BRIEF INTERVENTIONS: TREATING SLEEP AND BEDTIME PROBLEMS

BI-PED PROJECT (BRIEF INTERVENTIONS: PEDIATRICS)

Emotional Health Committee Maryland Chapter American Academy of Pediatrics

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Most infants, toddlers, and children with sleep problems are normal children who have simply learned maladaptive sleep patterns and habits. Their sleep and bedtime problems can be addressed easily and quickly.

Normal Sleep Patterns

- **Sleep occurs in repeating cycles of REM and non-REM throughout the night**
- **Non-REM sleep divides into four stages, from drowsiness to very deep sleep**
- **Awakenings and arousals are normal**
- **Deepest sleep usually comes at the beginning and the end of the night**
- **There are developmental changes in children's need for sleep**

Common Sleep Problems

- **Bedtime resistance or stalling**
- **Difficulty falling asleep**
- **Nighttime awakenings**
- **Feedings during the night**
- **Parasomnias/ partial awakenings (sleep talking, sleep walking, sleep terrors)**

Assessing Sleep and Bedtime Problems

- **Determine whether the sleep problems represent the learning of maladaptive sleep patterns and habits or signify more severe and pervasive emotional problems**
- **Children with ADHD, anxiety, depression, autism or who are on certain medications may be more likely to have sleep problems**
- **If a child's sleep patterns are causing a problem for his/her parents or for that child, then there *is* a sleep problem**
- **Conduct a parent interview, including a history of the child's sleep and bedtime patterns, a history of sleep problems, and a history of parental attempts to mediate the problem**
- **Conduct a child interview (if old enough)**
- **Request a "sleep diary" to assess current sleep status**
- **Ask about the child's caffeine intake (coffee, tea, soda)/ ask breast feeding parents about their caffeine intake too**

- **Ask about work shifts- it is common for children with parents who work late night shifts to wake up when their parents return home**

Sleep Associations

- **Children learn to connect certain conditions with falling asleep (e.g., being in a particular bedroom, holding a favorite stuffed animal, feeding, being rocked by a parent). These are sometimes called "props" or "sleep crutches."**
- **When a child wakes during the night (as all children do between sleep cycles), he/she will look for the same conditions that existed when he/she fell asleep**
- **If the conditions have changed (different room, parent is not rocking him/her), the child may be unable to fall back asleep until the same conditions are recreated**
- **It is best to *avoid* using feeding or rocking as "props" to get a child to fall asleep**
- **The child should be put down to sleep when tired but awake – that is how they learn to fall asleep *without* "sleep props or sleep crutches"**

Interventions:

Sleep Attachment Approach

- **Viewed as difficulty with separation, this approach focuses on co-regulation through being present and soothing routines such as snuggling, bedtime stories, and soft talking to assist the child in falling asleep**
- **Parents stay with the child until they fall asleep- for some parents this may involve co-sleeping with a child over age one year**
- **Parents maintain this approach until the child is comfortable sleeping on their own**

Progressive Waiting Approach for Difficulty Falling Asleep

For parents who may be returning to work or simply cannot afford to be tired during the day, sleep training offers an alternative approach

- **The child will learn to fall asleep by him/herself at the beginning of the night under new conditions (new associations)**
- **The parent will maintain a consistent and comforting bedtime ritual practice (e.g., bath, brush teeth, bedtime story, kiss goodnight, and reassurance that the parent will check on them before going to bed)**
- **Ideally, the child will be in a *separate room* from the parents for this approach to be successful. If this is not plausible, putting up a room divider may be helpful**

- **Parents are warned that the child may cry and that they may not get a good night sleep for the first few nights, so they should wait until they are truly ready**
- **Make sure both parents are on board and comfortable letting the child cry (best not to start until parents are psychologically ready)**
- **Make sure the child is not ill or teething when starting the plan**
- **Parent puts the child to sleep *later than their usual bedtime* (up to an hour later) so that the child is tired**
- **After bedtime routines, the parent puts the child to bed and leaves the room**
- **If the child calls for the parent or cries, the parent will check on the child briefly at increasing intervals (e.g., parent goes in after 3 minutes, leaves and returns after 5 minutes, leaves and returns after 10 minutes, and then continues to return every 10 minutes until child falls asleep without parent in the room).**
- **The parent only returns to the room if the child is crying loudly**
- **The parent never spends more than one minute in the child's room and does not pick the child up**
- **Repeat the sequence if the child wakes during the night and cries**
- **Second night, repeat the sequence, although the parent waits longer before going in to the child the first time (5 minutes, then 10 minutes, then every 12 minutes until child is asleep)**
- **Third night, repeat the sequence starting with a 10 minute wait, then every 15 minutes until child is asleep**
- **Continue increasing intervals every night until up to 30 minutes, then maintain until the child falls asleep**
- **Parents control how fast they want to progress**
- **Parental *consistency* is critical. Starting the intervention, stopping and restarting inconsistently may render the program ineffective**
- **Warn parents that this may take a few weeks to work (although frequently it takes less time) and that the awakenings *may get worse* before they get better**
- **For a parent who is uncomfortable leaving a crying child alone, they can also set up a video camera in the child's room for observation and reassurance**

"Sleep Shuffle"

- **For parents who are unable to let their child cry unattended**
- **Parent sits right next to the child's crib/bed where they can comfort the child until the child falls asleep**
- **Every few days, the parent moves a little farther across the room towards the door**
- **After several days, the parent is now out in the hall, but they continue to comfort the child as needed (while staying seated)**

- **If the child is still having difficulty falling asleep by the time the parent is out in the hallway, the parent begins the Progressive Waiting Approach (see above)**
- **For the parent who is uncomfortable leaving a crying child alone, they can also set up a video camera in the child's room for observation and reassurance**

Limit Setting for Bedtime Resistance

- **For children who resist going to bed at night (e.g., come out of room, come into parent's bed)**
- **Children are smart and will do whatever works**
- **Question for parents is "Who is in charge?"**
- **The child needs to know that the parent is in charge**
- **Put the child to bed 1 to 2 hours later than usual, so that the child is very tired**
- **As the child begins to fall asleep without a struggle, gradually move the bedtime back by 15 minute intervals every few nights until a more appropriate bedtime is achieved**
- **The parent decides which child behavior they want to end and needs to understand how they may inadvertently be "giving in" to their child at night**
- **The parent develops the plan to end that behavior**
- **If the parent has difficulty setting limits at night AND during the day, they may need referral to a professional for parent training/behavior management prior to initiating a sleep program**
- **It is best if parents work cooperatively and back the plan**
- **Preschool and school age children often respond to an incentive program and sticker chart**
- **The child can also be given a "*sleep pass*" that allows them one opportunity per night to come to the parent or request a drink. Once the sleep pass has been used, the child must remain in the room for the rest of the night**
- **If the child will stay in bed, the parent can then use the Progressive Waiting Approach (see above)**
- **If the child is older or will not stay in bed, the parent can close the child's door and tell the child that the door will open if the child is quiet and stays in the room. The child learns to remain quiet and in the room so that the door can stay open**
- **If child still enters the parent bedroom, placing a sleeping bag on the floor of the parent's room can provide an alternative to having the child sleep in the parent's bed**

Nightmares

- **Use reassurance until the child is calm. Use a night light if helpful**
- **Avoid frightening TV shows, stories, movies and video games**
- **Have the child talk about the nightmares during the day when the child is not upset. Having the child draw a picture may help them to express their fears.**
- **Help the child think about a strong person or superhero or a magical weapon that helps him/ her feel protected**
- **Explore stressors that may be contributing to nightmares (e.g. parental conflict, new sibling, new school, recent move, etc.)**

Partial Awakenings

There are several types of episodes that typically happen during a partial wakening from non-REM sleep, and they often take place at the end of the first or second sleep cycle, between one and four hours after falling asleep (Ferber, 2006). These include sleep talking, sleepwalking, and sleep terrors and are sometimes called "confusional arousals". As these episodes occur during non-REM sleep, they are not dreams.

- **Confusional arousals are common in children**
- **Generally, they do not signify severe emotional disturbance**
- **Safety precautions should be emphasized for children who sleepwalk**
- **Sleep arousal episodes are generally brief**
- **Parent should *not* attempt to "arouse" their child in the midst of an event because this may further agitate the child**
- **If the child tends to have episodes around the same time nightly, the parent can gently arouse the child 15-30 minutes before the predicted episode. This may disrupt the sleep cycle and curtail the sleep arousal episode**

Sleep Hygiene Tips

1. **Put the child to bed and wake the child up around the same time each night and day. Try to stay on schedule, even on weekends**
2. **Get the child into bright light as soon as he/she wakes in the morning**
3. **Avoid caffeinated products in the afternoon**
4. **Try to avoid excessive exercise or activity right before bed**
5. **Keep temperature cool, but comfortable at night in the child's room**
6. **Keep the room quiet and dark for sleep (can use white noise machine and black shades if necessary) A night light is not a problem if the child has fears**
7. **Use bedroom primarily for sleeping. This will signal the child that when in the room, it is time for sleep**
8. **Engage in quiet time at night before bedtime**
9. **Consistent, comforting bedtime rituals should be implemented**
10. **Do not put the child to bed too hungry or too full.**
11. **A young child should be put down to sleep when tired but still awake.**
12. **Try to avoid rocking or nursing the child to sleep to avoid developing "sleep props"**
13. **Transitional objects such as blankets and stuffed animals may be helpful for young children**

Reference:

Krishna J, Kalra M, McQuillan M. Sleep Disorders in Childhood. ***Pediatr Rev*** **(2023) 44 (4): 189–202.**
https://doi.org/10.1542/pir.2022-005521