BHIPP BULLETIN

VOLUME 1, ISSUE 4 FEBRUARY, 2016

BEHAVIORAL INTERVENTIONS FOR SLEEP PROBLEMS

This is the second article of a three-part series discussing the assessment of and treatment of pediatric sleep disorders.

Medication is rarely the first-line treatment for sleep problems in children and adolescents, and there are no medications specifically FDA-approved for pediatric insomnia. Behavioral treatments can be very effective. One of the cornerstones of these treatments is good sleep hygiene. Principles include: going to bed/waking up at the same time each day, exposure to bright light upon awakening, restricting caffeine, especially in the afternoon, avoiding alcohol, which can disrupt sleep architecture, making sure the bedroom is cool/comfortable/dark, "quiet time" or a relaxing ritual at night before bedtime, avoiding naps if possible, regular exercise during the day, and limiting use of electronic media, especially before bedtime.

In young children, sleep problems are common, and may be related to poor sleep habits or to anxiety about going to bed and falling asleep. For young children, bedtime is a time of separation. Some children will do all they can to prevent separation at bedtime. As mentioned above, a parent should develop consistent bedtime sleep routines such as reading stories and teeth-brushing. For children with anxiety, the "get out of bed free" card, which provides the child with 3 cards for a drink, hug, bathroom, etc., can be a useful strategy for preventing multiple trips out of the bedroom. Avoiding activities that require the parents' presence, and using a special blanket, a picture of the parent(s), or a stuffed animal to hold while falling asleep can also help with learning self-soothing.

Nightmares and sleep terrors are relatively common during childhood. Nightmares begin at a variety of ages, affect girls more often than boys and are remembered by the child. Nightmares may be serious, frequent, and may signal a new or ongoing stressful event for the child or the family. Sleep terrors are different from nightmares. The child with sleep terrors will scream uncontrollably and appear to be awake, but is confused and can't communicate. The child usually has no memory of the sleep terror in the morning. Sleep terrors usually begin between around age 4 and occur one to two hours after the onset of sleep, whereas nightmares typically occur later in the night, during REM sleep phase.

Waking up at night can also become a habit. Social contact with parents, feeding, and availability of interesting toys encourage the child to be up late, so it is important to set limits on attention-getting behaviors at night. In the case of both nightmares and sleep terrors, parents should briefly ask the child to tell them about the dream rather than ask if s/he is having a nightmare, comfort and reassure him/her and encourage him/her to go back to sleep (on their own).

In older children and adolescents, one of most effective interventions is Cognitive Behavioral Therapy for Insomnia (CBT-I). Principles of this treatment include stimulus control, or removing factors that condition the child to reduce sleep i.e. being in the bedroom or bed only when sleepy; relaxation training, including muscle relaxation and imagery; and remaining passively awake, or avoiding any effort to go to sleep, thus "letting go" of sleep-related worries which can keep the child awake.

If behavioral strategies are ineffective, or if sleep troubles are significantly worsening an existing medical or psychiatric disorder, medication, which will be the topic of our next newsletter, can be considered.

-Dr. Rheanna Platt & Dr. Joyce Harrison, BHIPP Consultants

FROM THE BHIPP TOOLBOX

- Maryland AAP BI-PED Project
- Zero to Three National Center for Infants, Toddlers, and Families
- *Pediatrics in Review*, Sleep Disorders, (Howard & Wong, 2001)

Behavioral Health Integration in Pediatric Primary Care

Phone & Fax:
855-MD-BHIPP
(855-632-4477)

Website:
www.mdbhipp.org