Association of Maternal Self-Medication and Over-the-Counter Analgesics for Children

WHAT’S KNOWN ON THIS SUBJECT: Self-medication with over-the-counter (OTC) analgesics, particularly paracetamol (PCM), among children is widespread and increasing. Parents often administer the medicine. The health care system has little knowledge or possibility to regulate OTC medication, and use of PCM for children may be partly unjustified.

WHAT THIS STUDY ADDS: Maternal frequent self-medication with OTC analgesics is associated with frequent use of OTC analgesics, particularly PCM, among 6- to 11-year-old schoolchildren, even when the child’s frequency of pain is accounted for.

abstract

OBJECTIVE: Self-medication with over-the-counter (OTC) analgesics, such as paracetamol (PCM), among children and adolescents is increasing and constitutes an important public health issue internationally. Reasons for this development are unclear; parental influence is suggested. Our objective was to examine whether self-medication with OTC analgesics among school-aged children is influenced by maternal self-reported health and medicine use, taking the child’s frequency of pain into account.

METHODS: A quantitative cross-sectional survey was conducted on 131 children aged 6 to 11 years and their mothers in the framework of the Demonstration Of A Study To Coordinate and Perform Human biomonitoring on a European Scale (DEMOCOPHES) European project. Participants were selected from 1 urban and 1 rural area of Denmark, and equally distributed in age and gender. Data were collected through structured interviews with all children and self-report questionnaires for mothers regarding health, pain, and medicine use.

RESULTS: After adjusting for several sociodemographic and health parameters, maternal use of OTC analgesics was significantly associated with self-medication with OTC analgesics, particularly PCM, in our population of schoolchildren, even when the child’s pain was adjusted for (odds ratio 3.00, P = .008). A clear association between child pain and OTC analgesic use was not found. Additionally, maternal health (self-rated health, chronic pain, chronic disease, daily medicine intake) did not significantly influence child use of OTC analgesics.

CONCLUSIONS: Maternal self-medication with OTC analgesics is associated with self-medication of OTC analgesics, predominantly PCM, among school-aged children, perhaps more than the child’s pain. Maternal health seems of less importance. Information to parents about pain self-management is important to promote appropriate PCM use among schoolchildren. *Pediatrics* 2014;133:1–8

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KEY WORDS

medicine use, children, parents, paracetamol, pain

ABBREVIATIONS

BMR—backward model reduction
DEMOCOPHES—Demonstration of a study to Coordinate and Perform Human biomonitoring on a European Scale
HRQol—health-related quality of life
OR—odds ratio
OTC—over-the-counter
PCM—paracetamol
SRH—self-rated health

Dr Jensen conceptualized and designed the study, designed the data collection instrument, carried out the recruitment, data collection, and statistical analyses, and drafted the initial manuscript; Miss Gottschau carried out the data collection and statistical analyses, and reviewed and revised the initial manuscript; Dr Siersma supervised the statistical analyses, and reviewed and revised the initial manuscript; Dr Graungaard assisted in the design of the study and data collection instrument, and reviewed and revised the initial manuscript; Professor Holstein supervised the design of the data collection instrument and the statistical analysis, and reviewed and revised the initial manuscript; Dr Knudsen supervised the design of the data collection instrument, coordinated recruitment and data collection, supervised statistical analyses, and reviewed and revised the initial manuscript; and all authors approved the final manuscript as submitted.

(Continued on last page)
Use of over-the-counter (OTC) analgesics to treat pain among children is common behavior internationally.1–3 This treatment is often managed by parents without consulting a physician.4 The act of self-administering OTC medicine, or giving it to one’s child without medical supervision, is termed self-medication.1 In many highly developed countries, self-medication for children and adolescents in case of pain and other minor ailments has increased within the past decades.5,6 The reasons for this development are still unclear. A recent US survey showed that in 1 week, twice as many children aged 0 to 11 years received OTC drugs as prescription medications.7

Paracetamol (PCM) is the most widely used analgesic to treat mild pain in children in the United States7 and internationally.8 Correspondingly, it is the most frequently sold and used OTC preparation for children.1,7,9 It is offered in pharmacies and supermarkets worldwide. Because individual purchase of OTC preparations is not registered, the healthcare system’s knowledge and regulation of PCM use is limited. PCM was introduced in the 1950s as a mild analgesic and antipyretic. It is considered safe for pediatric patients when administrated in therapeutic dosage. Taking PCM frequently can lead to medicine-induced headache.10 Overdosing can lead to liver damage and, in worst case, liver failure.8 Intoxication may happen after a single overdose accident, as well as after repeated doses above recommendations.11 This is noteworthy because parental dosing errors with PCM are not uncommon.12 US data showed more than 70,000 emergency department visits in a 2-year period because of unintentional medicine overdose in 0- to 18-year-old children, PCM accounting for 10% of those visits.13 Several factors might affect the use of OTC analgesics for children and adolescents. In European adolescents, female gender and a self-reported poor self-rated health (SRH) predict a more frequent use of OTC medications, including analgesics.14,15 Being bullied by peers also seems to promote use of pain medications in schoolchildren.16 Recently, parental influence on child self-medication has gained attention. Several studies have examined the influence of parental socioeconomy. Some show an association with high income and level of education,1,4,17 whereas another found an association with low socioeconomic status.18 Parental attitudes toward OTC medicines may affect the self-medication for their child.19,20 Additionally parental health and pain symptoms have been suggested to be of importance.2 Mothers could be of particular influence, because they most often purchase and administer OTC medications, including PCM.21

The current extensive self-medication with OTC analgesics for children constitutes an important public health issue internationally.5 By increasing our understanding of what influences child use of analgesics we can improve safety and efficacy of preparations such as PCM. Further knowledge of parental aspects that promote administration of analgesics for children may contribute. The purpose of this study was to examine the influence of maternal health and medicine use on medication with OTC analgesics, especially PCM, among school-aged children.

**METHODS**

**Setting**

This study was carried out in school settings of 2 locations: an urban and a rural area in Denmark during the fall of 2011. Recruitment and sampling was closely connected with the Danish part of Demonstration of a study to Coordinate and Perform Human Biomonitoring on a European Scale (DEMOCOPHES), a European Union project demonstrating the feasibility of a coordinated approach on human biomonitoring at the European level by examining levels of chemicals (mercury, cadmium, phthalates, and cotinine) in comparable populations of schoolchildren and their mothers in 17 European countries.22,23

**Design/Population**

The design was a quantitative cross-sectional survey by using structured interviews with children and corresponding self-report questionnaires for mothers.

In DEMOCOPHES, 144 Danish children aged 6 to 11 years and their mothers were included. The participants were recruited from 4 schools in each area. All parents of first to sixth grade pupils received written information about DEMOCOPHES and this study via the schools’ E-mail systems. Furthermore, information was posted in local newspapers. Participants were invited to self-assign on a project Web site.

The children were equally distributed in age, gender, and urban/rural location. Only children who had lived in the area for 5 years and stayed with their mothers a minimum of 16 days per month were included. Children or mothers with diabetes, liver or kidney disease, or who did not understand Danish were excluded.

At the day of participation, all DEMOCOPHES participants were invited to also take part in this study: 131 pairs of mother and child agreed. Reasons for not participating were lack of time (9 pairs), discomfort after blood sampling (2 pairs), and unwillingness of the child (2 pairs).

**Data Collection**

Collection of data took place in the school nurses’ facilities of 3 schools. All participants had specific appointments; 1 hour was scheduled for each pair. They delivered questionnaires, and urine, hair, and blood samples, and subsequently the mother filled out the questionnaire for the current study while the child was
interviewed by the first author (J.F.J.) in a separate room. J.F.J. is trained in structured interviewing and has 3 years’ experience as a physician in hospitals and general practice. If a mother had problems answering the questionnaire, she could ask J.F.J. for advice.

The structured interview guide contained 21 items regarding health and health-related quality of life (HRQoL), experiences with pain, and medicine use of the child. The questionnaire for mothers contained 39 items: 25 concerning health, pain, and medicine use of the child, and 14 concerning health of the mother. Completing the questionnaire and interview took 10 to 15 minutes.

HRQoL of the children was measured by the validated Pediatrics Quality of Life inventory. Items regarding child pain were developed from the Lübeck Pain Screening Questionnaire. Items on medicine use were designed specifically for this survey. Maternal SRH was assessed by 1 item from the Danish Short Form-36 inventory. The final questionnaires were pilot tested with 5 mother-child pairs before use. Only minor corrections were made.

**Measurements**

Two items in the self-report questionnaire covered the use of OTC analgesics for children: if the child had received OTC analgesics in the past 3 months (replies were dichotomized into yes versus no/do not know), and how often in the past year the child was given PCM (replies were dichotomized into every second month or more often versus not at all/only a few times). These items constitute the 2 key outcomes for this study (Fig 1).

To clarify child recurrent pain, both the child and mother reported if the child often experienced pain and described the frequency (Fig 1). Pain occurring a minimum of weekly in a period of 3 months was described as recurrent pain in accordance with previous studies. Maternal health was described by 5 items for the mother concerning SRH, pain, chronic disease, and medicine use (Fig 1). Maternal SRH was dichotomized into excellent/very good versus good/fair/poor. Maternal use of analgesics was dichotomized into less than once a month versus monthly or more often.

**Statistics**

Data were analyzed with SPSS for Windows statistical software, version 20 (IBM SPSS Statistics, IBM Corporation, Chicago, IL). P values < .05 were considered significant.

Sociodemographic variations in medicine use were assessed by χ² tests. Associations between maternal health and the key outcomes were assessed by univariate and multivariate logistic regression analyses. Because the included maternal health factors might be correlated and hide each other’s effects in a full multivariate model, we did a backward model reduction (BMR) for each health factor; iteratively, the health factor with the lowest P value was removed until only the examined health factor and factors with P < .05 were left in the model.

**Ethics**

The DEMOCOPHES study was approved by the regional ethics committee (approval no H-3–2011–075). Participation was
voluntary and it was at any time possible to withdraw from the study, or part of it. All participants received a cinema ticket for their contribution. Children were not asked questions interpreted as worrying or burdening to them. The current study and DEMOCOPHES were reported to the Danish Data Protection Agency. All data are anonymous and stored according to Danish law regarding data storage.

RESULTS

Table 1 shows the population characteristics and the proportion of children who used OTC analgesics. In total, 59 children (45%) had been given OTC analgesics in the last 3 months. Of these, 49 children received PCM, 2 were given ibuprofen, and 8 mothers did not register the name of the given analgesic. Of the 131 children, 29 (22%) had received PCM at least every second month in the past year. Only 2 children reported to self-administer OTC analgesics.

There was no significant difference in child age, gender, or HRQoL for any of the 2 child self-medication outcomes. Neither was maternal age, education, or the family’s place of residence or income associated with use of OTC analgesics for the child (Table 1).

The 41 children reporting recurrent pains showed a tendency to self-medicate with OTC analgesics more frequently; however, this association was insignificant. Maternal report of child recurrent pain was associated with self-medication of the child with PCM at least every second month in the past year (Table 1).

A third of the mothers reported chronic pains (headache or musculoskeletal pains); a similar proportion reported chronic disease (hypertension, asthma, or allergy). One in 4 mothers took medicine daily (asthma or allergy medications, antihypertensives, analgesics, or antidepressants). Fifty-one mothers (39%) used OTC analgesics at least monthly. Maternal monthly self-medication with OTC analgesics was significantly associated with a more frequent use of analgesics for her child in both child self-medication outcomes (Table 1).

Maternal Health and Child Use of OTC Analgesics

The univariate analysis in Table 2 shows that maternal monthly self-medication with OTC analgesics was significantly associated with a more frequent use of OTC analgesics for her child in the past 3 months and the previous year (odds ratio [OR] 2.82 and OR 2.79, P < .05). This association remained significant when adjusting for background factors (child age, gender, and number; maternal age and education level; place of residence; and household income), the other maternal health parameters, and child recurrent pains (OR 3.07 and OR 4.71, P < .05).

After BMR, the association between maternal monthly self-medication with analgesics and child self-medication with analgesics within the past 3 months remained significant (OR 3.00, P < .05). However, BMR resulted in the association between maternal monthly use of OTC analgesics and frequent self-medication with PCM in the past year becoming insignificant (OR 2.54, P = .069). No other maternal health parameters showed association with child self-medication with OTC analgesics.

Child Recurrent Pain and Use of OTC Analgesics

Table 2 shows that child report of recurrent pain was significantly associated with the child’s use of OTC analgesics in the past 3 months when adjusting for background and health factors, whereas maternal report of child recurrent pain was not. However, the mother’s report of child recurrent pain predicted child self-medication with PCM at least every second month in the past year by an OR of 7.02, P < .05, after BMR.

DISCUSSION

Main Findings

This study demonstrates a clear association between self-medication with OTC analgesics in schoolchildren and their mothers. It appears that maternal medicating behavior regarding OTC analgesics influences whether her child receives an OTC analgesic, particularly PCM, even when the child’s pain is taken into consideration.

Our study did not find any association between maternal SRH, chronic pain, chronic disease, or daily medicine intake and the self-medication with OTC analgesics for her 6- to 11-year-old child. We found a weak association between reports of child recurrent pain and the child receiving OTC analgesics more often, however, this was not consistently significant.

Relation to Previous Studies

The number of published works about child self-medication is small, so this makes the basis for comparison limited. However, our results are in accordance with previous studies showing an association between maternal and child self-medication with OTC medications. We did not detect any influence of socioeconomic factors, as suggested by earlier studies, perhaps due to our limited study population. In 2003, Tobi et al found a high parental education level to be associated with increased child OTC drug use. Correspondingly, Du and Knopf showed more frequent child self-medication in families with well-educated mothers and high family income in Germany, whereas Holstein et al found higher rates of medication for aches among children from lower socioeconomic groups. Two studies found no influence of parental socioeconomic status.

Our findings concur with recent research indicating that parents’ own health and medicating behavior influence the self-medication of their children.
Parents have shown to be the most important source of OTC medications for 11- to 13-year-old schoolchildren.\textsuperscript{29} In 2012, Andersen et al\textsuperscript{2} found that children aged 2 to 17 years whose parents suffer from headaches receive more medicine for headaches, even when the child's symptom is adjusted for. Parental attitudes and experience with medication seem to affect their willingness to administer medicine to their children,\textsuperscript{19,20} and possibly for the

### Table 1: Characteristics of the Study Population and Children's Use of OTC Analgesics and PCM (n = 131)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total</th>
<th>Child Given OTC Analgesics in Past 3 mo</th>
<th>Pearson χ², P</th>
<th>Child Given PCM Every Second Month in Past Year</th>
<th>Pearson χ², P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (Valid Percent)</td>
<td>(n Valid Percent)</td>
<td>n (Valid Percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
<td>59 (45)</td>
<td>.17</td>
<td>29 (22)</td>
<td>.47</td>
</tr>
<tr>
<td>Girls</td>
<td>69</td>
<td>35 (51)</td>
<td>.17</td>
<td>17 (25)</td>
<td>.47</td>
</tr>
<tr>
<td>Boys</td>
<td>62</td>
<td>24 (39)</td>
<td>12 (19)</td>
<td>10 (22)</td>
<td></td>
</tr>
<tr>
<td>Age 6–7 y</td>
<td>41</td>
<td>19 (46)</td>
<td>.81</td>
<td>9 (22)</td>
<td>.99</td>
</tr>
<tr>
<td>Age 8–9 y</td>
<td>46</td>
<td>19 (41)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 10–11 y</td>
<td>44</td>
<td>21 (48)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First born</td>
<td>62</td>
<td>30 (48)</td>
<td>.71</td>
<td>12 (19)</td>
<td>.72</td>
</tr>
<tr>
<td>Second born</td>
<td>47</td>
<td>19 (40)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third+ born</td>
<td>22</td>
<td>10 (46)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recurrent pains, child report</td>
<td>41</td>
<td>23 (56)</td>
<td>.08</td>
<td>13 (32)</td>
<td>.08</td>
</tr>
<tr>
<td>No recurrent pains, child report</td>
<td>90</td>
<td>36 (40)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recurrent pains, mother report</td>
<td>40</td>
<td>22 (55)</td>
<td>.13</td>
<td>16 (40)</td>
<td>.001</td>
</tr>
<tr>
<td>No recurrent pains, mother report</td>
<td>91</td>
<td>37 (41)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child with chronic disease</td>
<td>25</td>
<td>11 (44)</td>
<td>.88</td>
<td>10 (40)</td>
<td>.02</td>
</tr>
<tr>
<td>No chronic disease</td>
<td>103</td>
<td>47 (46)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Missing</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lowest quartile physical HRQoL\textsuperscript{a}</td>
<td>36</td>
<td>17 (47)</td>
<td>.76</td>
<td>10 (28)</td>
<td>.34</td>
</tr>
<tr>
<td>Highest 3 quartiles physical HRQoL</td>
<td>95</td>
<td>42 (44)</td>
<td></td>
<td></td>
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<tr>
<td>Lowest quartile psychosocial HRQoL</td>
<td>35</td>
<td>18 (51)</td>
<td>.38</td>
<td>9 (28)</td>
<td>.55</td>
</tr>
<tr>
<td>Highest 3 quartiles psychosocial HRQoL</td>
<td>96</td>
<td>41 (45)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 31–37 y</td>
<td>27</td>
<td>9 (33)</td>
<td>.58</td>
<td>3 (11)</td>
<td>.33</td>
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<tr>
<td>Age 38–40 y</td>
<td>34</td>
<td>17 (50)</td>
<td></td>
<td></td>
<td>.24</td>
</tr>
<tr>
<td>Age 41–43 y</td>
<td>34</td>
<td>18 (47)</td>
<td></td>
<td></td>
<td>.21</td>
</tr>
<tr>
<td>Age 44–52 y</td>
<td>36</td>
<td>17 (47)</td>
<td></td>
<td></td>
<td>.31</td>
</tr>
<tr>
<td>Primary/secondary school</td>
<td>15</td>
<td>7 (47)</td>
<td>.64</td>
<td>3 (20)</td>
<td>.84</td>
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<tr>
<td>Short-cycle higher education/Bachelor</td>
<td>75</td>
<td>36 (48)</td>
<td></td>
<td></td>
<td>.24</td>
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<tr>
<td>Master, PhD, etc.</td>
<td>41</td>
<td>16 (38)</td>
<td></td>
<td></td>
<td>.20</td>
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<tr>
<td>SRH poor/fair/good\textsuperscript{b}</td>
<td>35</td>
<td>16 (46)</td>
<td>.93</td>
<td>9 (28)</td>
<td>.55</td>
</tr>
<tr>
<td>SRH very good/excellent</td>
<td>96</td>
<td>43 (45)</td>
<td></td>
<td></td>
<td>.21</td>
</tr>
<tr>
<td>Chronic pains, current or previous</td>
<td>43</td>
<td>21 (49)</td>
<td>.62</td>
<td>12 (28)</td>
<td>.30</td>
</tr>
<tr>
<td>No chronic pains</td>
<td>86</td>
<td>38 (44)</td>
<td></td>
<td></td>
<td>.20</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>.02</td>
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<tr>
<td>Monthly use of analgesics</td>
<td>51</td>
<td>31 (61)</td>
<td>.005</td>
<td>17 (33)</td>
<td>.02</td>
</tr>
<tr>
<td>No monthly use of analgesics</td>
<td>79</td>
<td>28 (35)</td>
<td></td>
<td></td>
<td>.15</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic disease</td>
<td>43</td>
<td>18 (42)</td>
<td>.57</td>
<td>11 (26)</td>
<td>.53</td>
</tr>
<tr>
<td>No chronic disease</td>
<td>87</td>
<td>41 (48)</td>
<td></td>
<td></td>
<td>.21</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily medicine intake</td>
<td>31</td>
<td>13 (42)</td>
<td>.66</td>
<td>8 (26)</td>
<td>.54</td>
</tr>
<tr>
<td>No daily medicine intake</td>
<td>97</td>
<td>45 (48)</td>
<td></td>
<td></td>
<td>.21</td>
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<tr>
<td>Missing</td>
<td>3</td>
<td></td>
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<tr>
<td>Family/Household</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Rural</td>
<td>65</td>
<td>30 (46)</td>
<td>.80</td>
<td>15 (23)</td>
<td>.87</td>
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<tr>
<td>Urban</td>
<td>66</td>
<td>29 (44)</td>
<td></td>
<td></td>
<td>.22</td>
</tr>
<tr>
<td>Low income, &lt;78 000 $/year</td>
<td>43</td>
<td>19 (44)</td>
<td>.91</td>
<td>11 (26)</td>
<td>.36</td>
</tr>
<tr>
<td>Middle income, 78 000–105 000 $/y</td>
<td>33</td>
<td>14 (42)</td>
<td></td>
<td></td>
<td>.27</td>
</tr>
<tr>
<td>High income, &gt;105 000 $/y</td>
<td>51</td>
<td>24 (47)</td>
<td></td>
<td></td>
<td>.18</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td></td>
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</tbody>
</table>

\textsuperscript{a} HRQoL of the children was assessed from the child report of the Pediatric Quality of Life inventory.

\textsuperscript{b} SRH of the mothers was assessed by a validated item from the Short Form-36 inventory.
children to self-administrate OTC products in adolescence. A qualitative survey by Hatchette et al. concluded that maternal advice and medicating behavior affects the pain self-management in adolescents.

Interestingly, we did not find a correlation between child recurrent pains and use of OTC analgesics, as other studies have found. This also may be explained by a relatively small study population. However, a survey has shown that although medication with analgesics among adolescents has increased in the past decades, the prevalence of self-reported pain is unchanged. Thus, other factors may account for the increasing self-medication among children and adolescents.

**Limitations**

The 2-question outcome of this study is simplistic; however, this design was chosen to maximize compliance and dedication of the participants, and receive the most accurate information with a small population. Previous OTC medication studies have applied 1-question outcomes. Our limited sample size may result in associations between maternal health and child self-medication to remain undetected. Our population also meant we could not investigate the influence of paternal health. However, Danish research shows that in 90% of families, the mother is the main administrator of medicine to the children. Correspondingly, most OTC medicine ads are targeted for women. Maternal influence may be of more importance than paternal.

The retrospective design means that our results might be influenced by recall bias. Previous medication studies have applied short report periods of 2 days or 1 week. Our report period of 3 months and 1 year could lead to imprecise replies. However, this period was chosen to identify a long-term use of analgesics rather than the specific use during a few randomly selected days.

The validity of self-reported medicine use is unknown. One study demonstrates a high agreement between adolescents’ and mothers’ reports of child medication for aches. Further validation of PCM intake by measurements of urine concentrations was not performed, as it reflects PCM intake only of the previous day.

**Implications/Perspectives**

Because parents are responsible for the self-medication of their children, it is important to understand what leads to the parent giving a drug or not, and to target parents risking inappropriate use of OTC analgesics. This article contributes to this understanding. It seems that mothers who react to pain by self-medicating with analgesics tend to treat their child the same way. Taking analgesics can be seen as a coping strategy to lessen the discomfort of pain. Children adopt the coping
strategies of their parents, and self-medication behavior may be passed on within families. This socialization pathway explaining the association between parental health and child self-medication has previously been described.2,3,4 Our results suggest that maternal illness, pain, or prescription medicine intake plays a smaller role in PCM use for children. Perhaps a mother’s view of PCM affects the use for her child more than her own health does.

Because PCM is available OTC, the purchase is mainly controlled by package size and price, besides health information campaigns. However, it is important to facilitate the appropriate parental use of PCM for children to improve safety and efficacy of the drug. Parents should be informed about indications as well as risks, storage, and dosing.

When should a child receive PCM? Opinions are varied also among health care personnel.3,5 PCM is considered a safe and effective treatment of fever and mild childhood pain, and has few risks associated with intermittent use. It should not be used to treat colds, coughs, sleep problems, or mood swings in children, as previous studies disclose.3,4 Sometimes a child’s recurrent pain is a sign of psychological issues that need attention. Functional pain is a well-known phenomenon in children, where analgesics are of little benefit.6 In other cases, analgesics may mask serious symptoms and thereby postpone treatment of an underlying disease. Persistent pain of unknown reason in a child should always be examined by a physician.7

Excessive PCM use involves risks of medicine-induced headache and hepatotoxicity. New research implies that PCM may affect the decreasing reproducibility of abilities of Danish men.37 Additionally, PCM is the most frequently used drug in teenage suicide attempts, perhaps because it is well-known and accessible at home.29 Therefore, it is relevant to look into the attitude of “Try giving PCM and see if it helps” that seems to exist in the population and perhaps among health care employees. Debating use of OTC analgesics in the medical community and improving communication with parents about childhood pain management may affect and ensure the safety of child PCM use.7,35 In this regard, health education programs, such as the US PROTECT initiative, to keep children safe from accidental overdoses are valuable.

CONCLUSIONS

Maternal self-medication with OTC analgesics influences the use of OTC analgesics, predominantly PCM, for her child, even when the child’s frequency of pain is taken into account. Other maternal health parameters, such as maternal SRH, chronic pain, chronic disease, or daily medicine intake were of less importance to self-medication with PCM in our population of 6- to 11-year-old children.

To further investigate the self-medication with OTC analgesics for children, prospective studies documenting child pain and analgesic use are needed. Intervention studies implementing parental education might clarify how pain management campaigns targeted for parents affects child analgesic use. An investigation of OTC analgesic use among physicians, nurses, and pharmacists may show varying administration across countries or sections of the health care system. Finally, measuring PCM levels in blood or urine will give objective information about the extent of PCM exposure.

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