Ivanenko A, Crabtree VM, Gozal D. Sleep and depression in children and adolescents. *Sleep  
Med Rev* 2005;9(2):115-29.

- 1  
2  
3 39. Liu X, Kurita H, Guo C, Miyake Y, Ze J, Cao H. Prevalence and risk factors of behavioral and  
4 emotional problems among Chinese children aged 6 through 11 years. *J Am Acad Child Adolesc*  
5 *Psychiatry* 1999;38(6):708-15.  
6  
7 40. Siegel JM, Platt JJ, Peizer SB. Emotional and social real-life problem-solving thinking in  
8 adolescent and adult psychiatric patients. *J Clin Psychol* 1976;32(2):230-2.  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
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Table 1. Demographic characteristics of the total sample.

Variable	Number (%)
<b>Total</b>	3186 (100.0)
<b>Gender</b>	
Male	1700 (53.4)
Female	1486 (46.6)
<b>Age (years)</b>	
13-14	420 (13.2)
15-16	1687 (53.0)
17-18	1079 (33.9)
<b>Grade</b>	
7 <sup>th</sup> -9 <sup>th</sup>	1686 (52.9)
10 <sup>th</sup> -12 <sup>th</sup>	1500 (47.1)
<b>Living arrangement</b>	
Two biological parents	2836 (89.0)
Only father or mother	149 (4.7)
Others	201 (6.3)
<b>Family economic status</b>	
Above average	975 (30.6)
Average	1942 (61.0)
Below average	269 (8.4)
<b>Family relationship</b>	
Above average	2501 (78.5)
Average	502 (15.8)
Below average	183 (5.7)
<b>Parental caring</b>	
Satisfied with father or mother	545 (17.1)
Satisfied with both of them	2471 (77.6)
Dissatisfied with both of them	170 (5.3)
<b>Academic achievement</b>	
Above average	1361 (42.7)
Average	932 (29.3)
Below average	893 (28.0)
<b>Academic pressure</b>	
Above average	1344 (42.2)
Average	1376 (43.2)
Below average	466 (14.4)
<b>Relationship with teachers</b>	
Good	1552 (48.7)
Average	1408 (44.2)
Poor	226 (7.1)

Table 1. Demographic characteristics of the total sample (continued).

Variable	Number (%)
<b>Relationship with classmates</b>	
Good	2220 (69.7)
Average	846 (26.6)
Poor	120 (3.8)
<b>Feel lonely</b>	
Less than 1 day/week	1733 (54.4)
1 to 4 days/week	1073 (33.7)
More than 4 days/week	380 (11.9)
<b>Suicide ideation</b>	
Never	2589 (81.3)
Occasionally (1-2 times/year)	391 (12.3)
Sometimes (3-6 times/year)	75 (2.4)
Often (over 6 times/year)	131 (4.1)
<b>Suicide attempt</b>	
Never	3083 (95.8)
Occasionally (1-2 times/year)	81 (2.5)
Sometimes (3-6 times/year)	14(0.4)
Often (over 6 times/year)	38 (1.2)
<b>Hurt themselves on purpose</b>	
Never	2807 (88.1)
Occasionally (1-2 times/year)	269 (8.4)
Sometimes (3-6 times/year)	61 (1.9)
Often (over 6 times/year)	49 (1.5)
<b>Running away from home</b>	
Never	2262 (71.0)
Considered	815 (25.6)
Planned	48 (1.5)
Attempted	61 (1.9)
<b>Habit of sleeping after lunch</b>	
Never	308 (9.7)
Occasionally (1-4 times/week)	1598 (50.2)
Often (over 4 times/week)	1280 (40.2)

Table 2. Univariate chi-square analysis for sleep disturbance and depressive symptoms, n (%).

Variable	Total	With sleep disturbance	With depressive symptoms
<b>Total</b>	3186 (100.0)	1261 (100.0)	205 (100.0)
<b>Gender #</b>			
Male	1700 (53.4)	729 (57.8)	92 (44.9)
Female	1486 (46.6)	532 (42.2)	113 (55.1)
<b>Age (years) *</b>			
13-14	420 (13.2)	240 (19.0)	22 (10.7)
15-16	1687 (53.0)	667 (52.9)	111 (54.1)
17-18	1079 (33.9)	354 (28.1)	72 (35.1)
<b>Grade *</b>			
7 <sup>th</sup> -9 <sup>th</sup>	1686 (52.9)	740 (58.7)	108 (52.7)
10 <sup>th</sup> -12 <sup>th</sup>	1500 (47.1)	521 (41.3)	97 (47.3)
<b>Living arrangement **</b>			
Two biological parents	2836 (89.0)	1125 (89.2)	169 (82.4)
Only father or mother	149 (4.7)	51 (4.0)	16 (7.8)
Others	201 (6.3)	85 (6.7)	20 (9.8)
<b>Family economic status #</b>			
Above average	975 (30.6)	437 (34.7)	45 (22.0)
Average	1942 (61.0)	738 (58.5)	127 (62.0)
Below average	269 (8.4)	86 (6.8)	33 (16.1)
<b>Family relationship #</b>			
Above average	2501 (78.5)	1063 (84.3)	115 (56.1)
Average	502 (15.8)	155 (12.3)	46 (22.4)
Below average	183 (5.7)	43 (3.4)	44 (21.5)
<b>Parental caring #</b>			
Satisfied with father or mother	545 (17.1)	184 (14.6)	58 (28.3)
Satisfied with both of them	2471 (77.6)	1029 (81.6)	118 (57.6)
Dissatisfied with both of them	170 (5.3)	48 (3.8)	29 (14.1)
<b>Academic achievement</b>			
Above average	1361 (42.7)	558 (44.3)	84 (41.0)
Average	932 (29.3)	362 (28.7)	59 (28.8)
Below average	893 (28.0)	341 (27.0)	62 (30.2)
<b>Academic pressure #</b>			
Above average	1344 (42.2)	399 (31.6)	137 (66.8)
Average	1376 (43.2)	625 (49.6)	49 (23.9)
Below average	466 (14.4)	237 (18.8)	19 (9.3)
<b>Relationship with teachers *</b>			
Good	1552 (48.7)	694 (55.0)	69 (33.7)
Average	1408 (44.2)	493 (39.1)	95 (46.3)
Poor	226 (7.1)	74 (5.9)	41 (20.0)

**Table 2. Univariate chi-square analysis for sleep disturbance and depressive symptoms, n (%) (continued).**

<b>Relationship with classmates #</b>			
Good	2220 (69.7)	928 (73.6)	94 (45.9)
Average	846 (26.6)	289 (22.9)	79 (38.5)
Poor	120 (3.8)	44 (3.5)	32 (15.6)
<b>Feel lonely #</b>			
Less than 1 day/week	1733 (54.4)	830 (65.8)	34 (16.6)
1 to 4 days/week	1073 (33.7)	335 (26.6)	98 (47.8)
More than 4 days/week	380 (11.9)	96 (7.6)	73 (35.6)
<b>Suicide ideation #</b>			
Never	2589 (81.3)	1108 (87.9)	88 (42.9)
Occasionally (1-2 times/year)	391 (12.3)	88 (7.0)	68 (33.2)
Sometimes (3-6 times/year)	75 (2.4)	12 (1.0)	18 (8.8)
Often (over 6 times/year)	131 (4.1)	53 (4.2)	31 (15.1)
<b>Suicide attempt #</b>			
Never	3083 (95.8)	1223 (97.0)	169 (82.4)
Occasionally (1-2 times/year)	81 (2.5)	17 (1.3)	20 (9.8)
Sometimes (3-6 times/year)	14 (0.4)	4 (0.3)	3 (1.5)
Often (over 6 times/year)	38 (1.2)	17 (1.3)	13 (6.3)
<b>Hurt themselves on purpose #</b>			
Never	2807 (88.1)	1147 (91.0)	140 (68.3)
Occasionally (1-2 times/year)	269 (8.4)	78 (6.2)	43 (21.0)
Sometimes (3-6 times/year)	61 (1.9)	20 (1.6)	7 (3.4)
Often (over 6 times/year)	49 (1.5)	16 (1.3)	15 (7.3)
<b>Running away from home #</b>			
Never	2262 (71.0)	1006 (79.8)	79 (38.5)
Considered	815 (25.6)	226 (17.9)	103 (50.2)
Planned	48 (1.5)	14 (1.1)	6 (2.9)
Attempted	61 (1.9)	15 (1.2)	17 (8.3)
<b>Depressive symptoms *</b>			
Yes	205 (6.4)	29 (2.3)	-
No	2981 (93.6)	1232 (97.7)	-
<b>Sleep disturbance **</b>			
Yes	1261 (39.6)	-	29 (14.1)
No	1925 (60.4)	-	176 (85.9)

#: According to the chi-square test, without adjusting for other variables,  $P < 0.05$  in both the sleep disturbance group and the depressive symptoms group.

\*:  $P < 0.05$ , only in the sleep disturbance group.

\*\* :  $P < 0.05$ , only in the depressive symptoms group.



Table 3. Adjusted OR (95% CI) for sleep disturbance by multi-level logistic regression.

Covariate	Adjusted OR (95% CI)	P-value
<b>Age (years)</b>		
13-14	1.00 (reference)	
15-16	2.40 (1.87-3.08)	<.001
17-18	1.36 (1.15-1.62)	<.001
<b>Gender</b>		
Male	1.00 (reference)	
Female	1.27 (1.08-1.48)	0.003
<b>Habit of sleeping after lunch</b>		
Never	1.00 (reference)	
Occasionally (1-4 times/week)	1.68 (1.27-2.22)	<.001
Often (over 4 times/week)	1.05 (0.89-1.23)	0.590
<b>Family relationship</b>		
Above average	1.00 (reference)	
Average	1.08(0.71-1.64)	0.723
Below average	1.54 (1.06-2.26)	0.025
<b>Academic pressure #</b>		
Above average	1.00 (reference)	
Average	0.80 (0.65-0.99)	<.001
Below average	0.41 (0.33-0.51)	<.001
<b>Relationship with teachers</b>		
Good	1.00 (reference)	
Average	0.79 (0.57-1.11)	0.174
Poor	1.26 (1.19-1.77)	<.001
<b>Feel lonely</b>		
Less than 1 day/week	1.00 (reference)	
1 to 4 days/week	1.64 (1.39-1.94)	<.001
More than 4 days/week	2.22 (1.70-2.89)	<.001
<b>Suicide ideation</b>		
Never	1.00 (reference)	
Occasionally (1-2 times/year)	1.78 (1.36-2.34)	<.001
Sometimes (3-6 times/year)	2.37 (1.25-4.54)	0.009
Often (over 6 times/year)	0.80 (0.54-1.20)	0.280
<b>Running away from home</b>		
Never	1.00 (reference)	
Considered	1.76 (1.46-2.13)	<.001
Planned	1.42 (0.74-2.73)	0.298
Attempted	2.59 (1.38-4.88)	0.003
<b>Depressive symptoms</b>		
No	1.00 (reference)	
Yes	2.47 (1.61-3.79)	<.001

NOTE: Adjusted OR means odds ratio adjusted by multivariate analysis for screening risk factors for adolescents with sleep disturbance; 95% CI=95% confident interval.

Table 4. Adjusted OR (95% CI) for depressive symptoms by multi-level logistic regression.

Covariate	Adjusted OR (95% CI)	P-value
<b>Family relationship</b>		
Above average	1.00 (reference)	
Average	1.22 (0.82-1.81)	0.329
Below average	1.97 (1.24-3.15)	0.004
<b>Relationship with classmates</b>		
Good	1.00 (reference)	
Average	2.82 (1.62-4.90)	<.001
Poor	1.60 (1.14-2.25)	0.007
<b>Feel lonely</b>		
Less than 1 day/week	1.00 (reference)	
1 to 4 days/week	2.67 (1.75-4.07)	<.001
More than 4 days/week	4.24 (2.65-6.80)	<.001
<b>Suicide ideation</b>		
Never	1.00 (reference)	
Occasionally (1-2 times/year)	2.72 (1.85-3.98)	<.001
Sometimes (3-6 times/year)	2.77 (1.46-5.26)	0.002
Often (over 6 times/year)	3.38 (1.89-6.04)	<.001
<b>Running away from home</b>		
Never	1.00 (reference)	
Considered	1.71 (1.20-2.44)	0.003
Planned	1.08 (0.40-2.90)	0.885
Attempted	1.42 (0.65-3.10)	0.386
<b>Sleep disturbance</b>		
No	1.00 (reference)	
Yes	2.52 (1.64-3.86)	<.001

NOTE: Adjusted OR means odds ratio adjusted by multivariate analysis for screening risk factors for adolescents showing depressive symptoms; 95% CI=95% confident interval.

## STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation
<b>Title and abstract</b>	1	(a) Indicate the study's design with a commonly used term in the title or the abstract (b) Provide in the abstract an informative and balanced summary of what was done and what was found
<b>Introduction</b>		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
<b>Methods</b>		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(a) <i>Cohort study</i> —Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up <i>Case-control study</i> —Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls <i>Cross-sectional study</i> —Give the eligibility criteria, and the sources and methods of selection of participants (b) <i>Cohort study</i> —For matched studies, give matching criteria and number of exposed and unexposed <i>Case-control study</i> —For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding (b) Describe any methods used to examine subgroups and interactions (c) Explain how missing data were addressed (d) <i>Cohort study</i> —If applicable, explain how loss to follow-up was addressed <i>Case-control study</i> —If applicable, explain how matching of cases and controls was addressed <i>Cross-sectional study</i> —If applicable, describe analytical methods taking account of sampling strategy (e) Describe any sensitivity analyses

Continued on next page

**Results**

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed (b) Give reasons for non-participation at each stage (c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders (b) Indicate number of participants with missing data for each variable of interest (c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time <i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure <i>Cross-sectional study</i> —Report numbers of outcome events or summary measures
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included (b) Report category boundaries when continuous variables were categorized (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses

**Discussion**

Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results

**Other information**

Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based
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\*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at [www.strobe-statement.org](http://www.strobe-statement.org).