pediatric nursing clips — january 2017

behavioral insomnia of childhood

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Pediatric Nursing Clips by Pediatric Advanced Practice Nurses at Dayton Children's provides quick reviews of common pediatric conditions.

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case study

Jayden is a 3-year-old male who presented to his pediatrician's office with difficulty falling and staying asleep. There is no history of snoring or pauses in breathing during sleep, and Jayden's BMI is within normal range for his age. His physical exam is normal. The problems began when he was an infant with frequent nightwakings for which his parents have to soothe him back to sleep. About one year ago, he also began getting out of bed and coming into his parents' room or complaining of thirst or hunger in an attempt to delay bedtime. He often stays up past 11:00 pm and his poor sleep is causing the rest of his family to also have disrupted sleep.

case discussion

Jayden's history is consistent with behavioral insomnia of childhood. The pediatrician provided education on sleep hygiene, but the parents were still struggling with Jayden's insomnia, so he was referred to a pediatric sleep center. The sleep provider and sleep psychologist provided guidance to the family regarding enforcing good sleep habits and assisted in teaching Jayden to be able to sleep without the presence of his parents. Jayden is now going to bed and falling asleep within 30 minutes and has minimal problems with prolonged nightwakings.

about behavioral insomnia of childhood:

Limit-setting issues effecting sleep typically begin after 2 years of age. The child may employ bedtime resistance such as asking for more television time or another story to be read, complaining of thirst or hunger, or even expressing fear of a monster under the bed or in the closet. Children may also exhibit bedtime refusal. They simply refuse to get ready for bed or to stay in their bedroom. Limit setting problems occur most often when there are very few or no limits set on the child by the parents regarding sleep (Mindell and Owens, 2015).

Bedtime resistance is a common problem noted by parents and caregivers and is noted in 10-30 percent of toddlers and preschoolers. If not addressed, these problems may become chronic, in fact 15 percent of school-aged children have also been shown to have significant limit-setting sleep problems (Mindell and Owens, 2015).

Treatment for limit-setting sleep problems includes education about good sleep hygiene. Parents are encouraged to establish a set bedtime. If the child has become very used to late bedtimes, the transition to an earlier bedtime may need to be accomplished slowly by moving bedtime back by short intervals daily or weekly until the desired bedtime is reached. Naps should occur no later than 3:00 pm. A consistent bedtime routine should be established and consist of relaxing activities such as a bath, putting on pajamas, brushing teeth, and reading a bedtime story. A transitional object may also be useful, such as a favorite blanket or stuffed animal. Exposure to bright light first thing in the morning and avoidance of bright lights in the evening (including television, tablets, and phones) can help to regulate the child's circadian clock and promote appropriate sleep and wake times (Meltzer, 2010).

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Inappropriate sleep-onset associations are manifested by nightwakings, which is one of the most common sleep problems in infants and toddlers. Often, once established, the problem becomes chronic, persisting into the toddler years or even into the school-aged years (Mindell and Owens, 2015).

All infants and children have brief arousals through the night related to normal sleep cycles. The problem occurs when the nightwakings are prolonged due to the child's inability to fall back to sleep without intervention from a parent. Examples would be the infant who is rocked to sleep or the toddler who has a parent present in the room as they fall asleep. The infant or child has not developed the ability to soothe themselves to sleep because they have associated sleep with being held or rocked and therefore they remain awake until the parent provides the needed intervention. Unfortunately, this kind of response from the parent only further reinforces the inappropriate sleep onset association (Mindell and Owens, 2015).

Prevention of inappropriate sleep-onset associations starts with establishing a set sleep schedule and bedtime routine. Parents should also resist responding immediately to the child at night and give them a chance to soothe themselves back to sleep. Once inappropriate sleep-onset associations are present, the parents can be instructed to let the child "cry it out". This involves putting the child to bed at a set time and then ignoring them until morning. The child will learn to no longer require a parent to go to sleep. Though shown to not cause any harm to the emotional development of the child, many parents are unwilling to use this technique. A technique that may be more palatable to parents involves putting the child to bed drowsy, but still awake. The parents must wait progressively longer amounts of time before responding the child. When the parents do check on the child, the interaction should be brief and only to provide reassurance (Vriend and Corkum, 2011).

If attempts at behavioral modification and/or education regarding good sleep hygiene are failing to remedy the problem, a referral to a pediatric sleep center can be made. The child and family can consult with a practitioner specializing in sleep and/or a psychologist specialized in sleep behavioral therapy.

references

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Sarah Gehring, MSN, CPNP-PC has been employed at Dayton Children's for 12 years. She received her Bachelors in Science in Nursing from Wright State University in 2004. Upon graduation, she worked in the Intermediate Care Unit (ICU) for nearly 10 years. Sarah graduated with her Masters in Science from Wright State University in 2012 and obtained national certification as a pediatric nurse practitioner that same year. She continued her career at Dayton Children's neurology, then urgent care. She has found a home in the sleep clinic as a PNP since August 2016.

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