Practical Strategies for Managing Behavioral Sleep Problems in Young Children

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KEYWORDS

• Sleep • Insomnia • Infant • Toddler • Children • Pediatric • Parenting • Behavior management

KEY POINTS

- Empirically based treatments for young children with bedtime refusal and frequent night-waking have been often and fully described.
- Although clinicians are encouraged to draw from an evidence-based perspective when making treatment decisions, they are sometimes faced with unique cases or unusual circumstances that require them to think "outside the box" to solve pediatric sleep problems.
- Clinicians can build on the evidence-based approaches by identifying past treatment failures, creating a sleep-compatible bedroom environment, managing the sleep-wake schedule, optimizing parent-child interactions, adding reinforcement-based strategies, and addressing daytime behaviors or skill deficits that translate to improved child sleep.

INTRODUCTION

Sleep problems are common in early childhood and can affect virtually every realm of child and family functioning. Disturbed sleep is consistently identified among the most common concerns in clinical settings for children.[1–3] Research suggests that disturbed sleep is associated with several risk factors, including mood and anxiety disorders, disruptive behavior, and academic underachievement.[4–7] Further, this condition may become chronic and potentially persist into adulthood.[8–10] The systemic impact of sleep difficulties extends beyond the health of the affected child. Parents themselves may become frustrated and fatigued, resulting in negative parent-child interactions, parental depression, and impaired family satisfaction.[11,12]

The predominant sleep disturbance in young children is characterized as an extrinsic dyssomnia involving difficulty settling to sleep and frequent nighttime awakenings. These 2 symptoms often coexist and treatments targeting one symptom often generalize to the other because the process of initiating sleep is required not just at bedtime, but following nighttime awakenings that terminate each sleep cycle.[13–15] Although the International Classification of Sleep Disorders (ICSD), 3rd edition,[16] no longer includes specific insomnia subtype categories, the concept of "behavioral insomnias of childhood" (BIC), as put forth in the ICSD, 2nd edition (**Box 1**), is clinically still a useful one. Children with behavioral insomnia of childhood: sleep-onset association type (BIC: SOA) are often described in terms such as "she's always been a poor sleeper" or "he never learned to sleep through the night." These children frequently require parental presence and/or their physical contact to fall asleep. Once formed, however, sleep-onset

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Box 1
Characteristics of behavioral insomnia of childhood (BIC)

The child shows a pattern consistent with either the sleep-onset association type or limit-setting type of insomnia described below:

A. Sleep-onset association type (BIC: SOA) includes each of the following:
   1. Falling asleep is an extended process that requires special conditions.
   2. Sleep-onset associations are highly problematic or demanding.
   3. In the absence of the associated conditions, sleep onset is significantly delayed or sleep is otherwise disrupted.
   4. Nighttime awakenings require caregiver intervention for the child to return to sleep.

B. Limit-setting type (BIC: LS) includes each of the following:
   1. The individual has difficulty initiating or maintaining sleep.
   2. The individual stalls or refuses to go to bed at an appropriate time or refuses to return to bed after a nighttime awakening.
   3. The caregiver demonstrates insufficient or inappropriate limit-setting to establish appropriate sleeping behavior in the child.

From American Academy of Sleep Medicine. The international classification of sleep disorders, second edition: diagnostic and coding manual. Westchester (IL): American Academy of Sleep Medicine; 2005. p. 23; with permission.

associations are active regardless of the time of night a child is attempting to sleep. Thus, parents of young children with BIC: SOA rarely complain about the process required to "put" the child to sleep at bedtime, but they may not appreciate having to re-create those familiar routines several times during the night by rocking, nursing, or driving the child around in a vehicle (Fig. 1).

Once children develop the ability to self-soothe and initiate sleep independently, the transition from the crib to sleeping in a bed frequently presents the next challenge for families. When a toddler masters the ability to crawl out of the crib, parents suddenly find themselves without their toddler "containment device." This event places pressure on parents' ability to set and enforce effective behavioral limits to get young children into bed and then keep them there. Bedtime and naptime refusal often emerges at this stage, with frequent "curtain calls," special requests, crying, tantrums, and exiting the bedroom. Children may engage in a wide variety of refusal behaviors to delay going to bed, to secure parental presence and attention, or to avoid separation. Children's sleep can be negatively impacted when parents are unable to effectively manage bedtime refusal. Children with behavioral insomnia of childhood: limit-setting type often obtain insufficient sleep because of delayed sleep onset; however, they typically have few arousals once they finally fall asleep (see Fig. 2). In cases of BIC: LS, professionals must be especially careful to avoid "blaming" the parents while at the same time giving them responsibility for making necessary changes. Before making this diagnosis prematurely, clinicians are encouraged to identify additional clues that insufficient or ineffective parental limit-setting is the primary factor contributing to the child's sleep disturbance. For example,

- Inappropriately late bedtimes that greatly vary from night to night
- Children who frequently fall asleep in various locations throughout the home depending on where they may be playing or are watching TV
- Children who are routinely allowed to stay up "just a bit longer" when they repeatedly leave the bedroom after bedtime
- Parent language suggesting the "cart is leading the horse"("He won't let us…"; "He insists that we…")
- Children who go to bed cooperatively, and fall asleep more easily or rapidly for other caregivers
- Behavior problems during the day (eg, tantrums, disruptive behavior), especially if the child is well behaved for other caregivers or in other contexts (eg, day care)

ASSESSMENT

Laboratory testing, daily sleep diaries or actigraphy, and standardized rating scales all play a role in the evaluation of disordered sleep. For behaviorally based pediatric sleep problems, however, the most useful tool is a skillfully executed clinical sleep history or initial clinical interview. Until late childhood or adolescence, sleep-related complaints come from the parents rather than the child.[17] Parents serve as the primary informants of children's sleep habits and behaviors, and it is the parents who typically make the final determination of what will be done, if anything, to address those habits and behaviors. In 2-parent

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