



Kids and Sleep 2016

Dan Shapiro, M.D.

Developmental-Behavioral Pediatrics

drdanshapiro@gmail.com

www.raisingyourchallengingchild.com

Samuel Johnson -

*“The existence of twilight
does not obscure the
difference between day and
night.”*

What's normal sleep?

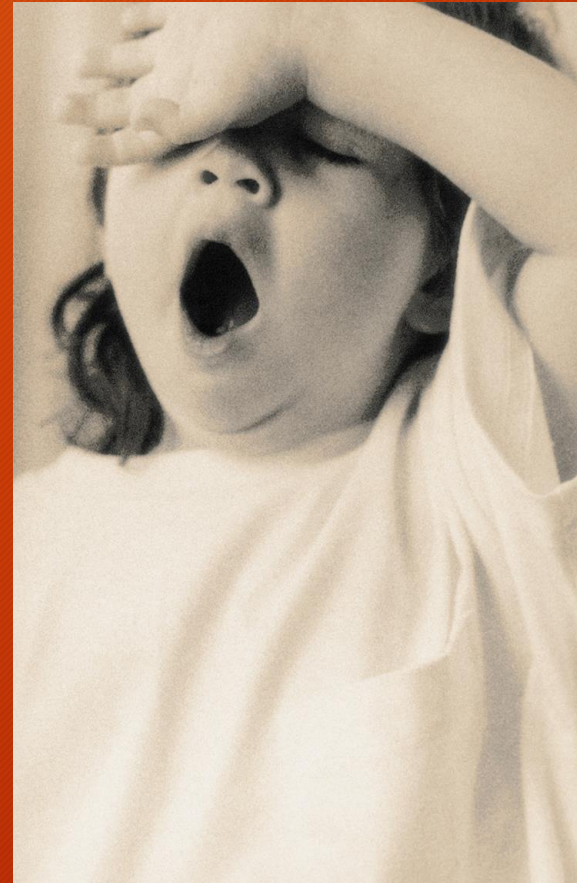
- Sleep norms change over the years
 - Infants 12-13 hours
 - Toddlers 11-12 hours
 - Pre-KG-KG 10-11 hours
 - Elementary school 9-10 hours
 - Teenage 8-9 hours
- Not a steady state
 - Grade I-IV, REM, non-REM
 - It's *normal* to wake up at night

Realistic goals

- *Unrealistic*
 - Getting your child to fall sleep
 - Getting your child to stay asleep “through the night”
- *Realistic*
 - Teaching your child to settle him or herself to sleep at the beginning of the night
 - Teaching your child to settle him or herself back to sleep when there is normal - and inevitable - night-waking

So what if you don't get enough sleep?

- Fatigue
- Malaise
- Irritability
- Behavior problems
- Impaired cognition/ attention
- Impaired health
- Poor school performance
- Social problems
- Family problems



Pediatric Sleep Disorders



- Behavioral Insomnias of Childhood
 - Sleep-onset association type (learned cue dependence)
 - Limit setting type (unintentional reinforcement of resistance)
- Sleep Related Breathing Problems
 - Sleep apnea of infancy
 - Obstructive apnea
- Hypersomnias
- Circadian Rhythm Sleep Disorder (delayed/ advanced sleep phase)

More Pediatric Sleep Disorders

- Parasomnias
 - Confusional arousals
 - Sleep walking
 - Sleep terrors
 - Sleep enuresis
- Sleep Related Movement Disorders
 - Restless legs syndrome
 - Periodic limb movement disorder
 - Sleep related Rhythm Movement Disorder



Rule out

- Obstructive sleep apnea
- Allergy
- Seizures
- Gastroesophageal Reflux (“heartburn”)
- Any illness; acute or chronic; ranging from ear infection to cardiac disease

Consider chemicals

- Any medication
 - asthma, seizures, allergy, ADHD, etc.
- Medication rebound
- Alcohol
- Caffeine
- Passive smoking

Consider parent/ environmental factors

- Primary trained dependence
 - “trained crying”, “trained night-waking”, “trained helplessness”
- Secondary reinforcement of child factors
 - “vulnerable child syndrome”
- Chronic success deprivation
 - school, social; resulting in avoidance behaviors
- Child abuse
 - sexual or physical
- Exposure to violence
 - direct or media
 - Post-Traumatic Stress Disorder
- Family/ marital stresses

Assessment

- Polysomnography (sleep study)
- Pediatric sleep questionnaire
 - Children's Sleep Habits Questionnaire (CSHQ, Owens)
 - Pediatric Sleep Questionnaire (PSQ, Chervin)

Management of Behavioral Insomnias

Targeting Bedtime resistance and Night-time awakenings

- Curtain calls
- Call-outs
- Coming to parent's bed
- Night-time fears
- Bed/ crib aversion
- Crying
- Tantrums
- Going to kitchen
- Accessing electronics

Strategies



- Proactive for sleep initiation
 - Daytime
 - Transitioning to bedtime
 - Bedtime
 - Sleptime
- Reactive for sleep initiation
 - “Cold turkey/ cry it out”
 - Graduated extinction
- Nightwaking
- Sleptime anxiety

Daytime

- Golden rule of behavior modification
 - attend to behaviors you want to reinforce
 - downplay response to behaviors you want to extinguish
 - daytime expectations carry over into the night
- Set regular times and places to eat (not anytime, anyplace)
- Set regular times and places for sleep
 - Naps less than 15 minutes
 - Regular wake-up time each morning
 - No sleeping in cars, strollers, sofas, other's bed
 - No playing/ electronics in bed
- Schedule regular exercise
- Schedule (and limit!) regular homework time
- No caffeine



Transitioning to bedtime

- *Sequence routine from activating to calming*
 - Physical/ motor
 - Intellectual
 - Emotional/ interpersonal/ play
 - Environmental/ sensory (noise, light, climate)
 - *No electronics for 30-60 minutes before bedtime*
- *Sequence pre-bed activities/ tasks from non-preferred to preferred*
- *Quiet together-time before bedtime*

Bedtime

- Appropriate and regular bedtime
 - Not too early
 - Consider sleep restriction to increase “sleep debt”
 - Not too late
 - Avoid large weekday/ weekend discrepancies
 - For “sleep phase shifts”, consider “chronotherapy”
- Comfortable, calming, quiet sleep environment
- Positive, appropriate, bedtime routines and rituals
 - Quiet reading
 - Quiet singing, listening to music
 - Quiet play

Sleeptime

- Eliminate reinforcers, cues, associations that interfere with independent wake-sleep transition
 - No parent, holding, rocking, bottle, breast, food, cup, electronics
 - Introduce transition objects / associations that promote independence
- Fade parent involvement
 - For infants, put down sleepy but awake
 - For all, give opportunity to learn self-settling with parent out of room



Cold turkey or graduated extinction?

How to choose



- Consider your child's general temperament
 - If negative initial reaction but adaptable, then “cold turkey” (do not prolong torture)
 - If generally poor adaptability, then graduated extinction
- Refer to your own temperament
 - Parents might need gradual extinction of their own anxiety
 - Which approach will you be able to use most consistently

Cold turkey or graduated extinction: *Technique*

- “Cold turkey” / “cry it out”
- Graduated extinction (spacing and fading)
 - Quick check (fixed and equal interval visits)
 - Kuhn’s “excuse me drill” (irregular visits)
 - Ferberizing (incremental fading of visit distance, interval, quality, and duration)
 - Bed-time pass/ ticket

Strategies for night-waking

- Accept as normal
- First, fix the daytime and the front of the evening then use those strategies for night waking
- Wait to respond
- “Don’t wake us up” vs. “stay asleep”
- Consider sleep restriction to increase sleep debt
- Consider scheduled preemptive waking for “timed dyssomnias”



Teach your child to “STOP” sleeptime anxiety



- Scared?
- Thinking about what?
 - Bedtime fears (monsters, burglars, separation, etc.)
 - Not being able to fall asleep
- Other things I can think or do to help myself relax
- Pat myself on the back for “STOP-ping” my own worries

Other things I can think to help myself relax


- “It’s normal to have a little trouble falling asleep or waking up in the middle of the night.”
- “It’s no big deal if I’m a little tired tomorrow.”
- “I’m going to be the boss of my worries and not let my worries be the boss of me!”
- “I can use my relaxation strategies.”

Other things I can do to help myself relax

- Listen to music (or sing inside my head)
- Read (poetry)
- Write
- Draw
- Meditate
- Yoga
- Mindfulness
- Self-hypnosis
- Progressive muscle relaxation
- Breathing awareness
- Lavender pillow
- Calming mental imagery (“mind-trip/ favorite place”)
- Paradoxical suggestion (“I will not fall asleep”)



Beware

- Too many chefs in the kitchen
- Too many kids
- Giving up too quickly
 - Be consistent
 - Be persistent
- Not giving up quickly enough
 - Monitor trends/ effectiveness
 - Consider strategy change
 - Ask for help 

When all else fails

- Consultation
 - Pediatrician
 - Behaviorist (BCBA, DBPeds, Psychologist, Social Worker)
 - Sleep expert/ Psychiatrist
- Medication
 - Benadryl (diphenhydramine)
 - Melatonin
 - Clonidine, guanfacine and - yes - stimulants (if underlying adhd)
 - Remeron, Trazadone
 - Prozac, Lexapro, Zoloft and other SSRIs (if underlying anxiety)
 - Neuroleptics and mood stabilizers (if underlying mood disorder)
 - Ambien, Lunesta (no studies in children)
- Morning light box

References

- Richard Ferber, [Solve Your Child's Sleep Problems](#)
- Jodi Mindell, [Sleeping Through the Night](#)
- National Sleep Foundation: [Sleepfoundation.org](https://www.sleepfoundation.org)

