Controversies in Behavioral Treatment of Sleep Problems in Young Children

Jocelyn H. Thomas, PhD[a], Melisa Moore, PhD[a],
Jodi A. Mindell, PhD[a,b,*]

KEYWORDS

• Sleep • Young children • Behavioral intervention • Age • Sleep aids • Pharmacologic agents
• Child and family outcomes

KEY POINTS

- Behavioral interventions to treat sleep problems in young children are efficacious and should be tailored to meet the needs of the individual child and family.
- Evidence suggests that treatment strategies can be initiated after 3 to 4 months of age and may include a sleep aid as a noncritical component.
- Pharmacologic agents are not likely to be effective as the sole intervention, and behavioral strategies should be used as the primary treatment procedure.
- Behavioral treatments have not been found to have iatrogenic effects on the child, parent, or parent-child relationship.

Sleep problems are a common parent complaint, with estimates that approximately 30% of children experience some difficulty sleeping.[1,2] Trouble falling asleep and waking during the night are the most prevalent concerns for young children and occur in 20% to 30% of infants, toddlers, and preschool-aged children.[3,4] In addition, longitudinal studies have shown that sleep difficulties may persist for months to years and can become a chronic problem. For example, a longitudinal study of 359 mother/child pairs found that 21% of children with sleep problems in infancy, compared with 6% of those without, had sleep problems in the third year of life.[5] Furthermore, sleep problems can have a negative impact on mood, behavior, academic achievement, learning, and memory consolidation.[6,7] Untreated sleep problems are also a public health concern as insufficient and inappropriately timed sleep has been linked to an increased risk of obesity and a considerable estimated economic burden.[8,9]

Treatment options and the implementation of intervention procedures may seem confusing and overwhelming to parents (especially to those who are sleep deprived). Practitioners also often look for guidance. This article seeks to address some of the most frequent controversial issues and common questions related to the implementation of behavioral interventions in young children, including (1) which behavioral techniques have the most empiric support, (2) what is the best age to begin to implement these strategies, (3) should sleep aids or transitional objects be used, (4) what is the role of pharmacologic agents as an adjunct to behavioral interventions, and finally (5) what are the potential negative consequences

[a] Sleep Center, Division of Pulmonary Medicine, Children's Hospital of Philadelphia, Civic Center Boulevard, Philadelphia, PA 19104, USA; [b] Department of Psychology, Saint Joseph's University, City Avenue, Philadelphia, PA 19131, USA
* Corresponding author. Department of Psychology, Saint Joseph's University, Philadelphia, PA 19131.
E-mail address: jmindell@sju.edu

Sleep Med Clin 9 (2014) 251–259
http://dx.doi.org/10.1016/j.jsmc.2014.02.004
1556-407X/14/$ – see front matter © 2014 Elsevier Inc. All rights reserved.

sleep.theclinics.com

of implementing behavioral interventions on the child, parent, and the child-parent relationship.

WHICH TECHNIQUE IS BEST FOR INFANT AND TODDLER SLEEP DISTURBANCES?

A variety of behavioral treatment methods have been shown to be efficacious in the treatment of sleep problems in young children and are both widely recommended in clinical practice and used by parents with or without professional guidance.[3] However, parents as well as practitioners may be overwhelmed with the variety of behavioral approaches and have difficulty choosing which intervention to implement.

Most behavioral strategies are based on the premise that difficulties falling asleep and frequent awakenings throughout the night are related to parental involvement at the time of sleep onset. If parents habitually assist their child in falling asleep at bedtime, the child may not be given the opportunity to develop the self-regulatory skills necessary to soothe him or herself to sleep. Arousals and brief night wakings are a normative part of the ultradian rhythm of sleep[10] and are not inherently pathologic. However, children who have failed to develop self-soothing skills are often unable to return to sleep independently after these naturally occurring wakings and require parental assistance to return to sleep. If parent intervention is not offered, prolonged night wakings with crying and protest behavior ensue. Behavioral treatment strategies are based on principles of learning and behavior and recruit the parent to act as the agent of change to decrease bedtime problems and frequent night wakings. These strategies include traditional extinction, variations of graduated extinction, and parental education regarding fostering healthy sleep habits.

Traditional or unmodified extinction[11] involves the parent putting the child to bed at bedtime and ignoring the child until a set wake time in the morning while monitoring for safety and/or illness.[12–14] The parent also ignores disruptive behavior that may be displayed by the child, including crying, tantrums, and calling out for the parent. An audio and/or video monitor can be used to ensure the safety of the child while implementing these procedures. It is thought that after the child protests, the combination of sleep pressure and the consistent absence of parental reinforcement will result, over time, in the development of self-soothing skills and the subsequent ability to return to sleep independently. This technique is often referred to as *cry it out* in the public domain.

Although extinction procedures have been demonstrated to be highly effective in teaching children to initiate and maintain sleep without parental assistance, there are several limitations that have been noted in the literature.[14,15] Perhaps most important for parents is that disruptive behaviors (eg, crying, tantrums, calling for parent) typically increase in frequency and severity before improvement (*extinction burst*).[16] Parents must also implement this strategy with consistency and continue to ignore problematic behavior no matter how long the behavior lasts.[14] However, because this procedure can be stressful for parents, many caregivers are unable to use this method with the consistency that is needed to be effective. When implemented inconsistently, parents may actually inadvertently reinforce the disruptive behavior. For example, if parents initially ignore but then eventually respond to the child, thus allowing the child to escape the situation after a certain amount of crying, the child will learn to cry longer the next time to elicit the same response (intermittent reinforcement). Thus, reinforcing the inappropriate behavior may result in protest behaviors that are more severe and intense than before the initial implementation of the extinction procedures. Given the difficulties in implementing standard extinction procedures, there is often a high attrition rate and parental resistance to implementing such a strategy.[17]

Graduated extinction theoretically involves the same underlying process as extinction but involves a more gradual approach. This method is often referred to as *sleep training* or the *checking method*,[18] and parents are instructed to ignore undesired behaviors after bedtime for a specified duration of time while checking in at specific intervals.[11,19] Unlike traditional extinction, some graduated extinction procedures are only implemented at bedtime, and parents are permitted to continue to respond as they typically would if the child wakes during the night. The expectation is that the development of self-soothing skills at bedtime will generalize, making nighttime intervention unnecessary.[20] This strategy has a plethora of empiric support and has also been shown to have better parental adherence and less parental stress when compared with standard extinction.[3,21]

This type of intervention also allows the length of intervals and content of the check-in to be customized to the needs of the family (eg, how long they can tolerate the child's protesting) as well as the child's age, temperament, and developmental level. Check-ins involve the parents comforting the child for a brief amount of time, with a typical range of 15 to 60 seconds. Parents are also encouraged to minimize interaction with their child during this time and may be instructed to repeat the same phrase if they must speak to their child (eg, I love you; it is time to go to sleep).

Download English Version:

https://daneshyari.com/en/article/3837337

Download Persian Version:

https://daneshyari.com/article/3837337

Daneshyari.com