Putting Sleep Problems to Bed

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Solutions for Children, Ages 0-18

By
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and Professor David Gozal

Cambridge
Scholars
Publishing

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This book first published 2019

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-3831-1
ISBN (13): 978-1-5275-3831-3

This book is dedicated to the late Thomas Hobbins, M.D., who stirred my passion for the sleep field at the age of 17. It is also for my loving parents, Betty Slavin Medalie and George Robert Medalie, M.D., whose unstinting support and guidance paved the way for my career passion.
—L.M.

This book is dedicated to my wife and partner in life Leila who shared with me the many sleepless nights that enabled some of the solutions included in this text. It is also a tribute to my children who tirelessly challenged us every time we thought we had it all figured out.
—D.G.

CONTENTS

INTRODUCTION

How to use this book

We are thrilled to see you made a choice to take action and begin a path towards better nights! This book teaches you how to change habits to improve sleep problems in your child. There are two approaches parents may take when reading this book:

1. Read cover to cover: This approach will allow parents to address the current problem their child is experiencing and be prepared to potentially prevent future problems in their child. As well, parents who take this approach will be equipped to address or prevent sleep problems that may occur with their other children.

2. Start with the chapter that best applies: Parents on this path may start by reading the contents, then focus on the chapter title(s) that best describes their child.

Stories are a significant part of each chapter. A common type of sleep problem is described through the story of a child so that you can understand the diagnosis in an entertaining and easy-to-relate-to fashion. The stories highlight the distress and turmoil experienced during the night, and impact on daytime functioning. Relationships, academics, mood and behavior are examples of impact covered in the stories. The effects on parent sleep, and related distress and dysfunction of the parents are also detailed in each story. The stories each highlight how problems with sleep in children become a family problem. Reading the stories will help parents feel less alone in their struggles with sleep problems.

After the story, the authors detail the **impressions and diagnosis** pertaining to the story. This section allows parents to understand how the authors conceptualize the set of symptoms described. The authors aim to describe the diagnosis that would be given if that family saw them at their sleep disorders center. This also allows parents to learn about this type of sleep problem and start understanding if it matches what their child is experiencing.

A **quiz** is also present after each story. The quiz is a way for parents to better clarify whether the story and diagnosis might be what their child is experiencing. The quiz is not meant to provide readers with an accurate diagnosis. Parents who want to be sure that they know what diagnosis best fits their child's problem should consult with a sleep doctor.

Each story concludes with a detailed description of what **evidence-based behavioral treatment** strategies apply. The authors included descriptions of the changes that are shown in research to reduce the symptoms pertaining to that diagnosis. **Barriers to change** are the common problems that get in the way of change. The authors want parents to succeed with making changes and avoid the common pitfalls that many families face when trying to fix sleep problems.

Contents Overview

Chapters

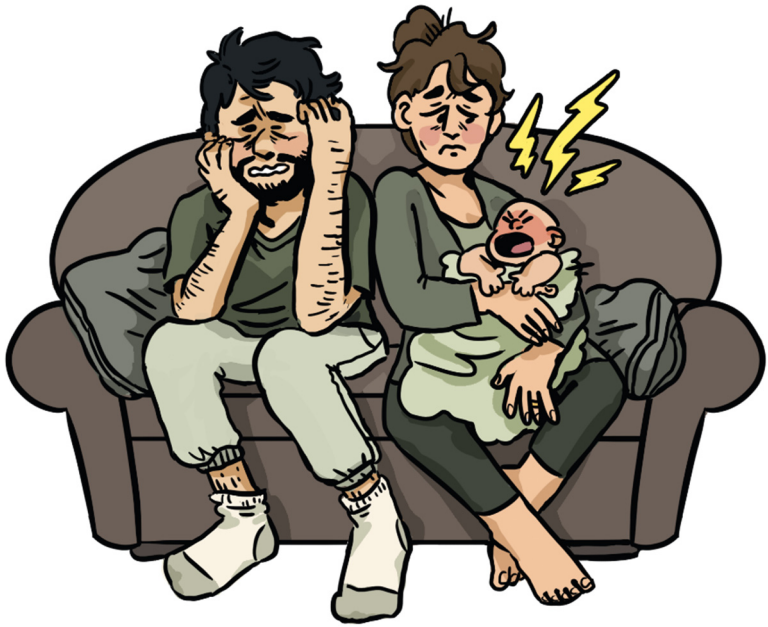
The first five chapters are focused on common sleep problems related to insomnia (i.e., difficulty falling asleep or returning to sleep) and poor sleep habits. Chapter six covers other types of sleep problems that are less habit-related. Chapter seven covers common co-existing conditions, including both medical and behavioral disorders that can be linked to insomnia.

Appendix

Throughout the book, parents will learn detailed instructions for behavioral changes. To track progress with making changes, parents are encouraged to use sleep logs. The authors included a sleep log in the appendix for such tracking. Parents can make photocopies of the sleep log to allow ongoing use of this tracking. Parents who are interested in learning how many hours of sleep their child should get can view this information in the appendix. There are also worksheets to implement the behavioral strategies (e.g., behavior chart, worry-time, cognitive restructuring) which can be photocopied and used for tracking and making change. Finally, there are scripts and details for using relaxation strategies in the appendix. To see the best results with making changes discussed in this book, parents are highly encouraged to use the tools int eh appendix.

Chapter One

Baby Brynn



Story

This first story is about Baby Brynn. Actually, no, our first story is really about Baby's Brynn's mother—Jill. Jill is a 40-year-old lawyer, and is married to John. Jill met John a bit later in life because she was busy building her career as an attorney. Before getting married, she worked around the clock to impress a male-dominated group of partners, and advance in that highly competitive environment. She always dreamed of one day making partner at her firm. Even though she had ambitious career goals, she also always wanted to get married and have a baby. After all, this was 2016, why couldn't she have it all?

Jill married John only six months after meeting him, and with the feeling that her biological clock was ticking fast, they immediately tried conceiving. Jill and John were shocked, thrilled, elated, awed and at least another 1,000 terms of the strong feelings that rushed through them when they saw that glorious pink plus sign on the pregnancy test only two months after their wedding. They experienced an equal level of shock and distress, in the worst possible way, when five weeks later Jill miscarried. They then began trying again, but this time, it was not working. Eleven months later, they decided to try IVF. It took two rounds of IVF but finally, Jill was again pregnant. This time, she carried her pregnancy full term and Brynn was born. It felt like a miracle! All those months of emotional pain and finally, they had this beautiful healthy baby in their arms. The cutest baby in the world was theirs to raise and cherish.

Jill told her firm she was taking three months off, but also that she planned to work on legal briefs in the second and third months of her maternity leave. Her powerhouse of a best friend only took off six weeks and worked from home the entire time. She was clearly already slacking off by making her maternity leave decision. Jill also remembered hearing how painful it was for other moms to leave the baby that soon after birth and return to work, so Jill decided that three months was the perfect compromise for her. While her best friend hired a nanny to care for the baby, Jill and John decided not to, because John worked from home and they felt like they had it all covered. The first month, they were so obsessed with Baby Brynn they could not even remember a minute when they were not holding their precious angel. For Jill, it felt like such a long journey to find the space in her career to start a family, and then after all the battle to get pregnant, she just could not believe she finally got to be a mother. Jill was never religious, but she even looked up to the sky a few weeks after bringing Brynn home, put her hands together and just said thank you!

Months two and three went on in a similar fashion, with Jill and John feeling blessed and continuously holding Brynn. Jill was convinced that there was no better way than the feeling of letting her beautiful angel fall asleep in her arms, while she fed or rocked Baby Brynn. How else would it be even conceivably better? They had the bassinet that John's dad bought them in their bedroom, so when Jill was ready to sleep herself, she would put Brynn carefully and gently into the bassinet making sure that the transition was so delicately done that Brynn would not even budge. She held onto every last minute holding Baby Brynn, and even found herself trying to type up briefs with the baby in her arms. Jill was happy, fulfilled, felt blessed, and yet she was utterly exhausted. Days kept going on, and the same would happen, Jill always alert and awake trying to second-guess every little need that Baby Brynn might have, holding Baby Brynn as much as possible, feeding her on her lap and in her arms, and rocking her day and night. Jill could not believe how little sleep she was getting, and yet she felt that she needed to give even more and felt guilty about the moments she would fall asleep with one eye open, just in case Brynn would need anything. She also began feeling anxious about how little work she was actually able to complete during her maternity leave. She increasingly wondered what the partners were thinking, whether by being away this would put her career in danger of never advancing. She started having a sense of feeling unworthy, and yet every time she would refocus her attention on Brynn, she felt that she needed to give all this time to her baby, and just set aside and forget that anxious inner voice. Simply, she just needed to focus on the precious time she had left with Baby Brynn.

Jill returned to work after three months of being home and the day before returning she felt more exhausted than ever, and felt guilty leaving her baby behind. Jill had to be at work by 7:00 a.m. for morning meetings. She will never forget how she felt on the first day back. She had barely slept three hours the night before, and had been up all night with Baby Brynn. She dozed at a stop light on the drive to work, then dozed off again in the morning meeting. Her co-workers looked strangely at her … how embarrassing! Before returning to work, John would take Baby Brynn in the morning while Jill would catch up on sleep for a few hours. Waking up at 6:00 a.m. after barely sleeping during the night felt awful. She found herself dozing at her computer, feeling moody and struggling to focus. She was not feeling like herself at work, it was like being in a strange place where she did not belong. Jill used to love being at work, was always on the go, took the initiative and led others, felt inspired by every discussion with any of the partners or other associates. Ten times out of ten, she did her best with every task. She was on a mission to make partner one day. Now, she found

herself watching the clock, frustrated by every extra task and could not wait until the day would end.

When Brynn turned six months, Jill and John decided it was time to move Baby Brynn into her own bedroom. They thought maybe everyone would get more sleep if they made this shift. But somehow, it was not working! Baby Brynn was still waking up constantly! She wailed and cried every time she woke. Nights began to feel like torture. Jill began to feel like a prisoner of the night. She began feeling annoyed as darkness set, because she knew as soon as she fell asleep, she would be awoken by loud cries. She found herself sad that she could not get the same level of enjoyment holding and rocking Baby Brynn during night feeds because she felt so pressed for time to sleep. As awful as she felt thinking about it, during some moments, she found herself feeling regret that she ever decided to have a baby. She felt overwhelmed with the lack of control she had over her life and well-being. Jill's work began to suffer. Her brain was just not as fast or efficient, so it took two to three times as long to complete tasks, many times with oversight mistakes that made her look sloppy and careless. She was missing deadlines. She was not keeping up in meetings because she was struggling to remember details and find words. She was finding her patience short with the staff, she blamed them and recriminated them constantly, and partners seemed less inclined to engage her in small talk during lunch. After all the work she did to graduate top of her law school class, and be on the clear path to the partner track in a male-dominated law firm, Jill was devastated by how Baby Brynn's sleep troubles were ruining her life.

Impressions and diagnosis

The problem in Jill's story is that Baby Brynn could not sleep without her, so Jill lost control over her sleep and ultimately her mood and productivity. Jill's story highlights how parents who stay intimately and excessively involved with the sleep of their baby, end up having babies who continue requiring parents for sleep. This is what is formally called behavioral insomnia of childhood (BIC), sleep-onset association type.

To meet the full criteria for any insomnia in children, we are looking to see that the problem occurs three or more nights per week for at least three months and results in distress or problems functioning. In the past, the diagnostic manual for sleep disorder (*International Classification of Sleep Disorders, 2nd Edition, 2005*), included behavioral insomnia of childhood, sleep-onset association type (discussed in previous chapters), limit-setting type (discussed here) and combined type (features of both sleep-onset

association type and limit-setting type are present). The newer version of our sleep disorder manual (*International Classification of Sleep Disorders, 3rd Edition, 2014*) does not use these specific diagnoses any more, and instead puts everything together in a very broad and general diagnosis of "insomnia disorder" where chronic (at least three months) or short-term (less than three months) is specified. Insomnia disorder, chronic is diagnosed when a patient struggles to fall asleep or return to sleep, three or more nights per week, for at least three months with distress or dysfunction resulting.

While we can see the utility of creating a broad diagnosis (i.e., overlap and trouble consistently defining who meets what criteria for many patients), we often still use our previous diagnostic specifications to share with families a more detailed description of the problem.

BIC, sleep-onset association type presents a bit differently in babies and older children. For this chapter, we will focus on the problem in babies. Many times, first time parents, older parents or parents who struggled with fertility or experienced challenges during pregnancy or delivery, feel an extra level of attachment toward their newborn babies. Parents who have babies with some kind of medical problem may also find themselves overly attentive to their newborn. Of course, most parents want to hold their new baby, but, some parents, like Jill, who had difficult pregnancies or worry about the well-being of their newborn, may find themselves holding the baby more than the average parent. These parents are more vulnerable to struggle with BIC, sleep-onset association type.

Sleep-onset associations are "conditions," outside of the baby, that are required for sleep. For example, if a baby learns to fall asleep while being held, rocked or fed, that is how the baby learns to sleep. This means when the baby wakes during the night, they will need those same conditions present to return to sleep, and unless they learn how to do it by themselves, which is highly unlikely to happen in young infants, parents will be awakened and go through the motions over and over, and over again. This is why Baby Brynn cried each time she woke. She was held, fed and rocked to fall asleep at the start of the night, and therefore does not know how to get back to sleep until those same conditions are presented. All of us including babies sleep in cycles and wake at the end of each completed cycle. Babies have shorter cycles than adults, so they naturally wake up more times throughout the night. In the first few months they require feeds during the night, but by the fourth to sixth month, they no longer need those

feeds. They should get all the calories their body needs to grow and develop during daytime feeds.

Sleep is not only a natural event but is also a developmental milestone in many ways. By developmental milestone we mean changes that occur with time at a certain pace so that by X number of weeks or months, babies are expected to be able to do things they did not do beforehand; for example, smile back at you or pass an object from one hand to the other. Like all other skills, sleep is a skill that needs to be learned and practiced. When a child is learning to talk, it is best for the parent to let the child practice on their own without talking for them. When a child is learning to walk, it is best for a parent to eventually let go of their hands so they can try a step on their own. Children need to learn and practice skills by themselves to master milestones. Babies need to learn and practice how to fall asleep by themselves.

Self-soothing is the developmental milestone required in order to learn to sleep through the night without creating havoc in the house. During the first weeks or months, newborn babies do not have the capacity to self-soothe and therefore they cannot learn this skill this early in life. So, initially it is important for the parents to respond to crying and help them calm down. This helps to form a secure infant–parent attachment. Around 12 weeks of age, babies have now developed the neurodevelopmental capability to self-soothe. This means that they can learn this skill and master it with practice. Practically speaking, parents can let them cry in order to figure out how to calm themselves down. Again, this is a skill that is needed and if parents do not teach their babies how to excel at this self-soothing business, they will pay the price ... and not get the Zs they need. Parents must give their offspring the opportunity to learn how to tolerate distress and calm from that state of turmoil back to sleep by themselves.

Therefore, the problem with Baby Brynn is not that she would not sleep—that was only the result of the problem. The problem was that Jill and John did not give Baby Brynn the chance to learn how to sleep. Jill not only held her constantly the first three months she was home, she continued to hold, rock and feed her to sleep. The price? Baby was fine but mom was a wreck!

Quiz

1. Is your baby falling asleep in your arms after 12 weeks?
2. Are you losing sleep because of your baby after 12 weeks?
3. Are you feeding your baby during the night after 4–6 months?
4. Do you pick up your baby when they cry during the night?
5. Do you feel like your baby will not fall back asleep unless you pick them up?

Evidence-based treatment plan

If you answered yes to one or more of these quiz items, you may consider trying some simple strategies to fix the problem. The strategies below are aimed to remove parent involvement from their babies sleep. Remember, it is in your baby's best interest to learn and practice self-soothing and ultimately sleep independently. If your baby does not learn and practice self-soothing, this can make for challenges dealing with distressing emotions as they grow older.

Barriers to treatment

We find that many parents struggle to fix this problem because of several common barriers. The most common barrier is related to **guilt and distress** when hearing their baby crying. You will instinctively want to run in and help when hearing your precious treasure wail. Many parents start off trying to incorporate a sleep treatment plan, but will usually stop the process because they feel they might be hurting their baby if they do not calm their crying. There is not solid evidence of any kind to suggest that letting your baby cry during a sleep plan will cause any harm to your baby. We understand that you might have read somewhere that it is bad or harmful to let your baby cry. We feel that it is actually in the best interest of your baby to let them learn how to self-soothe. There is more to be gained by allowing them the opportunity to cope with distress, so they can grow into the best versions of themselves emotionally and take advantage of the changes required in the brain in this learning process to develop additional skills of emotional stability. Remember that learning to deal with stress is a crucial component of evolving emotionally. Trying to show your love for your baby by giving them this opportunity to evolve emotionally and practice distress

tolerance is a beautiful component of sleep training and an act of proper and adequate parenting.

Even though you might understand the importance of letting your child learn to self-soothe and sleep independently, when you are in the moment you might find it devastating, heartbreaking, cruel and many other epithets to hear the crying and not do anything. We suggest trying your best to use distraction during those moments. You can check the video monitor to ensure that your baby is safe but if needed, do not hesitate and use ear buds, and listen to music or read or anything else to distract you, even a little bit, from the crying. If you find yourself feeling too anxious or distressed, you might even want to try downloading a meditation or relaxation technique. Try your best to manage the guilt and distress you might experience while implementing the sleep plan so that it ultimately does not detract you from meeting your goals, and most importantly you need to convince yourself that you are correct and doing it for your baby, that this temporary difficult period is going to help your baby and everyone else, but mostly your baby!

Another common barrier to achieving good results with treatment for BIC, sleep-onset association type in babies, is what we call the **extinction burst**. This means, the crying will get worse, really worse, before it gets better. Your baby will recognize that you are doing something different and will not like the change. Not even a little bit! Going from the king of the house to being left to their own recourse, is unpleasant to anyone going through the experience, but babies just have in them the vocal skillset to twist your heart with their protesting crying. They will try and get you to go back to what you were doing before by crying louder, and louder, and sob and cry even more, and it will go on for longer than you have ever heard, and every time escalate to more desperate tones. However, the worst thing you can possibly do is go back to what you were doing before when they cry louder or longer. If you do, you are teaching your baby, if you cry louder and longer, you win and I will give you what you want. This is based on reinforcement principles. The originator of behavioral theory, B. F. Skinner, found through his research that behavior only continues when reinforced. This means, a babies crying continues when the desired outcome (parent presence) occurs. When the desired outcome stops, the behavior stops. The concept of behavior stopping when it is no longer reinforced is also called extinction. If you can mentally prepare for this worsening of crying and understand it is supposed to happen as part of the process, it will help you tolerate that initial and temporary “burst,” even when the crying takes the perceived tone of desperate and projects the image that “something really bad will happen to me if you do not come right now!”

We have also seen many parents struggle with treatment because of trouble keeping on a **continuous and regular schedule**. Another important component of behavior theory is that continuous schedules (i.e., consistently using the same approach) are typically more effective than intermittent schedules (i.e., using varying approaches). Once you decide on your sleep plan from the options listed below, it is extremely important to commit to a consistent approach with no variation. If you try a consistent approach for only the first couple nights and then return to your old approach (you give in even for one time!) or change to some other, new approach, you can expect that your baby will not learn the lesson you are trying to teach. Behavior change only results when a clear message is delivered from a consistent reinforcement style. We encourage you to make sure you find the best time frame to start your sleep plan. If you start a sleep plan during a stressful time when other factors may interfere with your ability to stay consistent, you are not likely to see improvements. This is unfortunate because then you may also find yourself feeling that the sleep plan did not help. There is no way to see if the sleep plan helps unless you consistently implement the standardized plan. Inconsistent or intermittent approaches to trying these strategies will never work. If you stumble on sickness, unprompted stressors or some other unpredicted variable that leads you to not keep a consistent sleep plan, it is best to stop the sleep plan for the time being and start again during a better time frame. Alternatively, seek help during that period—the other parent, grandma or grandpa, anyone else you trust is fine as long as you can get the respite you need but the program continues without changes.

Similar to the point of keeping a consistent plan from start to finish, we also know that the plan must be delivered consistently between caregivers. **Opposing caregiver styles** is another common barrier to improvements from sleep treatment. Sometimes, actually many times, we find that while one parent is ready to make a consistent structured change, the other parent is not yet ready, motivated or equipped to tolerate the sleep plan. It is important to determine whether all parties involved with your baby's sleep agree on the sleep plan (e.g., spouse, extended family member, babysitter etc.). Once all are in agreement that the baby's sleep needs to improve, we recommend identifying a sleep plan leader. The sleep plan leader should be responsible for the bulk of implementation of the sleep plan. It is ideal for the person who can best tolerate guilt and distress and can stay consistent, regardless of the likely challenges that will come their way, to take the lead on the sleep plan. We typically advise the "least attached" caregiver to take the lead. Sometimes, if possible, we advocate for a grandparent or extended relative to implement the protocol if feasible. If one person cannot take the

lead, we at least encourage all caregivers being on the same page with the sleep plan. Having a family meeting to discuss the plan can help make sure everyone is on the same page. Planning for the worse, expecting and knowing that it will happen, going over the guilty feeling(s), remorse, sadness, anxiety, etc. while talking about the what if …, all this will be very helpful to you and your partners. Just do not give in!

A final barrier pertains to **relapse** of the sleep challenge. The term relapse means return of the problem even after the problem originally improved from treatment. Even if you do a great job sticking to a consistent sleep plan and reach your goal of improving the sleep of both parents and baby, we know that relapse is possible, and actually very likely. Imagine you love donuts. You know that donuts are not good for your health, but you used to eat donuts every day, and gave up on the donuts because of your outstanding self-discipline. Now you resist the temptation of stopping by the donut store on your way to work every day. It is always possible that one of those days, for whatever reason, you will let yourself be tempted and cave in to the craving, and buy just one donut, and then another one … and another one. This is a RELAPSE! It is helpful to identify possible triggers for a relapse of sleep problems and do your best as a family to manage those triggers and prevent relapse. Any circumstance where you might find yourself again overly involved with sleep for your baby can make relapse possible. The most common trigger is when your baby gets sick, because parents then feel more inclined to respond to crying again. We often advocate to do your best to respond only when necessary (i.e., instructed by your doctor) and otherwise continue to ignore crying. Travel is another common relapse trigger. Many times when sleeping at a hotel or at an extended family member's house, you may need to share a room with your baby. This of course, will again lead your baby to see you and "request" (that is "demand, order, dictate" ☺) your involvement with sleep with excessive crying. If there is any possible way to get creative (e.g., put up a curtain or face the baby somewhere they cannot see you), that would help. If not, at least you can make sure that you are not present at the start of the night when your baby initially falls asleep. The most important thing to remember is that relapse can happen but it does not mean you are back to square one! If you did a great job initially implementing your sleep plan and saw results, you can expect to see the same results (often faster) when you re-implement your sleep plan.

Treatment strategies

We discussed above how the problem with Jill is that she was too involved with Baby Brynn's sleep. She was holding, rocking and feeding her while she fell asleep. When Jill did the work for Baby Brynn to get her to sleep, Baby Brynn never had the opportunity to learn how to sleep on her own. Therefore, when Baby Brynn woke in the middle of the night, she required the same involvement from Jill in order to return to sleep. We emphasized the importance of remembering that babies waking up is never the problem. All people wake during the night (even if you do not remember waking the next day). The problem is that when babies wake up, they need to learn to put themselves back to sleep through self-soothing. Jill has to give Baby Brynn the chance to learn and practice self-soothing so she can learn to sleep on her own and not disturb the sleep of her mother.

There are several steps to consider when making changes to remove parent involvement from sleep. We often start by discussing use of a **relaxing pre-sleep ritual.** In order to help prepare your baby to learn and practice self-soothing, it helps to prepare them with a relaxing pre-sleep ritual. The pre-sleep ritual is a way of telling your baby, "get ready, sleep is coming soon." If you can repeat the same two or three relaxing activities in the same sequence at the same time every night without exception, your baby will learn to associate such cues with preparation for sleep. We suggest starting with a hot bath. The warm water will increase the baby's body temperature and when you bring the baby out of the tub, their body temperate drops and this makes all of us, and babies in particular, more ready for sleep. You can then proceed with getting them changed and ready. Finishing the pre-sleep ritual playing the same identified sleep song (or lullaby) is a great way to cue that sleep is near. After the sleep song is played, you can put your baby down awake but drowsy, and then turn on a white noise machine or do nothing else. If this exact process is repeated in the same order every night it is very helpful for your baby to learn to prepare for sleep. You can see from Jill's story that she did not have a set pre-sleep ritual. Instead, she was often completing work tasks and let Baby Brynn fall asleep in her arms during that time. If she was not working during that time, she was rocking or feeding Baby Brynn while she fell asleep. She was just putting Baby Brynn down after she had already fallen asleep. This robbed Baby Brynn of the opportunity to learn to get sleep-ready.

The next aspect of a sleep plan that is important to consider for sleep in babies is **feeding**. We can see in Jill's story that she was often feeding Baby Brynn at the start of the night and when she woke during the night. This is

a very common practice among many parents, and what it does is to strengthen an attachment of the baby to the parent for sleep. When you let your baby fall asleep during feeds, you are teaching them to associate the act of eating and having a full belly with sleep. You are also not allowing the opportunity to put themselves to sleep. Whenever they wake during the night, they will again then need you to feed them again in order to return to sleep. It is essential to separate feeds from sleep. For this reason, we encourage parents to do their best to keep their babies awake during feeds (day and night). By their fourth to sixth month, most babies do not need additional feeds during the night. They should by then have enough daytime calories to hold them over through the night. This means, parents can then try to progressively eliminate nighttime feeds from that point.

As most babies are conditioned to associate nighttime awakenings with feeds, this change is challenging. Some parents may wish to gradually reduce nighttime feeds to make the process easier. To gradually reduce feeds, parents could slowly give the baby fewer calories during nighttime awakenings (e.g., either less and less breastfeeding time or more and more water added to bottles, or a smaller amount in each bottle). They can also gradually move the feeds from bedtime by slowly backing up the final feed. Ultimately, the final feed should be 30–60 minutes before bedtime. If parents are eager to quickly fix the sleep problem, they can abruptly shift to a final feed 30–60 minutes before bedtime and eliminate all nighttime feeds in one night. As mentioned above, they can expect more of an extinction burst with this method, but the change can then occur more quickly.

Even if your baby cries for food, you can assure yourself that they have received enough calorific intake the day before and will again receive more calories upon waking. They are ready, from a nourishment standpoint, to get through the night without those feeds. Just because they are used to getting the feeds, does not mean that is what is best for them or that they are really hungry and need those calories for their well-being. As discussed earlier, it is in the best interest of your baby to practice self-soothing and learn to sleep independently. Elimination of feeds is a necessary step toward achieving that goal. In the story of Jill, she recollects how initially, she found it pleasant feeding Baby Brynn and then began feeling “stuck” by Baby Brynn being so dependent on her for nighttime feeds that she was losing sleep. If you are anywhere near that prisoner feeling, that is a sign that something needs to change. It is not helping you or your baby to keep feeding them during the night.

Getting on a **schedule** is another really important component of a sleep plan. A consistent bedtime, awake time and nap times are needed to best help your baby anticipate and prepare for sleep. As well, a consistent sleep schedule helps to entrain the circadian rhythm, which is the internal clock of your baby. When the internal clock is set and entrained, your baby will be more successful with falling asleep at the desired bedtime. This means that even during the day, your baby needs to be exposed to daylight at regular times which help the baby internal clock be in tune with the outside schedules of our lives. As you start to give your baby the opportunity to learn to sleep independently, you want them to have the best chance of success. The consistent schedule is an essential start of that preparation for success. In Jill's story, she was often letting Baby Brynn naturally fall asleep whenever she happened to fall asleep (e.g., while Jill was holding her working, while Baby Brynn was being fed etc.). Unplanned sleep starts did not allow Jill to set the internal clock for Baby Brynn through use of a consistent sleep schedule.

The most crucial aspect of the sleep plan needed to teach your baby to sleep independently is addressing **parent involvement**. The concept of making sure parents do not let their babies fall asleep while rocking has been around since Emmett Holt's 1894 book titled *The Care and Feeding of Children.* In his book, he encourages parents to put their baby down awake, fed and comfortable, and that parents should not rock their baby to sleep. Since then, other experts like Dr. Ferber and Dr. Weissbluth have solidified instructions for how to remove parent involvement from sleep.

There are two evidence-based approaches for removing parent involvement from sleep. The first original approach is referred to as **standard extinction**. Standard extinction requires you to put your baby down awake but drowsy at the start of the night and leave the room thereafter. You ignore all crying and protests and do not return to the baby until morning. You may opt to use video monitoring to ensure safety as at times the crying can be so extreme that babies may need assistance.

Many parents describe trouble executing standard extinction because of trouble tolerating prolonged crying. **Graduated extinction** is a valid alternative to standard extinction. In graduated extinction the parent removes their involvement over time. Just like with standard extinction, graduated extinction also involves putting your baby down awake but drowsy. However, instead of not returning until morning, you can slowly remove your presence. One approach to gradual extinction is a method called **camping out**. This approach involves slowly moving away from the baby every few nights. For

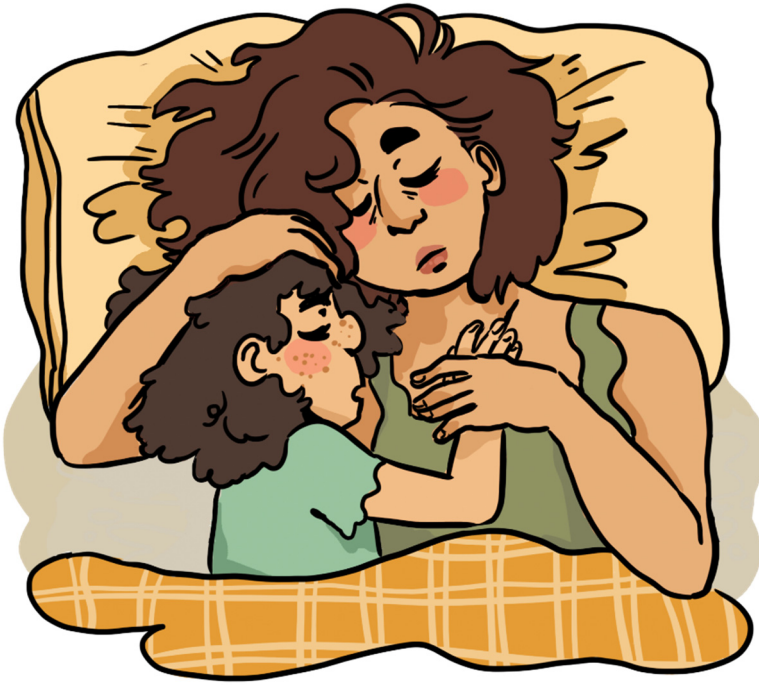
example, you may start by standing next to the crib rubbing your hand on your baby while they fall asleep. After two nights on that step, you can move to standing next to the crib with no contact (two nights), sitting next to the crib in a chair (two nights), moving the chair to the middle of the room (two nights) and then moving the chair by the doorway (two nights). Whichever level of involvement you are at during bedtime, should be what you repeat when you hear your baby cry in the middle of the night.

Another method for gradually removing parent involvement is called **scheduled checks.** This approach can either be utilized instead of camping out or after camping out is completed. You can start by putting your baby down awake but drowsy and leaving the room. Instead of ignoring crying until morning, you can pop your head back into the bedroom every three minutes. When you pop your head in, you must not say anything and just stand in the doorway for one or two minutes. You can return every three minutes until your baby is asleep. When your baby wakes during the night, you can again pop your head in every three minutes until your baby returns to sleep. After two nights of popping in every three minutes, you can then pop your head in every five minutes (two nights), then every ten minutes (two nights), fifteen minutes (two nights), twenty minutes (two nights) and after then after thirty minutes to complete the protocol. These graduated extinction protocols (i.e., camping out and scheduled checks) take longer to complete than standard extinction. That said, parents report less distress and improved adherence when using graduated extinction.

Jill and John discussed these various options at length. They decided John would be the identified lead parent to implement the sleep plan as they felt that Jill would struggle more with staying strict with the steps. They also agreed that Baby Brynn no longer needed feeds at night so the breastfeeding was not a necessary factor in the decision. They were able to abruptly shift to stopping all feeds 60 minutes before bedtime with no problems because Baby Brynn was eating plenty throughout the day. Jill decided since she was not taking the lead with the sleep plan, she would take the lead with pre-sleep ritual by giving Baby Brynn a bath and then playing her favorite symphony album each night leading up to bedtime. John used the scheduled checks protocol to gradually remove involvement with sleep. He was able to actually start with checking every five minutes. He was finished with the sleep plan by the fifteen minute check. After two weeks of keeping to the plan consistently, Baby Brynn was sleeping through the night. Jill was back to her old self. She was re-energized at work, felt happy and made partner six months later. She not only felt thrilled to have her work goals met but relieved that she could again control her sleep and have her personality back!

Chapter Two

Co-Sleeping Chloe



Story

Our next story is about Chloe. Chloe is a four-year old girl who is afraid to sleep alone. Her mother Sara is a stay-at-home mom with two other children who never had this problem. Chloe's father, Jack, is a hard-working police officer who finds himself sleeping on the couch and is desperate to get back in bed with his wife.

Chloe presented with wheezing early on in life. Soon after, she was diagnosed with asthma. Her asthma was always worse at night. One night it was so bad that Sara and Jack had to take Chloe to the emergency room at 2 a.m. Ever since then, Sara watched Chloe like a hawk during the night. Sara was a big worrier in general, but the fear she felt about Chloe's safety was overwhelming in a way she had never felt before. She admits she was probably a bit overly cautious. She found herself losing sleep standing over the crib to make sure Chloe was safe. Chloe was also not a great sleeper because there was a steroid component to her asthma treatment that seemed to keep her awake much of the night.

Sara decided early on, it just made sense to bring her into the bed. Chloe did seem to sleep better in Sara's bed and with less worry; Sara was able to sleep as well. At the time, Jack supported this sleep arrangement, since not only did he share Sara's concern and worry, he felt it was best for the whole family. Since Jack sometimes got home late due to late shifts as a police officer, he started spending some nights on the couch, so he would not wake up Chloe on those nights. "Some nights" eventually turned into "all nights."

About six months ago, Jack and Sara took Chloe to the doctor for her fourth year check-up. At that appointment, the doctor reported that Chloe no longer exhibited signs of her asthma. Chloe had not experienced an asthma attack in over a year, her lungs sounded clear and she was doing great.

Ever since that appointment, Jack noticed feelings of resentment that he was still sleeping on the couch. He missed those nights sleeping with his wife. Jack remembers how good it was after a long shift to be next to his wife, to hold her and the comfort he felt with her in his arms. He was going through his own struggle as his close friend was promoted, over him, for a position he truly felt he had earned. Jack was feeling unappreciated at work as he had given everything to this job. He was starting to feel defeated as he was not happy at work and not feeling comforted at home either. These feelings were unlike anything Jack had felt before.

Jack told Sara it was time for things to change. He needed to be back in bed with Sara as Chloe was fine and did not need watching over anymore. Sara saw the sadness in his eyes when he came to her with this request and she wanted to be a good wife, so she agreed it was time to make a change. That night, Sara walked Chloe up to her bed and told her it was time she slept in her bed. Chloe cried and grabbed her mother's hand. Jack walked in and glanced over at Sara. Sara begrudgingly walked out of Chloe's room. Chloe cried and yelled "mommy mommy, I'm scared, please come back … please mommy please, mommy I need you." Sara got into bed with Jack and tried to be strong. Five minutes later, Chloe walked over to their room, stood by the door crying and saying, "there are monsters in there and I'm afraid of my bed." She then got into the bed and Sara could not find in her heart to say no. Jack tried to sleep in bed with the two of them, but the resentment he felt would not allow him to sleep. He got up from the bed and went back to the couch.

Each time they tried again, Chloe appeared more and more afraid of her bed. She seemed genuinely alarmed about these monsters. Sara really felt that she was truly afraid and could not convince herself to turn down Chloe's requests to get into bed. The next several nights, Sara would try to put her into her bed again. Chloe would look around the room and cry. She would look at the shadows and think everything was a monster. It didn't help that she just had watched a monster movie with her older brother a few weeks back and ever since was always talking about monsters. Her older brother was teasing her and would try to scare Chloe by pointing to things and saying, "look Chloe, there's a monster." While Sara was able to stop the older brother from scaring his sister, she could not succeed in easing Chloe's nighttime fears. She told Chloe, "I checked under the bed, I checked in the closet and looked everywhere in the room, I did not see any monsters." Somehow that never seemed to take the fear from Chloe's face as she continued to insist there must be monsters in her room. Sara tried and tried but she could not seem calm Chloe in anyway but bringing her into her bed and letting Chloe lie right on her chest while she fell asleep.

This problem reared its ugly head at school too. Sara would try to drop Chloe at school in the morning, but Chloe would grab onto her mom's leg and cry every time. One of the teachers would have to walk over, and after a big ordeal, finally get Chloe to join the class. Chloe did the same thing when Sara and Jack tried to hire a babysitter and even when Chloe's grandparents would try and take her for the night. Chloe's co-sleeping was disastrous! It was affecting her parents, her teachers and certainly was not doing her any good as she was becoming more and more scared at night.

Impressions and diagnosis

The story of Chloe can best be described by two conditions. Similar to Baby Brynn, Chloe also struggles to sleep independently. She requires parent involvement to fall asleep and return to sleep. Without parent involvement, Chloe seems unable to sleep. This problem is again what we previously referred to as BIC, sleep-onset association type. This problem can present in babies or children of any age. It tends to be most common in babies and younger children. That said, we have even seen older kids who still need a parent to lie next to them while they fall asleep.

It is very common to see a scenario like Chloe's. When medical problems, injuries or illness lead to parents increasing their involvement at bedtime and during the night, babies and children become dependent on such conditions to sleep. While there might be some stretches where doctors even ask parents to check throughout the night, parent involvement during the night is not expected to be a long-term scenario. The reason that a temporary increase in parent involvement turns into BIC, sleep-onset association type is because habits are formed and children become accustomed to such scenarios. When children do not learn or practice the skill of independent sleep they develop insomnia when asked to sleep alone. It is understandable that some circumstances suggest or even demand increased involvement from parents at night, however, we encourage parents to set clear boundaries so that temporary solutions do not become long-term arrangements.

We see parents who tell us "our other kids sleep great, but this kid is just a terrible sleeper." Often when we explore more, we find that the troubled sleeper had some unique component about their birth, development or medical history that somehow prompted increased parent involvement with sleep. Even the best-intentioned parents, who "did everything right with the other kids" end up like Sara and Jack when faced with a similar scenario. It is very challenging to juggle the increased needs some kids have at night with doing what is required to encourage independent sleep and minimize insomnia.

We also must look at how Sara's experience contributed to the evolution of Chloe's co-sleeping. While sure, the steroid-based asthma treatment made it hard for Chloe to sleep, and yes, Chloe's breathing needed some watching at some points during her early years, Sara chose to bring Chloe into the bed. Sara was worried and noticed that the closer she was to Chloe during the night, the less worried she felt. Let's face it, mild anxiety can be