Understanding and Addressing Sleep Problems of Young Children and Adults with ASD

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ONTABA

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Why Study Sleep?

• Sleep problems in young children are a:
  
  – common child-rearing difficulty
    (Lozoff, Wolf, & Davis, 1985)

  – frequent complaint to pediatricians
    (Mindell, Moline, Zendell, brown & Fry, 1994)

  – common reason for prescribing psychotropic medications (Minde, 1998)

    • despite no FDA approval, no medication labeled for pediatric insomnia, no efficacy signal in literature
Why is Good Sleep Important?

• Good sleep is restorative; without it, children are:
  – more irritable
  – more easily fatigued
  – more likely to suffer from unintentional injury
  – less likely to follow instructions
  – less likely to learn academic concepts
  – more likely to engage in problem behavior (SIB, tantrums)

(Dahl, 1996; Gruber et al., 2010; Koulouglioti, Cole, & Kitzman, 2008; Richman, 1981; Schreck, Mulick, & Smith, 2004; Wiggs & Stores, 1996)
Good sleep is restorative; without it, people with autism may be more likely to engage in stereotypy.

\[ r = -0.484, \ p < 0.05 \]

(A moderate, negative, and statistically significant correlation exists between Jack's levels of stereotypy and hours slept the previous night.)
Why is Good Sleep Important?

• Persistent sleep problems in childhood is also associated with:
  – childhood and adult obesity
  – adolescent behavioral and emotional problems
  – anxiety in adulthood
  – sleep problems through adulthood

(Bell & Zimmerman, 2010)
Why is Good Sleep Important?

• Children’s sleep problems can lead to:
  – Maternal malaise and depression
  – Parental sleep problems
  – Erosion of the parent’s relationship with each other and with their children

(Chavin & Tinson, 1980; Kataria, Swanson, & Trevathan, 1987; Meltzer & Mindell, 2007; Richman, 1981)
How Prevalent are Sleep Problems?

• **Sleep problems are prevalent**
  – 15 -35% of young children
    • (Holliday, Sibbald, & Tooley, 1987; Richman, 1981)
  – 40-80% of children diagnosed with autism
    • (Richdale, 1999; Richdale & Schreck, 2009)

• **Sleep problems are persistent**—they do not typically remit with time
  – (Jenkins, Owen, Bax, & Hart, 1984; Pollock, 1992)
How Prevalent are Sleep Problems?

• **Sleep problems are prevalent**
  
  – 35 - 50% of young children
    
    (Holliday, Sibbald, & Tooley, 1987; Johnson, 1991; Polimeni, Richdale, & Francis, 2005; Richman, 1981)
  
  – 63-73% of children diagnosed with autism
    
    (Johnson, 1991; Polimeni et al., 2005; Souders et al., 2009; Richdale, 1999; Richdale & Schreck, 2009)

• **Sleep problems are persistent**—they do not typically remit with time
  
  (Jenkins, Owen, Bax, & Hart, 1984; Kataria et al., 1987; Pollock, 1992)
Common Sleep Problems

• Nighttime routine noncompliance
• Interfering behavior
• Delayed sleep onset
• Night awakenings
• Early awakenings
• Confusional Arousals (Night terrors)
• Nightmares
Assumptions Regarding Sleep

• Falling asleep is a behavior

• Influenced by our ancestral history (our genetics) and our present culture

• Also, can be influenced by past and present events in one’s sleeping environment
  – can be motivated (or demotivated)
  – can become reliant on environmental cues
  – can be affected by other reinforcers for other behaviors available at night
To understand a sleep problem:

Conduct a contingency analysis

\[ EO + SD \rightarrow R \rightarrow Sr \]

\[ R = Falling\ Asleep \]

• Sr for falling asleep is *sleeping*.

• What are the EOs altering the value of sleep?

• What are the S^D_s signaling that sleep is available, and how consistent are they?

\[ EO + SD \rightarrow R \rightarrow Sr \]

\[ R = Incompatible\ behavior \]

• What are the Sr(s) for behaviors incompatible with falling asleep?

• What are the EOs altering the value of these other reinforcers?

• What are the S^D_s signaling that other reinforcers are available?
To understand a sleep problem, we find answers to important questions like these:

• What is devaluing sleep at the times it should be most valuable?
• What is making sleep valuable and signals that it's available at the wrong times?
• On what is sleep dependent?
• What other rewarding interactions or activities are available when a child should be sleeping?
  – What establishes their value and signals their availability at night?
How do we assess and treat the sleep problem?

• Through a general understanding of the factors that influence sleep and sleep problems

• By collecting data via open-ended indirect assessment to identify the personal factors influencing the sleep problem

• By allowing parents to develop the intervention with us and then we support parents in their implementation of the assessment-based treatment
I have found that almost all of the children we have treated have a history of being given ineffective medications (with unknown side-effects) to address their sleep problems.

The only medication that has an “efficacy signal” in the literature is melatonin, and it alone will not solve a sleep problem, but it may interact favorably with behavioral intervention.
Getting at the EO for Sleep
Total Sleep: How much is enough?

• Recognition of age-appropriate day and night sleep amounts
# Age-Based Sleep Averages:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total Sleep</th>
<th>Night Sleep</th>
<th># Naps</th>
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<tbody>
<tr>
<td>2</td>
<td>11 hrs 30 min</td>
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</table>

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
<table>
<thead>
<tr>
<th>AGE</th>
<th>Hours of Sleep</th>
<th>Total Hours of Sleep</th>
<th>Typical Range</th>
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<td>8 1/2 - 9 1/2</td>
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*Divided into typical number of naps per day. Length of naps may be quite variable.*
Total Sleep: How much is enough?

• Caveat: Be sensitive to possible individual differences by analyzing response to intervention via objective measures

Cautions:
• Difficulty falling asleep, staying asleep, or complying with nighttime routines may occur if child is expected to be in bed too long
• Difficulty waking up or day time tiredness may be related to child being in bed for too short of a time

Implication: Select the right sleep total for your child.
Important Factoid to Consider

• We have a tendency to go to bed later and wake up later because of our 24.2 hr clock, artificial light, and ample pm activity (w/ the latter 2 leading to a 25-hour clock)

• **Implication:** Recognize your child’s current *sleep phase* and capitalize on *sleep pressure* when beginning any sleep problem treatment
What Schedule is Appropriate?

- **Caution:** Putting children to bed during the *Forbidden Zone* (the few hours prior to his/her sleep phase) may increase the likelihood of *nighttime routine noncompliance* and *interfering behavior*.

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
What Schedule is Appropriate?

- **Consideration:** Go with the flow (capitalize on “sleep pressure”) by using a *Faded Bedtime*

- Put child to bed ½ to 1 hour later than current start of sleep phase (i.e., the time in which they typically fall asleep)

- Gradually transition sleep phase earlier:
  - If child falls asleep within 15 min move bedtime earlier next night (15 to 30-min increments)
  - Wake child each morning at target wake time regardless of time required to fall asleep (i.e., do not let child “sleep in”)

- Once at desired bedtime, maintain sleep phase by adhering to a similar bed time and awake time
Extreme Sleep Phase Shift?

• **Consideration:** Try *chronotherapy* if sleep phase is more than 4 hours past desirable sleep time:
  
  • Move sleep and awake times *forward* by 1 to 2 hours each night (larger leaps can be made with older children)
Getting at the $S^D$s for all relevant reinforcers

Nighttime Routine

- Develop a nighttime routine that is as pleasant, relaxed, and consistent as possible to occasion “behavioral quietude.”

- Example: Dim lights, eat light snack, (bath), pjs, brush teeth, read book in bed, bid good night, lights out

- Consider a picture schedule depicting the nighttime routine
Other Pre-Sleep Considerations

• What is the ambient lighting like?
  – Morning: well lit
  – Just prior to bed: Dimly lit
  – While in bed: Dark; Barely lit

• What is the ambient noise like?
  – Noise level should not vary much

• What is the ambient temperature like?
  – Cool is best

• Residential Consideration: Make sure lighting, noise, and temperature are geared towards the residents’ needs
  – *Take close look at shift changes and when, where, and how they occur, and consider their impact on your residents’ sleep*
Nighttime Routine Noncompliance

• Tendency to not follow instructions or resist guidance to, for example, put on PJs, brush teeth, or get in bed.
Nighttime Routine Noncompliance

Solutions:

• Start routine just prior to natural sleep phase

• Promoting instruction following during the day
  – More on this in a moment

• Arrange big discrepancy in consequences for compliance vs. noncompliance to routine
Nighttime Routine Noncompliance

Try to promote instruction following during the day by:

1. Decreasing the overall amount of instructions, eliminating instructions from play-based interactions, and making sure that the only instructions provided are those with which you can follow through (i.e., no instructions to eat, *sleep*, pee, talk, etc.).

2. Providing many choices during the day outside of instructional situations to give the child some degree of control.

3. Always calling the child’s name prior to an instruction, pausing, and then only delivering clear, concise, and explicit instructions.

4. Teaching the child to respond to his name effectively by stopping what he is doing, looking up, and saying yes, whenever his name is called (we teach parents/teachers to provide rewarding interactions following at least half of the name calls).

5. Delivering instructions using 3-step prompting (tell, show, help) and always following through with that which was instructed.

6. Providing much praise and different forms of attention, interaction, and “upgrades” every time the child complies.

7. Withholding all forms of attention following noncompliance (and ensuring that follow through is provided).
Getting at the more influential $S^D$s for Sleep:

Sleep Dependencies

• Transitioning from behavioral quietude to sleep depends on things that are associated with falling asleep

Problems:

• Things that occasion sleep are not present when the child wakes up during the night = Night Awakenings.

• Things that occasion sleep are suddenly removed or inconsistently available = Sleep Onset Delay and possibly IB

• Examples: TV, radio, books, bottles, “full belly”, presence of another person, being rocked or patted, lights, fallen stuffed animal or blanket
Stimuli that set the occasion for sleep must be there through the night because children wake up often during the night.
Sleep Dependencies

_Solutions:_

- Occasion sleep with things that
  (a) don’t require your presence,
  (b) can be there in the middle of the night, and
  (c) are transportable (e.g., for nights away from primary residence)

- Examples: pillow, blanket, stuffed animal (when using bed rails), pacifier (depending on age), sound machine on continuous

_Important points:_

- Child should be put in bed and you should leave the room while he/she is still awake
- May want to _fade_ or _sequentially eliminate_ unwanted sleep dependencies
Getting at the Reinforcers for Interfering Behavior (IB)

- **IB** = Behaviors that interfere with behavioral quietude necessary for sleep onset; the big three are:
  - leaving bed (curtain calls)
  - crying / calling out
  - playing in bed or in bedroom
    - this includes motor or vocal stereotypy

- Be sure to first properly consider what the likely reinforcers are for the interfering behavior
  - Attention / Interaction
  - Food/drink
  - Access to TV or toys
  - Escape/avoidance of dark or of bedroom
  - Automatic reinforcers (those directly produced by the behavior)
Addressing the EOs, $S^D$s, and Reinforcers for Interfering Behavior

- **Part 1:** Provide the presumed reinforcer prior to bidding the child good night

- **Part 2:** After bid goodnight, eliminate access to presumed reinforcer following IB
  - With socially mediated IB, we consider using:
    - Progressive Waiting, Time-Based Visiting, Quiet-Based Visiting, Quality Fading, Bedtime Pass, & Parent Fading
  - With automatically-reinforced IB, we consider using:
    - Relocation of relevant materials
    - Blocking
Eliminating Interfering Behavior

• **Progressive Waiting:** progressively delay your typical response to an IB during each night and across nights

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<thead>
<tr>
<th>Day</th>
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<th>Third wait</th>
<th>Subsequent waits</th>
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Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006

• Consider video surveillance for children with medical risk or history of dangerous behavior
Eliminating Interfering Behavior

• **Time-Based Visiting:** Visit child independent of behavior and at increasingly longer intervals within and across nights
  
  – During visit re-tuck them, bid good night, and leave

<table>
<thead>
<tr>
<th>Day</th>
<th>First visit</th>
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<th>Third visit</th>
<th>Fourth visit</th>
<th>Fifth visit</th>
<th>Sixth visit</th>
<th>Seventh visit</th>
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**Eliminating Interfering Behavior**

- **Quiet-Based Visiting:** Visit your child only when still and quiet for longer periods; during visit re-tuck them, bid good night, and leave.

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<tr>
<th>Day</th>
<th>First visit</th>
<th>Second visit</th>
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Eliminating Interfering Behavior

- **Bed Time Pass:** Give your child a *bed time pass* to be used as needed after the bid good night to have one request granted.
  - If # of IBs was high before you try this treatment, provide more than one bed time pass initially and then fade out the number each night.

- **Person Fading:** Sleep near but not in child’s bed and gradually increase the physical distance between you and your child each night

- **Quality fading:** Identify all of the rewarding features of your nightly interactions and gradually decrease the quality of them across nights
Addressing Night Awakenings

• Should be resolved with appropriate sleep schedule and healthy sleep onset dependencies

• If they continue to occur, consider using
  – Progressive Waiting
  – Bedtime Pass
  – **Scheduled (preemptive) awakenings:**
    • Wake your child about 15 to 30 min prior to his/her typical night awakening
    • Gradually increase schedule of awakenings until it coincides with the morning wake up.
      – Alternative: Decrease the frequency of the preemptive awakenings each week
    • Also good for addressing nighttime incontinence
# Nightmares or Sleep Terrors?

<table>
<thead>
<tr>
<th></th>
<th>Nightmares</th>
<th>Sleep Terrors (Confusional Arousals, Sleepwalking)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are they?</strong></td>
<td>Scary dreams occurring during REM sleep</td>
<td>Partial arousals from very deep non-dreaming sleep</td>
</tr>
<tr>
<td><strong>When are you aware your child had one?</strong></td>
<td>After dream is over and child cries or tell you about it</td>
<td>During event itself as child screams and thrashes (He is calm upon waking)</td>
</tr>
<tr>
<td><strong>When do they occur?</strong></td>
<td>Usually in 2nd half of night</td>
<td>Usually 1-4 hrs after falling asleep (when Non-REM Deep Sleep occurs)</td>
</tr>
<tr>
<td><strong>How does child appear and behave?</strong></td>
<td>Wide awake, frightened</td>
<td>Not fully awake, not responsive, glassy look, thrashing, talking, screaming, confused—all of which disappear when awake.</td>
</tr>
<tr>
<td><strong>How does child respond to attempts to calm him?</strong></td>
<td>Aware, reassured, capable of being comforted</td>
<td>Not aware of you, not capable of being comforted</td>
</tr>
<tr>
<td><strong>Can child describe dream?</strong></td>
<td>If language able, then yes.</td>
<td>No.</td>
</tr>
</tbody>
</table>

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
Confusional Arousal (Sleep Terror) Treatment Considerations

• Help your child develop good sleep habits (see above)
• Let episode run its course, then, when over, assist back in bed
• Eliminate nighttime “jobs” that your child must do before going back to sleep:
  – she should not have to call for something, look for something, or check her surroundings to get back to sleep
• If possible, remove materials that result in compulsive behavior from bedroom
Nightmare Treatment Considerations

• Develop good sleep in your child (see above)

• Soothe your child’s fears by talking to them, show them that you are in control and that they are safe

• Do not feel obligated to grant all requests (e.g., keep lights on, check for monsters, etc.)

• Help them with their anxieties during the day hours

• Address nighttime fears by teaching child relaxation tactics and reward “bravery” in the am
Prevention of Sleep Problems: Key Ingredients for Good Sleep

• Adherence to an agreed upon sleep schedule that is sensitive to age and recent sleep history
• Adherence to nighttime routines that foster compliance and “behavioral quietude”
• Development of sleep dependencies on things that are routinely and easily present throughout the night (and transportable)
• Experience with a clear discrepancy between what is available during the day versus the night
For you to consider...

• If you are considering addressing one or more sleep problems, start on a Friday or when you have some time off from work.

• Exercise—just do it; exercise helps people sleep better.

• Avoid caffeinated beverages after 5:00 pm.

• Consider writing down your reflections of the day and plans for tomorrow before you do your nighttime routine.

• To address long delays to sleep onset, consider:

  1. Making your bedtime 1 hr. later than usual,

  2. Getting out of bed if not asleep within 10-15 min, and sitting in chair & read a literary classic for 15 min or until drowsy,

  3. Gradually adjusting sleep and wake times to desired times.
Thank you.

Good luck with all that you do for all who you teach and provide care

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