Kids and Sleep 2016

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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
  - Sleeptime
- Reactive for sleep initiation
  - “Cold turkey/ cry it out”
  - Graduated extinction
- Nightwaking
- Sleeptime 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

- ***S***cared?
- ***T***hinking about what?
  - Bedtime fears (monsters, burglars, separation, etc.)
  - Not being able to fall asleep
- ***O***ther things I can think or do to help myself relax
- ***P***at 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