

Solve Your Child's Sleep Problems

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Richard Ferber, M.D.

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Part One

et al

YOUR CHILD'S SLEEP

At the End of Your Rope

The most frequent calls I receive at the Center for Pediatric Sleep Disorders at Children's Hospital in Boston are from a parent or parents whose children are sleeping poorly. When the parent on the phone begins by telling me "I am at the end of my rope" or "We are at our wits' end," I can almost predict what will be said next.

Typically, the couple or single parent has a young child (often their first), who is between five months and four years of age. Their child does not fall asleep readily at night and/or wakes repeatedly during the night. The parents are tired, frustrated, and often angry. Their own relationship has become tense and they are wondering whether there is something inherently wrong with their child, or if they are unfit parents.

In most cases the parents have had lots of advice on how to handle the situation from friends, relatives, even the pediatrician. "Let him cry; you're just spoiling him," they are told, or "That's just a phase; wait until she outgrows it." They don't want to wait but begin to wonder if they will have to, since despite all their efforts and strategies the sleep problem persists. Often the more the parents do to try and solve the problem, the worse it gets. Sooner or later they ask themselves, "How long do I let my child cry—*all night*?" And if he or she gets up four, five, and six times at night, "Will this phase pass before we collapse from our own loss of sleep?"

Everything seems pretty hopeless at first. If your child isn't sleeping well or has other problems—such as sleep terrors, bedwetting, nightmares, or loud snoring—which are sources of worry and frustration, it won't take long for you to feel as if you're at the end of your rope too.

Let me assure you there is hope. With almost all of these children we are able to at least reduce the disturbance significantly, and often we can actually eliminate the sleep disorder entirely. The information in this book will help you to identify your child's particular disorder and will give you practical ways of solving the problem.

At the Sleep Center I meet with the family—parents and child together—and learn all I can about the child's problem. How frequent and long-lasting has it been? What are the episodes like? How do the parents handle the child at bedtime and during the nighttime wakings? Is there a family history of sleep problems, and are there social factors that might be contributing to the problem? With this detailed history, a physical examination, and, in certain cases, after laboratory study, I can usually identify the disorder and its causes. At that point I can begin to work with the family to help them solve their child's sleep problem.

Our methods of treatment for the "sleepless child" rarely include the use of medication. Instead, I work with the family to set up new schedules, routines, and ways of handling their child. Sometimes the child's biological rhythms may need normalizing or he may have to learn new conditions to associate with falling asleep. The family may have to learn how to set appropriate limits on the child's behavior, and the child may need an incentive to cooperate. I always negotiate the specifics of the plan with the family. It is important that they agree with the approach and feel confident that they will be able to follow through consistently. If the child is old enough, we include him in the negotiating. Thus we use a consistent, firm, but fair technique, tailored to the child, the family, and the particular sleep disorder. This *works*, time after time.

Usually the sleep problem has nothing to do with poor parenting. Nor are the episodes (with a few exceptions) part of a "normal phase" that must be waited (and waited and waited) out. And finally there is usually nothing physically or mentally wrong with the child himself. Most parents are immensely reassured to know that sleep disorders are common in all types of families and social environments, and that most children with such disorders respond well to treatment.

In certain cases, such as in sleep apnea, or less often in bedwetting, medical factors may be involved and our intervention may include medication or surgery. In other instances, such as the sleepiness of depression, recurrent nightmares, adolescent sleep terrors, and extreme nighttime fears, emotional factors may play a role. Here the source of these feelings must be identified and satisfactorily dealt with

before the sleep problems will resolve. Sometimes professional counseling may be recommended.

The case studies in this book are based on my experience at the Sleep Center. The discussions of these cases, along with descriptions of the underlying sleep disorders and explanations of the methods of solving them, will help you to identify, understand, and deal with your own child's sleep problem.

Can a Child Just Be a "Poor Sleeper"?

If your child is a restless sleeper or can't seem to settle down at night, you should be very cautious about assuming that he is just a poor sleeper or doesn't need as much sleep as other children of the same age. Your own expectations can have a very strong influence on how your child's sleep pattern develops from the day you bring him home from the hospital. I have seen many families who were told by the nurse in the maternity ward, "Your baby hardly sleeps at all. You're in for trouble!" Because these parents were led to believe their child was just a poor sleeper and there wasn't anything they could do about it, they allowed their baby to develop poor sleep habits; they did not believe there was anything they could do to help him develop good ones. As a result the whole family suffered terribly. Yet I have found that almost all of these children are potentially fine sleepers and with just a little intervention can learn to sleep well.

It is true that children differ in their ability to sleep. Some children are excellent sleepers from birth. In the early weeks they may have to be waked for feedings. As they grow older, not only do they continue to sleep well, but it is difficult to wake them even when you want to. They sleep soundly at night in a variety of situations—bright or dark, quiet or noisy, calm or chaotic—they tolerate occasional disruption of their sleep schedules, and even sleep well during periods of emotional stress.

Other children seem inherently more susceptible to having their sleep patterns disrupted. Any change in bedtime routines, an illness, hospitalization, or guests in the house, may cause their sleep patterns to worsen. Even though these children may have always been considered "non-sleepers," we usually find that they too can sleep quite satisfactorily once we make appropriate changes in their routines, schedules, surroundings, or interactions with the family. Such children may still have occasional nights of poor sleep, but if the new routines continue to be followed consistently, the more normal patterns will return quickly.

There are, of course, children who sleep very poorly for reasons we have, as yet, been unable to identify. For these few, our treatment may help very little, or not at all. If your child is up a great deal in the night it may be tempting to assume that he is one of these poor sleepers. But this almost certainly is *not* the case. Such instances of truly poor sleep ability are quite rare among young children, and in all probability your child's sleep problem can be solved.

Virtually all children without major medical or neurological disorders have the ability to sleep well. They can go to bed at an appropriate time, fall asleep within minutes, and stay asleep until a reasonable hour in the morning. And while it is normal for each child (and adult) to have brief wakings during the night, these arousals should last only a few seconds or minutes and the child should go back to sleep easily on his own.

It is very probable that your child, regardless of his present patterns, is just such a child, with a normal inherent ability to fall asleep and remain asleep. This is true even if he has a sleep disturbance such as sleepwalking or bedwetting. These events occur during sleep or partial waking, and children with these symptoms still have a basically normal ability to fall asleep and stay asleep. Sleepwalking and bedwetting are actually a bit more difficult to treat than sleeplessness, but nevertheless they too usually improve, and are often resolved, with the appropriate intervention.

How to Tell Whether Your Child Has a Sleep Problem

When your child's sleep patterns cause a definite problem for you or for him, then he has a sleep problem. This is true, for example, if he complains of inability to fall asleep, or if you find you must be up with him repeatedly during the night. Sleep problems such as sleep terrors, sleepwalking, or bedwetting are also readily apparent and quite easy to identify as sleep disorders. But others may be less obvious. You may not recognize that your child even has a problem, or you may not realize that the problem he does have should be considered a disorder that can and should be treated. You may not be aware that loud snoring every night, besides keeping you awake, may be a warning that your child is not breathing satisfactorily while asleep. Other symptoms of possible sleep abnormalities which should be identified and treated are: frequent difficulty falling asleep at bedtime, waking during the night with inability to go right back to sleep alone, waking too early or too late in the morning, falling asleep too early or too late in the evening, or being irritable or sleepy during the day.

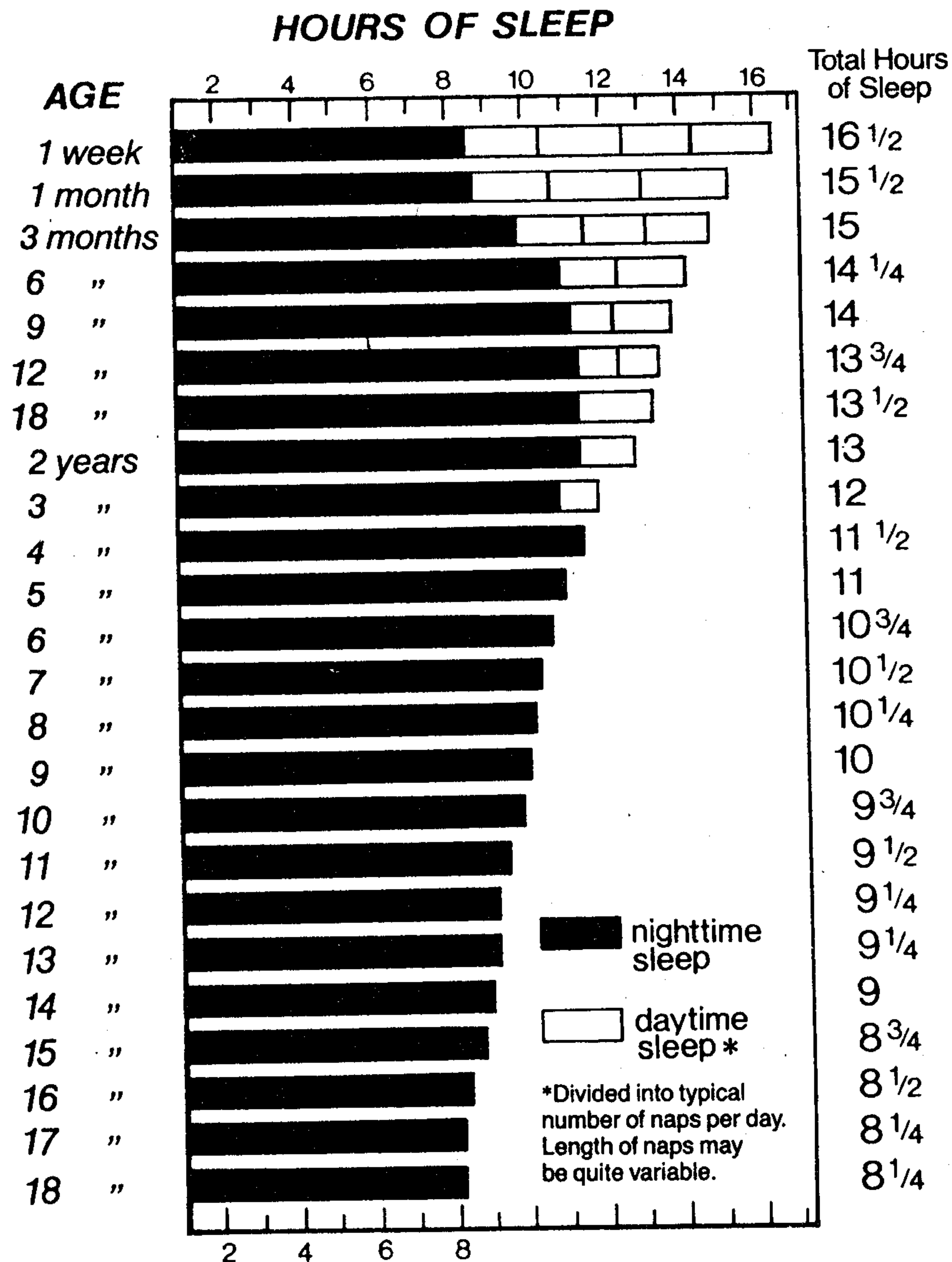


FIGURE 1 Typical Sleep Requirements in Childhood

One of the least obvious of sleep problems is that of insufficient sleep. There is no absolute way of measuring whether the amount of sleep your child gets per day is appropriate. Figure 1 on page 19 shows the average amount of sleep children get at various ages during the night and at naptime. But each child is different. We can watch each child's behavior during the day closely to see if he seems excessively sleepy or cranky. But the symptoms of insufficient sleep in a young child can be very subtle. If your two-year-old sleeps only eight hours at night but seems to be happy and functioning well during the day, it is tempting to assume he doesn't need more sleep. But eight hours is rarely enough sleep for a two-year-old, and with the proper intervention he can learn to increase his amount of sleep time considerably. You may begin to notice an improvement in his general behavior and only then will you be aware of the more subtle symptoms of inadequate sleep that actually were evident before you adjusted his sleep schedule. Now your child will probably be happier in the daytime, a bit less irritable, more able to concentrate at play, and less inclined to have tantrums, accidents, and arguments.

Adolescents often do not get enough sleep. Teenagers are not likely to wake spontaneously on school days and tend to sleep at least one hour longer on weekends. When adolescents have the opportunity to sleep as much as they like, they will average about nine hours per night, and this is probably closer to the optimal level for their age.

It is also difficult to decide when nighttime wakings are "abnormal." A young child from six months to three years may be getting adequate amounts of sleep at night, even though he wakes several times during the night and has to be helped back to sleep. Parents will say to me, "Tell me if this is normal. If it is, I will continue getting up; but if it is not, then we would like to do something about it!" I assure them that most healthy full-term infants are sleeping through the night by three or four months of age. Certainly by six months all healthy babies can do so.

If your baby does not start sleeping through the night on his own by six months at the latest, or if he begins waking again after weeks or months of sleeping well, then something is interfering with the continuity of his sleep. He should be able to sleep better, and in all likelihood his sleep disruption can be corrected. Chapters 5 through 9 will help you to identify his problem and show what you can do to remedy it.

How well your child sleeps from the early months affects not only his behavior during the day but also your feelings about him. I have often heard a parent say, "He is such a good baby. I even have to wake

him for feedings." Although the parent is saying the baby is a good sleeper, the words imply that the baby is "good" in the moral sense. It is easy to see that this distinction will influence how you relate to your child.

If your child does not sleep well, he may well be making your life miserable. It isn't hard to think of such a bad sleeper as a "bad" baby. You will probably feel enormously frustrated, helpless, worried, and angry if you have to listen to crying every night, get up repeatedly, and lose a great deal of your own much-needed sleep. If your child's sleep disturbance is severe enough, your frustration and fatigue will carry over into your daytime activities and you are bound to feel increasingly tense with your child, your spouse, family, and friends. If this is the case in your home, you will be pleased to learn that your child is almost certainly capable of sleeping much better than he is now, and you should be able to get a good night's sleep yourself. To do this, you will need to learn how to identify exactly what your child's problem is, and then you can begin to solve it.

First, I want to explain briefly what we know about sleep itself. Although it is not necessary for you to be conversant with all the scientific research on sleep, it will be helpful for you to have some understanding of what sleep really is, how normal sleep patterns develop during childhood, and what can go wrong. Then you will be better able to recognize abnormal patterns as they begin to develop, to correct problems that have become established, and to prevent others from occurring.

Although the information on sleep in Chapter 2 is not overly technical, you may be eager to read the chapters that follow it to learn about the actual sleep disorders and their treatments. If that is the case, I suggest you scan the material on sleep in the next chapter and then come back to read it more closely when you have identified your own child's sleep problem. The information is very interesting to almost everyone, and especially important to parents who want to help a child sleep better at night.

What We Know About Sleep

You may be surprised to learn that we still don't fully understand why people need to sleep and what purpose sleep serves. Obviously, without it we feel sleepy, and this feeling is only relieved by sleep. We know that sleep does serve some restorative function for our bodies and perhaps for our minds, and it is certainly necessary for normal functioning during the day.

Doctors and other researchers had thought until recently that sleep was a single state distinguished from waking. However, we now know that sleep itself is divided into two distinctly different states: REM (pronounced *rem*), or rapid-eye-movement sleep, and non-REM sleep. The non-REM stage is probably the closest to what we usually think of as "sleep," and most of the restorative function of sleep occurs in that state. During non-REM sleep, you lie quietly, with regular heart rate and breathing pattern. There is very little dreaming, if any, although thoughtlike processes may continue. In REM sleep there is much more activation of body systems, and it is in this state that we do our dreaming.

Non-REM Sleep

After the earliest months of life, non-REM sleep divides into four stages of its own. These stages represent progressive levels of sleep from drowsiness to very deep sleep, and each can be identified by monitoring brain waves, eye movements, and muscle tone on a machine called a polygraph.

As you begin to fall asleep, you enter Stage I, the state of drowsiness. Although you are unaware of it, your eyes move slowly about

underneath your closed eyelids. Your awareness of the external world begins to diminish as well. You are perhaps familiar with the experience of becoming drowsy in a lecture or meeting. As you nod off, you miss some of the speaker's comments, yet you will wake instantly, often with a start, when your name is called or when your head is bent far enough forward that you are at risk of falling off the chair. You might think you had not been asleep, but your lapse of awareness would prove you wrong. On waking from the drowsy state, you might remember some thoughts of the kind usually referred to as "day-dreams." Some people will report seeing or hearing things that seem more like true dreams. This "hypnagogic" (that is, in the act of falling asleep) imagery is similar to regular dreams that occur later, during REM sleep, except for being less well formed, shorter, and less strange.

As you continue your transition through drowsiness toward deeper sleep, you may notice a sudden jerk of your whole body which will actually wake you briefly and interrupt your sleep descent. This "hypnagogic startle" is quite normal, although it does not happen every time we fall asleep.

Drowsiness really represents a transition into the more fully established stages of non-REM sleep, but we can only identify the arrival of Stage II for certain if we monitor the brain waves. Short bursts of very rapid activity called sleep spindles, and large, slow waves called K-complexes, begin to appear (see Figure 2 on page 24). You can be waked easily from this stage, but on waking you may not believe that you had been asleep, depending on how long you had been in Stage II, how deeply into this stage you were at the time of waking, and, as always, on individual differences. After such a waking you would not likely report any odd dream images, but you might possibly describe some ongoing "thoughts."

As you fall more deeply asleep, you enter Stage III and finally Stage IV. The smaller and faster brain waves of light sleep and waking disappear and your brain waves now show predominantly large, very slow "delta" waves. Your breathing and heart rate become very stable, you may sweat profusely, and you will be very difficult to wake. Simply calling your name will probably rouse you out of Stage II, but you could well be oblivious to this stimulus in Stage IV.

However, if the stimulus is important enough, you would be likely to wake. Therefore it seems that even in the deepest Stage IV sleep our minds can still process some outside information.

Thus, although it may be difficult to wake you when it is your turn to get up and feed the baby, shouts of "Fire!" or a child's screams of

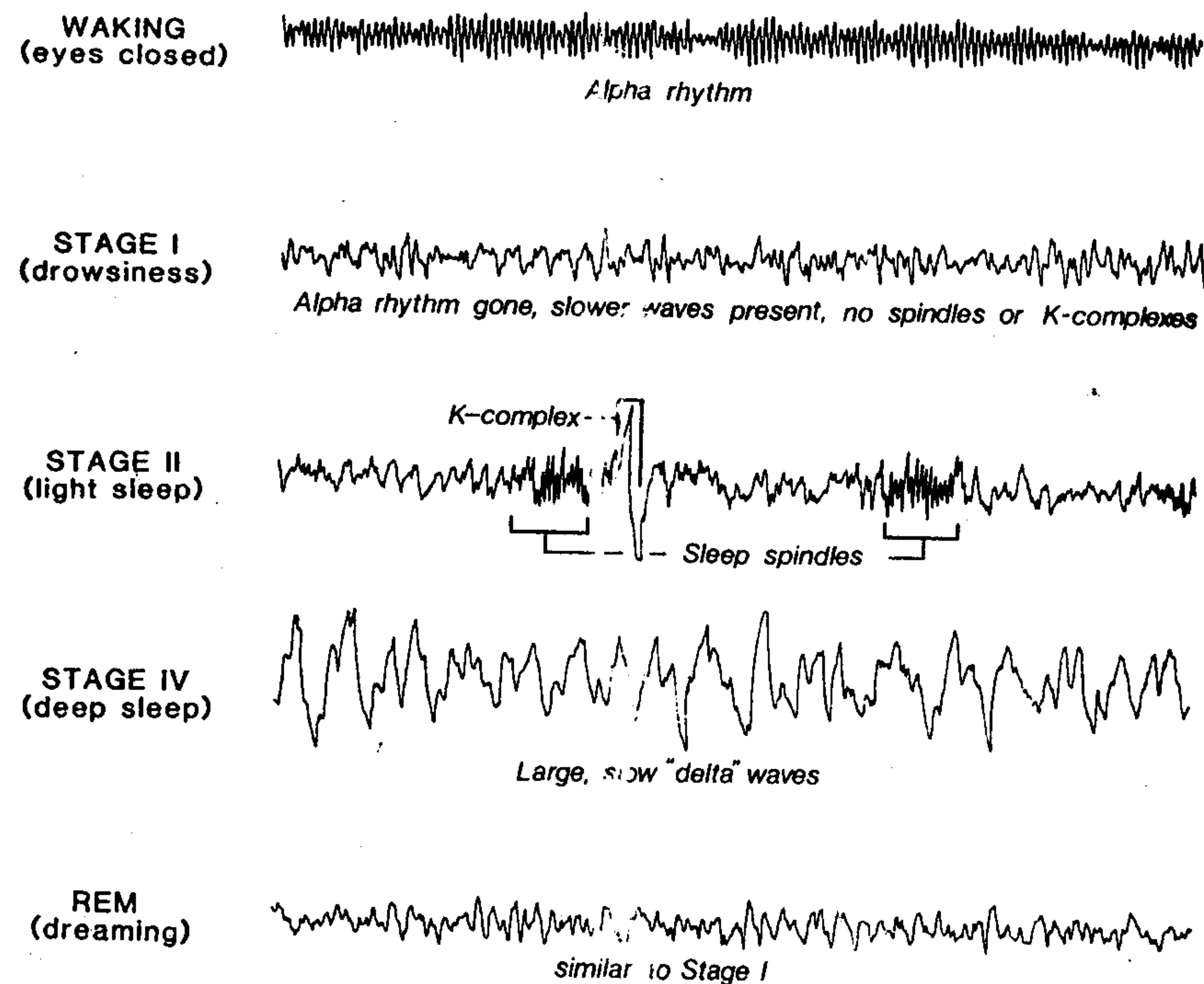


FIGURE 2 Brain Wave Patterns in Waking and in Sleep

pain will rouse you promptly. Even in these emergencies, however, you will find yourself awake but *confused*. You know that you must act quickly, but you have trouble thinking clearly, sorting out just what it is you should do, and "clearing the cobwebs" from your head. This difficulty in making the transition from Stage IV non-REM sleep to alert waking is very significant in several sleep disorders in children, as you will see when we discuss sleep terrors, extended periods of confused thrashing, and sleepwalking (Chapter 10).

In non-REM sleep your muscles are more relaxed than when you are awake. You still have the ability to move, since the connections of the nerves to the muscles they control are all working. However, you lie still because your brain is not sending messages to your muscles to move. Disorders such as sleepwalking and sleep-associated headbanging are exceptions to this rule and will be discussed at length later.

REM Sleep

After one or two cycles in non-REM sleep, you will enter REM sleep, a different state entirely. Both breathing and heart rate become irregular. Your reflexes, kidney function, and patterns of hormone release change. Temperature regulation is impaired, and so you will not sweat or shiver. Males will have penile erections in this state and females will have clitoral engorgement and increase in blood flow to the vagina, though the significance of these genital changes is not known.

REM sleep is an active state. Your body uses more oxygen, a sign that you are expending more energy. There is more blood flow to the brain, its temperature increases, and your brain waves will become quite busy again, resembling a mixture of waking and drowsy patterns. The mind now "wakes," but the wakefulness of the dream state is quite different from that of true waking. You respond mainly to signals originating within your own body instead of from the world about you, and you accept without question the bizarre nature of your dreams.

During this state you have very poor muscle tone, especially in the head and neck, where you become profoundly relaxed. Nerve impulses that otherwise would pass down the spinal cord and out to the muscles are blocked within the spinal cord, so that your muscles are not only relaxed but much of your body is effectively paralyzed. Signals to move may still be sent out from your brain, but they do not get through to your muscles. The only muscles spared are those controlling eye movements, respiration, and hearing. Because this blockade is not complete, some of the stronger signals will get through to the

muscles, leading to frequent small twitches of the hands, legs, or face. So although REM sleep is very active in terms of metabolic and brain function, and although your brain does send out signals to move, you will remain fairly still.

Perhaps the most striking features of REM sleep are the bursts of rapid eye movements. During these bursts the heart rate, blood pressure, respiratory rate, and blood flow to the brain all increase and show other irregularities. Furthermore, if you are waked after you have been in the REM state for some minutes and have been having frequent eye movements, you will almost certainly report that you were having a dream. And the length of the dream you describe will correspond roughly to the time you had been in the REM state. Children as young as two have described dreams after such wakings.

We cannot say for sure whether the pattern of eye movements always indicates you were actually "watching" your dream occur. But we suspect that this is partly true and that at least some of the muscle twitching is in accordance with the action taking place in the dream. Fortunately, because only a few of the signals to move actually reach your muscles, you will only twitch a little now and then and not get up and move about, dangerously acting out a dream. Thus you would be wrong to assume that sleepwalking or sleep terrors result from pleasant dreams or nightmares, because such complex body movements cannot occur during REM sleep.

Some researchers believe that REM sleep has certain psychological functions. They suggest that REM dreaming allows us to process daytime emotional experiences and transfer recent memories into longer-term storage. But such theories remain unproven. Certainly dreams do have emotional significance, but their ultimate importance to the dreamer remains a mystery. It seems that REM sleep must be important, since we all dream every night (even those of us who think we don't), and if we are deprived of REM sleep for several nights we will compensate by getting more REM sleep the subsequent night. Yet when people have been deprived of REM sleep for long periods of time (on some medications, for example), they do not seem to show any major ill effects.

Sometimes you can be waked easily from REM sleep and at other times it is very difficult, possibly depending on how important the waking stimulus is to you and how involved you are in your dream. So the clock radio may not wake you immediately from a really interesting dream, and you may even incorporate something you hear on the radio into your dream. On the other hand, a very meaningful

stimulus will wake you easily. Unlike the arousal from Stage IV sleep, you will become alert quickly.

Thus we seem to live in three distinct states. In the waking state we are rational and our thoughts can be carried out into actions so that we may maintain the necessary activity for survival. In non-REM sleep the body rests and restoration occurs. Mental processes are minimal in this state, although there may be some thoughtlike activity. And in REM sleep the mind is again active, although clearly not rational, but it is "disconnected" from the body; therefore major body movements do not take place despite the fact that the brain does send out signals to move.

One theory suggests that, over the course of evolution, REM sleep was an intermediate state between non-REM and waking in which the mind would "wake up" before being "connected" to the body. This would allow an animal to go to sleep and obtain the restorative value of non-REM sleep. In this state, with no movement and regular breathing, it would be safe from predators. A sudden waking from non-REM, however, would leave the animal confused and subject to attack. By switching first into REM sleep the animal's brain could become more alert but still disconnected from the muscles to prevent any movement that might alert a predator. Once the animal was sufficiently alert, it would wake fully, the muscle paralysis would disappear, and it could react appropriately to the danger.

This checking for danger may still be relevant in humans. We all tend to wake up briefly after an episode of dreaming. At this time, we will notice if something seems amiss in our environment: the smell of smoke, footsteps downstairs, or quiet sobbing from the next room. If all seems well, we simply return to sleep and usually do not remember this waking in the morning. Many young children, however, fail to return to sleep quickly after these normal arousals because something seems "wrong" to them. Perhaps when they wake, it feels wrong to be alone in their crib and not in a parent's arms. This is a common problem which will be discussed in detail in Chapter 5.

Now that you have a little background information on sleep stages, let's take a look at how infants develop normal sleep patterns.

How Sleep Stages Develop in Children

We have evidence that sleep patterns begin to develop in babies even before birth. REM sleep appears in the fetus at about six or seven months' gestation, and non-REM sleep between seven and eight

months. In the fetus and infant, REM sleep is referred to as "Active Sleep," and non-REM as "Quiet Sleep." By the end of the eighth month of gestation, both these states are well established.

In the newborn, REM sleep is easy to identify because the baby twitches, breathes irregularly, and you can see his or her eyes dart about under the thin eyelids. Sometimes you may also see her smile briefly. In Quiet Sleep she will breathe deeply and lie very still. Occasionally you may see her make fast sucking motions and now and then a sudden body jerk or "startle."

Although the Quiet Sleep stage is well formed, it is still somewhat different from the non-REM sleep of older children and adults. The brain waves during this stage show large slow waves occurring in bursts rather than in a continuous flow. Also, the infant's non-REM sleep has not yet divided into four stages. During the first month of life the non-REM brain waves become continuous and startles disappear. By one month of age sleep spindles begin to appear, and over the next month we can begin to identify a sequence of non-REM sleep stages. We do not see the K-complex waves until a baby is about six months of age.

REM sleep is the earliest stage to form. Premature babies spend 80 percent of their sleep time in this state and full-term infants 50 percent. We do not fully understand the reasons for the preponderance of REM sleep in the early stage of development. We do know that Quiet Sleep requires a certain degree of brain maturation, and so we do not expect to see as much of this stage in newborns. We believe the large amounts of REM sleep early on may be important to the ongoing development of the fetus and newborn. In REM sleep, the higher centers of the brain receive stimulation from deeper, more primitive areas. Impulses come up the same sensory pathways that are used for sights, sounds, and perhaps touch, smell, and taste. Later on, such stimuli are probably incorporated by the brain into dream imagery. While we can know nothing of infants' "dreams," this state might allow the baby's developing brain to receive sensory input (that is to "see," to "hear") even before birth. This input might be important to the development of the higher brain centers.

We also know that the baby in the uterus makes no breathing motions in non-REM sleep. If respiratory movements were never practiced, the child would be born with no experience at all in using these muscles so vital to survival. However, respiratory motions are practiced in REM sleep, and it is conceivable that the baby is also practicing sending out signals that control other motor activity. In the fetus these impulses are not as completely blocked as they are in children

and adults, so there is some actual ability to practice body movements in REM sleep. It is perhaps fortunate for the mother that there is some blockage of motor impulses during REM sleep, or the baby might never be still!

It may be, then, that REM sleep is most important in the early months as the fetus and baby develops, and progressively less so with increasing age. In fact, although at birth a full-term baby will have 50 percent of its sleep in the REM state, only 33 percent of sleep will be REM by age three, and the adult level of 25 percent will be reached by later childhood or adolescence.

Children's Sleep Cycles

It is important for you to have some knowledge of sleep cycles so that you may better understand the specifics of the various disorders children have.

Once non-REM sleep has developed four distinct stages, and most of the baby's sleep time is consolidated into a single nighttime sleep period, the patterns of sleep stage cycling take on a form that remains fairly constant throughout life. There are, however, changes in the length of sleep cycles and the amount of REM and deep non-REM sleep children and adults of various ages seem to require. The sleep cycle length, or the time between two consecutive appearances of the same sleep state, increases from about fifty minutes in a full-term baby to the adult level of ninety minutes by adolescence. The total amount and percentage of REM sleep decreases throughout childhood and levels out in adolescence. The total amount of Stage IV non-REM sleep also decreases throughout childhood and adolescence as total sleep decreases, but it continues to account for about 25 percent of the child's total sleep.

Although a newborn enters REM sleep immediately after falling asleep, by about three months of age she will enter non-REM first, a pattern that will continue for the rest of her life. A young child will plunge rapidly through drowsiness and the lighter stages of non-REM sleep into Stage IV usually within ten minutes (see Figure 3). In the youngster this is an extremely deep sleep, and waking a child from Stage IV sleep may be almost impossible. For example, if your child falls into Stage IV sleep at night in the car, you can probably carry her into the house, change her into her pajamas, and put her in bed with only the slightest sign of movement or arousal. A child who is rocked to sleep at bedtime and who keeps waking if put down before sleep is sufficiently deep will not wake when put into the crib once

this stage has been reached. And if you wake your child from Stage IV sleep to urinate, she may do so in a semi-awake state and then return to sleep instantly without any recollection of the arousal in the morning. The arousal is only partial in this case, and is very similar to those we see in disorders of sleepwalking or sleep terrors.

A child will remain in Stage IV for about an hour, then will have a brief arousal. At that time she will probably move suddenly. The brain waves will also change abruptly, showing a mixture of patterns from deep sleep, light sleep, drowsiness, and even waking. The child will perhaps rub her face, chew, turn over, cry a little, or speak unintelligibly. She may even open her eyes for a moment with a blank stare or sit up briefly before returning to sleep.

There is actually a spectrum of behaviors that may occur during these arousals. The mild ones just described are quite normal. More prominent behaviors may also occur at these times. They are not so normal. These include sleepwalking, sleep terrors, confused thrashing, and perhaps bedwetting. These events all occur during partial waking from deep non-REM sleep with the child showing features of both sleeping and waking at the same time. These disorders will be discussed at length in later chapters, but for now remember that they are *not* stimulated by a dream. As you know, dreams, including nightmares, occur only during the REM state.

The partial waking may last for only a few seconds or up to several minutes. Occasionally the child may briefly wake fully before the progression of sleep stages continues. Although Stage IV will sometimes merge almost imperceptibly with REM sleep with no arousal, this happens infrequently.

Following this arousal the child will have a period of a few minutes resembling drowsiness or perhaps a beginning attempt to form REM sleep. There may actually be a short REM episode at this point, especially in adolescents and adults. The first REM episode, whenever it appears, tends to be relatively short, lasting only five to ten minutes, and is usually not very intense. There will not be many eye movements, and the breathing and heart patterns will remain fairly stable. After this episode of REM or "almost REM" the child will return to another cycle of non-REM sleep. In young children, the descent back into Stage IV sleep will probably be quite rapid, although not as rapid as the initial one.

After forty to fifty minutes she will have another arousal, followed almost certainly by a REM episode lasting five to twenty minutes. This REM state may be interrupted by several brief wakings and a rapid return to sleep. The REM state will end with a brief arousal, and the

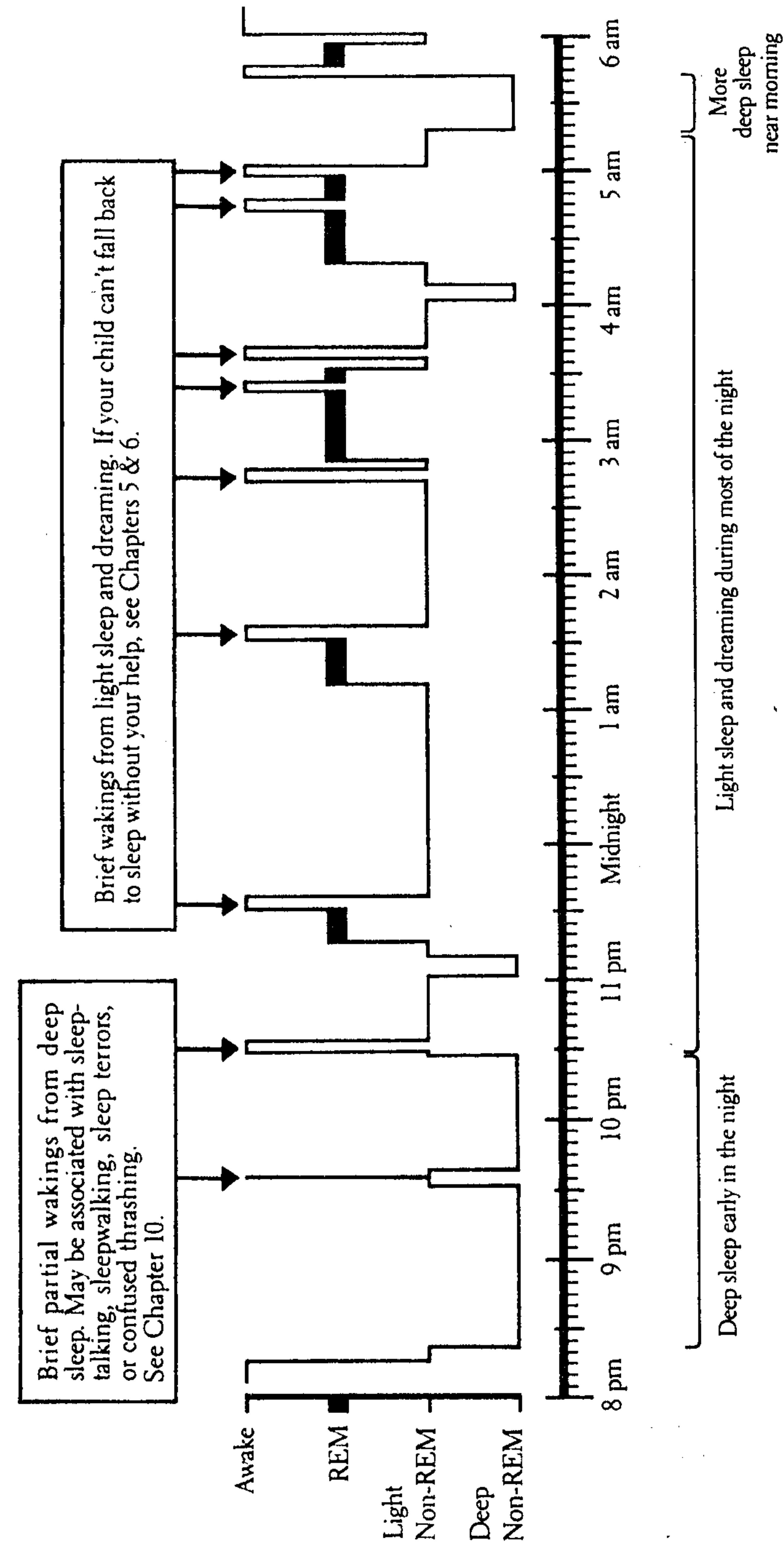


FIGURE 3 Typical Sleep Stage Progression

child will move about, adjust her covers, check to see that everything is normal, then go back to sleep. This waking thus has several functions. The child needs to change position for the health of skin surfaces, muscles, and joints; and she may check to see that things are the same as when she went to sleep. It is important that you are aware that these wakings occur in all children and adults and are quite normal. Often parents perceive them as abnormal, most frequently when the child cannot return to sleep after the arousals because the conditions associated with falling asleep, such as being rocked, are no longer present. This will be discussed more fully in Chapter 5.

After this REM period the child will have another period of non-REM sleep. There will be another slower descent back into Stage III or perhaps Stage IV sleep, then another arousal and a longer and more intense REM episode. The rest of the night is spent alternating between REM and Stage II. Young children will often descend once more into Stage III or IV prior to the final waking in the morning, although this is less common in older children and adults.

This overview will give you an idea of what is actually happening to your child during the different stages of sleep during the night. It will also help you decide what state your child is in, based on when she fell asleep and what her sleep behavior is like at a given time. These observations will be a great help to you as you try to determine what sort of sleep disorder your child has, and how to deal with it.

Sleep and Waking Patterns

A newborn baby sleeps about sixteen or seventeen hours a day, but is unable to sleep for more than a few hours at a time and will have about seven sleeping and waking periods fairly evenly distributed throughout the day and night. The episodes, which will vary from twenty minutes to five or six hours in length, will begin with a period of REM sleep and, depending on the length of the sleep time, show several REM/non-REM cycles. Even when your baby sleeps well for a few hours, you can usually observe brief arousals. By the age of three or four months your baby will sleep about fifteen hours a day and her sleep pattern will have consolidated into about four or five sleep periods with two-thirds of her sleep occurring at night. At this age most infants have "settled," that is they are now sleeping through most of the night—at least from a late-night feeding to one in the early morning.

By six months almost all infants will have settled, and the continuous nighttime sleep has increased. A typical baby of this age will sleep

about twelve hours at night with only occasional brief wakings. In addition she will take two one- to two-hour naps each day: one in mid-morning and a second in the afternoon. The pattern of settling varies with each child of course, and your baby may decrease the nighttime wakings very gradually, or she may settle quickly, as if the 2:00 A.M. feeding had suddenly been forgotten. Some babies settle in a very erratic fashion. In any case, at some point between three and six months, your baby should be sleeping well at night.

Most children by one year of age still sleep about fourteen hours a day altogether. If they still have a morning nap they will almost certainly give it up at some point during the second year. By age two, your child should sleep about eleven to twelve hours at night with a one- to two-hour nap after lunch. She will probably continue her afternoon nap until at least age three, and some children still nap up to age five.

From age three to adolescence, children need gradually less and less sleep. After the toddler period, napping is rare and nighttime sleep slowly decreases from about twelve hours in the preschooler to about ten hours in the pre-adolescent. During the four years of puberty rapid changes occur. Children aged fourteen to seventeen sleep only about seven or eight hours, although we believe this amount of sleep is culturally imposed and probably inadequate.

I must stress that these figures are only approximate and we cannot say precisely how much sleep your child needs. Sleep requirements vary among children. However, if your child is getting several hours more or less sleep than shown for her age in Figure 1 (page 19), you should at least be suspicious that she might have a sleep problem and you would do well to try to identify and correct it.

The Importance of Biological Rhythms

To understand certain childhood sleep problems, it is first necessary for you to know something about the circadian cycles that underlie sleep patterns. Circadian rhythms refer to biological cycles that repeat about every twenty-four hours. All of us have many such rhythms. They include patterns of sleeping and waking, activity and rest, hunger and eating, and fluctuations in body temperature and hormone release. It is important that these cycles be in harmony if we are to have a sense of well-being during the day. Our ability to fall asleep and to stay asleep is closely tied to the timing of these cycles. Typically we fall asleep as our body temperature is falling toward a daily minimum and we wake up as it starts rising toward a peak. The level of the

hormone cortisol, which is secreted by the adrenal gland, also drops off early in the night, then progressively rises to high levels prior to our spontaneous waking in the morning. If we have to wake up when our temperature and cortisol levels are still low, we do so only with great difficulty. Similarly, we may have trouble falling asleep when our body temperature is at a peak.

It is important to know that the inherent length of these cycles in all of us is actually somewhat longer than twenty-four hours—closer to twenty-five hours. We reset the cycles each day by using various cues such as mealtime, bedtime, and especially the time of waking. In fact if we do not use these signals to guide us, our cycles will “free run” at their inherent rate and we will operate on a twenty-five-hour day. Adults placed in a cave or laboratory away from windows and clocks begin to go to sleep about one hour later each day and get up one hour later in the morning. They begin to operate on a twenty-five- instead of a twenty-four-hour day. Many of us follow this same tendency on weekends or vacation. We go to bed later, get up later, then have great difficulty adjusting to the earlier schedule when we must return to work.

Although it is not difficult for us to stay on a twenty-four-hour schedule, problems do arise when our routines are irregular or when we try to sleep, or ask our children to, at times that do not match the underlying sleep-wake rhythms. Shift workers are particularly prone to having sleep problems, and people who travel across time zones suffer the malaise, sleep difficulties, and lack of well-being commonly referred to as jet lag.

It is the same with children whose sleep cycles have been disrupted or shifted. They may sleep poorly at night and be sleepy or behave poorly during the day. It is important that you understand this, because the treatment of problems related to shifts in sleep-wake patterns is different than for other disorders. I will discuss this in more detail in Chapters 8 and 9. For now it will be helpful for you to know that normal circadian rhythms are necessary for normal sleep and optimal daytime function and that many abnormalities having to do with circadian rhythm shifts are quite simple to identify and correct.

Chapter 3

Helping Your Child Develop Good Sleep Patterns

We all have different ways of interacting with our children at sleep times and different means of shaping their sleep habits. These differences may occur within families, among ethnic groups, and between different cultures. The sleeping child may be swaddled, lightly clothed, or naked; he or she may sleep in his or her own room, share a room with one or more brothers and sisters, or the entire family may sleep in a single room—even in the same bed. The child may go to sleep on his stomach, side, or back in a room that is dark, dimly lit, or brightly illuminated. It may be quiet or there may be constant sounds from a humidifier or air conditioner; intermittent sounds from a radio, television, or traffic outside; or occasional noises from airplanes, sirens, and other children. He may fall asleep while nursing at the breast, sucking on a bottle or pacifier, rocking in a chair, or alone in bed. He may say goodnight downstairs and go to bed alone, or fall asleep only after having a story read to him, saying his prayers, playing a quiet game, or discussing the day's events. A child may go to bed at different times every night with no set routine, or he may follow exactly the same routine each night.

The Importance of Your Child's Bedtime Routines

Although I do believe some bedtime rituals are better than others, there are few absolute rules regarding sleep behavior. If your routine is working, if you and your child are happy with it, if he falls asleep easily and night wakings are infrequent, if he is getting enough sleep, and if his daytime behavior is appropriate, then it's likely that whatever is being done is fine.

However, it is important to keep in mind that some routines and approaches are more likely to help your child develop good sleep patterns now and avoid problems as he gets older. For example, if you are in the habit of rocking your child to sleep for twenty to thirty minutes each night and getting up once or twice to rock him back to sleep in the middle of the night, you actually may be interfering with his sleep and postponing the start of his sleeping through the night. Even if you "don't mind" getting up, I suspect you would be happier if you could simply put him down at bedtime without rocking and have him sleep through the night as well. Whether this is true or not, you should still be aware that it is in your child's best interests to have uninterrupted sleep.

Similarly, even if you and your child seem happy about his sharing your bed at night, and even if he seems to sleep well there, in the long run this habit will probably not be good for either of you, and you should consider making some changes in the nighttime routines.

By bedtime rituals or routines, I mean of course all the activities that take place as your child prepares for bed and while he falls asleep. If he is an infant, you probably change his diaper and then hold him until he falls asleep. Perhaps you rock and nurse him until sleep comes. Then you move him to his cradle or crib. Or your infant may still be awake when you put him down, so that he falls asleep on his own. Generally any of these patterns are fine in the first few months when you do not expect your baby to sleep through the night anyway. But by about three months of age most full-term healthy infants are, or could be, sleeping through the majority of the night. If your baby hasn't settled by five or six months, then you should take a close look at his bedtime routines. If your child is always nursed or rocked to sleep he may have difficulty going back to sleep alone after normal nighttime arousals. To help him sleep better at night you may have to change his bedtime routines. Thus, it is very important for some children to be put down awake so that they can learn to settle themselves and fall asleep alone both at bedtime and after nighttime wakings (see Chapter 5).

As your child gets older, the routines at bedtime continue to be important. If bedtime is a pleasant time, your child will look forward to this part of the day instead of becoming fussy when it is time for sleep. Bedtime rituals differ, of course, and you should choose a routine that suits your family, but make sure you always allow enough time to spend with your child each night. Follow the routine as consistently as you can. Your child should know when he has to change into his pajamas, brush his teeth, and go to bed. He should know what

bedtime activities are planned and how much time will be spent on them, or how many stories will be read.

Bedtime means separation, which is difficult for children, especially very young ones. Simply sending a toddler or young child off to bed alone is not fair and may be scary for him. And it means you will miss what can be one of the best times of the day. So set aside ten to thirty minutes to do something special with your child before bed. Avoid teasing, scary stories, or anything that will excite your child at this time. Save the wrestling and tussling for other times of the day. You might both enjoy a discussion, quiet play, or story reading. But let your child know that your special time together will not extend beyond the time you and he have agreed upon, then don't go beyond those limits. It is a good idea to tell your child when the time is almost up or when you have only two or three more pages to read, and don't give in for an extra story. Your child will learn the rules only if you enforce them. If both you and he know just what is going to happen, there won't be the arguments and tension that arise when there is uncertainty.

Paul, for example, is a four-year-old boy. His father leaves for work early in the morning and doesn't see Paul until dinnertime at night. He likes to be the one to put his son to bed. If Paul's father did not handle the bedtime, the two would not have time together until the weekend. So the period from 7:00 to 8:00 each night is special for both of them.

At 7:00 they play together for about twenty-five minutes—with Paul's train or his Lego set—or in the warm weather they may play outside. Paul's father tells him when it is about 7:25 and then the bedtime routine begins. Paul has a bath and his father helps him put on his pajamas. Lately they have been reading a non-scary children's novel, one chapter each night. Both Paul and his father look forward to the night's reading, and the bedtime routine is one that Paul enjoys rather than resists. Paul's father tells him when only a few pages remain in the chapter. When the reading is over for that evening, the light is turned off, the night-light turned on, and the two lie quietly together for one minute. Paul then kisses his father goodnight, holds on to his stuffed monkey, lets his father leave the room, and goes to sleep.

In later years, your child will still appreciate having some time with you before he goes to sleep. He needs close, warm, and personal time. Simply watching television together will not provide this. Even if the shows are not exciting or scary (which is unlikely), and even if you are sitting next to him, the lack of direct personal interaction makes this

bedtime routine a poor one. Instead, use this time to discuss school events, plans for the weekend, Little League, chorus, or music lessons. It might also be helpful to talk over any worries your child may have so he will be less likely to brood over them in bed. As your child gets older the bedtime ritual does not have to be the same each night. Some nights you may enjoy a walk outside, a trip for ice cream, a board game, Ping-Pong, or helping with homework.

A ten- or twelve-year-old will probably want privacy as he readies for bed, but do stop in to say goodnight and chat for a while. A final routine before bed will still be important, although he can now handle everything himself. He may want to read, listen to music, or busy himself with a hobby before he turns out the light.

Phyllis, eleven, has a good bedtime routine. After dinner she finishes her homework, practices piano, and may call one of her friends on the telephone. She and her mother, a single parent, then spend some time together. They like to build things—a bird house or a picture frame—and they are currently working on a giant jigsaw puzzle. While they work, they get a chance to talk. Then at about 9:00 Phyllis changes for bed and begins to read with the radio on. Her mother stops in for a few minutes to discuss plans for the next day, and at 9:30 Phyllis turns off the radio and light and goes to sleep.

Of course not every night in Paul's and Phyllis's homes is quiet and pleasant, but most are, and major disruptions at bedtime are rare. If such is not the case in your home and bedtimes usually are unpleasant and a time of struggle, the solution may be to establish more pleasant and consistent bedtime routines. At first it may not seem easy for you to do this, and initially your child may resist. But if you persist, both you and your child should grow to enjoy the bedtime routines, and the struggles will be over. It is certainly worth the effort.

Should Your Child Sleep in Your Bed?

Many parents give in to their children's desires or demands to share their beds in order to avoid arguments at bedtime and to decrease nighttime disturbances. Some parents feel this is in their children's best interests. Others simply prefer to have their children in bed with them. Although taking your child into bed with you for a night or two may be reasonable if he is ill or very upset about something, for the most part this is not a good idea. We know for a fact that people sleep better alone in bed. Studies have shown that the movements and arousals of one person during the night stimulate others in the same bed to have more frequent wakings and sleep state changes, so they

do not sleep as well. But there are even better reasons for your child to sleep in his own bed. Sleeping alone is an important part of his learning to be able to separate from you without anxiety and to see himself as an independent individual. This process is important to his early psychological development. In addition, sleeping in your bed can make your child feel confused and anxious rather than relaxed and reassured. Even a young toddler may find this repeated experience overly stimulating. If you allow him to crawl in between you and your spouse, in a sense separating the two of you, he may feel too powerful and become worried. He wants the reassurance of knowing you are in control and that you will do what is best for him regardless of his demands. If you show you cannot do this and let him act out his impulses, he may become frightened.

These feelings may be heightened if only one parent is in the bed—if you are a single parent or if one of you is out of town, at work, or in another bedroom. If you take the easy way out and allow your child into your bed while one of you moves into his, your child will certainly not be reassured. Now he is literally replacing one of you in your bed as the other's partner. He may begin to worry that he will cause the two of you to separate, and if you ever do he may feel responsible. Often children of divorced or separated parents feel they caused the family upheaval, and they will feel even more confused and unhappy if they had been, or are now, sleeping in their parents' bed. And if as a single parent you begin a new relationship, your child will certainly resent being displaced in your bed by this "intruder."

Most children do not have serious ongoing problems sleeping alone. If your child is "too afraid" to do so, and you deal with his fear by letting him into your bed, you are not really solving the problem. There must be a reason why he is so fearful. You will help your child most if you work with him to find and solve the underlying cause of the fear and do not simply let him sleep with you to assure a quiet night. This may require considerable patience, understanding, and firmness on your part; and you may need outside help and support (see Chapter 4).

If you find that you actually prefer to have your child in your bed, you should examine your own feelings very carefully. Some parents who would otherwise be alone at night (single parents or people whose spouse works nights or travels frequently) find they enjoy the company, feel less lonely, and possibly are less afraid if their child is with them. If there is tension between parents, then taking a child into their bed may help them avoid confrontation and sexual intimacy. If any of this is true for you, then instead of helping your child you are

using him to avoid facing and solving your own problems. As such a pattern continues, your child, and your whole family, will suffer. You need to understand and deal with your own needs and feelings and to resolve the tension between you and your spouse. If these problems cannot be simply settled, then professional counseling may be required.

Finally, if your child always sleeps with you, you may have great difficulty leaving him with a sitter. Your own social life may be affected and you may find that you begin to harbor angry feelings toward your child for this infringement. And as he gets to the age where you feel he should be sleeping alone, you may find you have real problems moving him into his own bed.

There are situations in which your child may have to sleep in your room nightly for an extended period of time, when living conditions do not permit otherwise. You may have only one bedroom or two bedrooms but several children. Grandparents may be living with you and need a room for themselves. You may be living in someone else's home and have only a single room. These are all difficult situations, but there are solutions. If your child must share your bedroom, try to give him his own place to sleep—perhaps a cot or even a mattress on the floor. Make that corner of the room his. Try to have space for some of his things and even a place on the wall for his decorations. Perhaps that area can be closed off with a curtain. But as soon as you are able, move him to a new room, either alone or with brothers and sisters.

The Special Toy or Favorite Blanket

Better than lying with your toddler or young child until he falls asleep at night is for him to fall asleep with a "transitional object"—a stuffed animal, a doll, a toy, a special blanket. The toy will often help him accept the nighttime separation from you and can be a source of reassurance and comfort when he is alone. It will give him a feeling of having a little control over his world because he may have the toy or blanket with him whenever he wants, which he cannot expect from you. His toy will not get up and leave after he falls asleep and it will still be there whenever he wakes.

A child will often choose such a special object early in the toddler years and may continue to use it (or new ones) until perhaps age six or eight. If your child does not have a special toy it is reasonable to offer him ones which you think might take on this role. However, he will always make the final choice, and you cannot make him attach to

a toy because you think it will be appropriate. But if you always allow yourself to be used in the manner of such an object—to lie with him, to nurse or rock him, to be held, cuddled, or caressed by him, or let him twirl your hair whenever he tries to fall asleep—he will never take on a transitional object, because he won't need to.

If your child begins to favor a particular stuffed toy or doll, include it in the bedtime rituals. Have him tuck it in and let it "listen to" the story, or make sure he has his special blanket. It will make the final goodnight that much easier.

Developing Good Patterns

As you know from Chapter 2, newborn infants do not have regular sleep patterns, and it usually takes six to ten weeks for them to develop a good twenty-four-hour schedule, with the longest period of sleep at night. Your baby's sleep pattern during the first few days after birth should not be considered an indicator of things to come. Whether he sleeps well or quite fitfully in the hospital, and regardless of a nurse's reassurance that your baby is "extremely good" or her warning that she has never seen a baby who "sleeps so little," things may change considerably once you get home. If "problems" develop when you get home, you may assume your inexperience as a parent is to blame. If you do, you almost certainly would be wrong. And if you believe a nurse's warning about problems ahead, it may become a self-fulfilling prophecy.

Most babies show a sleep pattern emerging over the first two weeks, with many naps, some brief, some longer, distributed across the day and night. But some infants do seem to sleep unusually well from the beginning, even having to be waked for some feedings, but this is the exception rather than the rule. Try not to feel frustrated if your child takes a little time to fall into a reasonable and easy schedule.

Occasionally a baby will have his longest sleep period during the day and his longest period of waking at night. He seems to have his "days and nights reversed." This too will change. It is actually impressive that a child so young can show such a consistent (although inverted) pattern, since he has had little opportunity to form regular twenty-four-hour rhythms and even less chance to learn to distinguish day from night. This night-day reversal is less a problem than an indication that the child is inherently a good sleeper, and it will be easy to readjust his schedule if he doesn't do so on his own (see below and Chapters 8 and 9).

Although most infants will develop a good twenty-four-hour sleep

schedule despite us, there is no question that parents can assist their babies considerably in developing good sleep patterns. You can do this by using approaches that properly take into account your baby's schedules, habits, learned associations, and nutritional and emotional needs while avoiding approaches that could interfere with the development of normal rhythms.

Feeding patterns are an important part of an infant's daily schedule. Fortunately, most pediatricians no longer urge parents to put their babies on a precise four-hourly feeding schedule from the beginning. Instead, they now recommend that you try to follow your infant's cues. You will soon learn to recognize when his cries mean that he is hungry. Only if your baby was premature or has medical problems or feeding difficulties will you have to follow a rigid feeding schedule.

A newborn baby usually needs to be fed every two to six hours. But there are two problems to watch for in a feeding-on-demand schedule. First, not all cries are hunger cries, and it will take you a little time to discern which sounds mean your child is hungry. Second, you should follow your baby's cues, but within certain limits. Naturally if a newborn seems to cry for feedings only every twelve hours, something is wrong. He simply has to be fed more often. But what may be less apparent is that a full-term healthy infant does not need hourly feedings, even if he seems hungry at these times and nurses when you offer the breast or bottle. Hourly feeding is exhausting for the mother, painful if you are breast feeding, unnecessary for the baby, and interferes with his developing more normal and healthy sleep-wake and feeding patterns.

Of course you want to show your baby that he has been born into a good and caring world, and for this reason you respond to his cries and try to do whatever is necessary to soothe him. Helping him develop good sleep schedules is also an important part of his care. But to do this you may have to tolerate some crying or find ways to calm him other than nursing. Babies will often stop crying if they are walked, rocked, or stroked for a while, and sometimes go off to sleep without feeding.

If your baby has been feeding every hour, begin to increase the time between feedings by an amount you feel comfortable with—perhaps fifteen minutes per day—until he is being fed every two hours, then every two and a half or three hours. He will adapt to the better schedule, the hourly crying will cease, and he will begin to develop the good sleeping and eating rhythms which should be forming over the first three months.

If your baby is sleeping six hours at a time during the day but is

awake much of the night and if this pattern persists beyond the early weeks, then begin waking him earlier and earlier from the long sleep period so that he will start to treat this as a nap and move the longer sleep segment into the nighttime hours. Thus, although you are following your child's cues up to a point, you can still help structure his sleep-wake schedule.

Over the first three months most infants begin to adjust on their own to the external cues of darkness, quiet, and lack of activity at night, and light, noise, and activity during the day by developing a fairly well formed twenty-four-hour rhythm. By three or four months they will get most of their sleep at night, usually in a continuous episode of five to nine hours. Babies will continue to nap at three or four fairly predictable times during the day, and will have one period of more prolonged waking. At this point you should begin working with your baby to stabilize and further develop his schedule. You will be doing both your baby and yourself a favor, because as your baby settles you will be able to make better use of your own time and enjoy him more when he is awake.

As you begin to observe your baby's periods of waking, activity, feeding, and sleep, you will be able to anticipate his needs and know when to play with him, feed him, or put him down to sleep. Even if your baby is not crying for a feeding, he may be ready to eat at the expected time and will nurse quite eagerly. Similarly, he may be ready for his nap before he starts to yawn and become fussy. Although you can't tie your child's feedings, play, and sleep precisely to the clock, if you are aware of his emerging schedule you can encourage him to eat and sleep at reasonable and consistent times during the day. This will help him to further stabilize his developing twenty-four-hour cycles. In the early weeks you are for the most part following your child's cues, but by three months it becomes more important for you to provide increasingly consistent structure. If you keep to reasonable schedules as much as possible, then it is likely that your child will continue to develop and maintain good rhythms. And the more regular your baby's schedule is, the easier it is for you to keep your own schedule well adjusted.

Once your baby has developed a fairly predictable twenty-four-hour pattern, do your very best to provide him with a consistent routine from day to day so that he can maintain these rhythms. If the times of his feedings, play, bath, and other activities are constantly changing, chances are that his sleep rhythms will become irregular as well. It is very important once your child has achieved a good twenty-four-hour pattern, that you do not simply follow his cues without providing

any structure for him. Remember from Chapter 2 that people will tend to "free run" on a twenty-five-hour circadian rhythm, and if you don't supervise your child's sleep you might soon see a pattern emerge that wouldn't surprise a sleep scientist, but might be surprising to you.

I have seen families with this problem. They were surprised to find that their child was operating on a regular pattern but one cycling at twenty-five or twenty-six hours instead of twenty-four. As a result, they were actually following the child around the clock, allowing him to stay up later and later at night and getting up with him one to two hours later each morning. At times they had to get their own sleep during the day. Of course, the child was just operating on the normal circadian rhythm: a rhythm that must be reset to twenty-four hours each day by our external schedule.

It is just as important to help our children maintain consistent schedules through infancy, childhood, and adolescence. In fact all of us, regardless of age, function best when we keep regular schedules. Studies in adults have shown that irregular sleep-wake patterns lead to significant alterations in our moods and sense of well-being, and undermine our ability to sleep at the desired times. The same is true of young children, although many parents don't seem to appreciate this fact. So *don't* let your two- or three-year-old decide what time he should go to bed. It would usually be only when he was so sleepy he could not stay awake any longer. Before long his schedule would be quite haphazard. He would fall asleep early one night and late the next; he might nap some days and not others; and when he did nap it might be in the morning, in the afternoon, or in the early evening. If his schedule were even more disrupted, his mealtimes would also fluctuate. He might have breakfast anywhere from 7:00 to 10:00 A.M. He would then want lunch and dinner at odd hours and might skip meals altogether. Such children can develop major sleep problems. Behavior problems may follow, though these can be subtle at first.

So do your best to help your baby establish a reasonable daytime schedule in his first three months and maintain it as much as possible throughout childhood. Your child cannot be expected to keep to a schedule on his own; you will have to set a reasonable one for him and then be willing to enforce it. Of course you should show some degree of flexibility. Some children need more sleep than others and some seem better able to tolerate variations in their day-to-day routines. You will have to learn from experience with your child what schedule is best and how rigidly it needs to be kept.

Consistent schedules also play a major role in treating sleep disorders. If your child is having a sleep problem, regardless of his age or

the cause of the disorder, a schedule will help the treatment approach to succeed and at times may be a cure in and of itself. So if you are about to work with your child to correct a sleep disorder, it is important to set up and maintain a very regular schedule and to continue it rigorously for several weeks after your child has begun sleeping well again. At that point you will be able to alter the daytime routine a little. For example, you can eliminate naps occasionally for a special outing or take your child with you in the afternoon even though he may fall asleep in the car at a time different from his naptime.

Once a baby has settled into a good sleep-wake pattern it is still subject to disruption. Teething, an illness, a trip, or an upset in the family may interfere with his sleep pattern. The disruption can continue for months unless you intervene. You may need to restabilize your child's schedule, help him get rid of some bad habits, deal with his anxieties, or be firmer yourself in setting limits. We will discuss all of these approaches in detail throughout this book.

Nighttime Fears

If your child is like most children, he or she will occasionally feel frightened at night. These fears will depend on her age and her stage of emotional and physical development. As your child grows, she will have to face all kinds of new challenges. She must learn to tolerate separation from you when you are out of the room or when she is left with a sitter, at day-care, nursery school, or kindergarten. And, she must learn to accept separation from you each night when she falls asleep. She must learn to control her behavior, her bowels, and her bladder. She will know that her feelings of anger, jealousy, and aggression must not get out of hand, and she will also have to learn the give and take of interacting with her family and friends. She will learn, wonder, and worry about death, God, heaven, and hell. She will find pleasure in genital stimulation but may worry about masturbation. She will know her parents have certain expectations for her and wonder if she can live up to them. She will question her ability to perform as well as her peers.

The Child Who Is Anxious

At any stage of your child's development, specific events may intensify certain anxieties. For example, when she begins nursery school, her concerns about separation may increase for a while. She may be reluctant to leave your side during the daytime, and she may not want you to leave her at bedtime. If you become sick, your child may feel guilty, believing her angry words or thoughts may actually have caused the illness.

During toilet training there are other concerns. Your child may

worry about her ability to control herself. She may be unsure that she wants to be trained and may even be tempted to soil. Yet, at the same time, she wants to please you and may fear incurring your displeasure. For many toddlers these worries may be heightened at night. To go to sleep means to relax control. How can they avoid soiling or wetting when asleep?

A scary movie may be particularly frightening for an older child. Your five- or six-year-old may be very upset by scenes of kidnapping or of a child showing aggression toward a parent. Such a movie can be very real to her. All children have aggressive fantasies and most feel a bit guilty about them, but seeing these thoughts acted out on the screen can become a source of great anxiety. And significant social stresses of any kind, over which the child has little control—illness, parental fighting, separation, divorce, alcoholism, death—may lead to a great deal of worry, guilt, anxiety, and fear at any age. At night, when a child must give up the little control she has over her world, and when she is unable to continually check in on her environment, fantasies stimulated by these strong feelings are most likely to emerge and be quite frightening. Bedtime difficulties and fears are to be expected.

Adolescents too have major worries as they undergo the rapid physical and emotional changes of puberty while they mature from children to adults. They start to worry about the future—college, jobs, money. Teenagers' sexual feelings are very intense. Moral issues become more relevant, and adolescents face constant dilemmas as they try to make many new and important decisions. They must weigh peer pressures, personal desires, and family standards against issues such as academic performance, sexual habits, and drug and alcohol use. They may try new value systems and abandon old ones. They may believe their parents no longer trust or support them, or they may reject their parents' help entirely.

During the day it is much easier to keep worries under control. Most children keep pretty busy and don't have time to brood over their problems. But at night as your child gets into bed, turns out the light, and prepares for sleep, she may begin to worry. If she lies quietly in bed, there is little to do but think, and her fantasies may run free. As your child gets sleepy, her ability to avoid certain thoughts diminishes. She has less control over her feelings, urges, and fears. In this state she begins to feel, and may even act, more childish. In this "regressed" state at night, a four- or five-year-old may need the same reassurance that a two- or three-year-old needs during the day. A five-year-old who has no difficulty leaving you for school in the daytime

may have much trouble leaving you to go to sleep at night. It is not helpful to scold her and tell her she is being a baby. It would be better to try and understand why she is feeling insecure. Even if your child feels fairly confident that she can take care of herself in the daytime, she may feel less sure of herself at night when her thoughts seem to run out of control. At such times she may need you to be more involved in her care.

Thus, the period of transition from evening activity to bedtime is difficult for many children and it is not surprising that they are reluctant to go to sleep. Most families experience bedtime struggles at one time or another. Children will stall with requests for extra water, stories, or television, and requests to have the light on, the room checked for "monsters," or to sleep in your bed. Children often choose bedtime to initiate fights with brothers and sisters. Once in bed, your child may appear restless, rolling all over the bed or getting in and out of bed as she attempts to avoid worrisome thoughts through physical activity.

If your child begins to have difficulty going to sleep because she is worried or fearful at bedtime, it is important that you talk it over with her during the day. Try to be empathetic, reassuring, and supportive. I do not recommend, however, that you make any substantial changes in her bedtime routine. Rub her back for a few minutes perhaps, or sit in the room with her a little longer than usual, but keep her on her normal schedule as much as possible.

The Child Who Is Afraid of "Monsters"

Your child may also have trouble sleeping from time to time because of anxieties that do not seem realistic to you. She may think that there is a monster in the closet, a goblin under the bed, or a robber outside the window. Although she will be genuinely frightened at these times, she will not usually show overwhelming panic. Simply reassure her firmly and matter-of-factly that she is safe and that you will take care of her; then put her to bed with her usual story or quiet talk. Your child will be more reassured in the long run if you show her that you can take care of her than if you give in to these "fears."

Although it may be helpful to show her briefly that the shadows in the closet are in fact shadows and not monsters, it is generally not helpful to get into extended searches of the room or rearranging the furniture during the night. Remember, the "monsters" are not real, but your child's feelings, her urges, worries, and fears, are. She does not understand that it is these feelings that are making her anxious. She must use her imagination to come up with an explanation for

these feelings; she must find something she can believe to be a cause of her fears—hence the monsters. So, your child does not need protection from monsters, she needs a better understanding of her own feelings and urges. She needs to know that nothing bad will happen if she soils, has a temper tantrum, or feels anger toward her brother or sister. At these times, she can be most reassured if she knows that you are in complete control of yourself and of her and that you can and will protect her and keep her safe. If you can convince her that you will do this, then she will be able to relax. Your calm, firm, and loving assurance will do more to dispel the goblins than will searches under the bed.

The Child Who Is Afraid of the Dark

The majority of children do not like to sleep in total darkness or with the door closed, and I see no reason why they should. There is no advantage in trying to train your child to sleep completely in the dark. It will be helpful if the bedroom is dimly lit by a night-light, a hall light, or even streetlights, so that when your child wakes up at night, especially after a dream, she can reorient herself within the room, re-establish a sense of reality, and put the dream in its proper perspective. And with the door open, she may feel less isolated and alone. So if your child has some anxieties at bedtime or after nighttime wakings, she may get some reassurance from being able to see about her room. With the door open, she will not feel shut off from everyone else in the house.

For some children, the fear of "shadows" is the same as that of monsters. Again, you may try to alter the lighting pattern in the room, but once you find a reasonable one, stick to it. Turning lights on and off or moving them around the room each night will do little to allay your child's fears. If she falls asleep with a particular light on at bedtime but becomes frightened on waking during the night and finding that light off, you should leave it on all night.

Bad Dreams

All children have nightmares now and then, but they are not a common cause of frequent nighttime disturbances. What many families consider to be frequent nightmares are really sleep terrors or other similar partial wakings (see Chapters 10 and 11). When your child does wake frightened from a scary dream, she should not have to stay alone, but you certainly want to avoid having to sit with her on a

nightly basis. It may be helpful to discuss the dream matter-of-factly, either at the time or in the morning. This will help her to orient herself and to realize that she is not in any real danger. There are a number of good books for children about dreams and nightmares (see Appendix A). You may want to read one or two of them with her. If your child has frequent nightmares, however, they should be handled differently. (This and other aspects of dreams and nightmares are discussed in Chapter 11.)

How to Cope with Nighttime Fears

When your child complains of fears, try to determine how frightened she really is. Most children say they are more terrified than they actually are. Sometimes they are not afraid at all but say so because they have learned this will always get you to come in. If your child says she is afraid but shows no sign of real panic (and I do find most parents can make this distinction), you must be firm. Stick with the bedtime routine, say goodnight, and leave. Do not return repeatedly. If you need more guidelines for being firm, setting limits, or getting your child to cooperate, see Chapter 5.

There are occasions, however, when children do become extremely frightened at night, truly panicky, and irrational. Their emotional conflicts have gotten out of hand. In such cases being firm will not work and may make matters worse.

Recently I saw Tammy, a seven-year-old girl who was generally very cooperative and well behaved, and she was doing well in school. She apparently had many friends and, to all outward appearances, was busy and happy during the day. She seemed to get along well with her parents and an older brother, and the family did not seem to have any major problems. It was not apparent that she had strong fears until bedtime. Then she seemed to change completely.

She pleaded in an almost irrational manner to stay up. She would beg to be allowed to sleep in her parents' room and would do anything, including accepting punishment, to be allowed to do so. She was willing to sleep on their floor in a sleeping bag, and if they tried to carry her to her own room she would hang on to their legs, sobbing.

The struggle became so intense that her parents finally gave in and let her sleep on their floor most nights. Although this helped, Tammy still refused to go up to the bedroom ahead of her parents. In the end, she became reluctant even to be on the second floor alone during the day.

Tammy did have tremendous anxiety, which became overwhelming

at bedtime. In the quiet darkness of the night while just lying in bed, scary fantasies which she seemed unable to control began to fill her mind. At this point, firmness would not have helped and would only have intensified the problem. If her parents had tried to put her in her room and close the door, Tammy would not have settled down or felt reassured, she would have become hysterical. Tammy needed sympathy and attention while her parents tried to help relieve her of the intense anxiety.

In situations like Tammy's, the nighttime fear is not a problem in and of itself. It is only a symptom of an emotional upset which needs to be treated first. Tammy and her parents began seeing a child psychologist. I suggested that during the first weeks of therapy Tammy should be allowed to continue to sleep on the floor in her parents' room and that one of the parents be upstairs at her bedtime to make it easier for her to go to sleep.

After several months in therapy, Tammy and her parents understood the cause of her fears. Some changes were made and gradually the fears resolved. Everyone was happier. And before long the nighttime problem took care of itself. Tammy redecorated her room a little, she began spending more time there during the day, and then she decided by herself to sleep in her own bed at night.

Psychotherapy, however, is not always necessary. If your child's fear is recent, even if it seems pronounced, it will likely disappear within a few weeks—with your support. You may have to find out what is causing your child to feel anxious during the day and help her overcome it. If she seems afraid to be in her room alone at night, it may be helpful to spend time there with her during the day, reading, talking, or playing a game. Gradually you can encourage her to spend more time there without you, first in the day, then in the evening, to help her feel comfortable again being there alone. At first you should be more lenient with her when she goes to bed. Sit with her if it is necessary. But as the intensity of her fear decreases, you will have to be firmer to re-establish normal routines and to prevent temporary adjustments from becoming permanent.

However, if your child is still extremely fearful and shows no sign of improvement in a month or so, if her nighttime fears are accompanied by a sense of real panic, and if your being firm leads to hysteria, not just angry crying, then, like Tammy's family, you may need outside help. This can be a difficult decision but you do not have to make it alone. Discuss the problem with your pediatrician or consult with a therapist for an initial evaluation to help you decide on a course of action. Many factors, usually relating to your child's age, stage of

development, and the particular circumstances of her life, can contribute to such intense fears. If you begin seeing a counselor or therapist trained to work with children, he or she will work with you and your child to help you identify and then deal satisfactorily with these factors. Once this is done, the nighttime fears should disappear, as they did with Tammy.

Part Two

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THE SLEEPLESS CHILD

What Your Child Associates with Falling Asleep—the Key Problem

Your infant or toddler may be one of the many children who suffer from a severe sleep disturbance: he or she can't seem to settle him or herself alone at night. Instead, he needs your help—you may have to hold and rock him, rub his back, or talk to him—until he falls asleep. Even then the problems are not over. During the night he wakes several times crying or calling out, and each time you must go in and help him go back to sleep again. In all likelihood you are tired and frustrated and probably angry at your child because your own sleep is so disrupted. At the same time you may feel guilty about your anger because you realize your child is not waking on purpose to spite you, and you feel that if he needs you it is your job to be there. You want to do what is best for your child, and if this means less sleep for you, then you believe you must learn to accept it. Furthermore, you may have been told that this behavior is part of a “normal” phase for some children and that there is nothing to do but wait until he outgrows it. Still, you wonder: “Is it really normal? Do I really have to wait, and if so, for how long?”

If you have such questions, you will be interested to learn that this behavior is not normal and that you do not have to wait for it to change. Although ongoing sleep problems are very common in young children, they are not an inherent and necessary part of growing up (unlike *occasional* problems, which may be). You can almost always identify correctable causes of these sleep disturbances and treat them successfully. If your child is at least five or six months old, you can begin to take the steps necessary to solve his sleep problems. If you wait and do nothing, his sleep will eventually improve on its own, but it could take many months or even years. However, if you find out

why your child is sleeping poorly and make the necessary changes, he should be sleeping well in a few days to two weeks.

Betsy was a ten-month-old baby who was causing her parents much distress. Although she began to sleep through the night when she was three months old, at four months she started to wake repeatedly. When I saw her she was still difficult to put down, and she continued to wake up several times each night. In the evening Betsy's mother or father had to rock her and rub her back until she fell asleep, which usually took twenty minutes. They said that Betsy seemed to be trying to stay awake instead of letting herself fall asleep. She would begin to doze off then would suddenly open her eyes and look around before starting to nod off again. Her parents could not move her into the crib until she had been solidly asleep for fifteen minutes, or she would wake and start crying again. It was difficult to decide when her sleep was deep enough for her to be moved successfully. If her mother or father moved too soon from the rocker, she might wake and they would have to start all over.

Occasionally when Betsy started to wake as she was placed in the crib it was possible to rub her back and get her to sleep again. But here too, if her parents stopped rubbing her back and began to leave the room too soon, she would wake and cry again. Once Betsy was so deeply asleep that she could be left or placed in her crib without waking, she would remain asleep for several hours.

Between midnight and about 4:00 A.M., however, Betsy would wake several times. Each time she would cry vigorously and would not settle on her own. At these times she did not seem to be in pain, and in fact when her mother or father went in, picked her up and began to rock her, she would quiet promptly and return to sleep quickly. Again, she had to be deeply asleep before being put down in the crib, but this was usually easier during the night than at bedtime and rarely took longer than five minutes. From 4:00 to 7:00 A.M. Betsy slept well, but she usually woke crying in the morning.

Betsy had two naps, one in the morning and one in the afternoon, and she had to be rocked to sleep for both of these just as at bedtime.

Betsy's parents had let her cry several times for fifteen or twenty minutes before rocking her to sleep. This did not help. On one occasion, at the doctor's suggestion, they planned to let her cry until she fell asleep on her own. Betsy just cried harder and harder, and after an hour and a half her parents decided they were being cruel and couldn't stand to listen to any more crying, so they went in to comfort and rock her. Finally they asked the doctor for medication for Betsy. He prescribed an antihistamine, which Betsy took for one week. Dur-

ing that time she fell asleep a bit more quickly at bedtime, but nighttime wakings and trouble at naptimes remained the same.

Although a problem like Betsy's is an extremely common one, it can be quite frustrating for you as parents. Yet once you understand the nature of the problem, it is usually fairly easy to correct.

What most parents don't realize is that what they view as abnormal wakings in the night are actually quite normal. And what they do to try to treat the "abnormal" wakings—namely going in to help their child go back to sleep—is actually *causing* the disturbance.

All children learn to associate certain conditions with falling asleep. For most children this means being in a particular bedroom, lying in a certain crib or bed, and holding a favorite stuffed animal or a special blanket. Such conditions are still present when these children wake normally at night between sleep cycles, and because they are, the children return to sleep rapidly. The conditions that Betsy and children like her have come to associate with falling asleep, however, are ones that are not present all night. The conditions are changed after these children fall asleep. This means these children cannot simply fall back asleep quickly after waking normally at night. For Betsy these conditions were being held, rocked, and having her back rubbed. When Betsy had normal nighttime arousals, however, she was lying in her crib alone, so she could not simply go back to sleep. She did not know how to do this by herself; she needed someone to come in.

Children like Betsy cannot fall asleep or return to sleep unless the "right" conditions are present. During the night these children have the usual nighttime wakings, but instead of these arousals being brief, they are prolonged because the children have not learned how to return to sleep on their own. The conditions they have learned to associate with falling asleep—rocking, back rubs, pacifier—are no longer present. Things are different from when the child fell asleep; something is "wrong." Instead of going back to sleep, the child wakes more fully and begins to cry. Thus the problem is *not one of abnormal wakings* but one of *difficulty in falling back asleep*. And the difficulty arises because of the child's particular associations with falling asleep. It will be easier to understand these problems in children if we are more aware of the types of sleep associations we all have.

Sleep Associations in Adults

As adults, we probably take our own associations with falling asleep for granted, but they are very important to us. We all learn to fall asleep under a certain set of conditions. For example, we usually go

to sleep on a certain side of the bed, with a hard or soft pillow, with a heavy or light blanket, or after watching the news, listening to the radio, or reading. If the routine varies we may have some difficulty falling asleep. Some of us are more able than others to tolerate such changes, but all of us will feel the change to some extent.

As you will remember from Chapter 2, we spend most of the first few hours of the night in deep non-dreaming (Stage IV non-REM) sleep and the rest of the night we alternate between lighter non-REM (Stage II) sleep and dreaming (REM). Children usually return to deep sleep near morning. We all have brief wakings, especially during the transitions between non-REM and REM sleep. During these arousals we change body position, which is important to our physical well-being, and briefly check our environment to make sure everything is as it should be. Typically we turn over, straighten the blanket, and reposition the pillow. If all is well we return to sleep rapidly, usually without memory of the waking. At these times, however, if there are strange noises or worrisome smells, we do not simply return to sleep, but wake more fully to investigate. It is not just potential danger that would keep us from returning to sleep. If anything doesn't seem "right," or if something is not the same as when we went to sleep, we may alert fully.

Think for a moment what it would be like if you had a normal waking during the night, turned over, and found your pillow gone. It would feel "wrong," and rather than simply returning to sleep you would wake more completely and begin to look for your pillow. If it had simply fallen on the floor, you would pick it up and probably return to sleep quickly. But what if your pillow was really gone? What if someone took it as a prank? It's unlikely that you would simply go back to sleep. Instead, you would turn on the light, get out of bed, and begin looking for it. You might get angry, curse, and show the same type of frustration that a child shows when he cries.

Even if your pillow fell out of bed every night, you would be able to reach over and pick it up and return to sleep fairly quickly. But if you were handicapped and if someone else had to come into the room to give you the pillow each time, then your sleep would show a pattern of what might be seen as "abnormal" wakings. Yet your friend would learn that by giving you back your pillow he or she could help you get to sleep again quickly. I think you will begin to see the parallel here.

Let's take this a step further. What if someone were stealing your pillow every night? If that happened, even falling asleep at bedtime would be difficult because you would know that as soon as you were asleep you would run the risk of having the pillow taken. Each time

you started to fall asleep, you might catch yourself and become alert in an effort to prevent this loss.

Wrong Sleep Associations

For Betsy, the act of falling asleep meant being held and rocked in a rocking chair. This felt "right," and anything else felt "wrong." She could fall asleep fairly easily in this setting and probably if she remained there all night her sleep would seem more continuous. The person holding her might note that she would occasionally stir during the night, move around, and fall back to sleep, but she would not cry. Betsy had learned that as soon as she fell asleep she would be put down, and she had to be on guard for this. This seemed to interfere with her initial descent into sleep. Either she self-alerted, checking to make sure that she was still being rocked, or she was slightly aroused by a change in the rhythm of rocking or by the movement of being transferred to her crib. Once she was so deeply asleep that she would not sense the move to the crib, she slept well until her first spontaneous waking. Then, instead of simply moving about and returning to sleep on her own, things again felt "wrong." So, like an adult who finds himself or herself without a pillow and is unable to return to sleep, Betsy became frustrated. And she showed her frustration by beginning to cry. One of her parents would come in and re-establish the conditions Betsy associated with falling asleep so that she could fall back asleep once again. The fact that she could fall asleep rapidly in her parents' arms was proof that she had no actual sleep impairment. There could be no inherent abnormality in her ability to sleep which would allow her to fall asleep quickly in her parents' arms but not alone in her crib. The inability to settle alone in her crib was due to her experience, her *sleep associations*.

This disorder occurs most often in infants and toddlers, because older children have more control of the conditions in which they sleep and are less likely to need your participation. It remains common up to about age four.

Recently I worked with Bill, a three-and-a-half-year-old who had always had problems settling at bedtime and then again after several wakings during the night. Six months ago he moved from a crib into a bed and the pattern changed somewhat. Instead of rocking him to sleep, his parents began to lie down on the bed with him. When they did this he would usually fall asleep fairly quickly, although occasionally he would wake up if they tried to leave his bed too soon. He would sleep for about four or five hours then wake up calling his parents. He

might complain about being "scared" or "seeing monsters," but he never seemed truly frightened. If his mother or father did not come in he would become more demanding and would sometimes go to their room and refuse to return to his bed. The parents were concerned about Bill's "anxiety" at night, so one of them always took him back to his bed and lay down with him. They knew he would then fall back to sleep within five or ten minutes. The parent would then return to bed, although occasionally he or she might fall asleep in Bill's bed. Typically Bill would wake one or two more times during the night. If his parent had remained in his bed, he seemed to sleep through the night.

Once again, Bill's problem was not one of abnormal wakings, but one of his particular associations with falling asleep. Bill could not fall asleep unless one of his parents was with him. However, not all problems with sleep associations have to do with the need to have a parent close by while falling asleep.

Sammy, age two, is another child who always had trouble going to sleep and staying asleep. His parents found it easier to let Sammy fall asleep on the couch next to one of them while they watched television. With this routine, the bedtime struggles seemed to disappear. Sammy could then be moved into his bed at their convenience, and he usually did not wake at that time. However, he would wake up several hours later, call out, seem to be wide awake, and not want to go back to sleep. In fact, if anything, he seemed to want to play. It could be difficult to get him back to sleep, even if the parents lay down with him or took him into their bed. He would not seem to be afraid, and sometimes his parents would just turn on his light and let him play, which he might do for an hour or so before falling asleep on the floor. Most often, however, he would not go back to sleep on his own. His parents found it easier to simply accompany him back to the living room, turn on the television and lie down on the couch while Sammy continued to play. Eventually he would lie down on the other end of the couch, fall asleep, and usually sleep through until morning.

Sammy certainly had developed the wrong associations with falling asleep, although in his case the associations were more focused on the living room, the couch, and the television than the need to be close to one of his parents. Furthermore, even though he could fall asleep only with the lights and TV on, he never fell asleep rapidly, because the light and TV also tended to keep him awake.

Most of us know that falling asleep listening to a TV or radio is not a good idea. If there is anything of interest it will catch our attention, and even if there is not, the constant changes in speech and music do

interfere with falling asleep and remaining asleep. And once we do fall asleep, we may wake abruptly when the TV or radio is turned off. It is much better to learn to associate falling asleep with a dark, quiet environment.

Some children may also have associations that interfere with falling asleep even if they always fall asleep in their own beds alone in a dark, quiet room. Martin, for example, was an eight-month-old baby who always fell asleep with a pacifier in his mouth. He usually fell asleep quickly at bedtime, although not always. He would get drowsy, stop sucking, then wake, as Betsy had if the rocking stopped too soon, and have to start sucking again. Unlike Betsy, who could let someone else handle the rhythmical motions associated with her falling asleep, Martin had to do the movements himself. He had to suck to fall asleep, and when he stopped as sleep approached, he would wake. Occasionally the pacifier would fall out too soon and he would cry until it was replaced. At night he would wake three or four times crying, until one of his parents went in and put the pacifier back in his mouth so that he could quiet and return to sleep.

Heather was very similar to Martin. At eighteen months of age she still fell asleep at bedtime sucking on a bottle. She too woke several times each night but always fell back to sleep when she was handed another bottle. Nobody had to be there to hold her. Since she took only one or two ounces each time and since she was not held during the feeding, her association with the bottle was the cause of her problem rather than drinking too much liquid at night (see Chapter 6) or associations with being held.

Even though Martin and Heather both fell asleep alone and in their own beds, on waking at night they could not, by themselves, re-establish the conditions they associated with falling asleep. Someone else had to get up, come in, and replace the pacifier or bottle.

If your pillow falls out of bed you can get it yourself and return to sleep normally. Similarly, a child who falls asleep sucking his thumb can put his thumb back in his mouth after waking at night. But if your child needs your help to re-establish sleep conditions, then you will have to get up during the night—often more than once.

Thus for your child to sleep well at night he must learn to fall asleep alone in his crib or bed *and* he must fall asleep under conditions that he can re-establish for himself after waking at night. These conditions should not be stimulating, like Sammy's TV, and they should not require ongoing activity, like sucking a bottle or pacifier. What is best for almost all children then, after the first few months of life, is to learn to fall asleep in a crib or bed alone in a room that is fairly dark

and quiet. They should not be held, rocked, or nursed and will be better off if they are not soothed with a bottle or pacifier, or the radio or television.

How to Solve the Problem

If you have a child like Betsy who is still in a crib, treatment of improper sleep associations is fairly simple and the change will be quite rapid. A young baby's sleep will show marked improvement, usually within a few days but at least within a week or two. You will have to help your child learn a new set of sleep associations. As you do so, you will need to be understanding, patient, and consistent until he adapts to the new patterns. There is no way to treat this problem without having to listen to *some* crying, but you can keep it to a minimum.

Think again about having to sleep without your pillow. If it became necessary, say for orthopedic reasons, that you sleep without a pillow, you would most likely find it quite difficult in the beginning. You would probably be uncomfortable at bedtime and thrash around searching for a comfortable position. You would no doubt curse your bad back and your doctor vehemently, even though you understood fully the importance of sleeping without the pillow. Also, even after you finally fell asleep, *you would find it hard to return to sleep after nighttime arousals*. Still, the only way that you could learn to fall asleep without your pillow would be to actually practice doing so. Each time you fell asleep without a pillow it would be easier, until it began to feel "right." At this point nighttime "wakings" would also cease to be a problem. And so it is with the children I treat.

The program I used with Betsy's family usually works quite well. I explained to them that Betsy was completely normal and that the nature of her sleep problem was her inability to fall asleep except while being held, rocked, and having her back rubbed. She had fallen asleep this way all her life and had never learned to fall asleep alone. I told them that Betsy would have to learn to fall asleep at bedtime under the same conditions that would be present when she woke spontaneously during the night, namely *alone and in her own crib*.

I used a progressive approach which is very effective and which I'll explain in detail here. The chart on page 78 (Figure 5) will help you to understand this method.

Once Betsy's parents understood the nature of her problem, we were ready to begin treatment. I asked them how long they felt they could listen to Betsy cry before feeling they had to do something.

Although they thought they could probably tolerate up to fifteen minutes of crying, we decided to start at five. I find that five minutes is usually a good place to begin, but if that seems too long you can even start at one minute!

Each night, at bedtime and after nighttime wakings, Betsy's parents were to be sure she fell asleep alone, without their being in her room. They were to allow her to cry for gradually longer periods of time before returning to her *briefly*, but they were always to leave while she was still awake. This was to continue until she finally fell asleep. The times of waiting before responding to her would then increase progressively on successive nights.

In Betsy's case, her parents got her ready for bed, had a little quiet play and talked to her, then put her in her crib *awake*. They were not to rock her or rub her back. They then left the room for *five* minutes and returned if she was still crying vigorously. They would stay in the room for two or three minutes, but were not to pick Betsy up or begin rocking her. Their return was to reassure Betsy that she was not being abandoned and that her parents were still there to care for her. It also helped to reassure the parents that even though Betsy was crying she was still all right and that they were not doing anything terrible to her. They were *not* going back in the room to help her fall asleep; in fact, Betsy had to fall asleep when her parents were out of the room. The parents agreed to speak to Betsy briefly and perhaps pat her back once or twice to help her quiet down, but within a few minutes they were to leave again, whether or not she was still crying and even if her crying intensified when they left.

If Betsy continued to cry vigorously for *ten* minutes, her parents were to return for the same brief intervention. And if she was still crying in *fifteen* more minutes they would return again. Fifteen minutes would be the maximum for the first night, and they would continue waiting for fifteen-minute intervals with brief return visits until Betsy finally fell asleep during one of the fifteen-minute periods that they were out of her room. If the crying had stopped, or if it was only mild whimpering, they were not to go back in. If Betsy woke up later in the night and began crying hard, they would begin the same type of program that they had used at bedtime, namely waiting for five minutes and working up to fifteen minutes. Since her usual waking time was 7:00 A.M., the parents were to continue this routine at all wakings until at least 6:30 A.M. If she woke after that, or if she was still awake then after waking earlier, they were to get her up for the morning.

They were to use the same routine at naptimes. However, if an

hour had passed and Betsy was either still crying or awake after a short sleep, they would end the nap for that period. If she was still tired and later fell asleep on the floor or in the playpen, that would be all right. At least she was falling asleep alone. As long as the time in her crib was enforced each day, she would eventually start to nap there—once she began to associate lying alone in her crib with falling asleep.

On the second day of the program, Betsy's parents were to wait ten minutes before going into her room for the first time, moving up to a maximum of twenty minutes. This five-minute increase of all times would continue on each successive night.

The response Betsy's family had was quite typical. They braced themselves for the worst and found that things went much better than they had expected.

Their first night was difficult, although Betsy did fall asleep during the third fifteen-minute episode of crying. She had three wakings during the night, but she seemed to go to sleep more rapidly after each of them. On the second night, Betsy fell asleep after the first intervention in her second period of crying and fell back asleep on her own after waking during the night. On the third night, Betsy fell asleep on her own before any interventions were necessary and went back to sleep after spontaneous wakings during the night. By the second week hardly any nighttime wakings were still apparent. Her naps improved even more quickly. There were difficulties the first two days—the first naptime she didn't sleep at all—but by day three she was doing fine (see Figure 4).

Her parents reported several facts that are quite typical. As things were getting better they found that even though the nighttime wakings persisted at first, they heard shorter and shorter episodes of whimpering, after which Betsy would return to sleep on her own. Eventually she did not cry at all during these wakings. Of course her natural arousals continued, but her return to sleep was so rapid and uneventful that we would only be aware of them if she was actually observed closely or monitored all night. Many parents report the whimpering and then spontaneous return to sleep during the period in which the child is learning the new associations.

Because the parents were allowed to go in during Betsy's crying, as opposed to having to leave her all night, they could see that she was not really suffering, and that made it much easier for them to follow through on the program. By the end of the first week Betsy was sleeping quite well. Throughout the second week her sleep patterns were essentially normal. It has been many months since Betsy's parents first decided to help her sleep better, and her sleep has remained excellent.

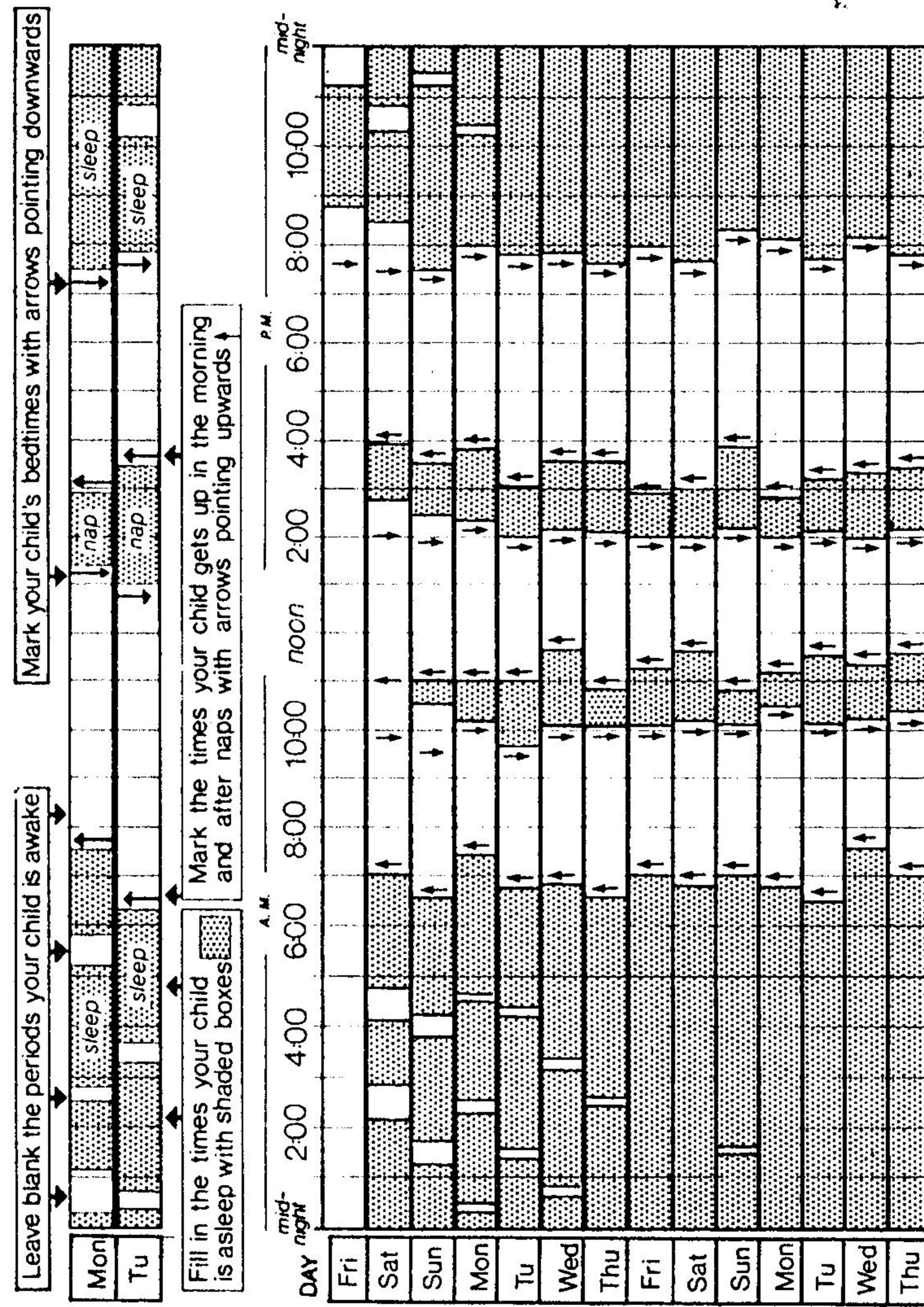


FIGURE 4 Betsy's Sleep Chart

This gradual approach is better for the child and easier for you to do than a "cold turkey" routine. Although putting your child in the crib at bedtime, shutting the door, letting him cry, and not returning until morning probably will work eventually if you never give in, there are good reasons to avoid this. Such an approach would be painful for you, it is difficult for your child, and you will be very tempted to quit in the middle. If, like Betsy, your child has always fallen asleep in your arms and if you have always gone to him quickly when he wakes, then to suddenly put him down awake one night and not respond to his cries until morning would be going from one extreme to the other. Such an abrupt change may be quite confusing to your child. He has learned to expect your prompt appearance when he cries. What is he to think if you don't come in? Where are you? What has happened? Are you ever coming back?

I believe it is better to use a more gradual approach. Your child has to learn some new rules, but he won't understand them at first. He should know that you are still nearby and taking care of him. And he can only learn this through experience. If you let him cry alone each night and do not return at all until morning, he will still learn that you always do come back eventually and that you are not really abandoning him, but the learning may be unnecessarily difficult. If you wait only a short period of time before going in, and then increase the waiting time progressively, the learning is much easier. Your child will begin to see after only a few minutes what you have planned. He finds out quickly that you are still around and responsive to him. There is much less uncertainty. And as you gradually increase the waiting times, he learns to expect this also. Eventually he will learn it is no longer worth it to cry for fifteen or twenty minutes just to have you come in briefly. He knows you will come, but there is little else to gain—no rocking, holding, or nursing. At the same time, he is learning how to fall asleep alone and in bed. This is the main goal. Because you are helping your child learn by progressive teaching, the amount of crying is kept to a minimum. A "cold turkey" approach, however, is more likely to keep the crying near maximum.

Although I don't recommend it, I did say that simply "letting him cry" could work. But parents often say to me, "If you're going to suggest I let my baby cry, forget it; we already tried it and it didn't work." What they tried was "cold turkey." If you have tried this approach unsuccessfully, you might be interested to learn why it failed. Perhaps you simply found, quite understandably, that you could not or would not listen to two or three hours of crying night after night. Although a child under one year of age may surprise you and fall

asleep on even the first night after only a short period of crying, an older child will likely continue to cry constantly or intermittently for at least one or more hours. And the longer he cries, the more likely it is you will change your plans and decide to go in. Also, you may not have understood fully how this approach was supposed to work. Since you may have been told that you were "spoiling" your child and that you should simply let him cry, the message was that the *crying* would lead to better sleep. But the crying does not help at all. Better sleep comes only when the child learns how to fall asleep, and return to sleep, alone. And this happens only when he gets practice doing just this. So when a family tells me, "We tried letting him cry for several nights," it usually turns out that this is all they did—they *let him cry* but did not *let him fall asleep*. For example, they might have let their child cry on waking at night, but after twenty or thirty minutes they would go in and rock him. And at bedtime they may have continued to rock him to sleep without letting him cry at all. Or they may have let him cry for up to three hours at bedtime several nights in a row, but always went in eventually to help him go to sleep. In effect then, all that crying was for nothing, because it is not the crying that helps but the practice of falling asleep under new conditions.

If the final transitions to sleep still occur under the old conditions, things will not improve no matter how much crying there is. You cannot learn how to fall asleep without a pillow if every night you go to sleep with a pillow but have someone take it away after you are sleeping soundly. To learn to fall asleep without a pillow it is best to be without one each and every time you fall asleep. Similarly, for a child to learn to fall asleep without being held or rocked, without the TV on, and without a pacifier, none of these "sleep aids" should be present at any of the times he goes to sleep—at bedtime, at naptime, or after nighttime wakings.

I believe you will understand, then, why crying does not help in developing appropriate sleep associations and why we try to keep crying to a minimum. Initially, as your child tries to learn to fall asleep a new way, he will be unhappy, but he should not have to feel abandoned or deserted. If you come in regularly to comfort him, he will feel less deserted, and the very long periods of crying we see with a cold turkey approach do not usually occur.

For Martin and Heather we used the same routine as with Betsy, except they were put down without a bottle or pacifier. I told the parents that it was better if they did not initially stay with their child while he or she learned to fall asleep without the bottle or pacifier, since this would only lead to new associations which would have to be

broken as a second step. Most families, like Martin's and Heather's, choose to correct the associations in a single step. Martin and Heather were typical of children who already know how to fall asleep in bed alone but need a bottle or pacifier. Once they had a few opportunities to practice falling asleep without them, these children quickly learned to sleep very well.

It is not necessary to wean your child in order to break the association of nursing with falling asleep. It is only necessary to dissociate the two. Thus, instead of nursing at bedtime you may nurse earlier in the evening, and daytime nursing need not be at naptime. If your child starts to fall asleep at the breast or with a bottle, stop and place him in the crib or bed—let him continue to fall asleep in that setting.

If your child is taking a lot of fluid at night, whether from bottle or breast, his sleep may be disturbed in several ways other than just by the effects of the sleep associations. At the same time, however, suddenly stopping the nursing at night would be hard on your child and difficult for you. For this reason it is a better idea to reduce gradually the number and frequency of feedings. The problems of excessive feedings and their solutions are discussed in the next chapter.

If your child uses the pacifier only when he is going to sleep, then once he learns how to fall asleep without it, he will no longer use it at all. But if he has it in his mouth most of the day, then it is going to be more difficult to simply eliminate it at night. In this case I suggest you work first to decrease the amount of time your child has his pacifier during the day. You can be with him then to give him extra attention and provide diversions so that he will get used to having it less often. Still, you may have to listen to some crying during the day as he learns to feel comfortable without the pacifier, just as you do when he learns new associations at night.

Decide on certain periods in the morning and afternoon when your child should not use the pacifier, then increase the time periods gradually each day. Once he is using the pacifier mainly at sleep or rest times, you can eliminate it and begin the progressive program we used for Betsy. By now he will be quite used to being without the pacifier and will only have to learn how to fall asleep without it.

The treatments for Bill and Sammy were based on the same progressive approach used for Betsy, although the procedures were a little different because they were older and able to get out of bed on their own. For older children, intervention sometimes has to proceed a bit more slowly, but should be just as successful. Still, the child must learn to fall asleep with the same set of conditions that will be present at the time of normal nighttime wakings, namely alone and in bed.

If your child is used to having you with him when he falls asleep and no longer sleeps in a crib, you can break the association in one of several ways.

Explain to your child, if he is old enough, that you can no longer lie down with him while he falls asleep. Make sure you have an appropriate and pleasant bedtime ritual, however (see Chapter 3). When you finish the story, quiet talk, or game, tuck your child in, then leave the room, but leave the door open. Some children will only keep calling out or crying; others will get out of bed. If your child simply calls out he can be handled in exactly the same way we treated Betsy. Simply increase progressively the amount of time between your brief responses to him. Go back into the room but do *not* lie on his bed, and always make sure he falls asleep when you are *out* of the room.

If your child gets out of bed, then you will need to employ a different approach. When you are certain your child has gotten out of bed, go back into the room and put him back in bed and tell him that he must stay in bed or you will have to close the door. If he gets out of bed again, put him back in again and close the door for a very brief period, about one minute. Don't lock the door, but hold it closed if he tries to pull it open. Locking a child in his room is very scary for him and will not help this new learning process. Simple door closing is a much more controlled pattern of enforcement than, for example, trying to hold your child in bed, spanking him, or locking the door and leaving. You want to show him that having the door open is under *his* control. If he stays in bed, the door stays open; if he gets out of bed, the door stays closed. It is as simple as that. If you prefer you may use a gate instead of a closed door, as long as your child is unable to open it. In this case just be sure that you are out of his view during the periods of gate closure.

Do *not* spank or threaten your child. It will only make matters worse. It is important that he know you understand he is having a tough time and you want to help him through this period. Please offer support, not punishment.

You may continue to talk to your child in a reassuring manner through the closed door, or from another room if you are using a gate, so that he will know you are still nearby. Tell him if he gets back in bed you will be able to leave the door open after the minute is up. If he does not get back into bed, go in yourself, put him down, close the door, and wait two minutes. If he continues to get out of bed, increase the door closure to three minutes and then to five minutes (see the chart in Figure 6 on page 79). Five minutes should be the maximum for the first night. When your child finally does stay in bed or goes

back to bed on his own, open the door after the time is up, give him a word of encouragement, then leave without going into the room. If he starts getting out of bed again later, perhaps after nighttime wakings, follow the same routine you used at bedtime, starting again at one minute. On the second night begin with two minutes and increase this each subsequent night as shown in the chart. If he wakes and cries but does not get out of bed, switch to the routine of waiting longer before you respond briefly (Figure 5). Naptimes too will have to be controlled with the door-closing technique, but if your child has not fallen asleep after one hour, or if he is awake again after a period of sleep, declare the nap over for that day.

The first few nights will not be easy, and children will vary in how much they are willing to struggle. Some will learn quickly that they would prefer to stay in bed and have the door open than get out of bed and have the door closed even briefly. Other children continue getting out of bed a number of times, being willing to accept longer periods of door closure before giving in. This method will likely take longer than with a child confined to a crib, but it works. If you persevere, things should still be much better within one or two weeks at the most. But you should follow the schedule consistently. Your child must learn exactly what to expect. If you are lenient sometimes and firm others, your child will always assume that this may be one of the times you are going to give in.

If your child is old enough, usually three or three and a half, you may want to try a reward system to help the initial phase of relearning go much faster. This can be done before, or in association with, the door-closing technique. You can set up a star chart like the one described in Chapter 12, so that he will earn stars or stickers and occasional small prizes for going to sleep without getting out of bed. The star chart will help to motivate him to try to go to sleep without your presence, and it will allow him to feel that you and he are working together to solve this problem. When the novelty of the star chart wears off he may begin to make more demands at bedtime again. If so, you will have to be especially careful not to give in or the old problems could reappear. However, now that your child has learned how to fall asleep on his own, it is no longer a matter of teaching him how to do it, but simply of enforcing the rules. If you are firm, and start or restart the door-closing routine if necessary, the good sleep patterns will return quickly.

If the sudden change from having you with him when he falls asleep to having to do so alone seems too large a step for your child to take all at once, then you can proceed in more gradual steps. But this will

take longer, and your child may have to go through a period of relearning each step of the way. If you want to try a more gradual approach, you should still institute a pleasant bedtime ritual. Tell your child that you cannot lie in bed with him when he falls asleep. But instead of actually leaving the room, agree to sit on a chair near his bed until he falls asleep. If he accepts this, fine. But if he tries to get out of bed or tries to get you into his bed, then begin the door-closing routine. However, on opening the door, return to the chair. Thus your child will learn that, by his own behavior, he can control having you either in the room near him or out of the room and the door closed. Your being in bed with him is not an option, and he will quickly learn that he prefers to have you nearby than outside. Once he has accomplished this, you have helped him with the major part of the relearning. He is now falling asleep in his bed alone, although you are still in the room.

The next steps may be taken at one- to two-week intervals. The first step is to move your chair farther away from your child's bed. Next move your chair just outside his bedroom door. Finally you should simply leave his bedtime area altogether after saying goodnight. Each of these steps should be enforced with the same door-closing routine as necessary. There may be struggles with each step, but the first—your getting out of his bed—will probably be the hardest. Usually the second most difficult step is removing yourself from his room altogether.

If your child seems to be very anxious, this gradual approach may be necessary. But in general I prefer the one-step method because it is less protracted and allows a good sleep pattern to emerge much more rapidly, with only one difficult period of relearning. Furthermore, in the more gradual approach, the time it takes your child to fall asleep may be extended, since he knows that you will leave once he falls asleep, and he may begin to fight sleep, alerting each time he enters the drowsy state, much as Betsy did.

Bill had always fallen asleep in physical contact with a parent, initially in the rocking chair, but more recently in his bed; and being alone in bed felt "wrong" to him. His parents opted for the first approach. They did in fact face major struggles over the first few days. They got little sleep and began to wonder if the plan would work. But they persevered and by the end of the first week Bill was beginning to sleep much better. By the end of the second week his protests when his parents left the room were very mild, and now he sleeps continuously through the night.

For Sammy, falling asleep meant not only being near a parent but

being in a room other than his own with the television on. Not many of us are faced with such difficulties. Imagine how you might react to waking at night and finding yourself in a room other than the one in which you went to sleep. This would certainly tend to rouse you rather than allow you to return to sleep. This is what was happening to Sammy. Unfortunately for him, the existing associations for falling asleep did not even include his own bedroom.

Sammy had had no formal bedtime ritual at all, and when he woke in the night the only way he could recreate the conditions he associated with falling asleep was to go to the living room and play while the television was on. Sammy's parents chose a program similar to Bill's. They began a pleasant bedtime ritual, which Sammy quite enjoyed, although he was less enthused at first about being put into bed and told to stay there. As with Bill, Sammy struggled valiantly over the first week to maintain the status quo, but by the second week he too was sleeping quite normally.

As you have seen, consistent, progressive learning of new routines can be very difficult to initiate, but it works remarkably well in a variety of situations. If your child's problem is similar to those of the children described in this chapter, your program can be very similar. The younger the child the easier it usually is to make changes, but children of all ages with this problem will respond well to the program if parents are willing to stick to it.

General Observations

There are some general points that are useful to keep in mind when you try to determine the cause of your child's sleep problem and correct it.

1. If after he wakes crying at night your child quiets rapidly and returns to sleep promptly as soon as you re-establish the conditions that were present at bedtime—such as rocking him in your arms—then you can be quite certain that his problem is only that he has learned to associate the wrong conditions with falling asleep. There is no inherent abnormality in his ability to sleep. The body systems controlling sleep in a child cannot function in such a way as to physically prevent that child from sleeping well unless he is being held or rocked. If these systems were not working properly, your child would not sleep well under *any* condition. Thus you can be sure that the cause of his sleep disturbance is not a neurologic abnormality, a dietary imbalance or food sensitivity, or significant discomfort. A child

who wakes because of pain may be soothed by being held, but he will not return to sleep almost immediately.

Does this mean that your child must have some physical problem if you are unable to get him back to sleep promptly? No it does not. He may stay awake because he is frightened. Or he may become so agitated if you do not respond to him instantly that it takes him a while to calm regardless of the conditions. Or, as we saw with Sammy, if he is accustomed to falling asleep in a stimulating environment (with the television on and people about), then he may have difficulty falling back asleep after waking at night, whether he is in a new non-stimulating environment (wrong conditions—too quiet and dark) or back in the stimulating one (because the television keeps him awake as much as it allows him to sleep).

There are a few situations, however, when physical problems can be responsible for sleep difficulties. These are discussed in Chapter 7.

2. You may have found that your child's sleep associations at bedtime do not always affect what happens later in the night. For example, he may sleep through the night without waking even though you always rock him to sleep at bedtime. Or he may fall asleep alone at bed- or naptime but needs to be rocked after nighttime wakings. This only means that your child has learned to associate different conditions with falling asleep at different times. He is no more or less normal than other children who seem to need the same conditions present each time they fall asleep. Therefore it is not necessarily wrong, or even sure to cause trouble, if you rock your child to sleep. If he falls asleep rapidly, is easy to move to his crib, and sleeps through the night, and if you are happy with this routine, then there is really no problem. Your only motivation to change would be the knowledge that if you teach him how to fall asleep on his own when he is young you can avoid having to go through the relearning process later when it may be more difficult, and your child will be more likely to continue sleeping through the night as he grows. But if the bedtime routine is prolonged, as it was with Betsy, you should certainly consider changing it. And if your child has wakings most nights that require your presence, then you definitely should alter the routines. It will be in your child's (and your) best interests to have continuous sleep at night.

3. Occasionally, when you are increasing the time before you respond to your child, he may cry so hard that he actually throws up. If you hear this happen you should go in even though the "time isn't up" yet. Clean him up and change the sheets and pajamas as needed. But do so quickly and matter-of-factly and then leave again. If you reward him for throwing up by staying with him, he will only learn

that this is a good way for him to get what he wants. Vomiting does not hurt your child, and you do not have to feel guilty that it happened. This, like the crying, will soon stop.

4. Even a child who wakes frequently at night may sleep well for several hours before his first nighttime waking and again after his last. For example, he may sleep from 7:00–10:00 P.M. and from 4:00–7:00 A.M. but be restless with frequent wakings between 10:00 P.M. and 4:00 A.M. This is only a reflection of the child's underlying normal pattern of sleep state cycling. As you learned in Chapter 2, the child spends the first few hours of the night in deep sleep and often returns to this same state near morning. The period of lighter sleep in between is more subject to wakings.

5. Once your child has learned how to fall asleep by himself with the proper associations, he will probably continue to sleep well. But there may be occasional disruptions. If you are visiting friends or relatives your child may have to share your room and you may want to respond to his whimpering quickly to be extra sure that he doesn't cry and disturb your hosts. Or your child may be sick with a high fever, perhaps in pain with an ear infection, so you sit with him or take him into your bed. Then when you get back home or when the illness passes, he wants to continue going to sleep under the "new" conditions. If you give in here, your child may well develop an ongoing sleep disturbance. This happens commonly, especially during the second half-year of life. Temporary changes on a trip or during an illness are necessary and reasonable. But if your child's sleep remains disrupted after everything else has returned to normal, then you simply have to go back to the progressive program described in this chapter for several days to re-establish the previous patterns.

6. Parents often ask me, when they realize they will have to let their child do some crying, "Won't this cause permanent psychological harm?" They want their child to feel safe and cared for and are afraid that even several minutes of crying in a room alone will be traumatic.

Although this concern is common, I have learned that it always turns out to be only a temporary one. Allowing some crying while you help your child learn to improve his sleep will never lead to psychological harm. It will be harder on you than on your baby. Even the most concerned parents with whom I have worked have told me afterwards that they found the relearning process very helpful and not harmful for their child.

You want to do what is best for your child, and helping him form good sleep patterns is part of that. Your child cannot yet understand what is best for him and will cry if he doesn't get what he wants. You

have to be the judge of what he can and cannot have and do. If what he wants is bad for him or dangerous, you won't give it to him no matter how hard he cries, and you won't feel guilty or be worried about possible psychological consequences. A poor sleep pattern is also bad for your child and it is your job to correct it. Therefore, there is no need to be overly concerned if he cries somewhat during the initial stages.

Of course if your child does not get enough love and attention during the day, then he may well develop psychological problems. But if you show your love and provide warmth and care during his early months and continue to show your affection during the day as he grows, then a little extra crying for a week or so—no matter how mournful or angry-sounding—will not hurt him in the least. Even when a child becomes more clingy for a day or two, as sometimes happens, the rapidity with which everything improves convinces parents that they have done the right thing. In fact, in terms of possible psychological effects, things can only improve. With better sleep at night, your child will feel better and be less irritable during the day. Since he will be more fun, and because you yourself will be more rested and less angry, you will be able to enjoy your child more and interact with him in a more positive and nurturing manner.

7. Once you decide on a schedule, follow it closely. Know ahead of time how long you are supposed to wait, and use a watch or clock. Your judgment in the middle of the night may not be very good, and ten minutes may seem like an hour. Sometimes, however, it may be better not to go in to your crying child even when the "time is up." If you notice that your baby is beginning to calm, going in and leaving again may only interrupt this and exacerbate things. If you sense that waiting a bit longer will actually be easier on your child, then do so. See if he will continue to calm on his own or if the crying starts to increase. You can always decide to go in if he becomes more upset.

8. If your child falls asleep by himself at naptime but needs you at night, then you can expect the relearning to go very quickly. He already knows how to fall asleep on his own; he simply has to learn to associate that behavior with nighttime as well.

9. If you have been going in to your child during the night to help him fall back asleep, you may have been told that you were spoiling him. That is not what is happening. You "spoil" a child if you give in to every request, never say no, and abdicate your responsibility to decide for him what is best. If you are going in at night it is more likely because you feel that is the right thing to do for him, not because you cannot say no or are incapable of discipline. In the daytime it may be

easier to distinguish your child's *wants* from his *needs*, and you will of course deny him any inappropriate requests without difficulty, even if he cries. But if he wakes and cries at night and only settles when nursed or rocked, you may decide he is hungry and needs to be fed or is in pain or has some basic need to be held. You may also think he has some inherent problem that makes it impossible for him to go back to sleep without the gentle rocking you can provide. Just as you know it is right to walk a colicky baby of two months, you may feel it is right to walk a sleepless crying child of six, twelve, twenty-four or thirty-six months. The problem is not that you are spoiling him but that you did not know enough about sleep and sleep associations to help you distinguish your child's *wants* from his *needs*.

Once you understand that your child's need is simply to learn a new way to fall asleep (whether it is what he wants or not) it is easier for you to see that this need is met.

10. When you are considering a program that will involve some crying or screaming at night, you may feel that it would be fine if you lived in the middle of the Sahara Desert or had only one child. But if you live in an apartment building you may be concerned about reactions from your neighbors and the landlord. If you have other children, and especially if they are young, you may be worried that they will be kept awake. And if you are going to use the door-closing technique, it is certainly more difficult with another child in the room.

Some of these problems are easier to solve than others. Explain to your neighbors what you are doing and tell them the problem should only last a few nights. Start the program on the weekend if they prefer. If they are still intolerant, you may want to wait until they will be away for a few days. Or you may have to use a very gradual approach, in which you stay in the room initially in an attempt to keep crying to a minimum.

As for your other children, you probably don't need to worry too much. Even if their sleep is disturbed for a few nights it will return to normal quickly. If another child shares the room with the one who will be doing the relearning, the other child may have to sleep in another room for a few nights, especially if you have to use the door-closing technique. Generally the child with the sleep problem wants his brother or sister back and that is further motivation for him to cooperate.

11. Since it is important that you follow through on your program consistently, you should wait for a convenient time to begin. Do not start at a time when you cannot afford to lose some sleep yourself—before an important meeting or a job interview, for example, or when

someone is coming for a visit. Even if the timing is otherwise all right, you may want to wait until a Friday night to begin so that you have the weekend to catch up on any missed sleep.

12. Many parents ask whether the same adult should handle all bedtimes and wakings during a period of relearning. Actually it is better if both parents take turns. Your child should feel comfortable with either parent at bedtime and after wakings. You do not have to alternate strictly—just pick a schedule that suits you best. One parent may find it easier to get up in the first half of the night and the other parent may prefer the second. Or, work demands may mean that one parent must do more on the weekends and the other on weekdays. If one parent has handled all the bedtimes and wakings till now, the other parent may have better luck breaking the old associations, since he or she isn't part of them. It is probably best that whichever parent is handling a particular waking, he or she should continue the responses until the child falls asleep, so that the child does not sense that by crying enough he can control who will come in.

For similar reasons it is good advice not to let your child insist that "I want Mommy" or "I want Daddy." You should decide who will handle each bedtime or waking and stick to it. You do more to convince your child of your love by staying than by giving in to his demands. Once he learns that you really mean that you want to be the one to care for him at that time, he will look forward to it, if that is part of the usual bedtime ritual, and in any case he will be more reassured.

During the actual relearning it is probably better not to use a sitter. But if this becomes necessary for a night or two you may let the sitter put your child to bed in the easiest manner. It is not fair to ask the sitter to follow through on your program, and the fact that he or she does it differently will not really affect what your child is coming to expect from you. So, if you have to be out one night, the program can be interrupted for that evening. Nothing will be lost in the long run. Just be sure to restart the program the next day. Once the new routines are well established, however, you might ask your sitter to try them.

If your child is left with a sitter most days, the sitter will know your child well, and he or she could be involved in the relearning program for naptimes. If this is not possible, or if you feel that it is inadvisable, then you may have to institute the program just at night. This should work anyway. When a sitter (or day-care provider) handles naptimes differently from the way you handle bedtimes, there are usually fewer problems than when you handle both bed- and naptimes yourself but do so in an inconsistent manner.

FIGURE 5 Helping Your Child Learn to Fall Asleep with the Proper Associations—The Progressive Approach

NUMBER OF MINUTES TO WAIT BEFORE GOING IN TO YOUR CHILD BRIEFLY

Day	At First Wait	If Your Child is Still Crying		
		Second Wait	Third Wait	Subsequent Waits
1	5	10	15	15
2	10	15	20	20
3	15	20	25	25
	20	25	30	30
5	25	30	35	35
6	30	35	40	40
7	35	40	45	45

1. This chart shows the number of minutes to wait before going in if your child is crying at bedtime or after nighttime wakings.
2. Each time you go in to your child, spend only 2 to 3 minutes. Remember, you are going in briefly to reassure him and yourself, not necessarily to help him stop crying and certainly not to help him fall asleep. The goal is for him to learn to fall asleep alone, without being held, rocked, nursed, or using a bottle or pacifier.
3. When you get to the maximum number of minutes to wait for that night, continue leaving for that amount of time until your child finally falls asleep during one of the periods you are out of the room.
4. If he wakes during the night, begin the waiting schedule at the minimum waiting time for that day and again work up to the maximum.

Continue this routine after all wakings until reaching a time in the morning (usually 5:30 to 7:30 A.M.) you have previously decided to be reasonable to start the day. If he wakes after that time, or if he is still awake then after waking earlier, get him up and begin the morning routines.

6. Use the same schedule for naps, but if your child has not fallen asleep after one hour, or if he is awake again and crying vigorously after getting some sleep, end that naptime period.
7. The number of minutes listed to wait are ones that most families find workable. If they seem too long for you, use the times shown on the chart in Figure 6 on page 79 (though without closing the door). In fact, any schedule will work as long as the times increase progressively.

8. Be sure to follow your schedule carefully and chart your child's sleep patterns daily (Figure 8, page 105) so you can monitor his progress accurately.
9. By day 7 your child will most likely be sleeping very well, but if further work is necessary, just continue to add 5 minutes to each time on successive days.

FIGURE 6 Helping Your Child Learn to Stay in Bed

NUMBER OF MINUTES TO CLOSE THE DOOR IF YOUR CHILD WILL NOT STAY IN BED

Day	If Your Child Continues to Get Out of Bed				
	First Closing	Second Closing	Third Closing	Fourth Closing	Subsequent Closings
1	1	2	3	5	5
2	2	4	6	8	8
3	3	5	7	10	10
4	5	7	10	15	15
5	7	10	15	20	20
6	10	15	20	25	25
7	15	20	25	30	30

1. This chart shows the number of minutes to close your child's door if he will not stay in bed at bedtime or after nighttime wakings.
2. When you get to the maximum number of minutes for that night, continue closing the door for that amount of time until he finally stays in bed.
3. Keep the door closed for the number of minutes listed, even if your child goes back to bed sooner. However, you may talk to him through the door and tell him how much time remains.
4. When you open the door, speak to him briefly if he is in bed, offer encouragement, and leave. If he is still out of bed, restate the rules, put him back in bed (if it can be done easily), and shut the door for the next amount of time listed. If he lets you put him back easily and you are convinced he will stay there, you may try leaving the door open, but if you are wrong, do not keep making the same mistake.
5. If your child wakes during the night and won't stay in bed, begin the door-closing schedule at the minimum time for that day and again work up to the maximum.
6. Continue this routine as necessary after all wakings until reaching a time in the morning (usually 5:30 to 7:00 A.M.) previously decided to be reasonable to start the day.

7. Use the same routine at naptimes, but if your child has not fallen asleep after one hour, or if he is awake again and out of bed after getting some sleep, end that naptime period.
8. If he wakes and calls or cries but does not get out of bed, switch to the progressive routine described in the chart in Figure 5 on page 78.
9. The number of minutes listed to close the door are ones that most families find workable. However, you may change the schedule as you think best as long as the times increase progressively.
10. Be sure to follow your schedule carefully and chart your child's sleep patterns daily (Figure 8, page 105) so you can monitor his progress accurately.
11. Remember, your goal is to help your child learn to sleep alone. You are using the door as a controlled way of enforcing this, not to scare or punish him. So reassure him by talking through the door; do not threaten or scream. By progressively increasing the time of door closure, starting with short periods, your child does not have to be shut behind a closed door unsure of when it will be opened. He will learn that having the door open is entirely under his control.
12. By day 7 your child will most likely be staying in bed, but if further work is necessary, just continue to add 5 minutes to each time on successive days.
13. If you prefer you may use a gate instead of a closed door as long as your child can't open or climb over it. In this case you must be out of his view during the periods of gate closure, but you can still talk to him reassuringly from another room.

Feedings During the Night— Another Major Cause of Trouble

It may seem hard to imagine that your child's nighttime feeding can be the cause of a major sleep disturbance, but in fact that is very often the case. Once your baby is about three months old, he or she no longer needs to be fed at bedtime and again several more times during the night. Yet you may find that having your child fall asleep as you feed her at night is very rewarding for you and satisfying for her. And there is nothing wrong with continuing to nurse your child to sleep during her first year as long as you are happy doing so and as long as she sleeps through the night. But if she wakes repeatedly and has to be fed to go back to sleep, then she is developing a sleep problem, and the feedings are the cause.

Certainly a baby with this problem has learned to associate nursing with falling asleep, as we discussed in the last chapter; but when your child has large amounts of milk or juice at night, her sleep will be disturbed for other reasons as well. If she drinks a lot at night, her diapers may be soaked and the discomfort could certainly wake her. Also, some of her body rhythms can become irregular and interfere with a good night's sleep. For example, the extra fluid and calories your child ingests at night will stimulate her digestive system, which should be "shut down" for the night. The additional nutrients may also alter her release of various hormones.

Even the timing of her feelings of hunger may be affected. We all feel hungry at times of the day or night when we are accustomed to eating. So if your child gets used to being fed often during the night, she may wake feeling hungry, then nurse or take her bottle eagerly, even though she has simply *learned* to eat on this schedule and does

not have a nutritional need for food at those times. This learned hunger then becomes a trigger of abnormal wakings.

Finally, it appears that a child's underlying sleep-wake and eating patterns may be disrupted by the repeated wakings as much as by the feedings. If your child becomes accustomed to being fed throughout the night, her system will begin to regard the nighttime sleep periods as only naps between feedings. You don't expect your baby to sleep for twelve hours when you put her down for her afternoon nap, and by the same token, because she is used to waking and being fed every few hours at night, she won't sleep twelve hours then either.

Sleep disruption caused by too much fluid at night usually occurs in children who are still breast feeding or using a bottle—in the first year or two. Cory, for example, was only eight months old when I first saw her. Her parents said that she fell asleep easily at bedtime while nursing at the breast. Once asleep, she could be moved into the crib without difficulty. She slept for two and a half hours, but then woke crying. Her father was unable to comfort her, and only her mother seemed able to put her back to sleep. When she picked Cory up and nursed her again, Cory would stop crying and go back to sleep within ten minutes. But she would continue to wake up every one or two hours during much of the night and the same process had to be repeated. Cory woke five or six times most nights and often had to be changed before nursing. Since her mother was always the one to take care of Cory in the night, she had become exhausted and frustrated. Occasionally she was so tired that she just wanted to let Cory cry, but her husband insisted that she go in. Not surprisingly, she was angry with both her husband and Cory, and there was a great deal of tension in the family.

You will probably recognize by now that Cory had associated falling asleep with being held and nursed. But when such associations are the only problem, a child usually has only a few full wakings at night. Only some of the normal partial wakings that occur during the night are followed by more complete waking with difficulty going back to sleep. Cory, however, woke much more often—sometimes hourly. I knew that something was either waking her frequently or was causing her to become fully awake after practically every partial arousal during the night.

Sandy, another child I saw with this problem, was two and had never slept through the night! She was no longer held or rocked to sleep but was handed a bottle when she was put down in her crib. She always finished all eight ounces (sometimes as much as twelve), turned over, and fell asleep. After about three hours, she woke crying and

would not stop unless she was given another five to eight ounces. Again she fell asleep quickly. But she would wake four to six more times during the night and need a bottle to go back to sleep each time. Thus Sandy would drink over a quart of milk each night.

Often when she woke she was soaking wet despite the fact that she was in double or triple diapers. At each waking her mother or father would go in, change her if necessary, hand her another bottle, and leave. When Sandy's parents went to bed they would prepare four or five bottles and leave them in the refrigerator or on Sandy's window ledge. Since either parent could go in, the entire burden did not fall on Sandy's mother as it had on Cory's, and since they did not have to hold their child the parents could go right back to sleep themselves. Still, after two years, they too were tired and frustrated and they usually went to bed early in the evening just to be sure they got enough sleep.

Sandy, like Cory, did have associations that interfered with falling asleep—in this case sucking on a bottle. Sandy did not need the bottle to actually fall asleep, however, because she usually did not fall asleep with the bottle in her mouth. She would finish it, toss it aside, roll over, and then go to sleep. Clearly her disturbance was more closely related to the large amount of milk she took during the night.

Originally Cory's and Sandy's wakings were probably the normal arousals of an infant who is just beginning to develop good sleep habits. But because their parents tried to "treat" the wakings with the extra feedings, the wakings did in fact become abnormal. The "cure" in this case was the cause of the disorder.

How to Tell If Your Child Has This Problem

If your child, like Sandy, is at least three months old and still requires a bottle at bedtime and several more during the night, add up the number of ounces she takes from the time she goes to bed until she wakes in the morning. If she drinks only six to eight ounces, then her problem is more likely one of associations with sucking rather than of too much fluid. But if your baby has more than eight ounces, then the extra liquid may be an added cause of the problem. If you are breast feeding her and have to nurse more than one or two times during the night, you should also be suspicious that your child is getting too much milk, especially if each nursing lasts more than two or three minutes.

If your baby's diapers are usually soaked when she wakes during the night, then it seems likely that she is drinking too much. She certainly

can't be thirsty or not getting enough fluids if she is wetting that much. If a medical problem such as diabetes were causing her to drink and wet so much at night, then it would cause the same problem in the daytime. If you are at all concerned, you should consult your doctor. But in all likelihood your child is probably just drinking too much fluid at night because this has become a habitual pattern. And the amount of fluid may be considerable. If your child takes four full eight-ounce bottles during the night, she is drinking one full quart—a great deal even for an adult. Is it so surprising then that your child, like Sandy or Cory, is not sleeping well?

How We Solve the Problem

Once you decide that too much fluid at night is disrupting your child's sleep patterns, you can take the steps necessary to correct the problem. In fact although this is one of the most severe disorders in terms of actual nighttime disruption, it is also one of the easiest to treat. You simply decrease gradually, and eventually eliminate, the feedings at bedtime, naptime, and after nighttime wakings.

If your child has this problem, you will have to begin by progressively decreasing the amount of milk or juice she takes when she falls asleep. It is not reasonable to stop suddenly. Your child would not suffer because of lack of nourishment at night, though at first she might feel hungry because she has learned to expect feedings then. Nevertheless, since she has become so accustomed to going to sleep while being fed and since she may feel hungry, a program designed to allow new patterns to develop gradually will be easier for her and probably for you.

You really have two jobs to do. One is to eliminate the feedings during the night to avoid the various disrupting effects these feedings have on sleep and to help your child learn to be hungry only at reasonable times during the day. The other is to teach your child new sleep associations so that she can fall asleep alone in her crib or bed without you or her bottle. If you find that decreasing both the feedings and the speed with which you respond to her crying is too much to do at the same time, then you may continue to go in to comfort her as soon as she cries at the times when she would previously have been fed. Once the feedings have been stopped you can correct your child's associations to your presence as a second step.

Use the chart on page 85 (Figure 7) as a guide for following the steps to solve this sleep problem. If your child uses a bottle, you know how much she usually takes. So begin by putting one ounce less in

each bottle at naptime and nighttime feedings. If you are breast feeding, you know how long your child usually nurses. You can start by shortening the time of nursing at night by a few minutes. If your child is nursing, or if you hold her while she takes the bottle, put her back into the crib or bed when the feeding is complete whether or not she is asleep. If she cries when the feeding is over, or on waking before two hours have passed since the last feeding, do not feed her again. Stick to the schedule. The baby may still be feeling hungry but she does not *need* nourishment; remember that you are helping her to change her feeding schedule so that she will feel hungry only during the day. If more than two hours have gone by since the last feeding, you may nurse her again or give her a bottle. This waiting period will be increased over the coming days. When she is awake and crying before the time for the next feeding, you may choose to go in to rub her back or otherwise try to comfort her. But do this only if you find it to be helpful. She may become even more upset if you are there but

FIGURE 7 Eliminating Extra Feedings at Sleep Times

Day	Ounces in Each Bottle or Minutes Nursing	Minimum Hours Between Feedings
1	7	2.0
2	6	2.5
3	5	3.0
4	4	3.5
5	3	4.0
6	2	4.5
7	1	5.0
8	No More Bottles or Nursing at Sleep Times	

- The ounces and times in this chart are general guidelines. You will want to alter them to fit your own routines.
- If your child takes less than 8 ounces in the bottle, start with 1 ounce less than she usually takes and continue reducing from there.
- If you are breast feeding, use the time spent nursing as an approximation of volume. Begin by nursing 1 or 2 minutes less than you usually nurse and continue decreasing the times from that point.
- If you prefer you may follow this chart but decrease every other day instead of every day. It will just take a little longer.

not feeding her, and she may calm more quickly with you out of the room. If you stay, try not to hold her. Soothe her or talk to her as she lies in her crib or bed. The purpose here is only to comfort her and help her fall asleep while she is learning not to expect a feeding. Of course, once the nighttime feedings are stopped entirely, you may have to break these other associations, but this can be done quickly and easily.

Each day, or every other day if you prefer, decrease the amount of fluid in each nighttime bottle by another ounce, or shorten the time of nursing by one minute, and increase the minimum time between feedings by thirty minutes. You handle naptimes like bedtime, except if your child does not fall asleep within one hour, you end that nap for that day.

By the end of the first or second week there should be no more feedings at sleep times. Many families tell me, however, that they actually stopped the nighttime feedings sooner. After they decreased the volume of liquid to two or three ounces, or shortened the length of nursing sufficiently, they felt it best to simply stop the bottle, or nursing at sleep times altogether rather than continue the gradual changes further. They did so because they found that the very short feedings seemed more upsetting than calming. Also, they had already seen such a marked decrease in the number of wakings that they became convinced that eliminating the nighttime fluids was indeed the correct approach. The response is usually so dramatic that children are often sleeping quite normally by the end of the first week.

Once your child is falling asleep without nursing or taking a bottle, then you have solved the problem of excessive fluids, and she no longer has the association of falling asleep with the bottle or breast. If your baby still needs you to rub her back or rock her in order to go to sleep, then you can begin to correct those associations as described in Chapter 5. Once the excessive fluids are no longer complicating the picture, this relearning usually happens quickly.

If you are a mother who is breast feeding and are following the program to eliminate frequent nighttime feedings, it may be helpful, often, to have your husband go in when your child is crying at a time that is too soon for you to nurse. If you go in you may have a "let-down" response, your child will smell the milk, and in any case if you are there she will expect to nurse. If your husband goes in, your child may still seem a bit frustrated, but at least the immediate temptation of the breast is not there. This will help your child learn not to expect you and the nursing during the night.

If you have been bottle or breast feeding your child only at bed- and

naptime—that is, if she drinks from a cup the rest of the day—you may want to wean her altogether. If so, you will accomplish this when you discontinue the sleep-time nursings. If you do not want to wean your child yet, you must still eliminate the nighttime feedings. But you can continue to nurse or bottle-feed her at times other than bedtime—earlier in the evening or during the day (except at naptime of course). If she starts to fall asleep when you nurse her at these times, stop and put her in her crib or bed so that she will remain accustomed to falling asleep without nursing or sucking on her bottle. If she cries it will be because she is still associating nursing with falling asleep. You can change this association the same way you change other sleep associations—by letting her cry for a little longer each day until she falls asleep without nursing and without much fussing (see Chapter 5).

If your child nurses or takes a bottle during the day as well as at sleep times, then decreasing the nighttime feedings will generally not affect her daytime feedings. If your baby has been getting most of her nourishment at night, however, you will eventually notice some increase in the amount she takes during the day (though this may take several weeks).

Bottle or breast feeding at appropriate intervals during the day will not interfere with your child's sleep at night or during naps. However, if your child walks around all day with a bottle or is put to your breast repeatedly whenever she so desires or each time she seems the least bit upset, then her nighttime sleep may be affected. In these cases the bottle or breast becomes as important as the pacifier does to a child who has it in her mouth all the time (see Chapter 5). Now your child associates the breast or bottle not only with drowsiness and falling asleep but with a feeling of well-being when she is awake too. If your child has never learned to feel comfortable without the breast or bottle always immediately available to her, then you may have difficulty eliminating extra feedings only at night. Still, if you are consistent, you should be successful.

If you find that you are unable to follow through, or that the difficulty at night is more than you want to face, then you may consider trying to decrease the nursing in the daytime first. Your goal is to help your child learn ways to calm herself other than by sucking on the breast or bottle, and you will be trying to limit the feedings to times she actually needs to be fed. This way she can begin to associate breast or bottle primarily with hunger and feedings. Once you do this and see that you were able to help your child accept these changes without bad effect—in fact, she probably will seem happier in the daytime—

you should be able to work on the nighttime changes with a new confidence.

There is one other approach that some families find helpful when eliminating the unnecessary bottles. They start by watering down the milk or juice in the bottle to half strength, then quarter strength, until the baby is just getting water. Even those children who seem to know instantly when their drinks have been diluted and protest loudly, usually will prefer it to no bottle at all. If your child will accept this, the wakings and feedings may progressively decrease on their own and it will be easier to finally eliminate the bottle at sleep times. If you want to try this approach, you should be aware that it may only be a first step. You still may have to progressively decrease the amount in each bottle and increase the time between feedings. But once your baby is only taking water the effects of the *nutritional* intake are no longer important. She may still be wet at night but she probably won't be hungry.

We used the gradual methods described in this section with both Cory and Sandy, and both little girls are now sleeping soundly through the night. Cory's mother still nurses her twice a day, but never at night. She will occasionally nurse Cory to sleep at naptime, because she found that this did not seem to affect the good sleep that had become established at night and because she continued to find it a rewarding and pleasurable experience. Cory's father realized that he had been wrong to insist that his wife get up to nurse through the night, and the tensions between the parents eased.

Sandy gave up the bottle within a week after the treatment began. Her mother followed through on the plan of decreasing the amount of milk in Sandy's bottle by one ounce each night and was surprised at how quickly things improved. Sandy did cry a little when the night bottle was taken away altogether, but this happened on only two nights and only lasted five minutes. Her parents can now enjoy their time together in the evenings and have found out what it is like to sleep through the night again!

In summary, then, it is important that you realize how disruptive large amounts of milk or juice can be to your child's sleep patterns. If your child stops crying when she is given a bottle or nursed, you may have made the reasonable assumption that she is hungry and needs to be fed. If so, you were right—and wrong. Your child probably does feel hungry at these times, but she does not *need* to be fed. Because the timing of hunger is learned, she is actually hungry at those times because you have been feeding her then. A normal child of four to six months or more can certainly get enough calories during the day so

that she will not need further nourishment at night. And if you allow the night feedings to continue, the problem may go on for a very long time—years even. On the other hand, when you begin to change the routine the resolution is usually very rapid. Quite likely your child—and you—will be sleeping well before the end of the first week.

Chapter 7

Colic and Other Medical Causes of Poor Sleep

Your child's sleep may be disturbed at night because of medical problems. Certainly any acute illness or condition, especially with fever or discomfort, can disrupt sleep patterns temporarily. If your child is ill, he or she may sleep fitfully at night and nap off and on during much of the day. Teething pain also can cause a young child to sleep poorly for several nights, but it does not cause sleep problems that go on week after week, as parents sometimes suppose. Such ongoing sleep disturbances in young children are not usually caused by medical factors. Still, you may have to consider a medical problem if you have investigated and ruled out the more common and obvious causes of sleep problems or if you know your child has a significant medical problem or condition.

Colic

Probably the most common cause of a significant sleep disturbance in the early months is colic. In the first weeks after birth some babies begin to have daily crying spells. The episodes usually occur in the late afternoon or evening and can go on for several hours. If your baby is colicky, he will be crying very hard and be difficult to calm. You may find it helpful to walk about with him for long periods of time or to place him over your legs while you rub his back. Often, however, nothing you do seems to help.

A baby who is colicky may have a distended stomach, his legs likely will be pulled up, and he may seem relieved by passing gas or having a bowel movement. For these reasons, colic is often considered to be caused by intestinal pain. If the colic is very severe, your pediatrician

may even want to prescribe a medication to help relax the bowels and ease the discomfort. But the distention, the increased gas, and at least some of the apparent discomfort may actually be caused by the swallowing of air that takes place during long vigorous crying. The initial cause of the crying, and much of the reason that it continues so long, may be something very different.

Frequently it seems that the colicky infant is either overly sensitive to things going on about him or is exposed to excessive amounts of handling and other stimulation. What he experiences—sees, hears, and feels—may seem like an unpleasant and disorganized barrage. This “chaotic” input is difficult for the infant to handle and may lead to upset and a build-up of tension throughout the day to the point that his coping abilities may become overloaded. If so, he may need an opportunity to discharge this tension at the end of the day. This is what is meant by a “need to cry.” So if your baby seems to have colic and cannot be easily comforted, allow him to cry alone in the crib for fifteen to thirty minutes. If he has not settled by then, you may try to console or feed him once again in a very calm, soft-spoken, and gentle manner. Avoid trying to quiet him by bouncing or similar vigorous stimulation. If your gentle attempts are still not helpful, you should allow him to cry for another fifteen- or thirty-minute period. By so doing you are responding to your child's needs, not ignoring them. If his need were to be held, nursed, rocked, or just to use a pacifier, then these interventions would calm him. It is often enough for your child to cry undisturbed in this manner during just two or three consecutive colicky periods. His crying spells will likely decrease in intensity and length within one or two days—and he will sleep better too. By allowing your infant to cry in this manner, you will be giving him a chance to release the built-up tension and he will be better able to “organize” himself and feel comfortable with the daily routines. This is probably why babies hospitalized for severe colic often seem “cured” just by being in the hospital—because the nurses there are more likely than the parents to allow the infants to cry by themselves if they do not accept comforting.

Colic is not, in and of itself, a sleep disorder. It is discussed in all books on baby care, and you should talk the matter over with your pediatrician. Fortunately, in almost all cases symptoms are completely gone by three months of age. However, colicky infants often do go on to develop long-standing sleep problems. These problems may seem to be the same as they had during the colicky months, but they are not.

What happens is that the habits that form when your child is colicky

may well persist after the colic has disappeared. If your baby is colicky, you may spend a considerable amount of time walking, rocking, holding, and otherwise trying to comfort him to help him get to sleep. But once the colic is gone, you should no longer have to use these methods. However, your child may still want you to, not because he is in any true distress (despite his crying), but because he has come to expect to be held, rocked, walked about, or patted until he falls asleep at bedtime, and after nighttime arousals. If this happens, you will have to help him learn new, more appropriate associations with falling asleep, as we discussed in Chapter 5.

The difficult part is to decide when the colic is gone. This happens gradually, not overnight, so it may not seem obvious to you when the time has come to change your pattern of response. Keep in mind that colic is usually gone by age three months. It occurs during the day, not just during expected sleep hours. A colicky baby seems to be distressed, not just frustrated, angry, or hungry. And it is difficult to ease a colicky baby's distress by any simple intervention. So if your baby cries mainly when you put him down in the crib at bed- and naptimes or when he wakes during the night, if he does not seem in pain, if the crying stops promptly when you pat his back or pick him up and begin to rock him, give him a pacifier, or feed him, and if he quickly returns to sleep, then it is unlikely that colic is still causing the trouble. Once you realize this, you may go on to identify the real cause of the current sleep problem and take the steps necessary to correct it. If you do not, it may persist for months, even years.

Chronic Illness

Many chronic conditions may contribute to ongoing sleep disturbances. A child may be in pain or discomfort—possibly he has a skin irritation with annoying itching, migraines with nighttime headaches and nausea, scoliosis with the need to wear an uncomfortable orthopedic brace, asthma with difficulty catching his breath, or a severe burn requiring painful operations. His sleep may be disrupted by the direct consequences of a disease or disorder—perhaps he wakes feeling jittery or with the need to urinate because of poorly controlled diabetes, or his sleep may be broken by epileptic seizures. Your child may also be bothered by the indirect consequences of a medical disorder; for example, poor sleep is a side effect of particular medications, or it may result from anxieties a child may have about his illness.

If your child has such a chronic illness or condition, then you're probably well aware of it. The difficulty lies in sorting out which fac-

tors related to the illness are causing the sleep disruption. Is it because of the effects of the illness itself on sleep systems, or is it because of the pain, medication side effects, or simply the child's concern and anxiety? Several factors may be contributing simultaneously. Thus, this can be a very complex problem and may be difficult for you to solve alone. Ask your pediatrician or the specialist who is treating your child to help.

Several conditions do seem to merit special discussion here. These are chronic middle ear disease, the use of certain medications, and brain damage.

Middle Ear Disease

Unlike most chronic conditions associated with sleep disturbances, chronic middle ear disease often goes unrecognized, yet it is very amenable to treatment. In this condition, fluid collects in the middle ear cavity behind the eardrum and does not drain satisfactorily. This fluid may or may not become infected, but even without infection the fluid buildup can lead to a temporary decrease in hearing and, if persistent, eventually damage the bones of the middle ear cavity permanently. For this reason the condition should be treated.

During an acute infection the pressure in the middle ear cavity increases, the eardrum bulges, and your child is in real pain. But when the fluid does not become infected, children usually do not complain of discomfort. Nevertheless, their sleep may still be disrupted.

I recently treated Tanya, an eighteen-month-old girl with a long history of frequent wakings at night despite the fact that she went to bed easily. Upon waking she was usually crying. She calmed somewhat if lifted, but returning to sleep was difficult for her, regardless of what her parents did to help. Even when they walked with her or rocked her she usually whimpered for ten to fifteen minutes before finally going back to sleep. Nothing they did seemed to help at all.

Tanya's history did not suggest a cause for her sleep disturbance except that her parents did report that Tanya had had three or four ear infections over the past year. When I examined Tanya I found that much fluid was still present behind her eardrums.

It is not clear how fluid in the middle ear disrupts the sleep patterns of children like Tanya. Possibly when the child is lying down at night, middle ear drainage is even more inadequate than during the day, more fluid collects, pressure increases, and the child feels discomfort. In any case, I have seen many children with this problem who had

significant sleep disturbances that did not seem to fit into any other category.

When I see a young child like Tanya, I always take a careful look at the eardrums before deciding on a diagnosis and plan of therapy. It is striking that when these children are treated medically or, if necessary, by having drainage tubes inserted through the eardrum, not only is their middle ear problem cured, but the sleep disturbance disappears as well.

Tanya's ears did not drain with medication. An ear, nose, and throat specialist then inserted drainage tubes, and her sleep problem resolved without further intervention. By recognizing the true cause of her problem we avoided a series of behavioral interventions that would have had no possibility of success.

Medication

In recent years the medical community has begun to appreciate that sleeping pills have *caused* far more sleep disorders in adults than they have ever *helped*. This is just as true with youngsters, and you may be surprised to know that sleep medication is misused in children *very* frequently. When a child is not sleeping well and supposedly everything has been tried, the family feels frustrated and hopeless and will often beg the doctor to help. Often he or she will prescribe some sort of sleep medication. The ones most commonly used are the antihistamines such as diphenhydramine (Benadryl—which has sleepiness as a side effect), a major sedative such as chloral hydrate or phenobarbital, or even a major tranquilizer such as diazepam (Valium). Yet such a medication will rarely solve the sleep problems of a child who is otherwise normal and healthy. Often there is a "paradoxical response" to the medication and your child becomes "hyper," unable to sit still and unable to sleep at all. Even if your child were to sleep well on the medication, he would be far better off if you could understand the cause of the disturbance and help him learn to sleep well without drugs. Sometimes medication will improve a child's sleep for several nights, possibly for a few weeks, but usually the old pattern returns. In addition, the stronger medications often affect your child's daytime mood and performance. He may become overactive or clingy, cranky, and babyish. In a very short time you would likely be feeling more upset than ever with your child. Only occasionally will short-term (one to two weeks) drug treatment serve to break the cycle of a poor sleep pattern and allow a good one to emerge so that normal sleep persists after the medication is stopped. If this is successful, the med-

ication probably does no harm, but proper behavioral approaches would also have been successful. If you are able to correct your child's sleep without medicine, you will not be left with a nagging anxiety that he has an inherent sleep problem (that is, that there is something basically wrong with him), and you will feel more confident in dealing with any problems that may emerge in the future without feeling that you have to head immediately for the medicine cabinet.

Not long ago Terrence, a three-year-old whom people had always thought of as tense and irritable, was brought to my office. His parents said he had great difficulty sleeping at night and wasn't very happy during the day. Because of the boy's repeated nighttime wakings the parents had sought medical advice and Terrence was given one milligram of Valium at bedtime at least three or four times a week. He had been on this medication for the past nine months.

When I saw Terrence he was such an unhappy and irritable child that I was quite concerned. He interacted poorly and I felt he would likely need psychological evaluation as part of the treatment. But to get a clearer picture of the situation and to provide a basis for making further decisions, I first had the family stop the medication altogether. When I saw them several weeks later, they were vastly relieved. After a few difficult nights in the beginning, Terrence was now going to bed easily and sleeping through the night for the first time in a year. In addition, he was much happier in the daytime and the parents had begun to enjoy him again. When I saw him in my office, Terrence was smiling, obviously happy, and good-natured in our conversation. In short he was a delightfully normal three-year-old. His good sleep pattern and normal daytime behavior have continued, and there has been no need for further intervention.

I am sad to say that I see too many young children given a powerful medication such as diazepam in an attempt to improve a sleep disorder that could be corrected by other means. In many cases the medication only makes matters worse. Most of the time, whatever the child's problem is, medication will simply complicate matters at night. In some cases, such as sleep apnea (see Chapter 14), medication can be very dangerous. Also, the child's daytime behavior and ability to concentrate and learn may well be compromised.

A child receiving sleep medication regularly may react the same as an adult on sleeping pills: he cannot sleep without the medication, yet with the medication his sleep is disrupted. So I do not recommend medication for a child with a sleep disorder except on *very* rare occasions, and when I begin to treat a child who has been taking medication just to improve sleep, I start treatment by stopping the

medication. You may want to speak with your doctor about doing the same.

There are many situations, of course, in which your child may have to take certain medications to treat particular medical conditions. Phenobarbital or other drugs with sedative properties may be required for the treatment of epilepsy. Theophylline (Slo-Phyllin), metaproterenol (Alupent), terbutaline (Bricanyl), or other similar medications may be necessary to treat asthma. Stimulant drugs such as the amphetamines, methylphenidate (Ritalin), or pemoline (Cylert) may be used to treat attentional-deficit disorders ("hyperactivity"). Your child may need certain antibiotics on an ongoing basis as protection against recurrent infections. These and many other medications may be associated with a sleep disturbance. Again the various effects of the underlying medical disorder, the medication, and other causes of sleep problems have to be sorted out—not always an easy task. The dilemma can be further complicated if your child has had many hospitalizations and has become fearful at night, or if you, understandably, find it hard to set firm limits on your child because he has a chronic illness or has suffered a great deal.

If it seems possible that the medication may be causing the sleep problem, you should discuss this with your doctor, since there are several approaches that may be helpful. The dosage or the time when you give your child the drug may be changed. Your doctor may try alternative drugs. Even if this is only done temporarily, it will help you decide if the original medicine was causing the sleep problem. Asthma medications taken by mouth may also be available in a form that is inhaled, with fewer side effects. Although it is unlikely that antibiotics themselves cause much of a sleep problem, the additives in the liquid preparations may. Switching to pills, or even to a different brand of liquid, may be helpful.

In any case, the changes will take time and require a certain amount of trial and error. But you should *not* make any changes before you talk to your child's specialist. With his or her help, it is quite possible that your child's sleep problem can be improved significantly.

Brain Damage and a True Inability to Sleep Well

Sometimes I do see children who apparently sleep poorly because of some impairment in the brain mechanisms that control the act of falling asleep or the ability to stay asleep. Most of these children will have an impairment significant enough to be quite obvious. Usually

they are retarded, and often they also have seizures or are blind or deaf.

When such a neurological disorder is accompanied by a sleep disorder, we have to consider all the factors very carefully. For example, the child could have any of the sleep problems described in this book *apart* from his illness, and the problem could be solved in much the same way as for any other child. Of course it may be more difficult for you to be firm at night if your child has a neurological disorder or sensory impairment. You may ask, "How can I leave my child, who is blind, alone in a room crying?" But very often the only way to solve his sleep problem is to be willing to listen to some crying as you help him learn new associations with falling asleep (see Chapter 5). It is still in your child's best interest that you do so. You may just have to proceed much more slowly than you would otherwise. Instead of setting an initial goal of being out of the room while he falls asleep, you might simply work on helping him learn to fall asleep when you are out of his bed, even if initially you remain in the same room. Other steps, such as correcting an inappropriate sleep schedule, are easier to carry out and are quite important, especially in sensory handicapped children who may have a poor sense of daily schedules (see Chapters 8 and 9).

Of course, any medications your child is taking for his disorder could also be the source of his sleep problem. Finally, it may be that your child's brain damage is directly responsible for his inability to sleep—that is, the brain systems that control sleep may not be working properly. Unfortunately, this is very difficult to test.

When I treat a child who is neurologically impaired I first try to identify and treat factors apart from the brain damage, such as medication or a separate sleep problem. I have been successful on a number of occasions, and the child's sleep problem was resolved despite the neurological illness. Only after all other factors are eliminated do I decide that the child is sleeping poorly as a direct result of the brain damage. This is thus a diagnosis of exclusion.

In a number of children the brain damage is in itself the cause of the sleep problem. I saw Reggie, a four-year-old boy who is moderately retarded following a birth injury. He had always been a poor sleeper and although he now falls asleep fairly easily it is not until 10:00 P.M., and he wakes at about 4:00 A.M. He will either stay awake for the rest of the night or not return to sleep for several hours. At the time of waking he calls out, throws toys around the room, and sits and bangs his head against the wall. The parents want very much to keep Reggie at home, but having to get up with him every night is a tremendous

strain, and some of Reggie's behavior is dangerous to himself. During the day Reggie will sometimes nap for about thirty minutes, but rarely longer than that.

When I treated Reggie for the sleep disorder by changing some of the ways his parents handled the bedtime routines and his nighttime wakings, he showed only minimal improvement over several months. Finally I had to assume that behavioral intervention would not work and that he had a true inability to get the sleep he needed. The only other explanation, which seemed to be unlikely, was that he simply didn't need very much sleep, in which case there would be little I could do.

In children like Reggie, sedative medication may be useful. Generally I will recommend such drugs only when I know that brain function has been impaired and am convinced that this is responsible for the sleep disturbance. I have had moderate success with such children using a significant dose of a sedative such as chloral hydrate. While I'm not at all happy about having to use such a drug, these children have been able to go to sleep more easily and, more important, to maintain their sleep long enough to get sufficient rest.

Reggie began sleeping from 9:00 P.M. to 6:00 A.M. While this was still less sleep than "normal" for his age, it was a major improvement and made life much easier for his parents. In addition, in a manner typical for children with neurological impairment, Reggie did not seem to show any lingering drug effects in the morning, and the teachers at his special school said he seemed more alert.

Thus it does seem that children such as Reggie are not sleeping poorly because of any major decrease in sleep requirements. It has also been interesting to note that such children, even when they are on this medication for extended periods, continue to sleep well, whereas a normal child kept on such medication will usually show progressively less effect, then eventual worsening of sleep. Even when I use medication I continue to monitor children frequently and carefully and we will try drug-free periods at appropriate intervals to see if they still need the medication. These are prescription drugs and can only be managed under the care of a doctor. My experience shows that when neurologically impaired children require medication to help them sleep, they seem to need a fairly powerful one in substantial doses. If children show improvement on a mild medication such as an antihistamine, then I am convinced that these children can show the same improvement without drugs.

If your child is neurologically impaired and not sleeping well, you may consider discussing a trial of medication with your doctor. But

before you decide to give your child a strong sleep medication, do try to identify other possible causes of a sleep disturbance and then to regulate his sleep patterns according to the methods outlined in this book. The program has been successful with a number of neurologically impaired children, and just might be all that is needed for your child.

Part Three

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SLEEP RHYTHM
DISTURBANCES

Daily Schedules and Their Effect on Sleep—Biological Rhythms Revisited

A major advance in understanding and treating sleep disorders came when researchers began to view sleep and waking as a rhythm that had to act in harmony with other body rhythms, including body temperature, eating, hormone release, and activity (see Chapter 2). If we are to sleep well and function at our best during the day, these biological rhythms have to be smoothly synchronized.

There are a number of ways in which our body rhythms become irregular and our sleep cycles adversely affected. Most of us are familiar with the condition of jet lag which occurs when you travel across the ocean to a new time zone but find that you do not feel alert when it is daytime there and that you can only sleep when it is nighttime back home. Shift workers experience the same difficulties—they must try to sleep when they feel awake and try to get up when they feel tired. If they change shifts too frequently, their sleep rhythms cannot stabilize and they may have ongoing sleep problems. They will probably have great difficulty sleeping at desired times and may never feel up to par while awake.

Children also have sleep disturbances caused by problems in their patterns of sleeping and waking and in their daily routines. Their schedules may be too irregular, they may be regular but inappropriate in certain ways, or the time of day your child is *able* to sleep may not be the time when you *want* him or her to sleep. If your child's daily patterns are inconsistent, then her sleep at night may be broken. If she naps or eats at unusual times, then she may wake too early in the morning or fall asleep too late at night. If she has become accustomed to sleeping at the "wrong" hours, then she may actually be unable to fall asleep as early or sleep as late as you wish.

Although alterations in daily schedules and biological rhythms may be the only factors affecting your child's sleep, these disturbances are often complicated by other problems. If your child is not tired when you want her to go to sleep, you may inadvertently teach her to associate being rocked or having a bottle with falling asleep as you try to help her settle down. Or if you have difficulty being firm at bedtime, your child may always stay up too late, and the time at which she is able to get to sleep may shift. As you can see then, the treatment may involve several factors. When a child has a sleep problem that includes a disturbance in her sleep rhythm, it will probably not be enough to simply correct her sleep associations or be firmer at bedtime. You will have to correct the schedule problems as well. But to do this, you must learn to recognize and understand your child's particular schedule disturbance so that you can best decide how to treat it.

Irregular Sleep-Wake Schedules

Many of the children I see have difficulty sleeping because their sleep-wake patterns are irregular. They fall asleep early one night, late the next, wake at odd hours, and never have their naps at the same time two days in a row. Mealtimes are just as varied.

Your child's daily pattern may be like this. If you are not sure, chart it (Figure 8, page 105) for one or two weeks. You may be quite surprised by what you find. If her schedule is very irregular, then in all probability her circadian rhythms (see Chapter 2) have become very disrupted. Her body temperature may be rising when she goes to bed and falling when she gets up, the opposite of what it should be. She may be hungry between meals or when she should be sleeping and not hungry at mealtimes. She may be active when she should be napping and sluggish when she should be playing. And your child may have difficulty falling asleep at bedtime—if there is one—and may wake during the night.

It is important that you realize, however, that her problem differs from those of the children with bedtime difficulties and nighttime wakings described in Chapters 5 and 6. For a period of time—hours even—your child *cannot* go to sleep, or back to sleep, no matter what you do. This is true even if you lie down with her, turn on a night-light, are firm, give her a bottle, or nurse or rock her. She *cannot* sleep because her sleep-wake rhythm is in the waking phase.

Children's daily rhythms can only become established and maintained in a regular twenty-four-hour pattern if they are set each day by events that always occur at the same times. The most important of

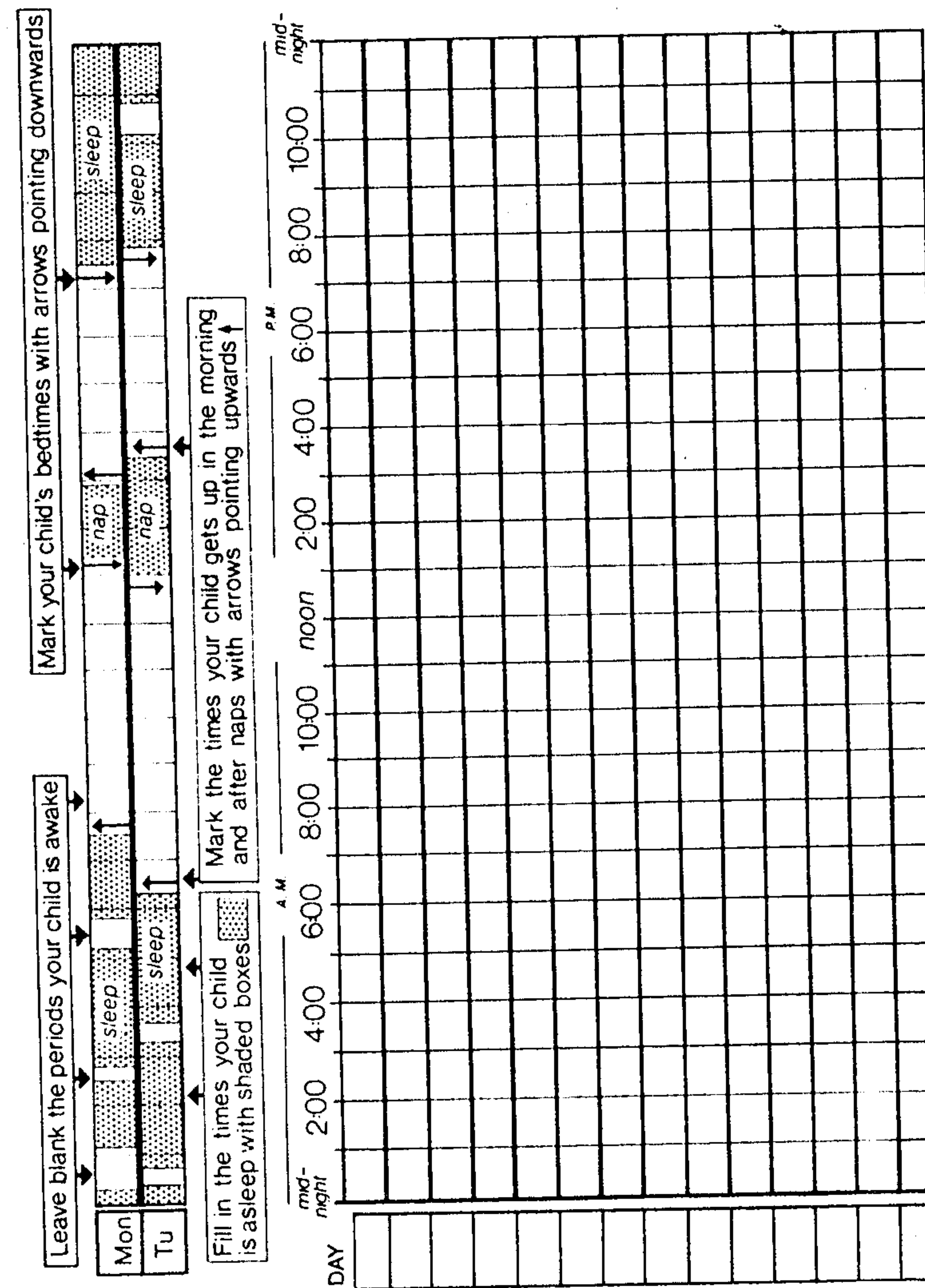


FIGURE 8 Sleep Chart for Parents to Use

these are waking in the morning, going to sleep at night, napping, eating, and exposure to light and dark. If your child does not have reasonable consistency in her daily routines, her system does not know when she should be asleep and when she should be awake.

If your child's circadian rhythms are disrupted, her sleep-wake patterns deteriorate. Her usual sleep pattern, which allows her to sleep for long periods at night and to nap during the day, begins to disappear. When she goes to bed at 6:00 or 7:00 P.M., for example, her body does not know if this is a late nap or an early bedtime. Should she wake up after one hour or ten? Her sleep patterns become disorganized into irregular fragments, none of which even approximates the ten or more continuous hours of sleep a young child should have at night. Instead of her nighttime sleep being interrupted by only brief arousals with rapid returns to sleep, she may have complete wakings for long periods. And some daytime naps may be unusually long.

Jimmy, for example, was a four-year-old boy who would wake in the middle of the night and not want to go back to sleep. He had no formal bedtime and no regular bedtime routines. He went to sleep any time from 7:00 P.M. to 11:00 P.M.—whenever he got sleepy, which depended somewhat on when he had napped that day. Sometimes he fell asleep in his own bed, but more often it was wherever he happened to be at the time.

When Jimmy woke during the night he seemed wide awake. He was not frightened or demanding, but he simply could not be made to go back to sleep quickly. Since he would stay awake even if he had to stay in bed, his parents allowed him to play until he grew tired and fell back to sleep—usually after one or two hours. He often woke a second time a few hours later. He got up in the morning anywhere from 6:30 A.M. to 10:00 A.M., depending on how much he had been up the night before. Jimmy's naps were also quite irregular. Some mornings, especially after little sleep the night before, he could nap as early as 9:00 A.M. On other days he would nap before lunch or skip a morning nap altogether. In the afternoon he might lie down at 1:00, 4:00, or sometimes as late as 6:00 P.M. His naps could be as short as thirty minutes or as long as four hours.

The loose structure in Jimmy's home was not due to family problems or to lack of caring. Rather it was a style typical in his family's community. Among Jimmy's family and their friends, irregular mealtimes and bedtimes were quite common and accepted. Jimmy's parents were not bothered by these irregularities—in the daytime—but they were concerned about his wakings at night. They did not realize there was a connection between the two.

When the family sought my help Jimmy did not have any appropriate associations with getting ready for bed and falling asleep. So, of course, it was important for the family to establish a pleasant bedtime ritual. But this alone, even if it were at a consistent time each night, would not have solved Jimmy's sleep problems. We needed to bring more order to his haphazard daily schedule as well.

Jimmy's fundamental problem with sleep was that his twenty-four-hour sleep-wake pattern had become badly disrupted. When he woke during the night, it was as though he had waked from an afternoon nap. He was happy, energetic, and ready to play, and it was simply *impossible* for him to return to sleep at that time. Although his problem seemed major, the solution was straightforward.

How to Solve the Problem of Irregular Sleep-Wake Schedules

Jimmy's parents agreed to set up a daily schedule for him so that he would have a regular bedtime, a constant time of morning waking, and a consistent naptime. In addition, they would give him his meals at the same times every day. And the parents decided upon an appropriate bedtime routine. Although these decisions were contrary to their customary less-structured lifestyle, they were quite willing to make the changes once they understood Jimmy would sleep better at night and probably feel better during the day.

Jimmy would go to bed at 8:00 P.M. after a story or quiet game, and they would wake him at 7:00 A.M. He would always sleep in his own room. When he woke during the night his parents were to go in; but they had to be firm and not allow middle-of-the-night play, which would only reinforce the wakings. They had to insist that he stay in bed at bedtime or after wakings even if he had difficulty at first falling asleep at these times. They could sit with him if necessary, but there was to be little discussion. Once his sleep rhythm was normalized, which I told them should occur within two weeks, and he could fall asleep or back to sleep quickly, they were no longer to stay with him. He would have to go to sleep alone. They agreed that if need be this would be enforced with the progressive waiting or door-closing techniques discussed in Chapter 5. But as I expected, since Jimmy was never demanding when he was awake, and since he never really associated his parents' presence with falling asleep, these were not necessary.

Naptime was to be at 1:00 P.M. and would be handled like bedtime. I told them that Jimmy should not be allowed to nap at other times. If he managed to fall asleep at the wrong time anyway, they were to

wake him after ten or fifteen minutes. He should have at least one quiet hour in his bed at naptime whether he slept or not. After his nighttime sleep became normal, it would become clear if he needed a daytime nap at all. If he did, he would start napping; if not, he would stay awake all day.

Although Jimmy's problem was long-standing, the family was able to follow through because they now understood the reason for keeping a good daytime structure. They charted his sleep patterns for two months. I asked them to do so for several weeks, but they continued longer because it was so helpful to them. Like most parents, they found it much easier to be consistent when they could see the progress in black and white. Jimmy resisted during the first week, partly because he was used to his old ways and partly because he really couldn't sleep at the new, regular times. His parents were firm and supportive, though at first they were up more at night than they had been before they started to make these changes. Jimmy and his parents came to look forward to the period before bed; it allowed for a closeness they hadn't had before. By the end of the second week Jimmy was falling asleep easily at a regular bedtime and sleeping through the night. It soon became apparent that he did not need to nap, so they didn't try to put him down in the afternoon. The only reason he had been napping once or twice each day was that his sleep rhythms were so disordered and some of the sleep that should have been occurring at night was shifted into the daytime.

Whether the irregular schedule is the main problem, as it was with Jimmy, or is only one factor complicating other problems, setting up and sticking to a regular schedule is a necessary, if not sufficient, step toward resolving most sleep problems. For the first few weeks it makes sense to stick to a fairly strict schedule for going to sleep, waking, and eating. Once things are going well, it is all right to be more flexible within reason. But remember, if your child's days and nights have been fairly unstructured in the past, they will become irregular again if you are not careful.

Usually I have found that schedules become disrupted because the parents have not understood the importance of keeping consistent daily routines. But occasionally the disorganization and loss of structure occurs because of underlying family problems. When issues such as marital strife, medical or psychiatric illness, death, separation, or divorce are involved, parents may find they are unable or unwilling to maintain a normal schedule for the children. In these cases I always urge the family to see a counselor before or during the time we begin to set up schedules to solve their child's sleep problem.

Regular Schedules Can Cause Trouble Too

It is very apparent that children function better when their daily schedules are fairly consistent. However, regular routines can cause problems when they are poorly timed. For example, if you turn on your child's light and practice your tuba every night at 3:00 A.M., your child's sleep will be disturbed—even though the schedule is perfectly regular. But more subtle factors can also influence sleep and result in early-morning wakings, bedtime difficulties, or nighttime wakings.

1. Early-Morning Wakings

One of the most troublesome disturbances, and often one of the hardest to correct, is that of early-morning wakings. Emily, for example, was a thirteen-month-old girl who would wake too early each morning. She went to sleep at 7:30 at night with no fuss but woke at 5:00 every morning and refused to go back to sleep. This meant that her parents had to get out of bed two hours earlier than they would otherwise. Frequently Emily's mother retired early at night just to be able to wake up early enough in the morning to take care of her. Although this was workable, she would have preferred to stay up later and have the time with her husband. Emily's mother said that during the day Emily did well: she napped early in the morning at about 8:00, and again right after lunch.

Emily's problem appeared to be quite different from Jimmy's. She had a regular routine, went to bed easily, and did not wake during the night. Her early waking was really her parents' only complaint. In Emily's case, however, there was one very pertinent fact: her morning nap was unusually early. It seemed that she had to nap early because she woke very early in the morning and would be tired a couple of hours later.

I believed there were two possible explanations for Emily's early waking. One was that she needed less than ten hours of sleep at night and thus would wake up nine and a half hours after an established bedtime. If this were true, then delaying her bedtime to 9:00 P.M. would gradually lead to a later morning waking. However, most children of Emily's age can sleep more than ten hours at night, and so I considered the second alternative first. I believed the early-morning nap was actually the cause of the problem.

I proceeded on the assumption that Emily's final sleep cycle, which should have taken place from 5:00 until 6:30 or 7:00 A.M., had become separated from the rest of the night and appeared several hours later as an unusually early morning nap. Therefore, I asked the parents to

keep her up progressively later each morning before allowing her to nap, aiming for a naptime of about 10:00 or 10:30 A.M. In addition they were not to go in to Emily as soon as she woke at 5:00. We agreed they would not go in before 5:15 for several days and then not until 5:30.

At first when Emily woke in the morning, she would cry. But within a few days after her parents started delaying the morning nap, she began falling back to sleep after a short while. After a week or so the early-morning crying became halfhearted. Emily would wake in the morning, perhaps whimper a bit or play in her crib, and then return to sleep for the final sleep cycle. By then she was waking between 6:30 and 7:00 in the morning and napping twice at more appropriate hours during the day. Thus Emily did not have a short sleep requirement. She could sleep eleven to eleven and a half hours at night and wake at an appropriate time in the morning—once her naptime had been adjusted.

Hillary was two years old and Rory was six. Their stories were very similar to Emily's in that they woke very early in the morning, but neither of them napped unusually early. However, Hillary was given a bottle of milk as soon as she woke at 5:00 A.M. and Rory would get up early and watch cartoons.

Hillary was not fed at bedtime or during the night, so her problem was not one of inappropriate associations or excessive feedings, but she had *learned* to be hungry at 5:00 A.M. If her hunger could be postponed until 6:30 or 7:00 A.M., then she could sleep later. You will find more discussion on the learned aspects of hunger in Chapter 6. By simply delaying the time she would be given the bottle by about ten minutes each day, regardless of when she woke, the parents found she started to go back to sleep after waking at 5:00 and would sleep another hour and a half to two hours.

Rory was simply getting up to watch cartoons. Like most people who are lucky enough to have something they want to do every morning, he learned to wake at the necessary hour. For Rory to learn to sleep later, his family had to insist that he no longer watch television in the morning. In exchange for giving up the cartoons, his family substituted other more appropriate rewards during the day, such as a magic show, a baseball game, and trips to a special playground. It took Rory longer than Hillary, but after about four weeks he too was sleeping later.

Early-morning wakings may also occur because of early-morning noise or light. By 5:00 in the morning your child will have completed most of her night's sleep—the drive to sleep is less strong than at bedtime or earlier in the night. Some children will wake at this hour

if there is even a mild disturbance. Light entering the room, traffic sounds, or noise from an early-rising family member can wake them. These environmental disturbances (like the tuba) may directly cause early wakings. In the process, they affect the sleep-wake rhythms. If the morning disruptions are frequent enough, your child will begin to anticipate them and may wake spontaneously just before dawn, or before the family gets up.

These problems are best solved by reducing the disturbing factors. Light can be reduced by room-darkening shades and perhaps curtains. The curtains will also help to mute sounds from traffic outside, and you may have to shut the windows as well. Sometimes it is helpful for a child who wakes early to switch to a quieter bedroom, changing with a sister or brother who sleeps more soundly. Sources of constant noise, such as "white noise" machines or vaporizers, are sometimes useful. They may help block outside noise that is quite loud and intermittent—heavy traffic or the sound you hear if you live near train tracks or an airport. Generally, however, I believe you should avoid these devices, because your child needs to learn how to sleep under natural conditions and should not be dependent on such a machine. If she is, she will have trouble sleeping where it is quiet.

There are two other situations in which regular schedules are associated with early-morning wakings. One is caused by an early sleep phase, with your child both falling asleep and waking too early (see Chapter 9). The other happens when your child has a short sleep requirement—she actually needs less sleep than you think she does and wakes early for this reason. However, you should not be too quick to arrive at this conclusion. You may find that your child continues to wake early even if you make her bedtime later. Perhaps your child has learned to associate something with waking at that time—a little light at the window, an increase in traffic, and the fact that you come in to her at that hour (which is likely if you view 5:00 as "early morning" and not as "middle of the night"). So, before deciding that your child needs little sleep, try to see if she will sleep longer in the morning. Keep her room dark, then postpone your response to her a little more each day, thus giving her a chance to go back to sleep. Use the technique described in Chapter 5 for teaching new associations. Try the plan for a few weeks and you may find that she begins returning to sleep for a final sleep cycle. If you do this frequently enough it may start to become routine, as it did with Emily.

When the approaches described in this section are successful we have reason to be pleased. But be aware that early-morning wakings are a tricky business. I have also worked with children who were very

early wakers and who continued to wake early despite our best efforts to change their sleep pattern a little. It is likely that these children are "larks"—they wake early feeling alert and active. The early morning is their best time and they tire in the evening. The same happens with some adults, but they are more bothered by difficulty staying up late than by their early wakings. If your child seems to wake too early and does not respond to any of the changes I have suggested here, you may just have to accept things as they are and look forward to the time when she is old enough to be up and about without waking you.

2. Bedtime Difficulties

We have already discussed several causes of bedtime difficulties, including irregular sleep-wake patterns. There are three other schedule-related causes of a true inability to sleep at bedtime, despite a regular schedule: a late sleep phase (discussed in Chapter 9), an inappropriately early bedtime (addressed later in this chapter), and problems related to the child's naps.

LATE AFTERNOON NAP If your child naps from 4:00 to 6:00 P.M. each day, she may be unable to fall asleep before 9:00 or 10:00 at night. If you try to put her to bed earlier you will likely be met with real struggles. Most families will recognize this problem and will make the nap earlier. But, if your child is used to napping at 4:00 P.M. and you want to have her nap at 1:00, she will probably be unable to do so. Again, gradual change works better. Make her naptime and her bedtime ten to fifteen minutes earlier each day until she is sleeping at the desired times. If your child still has a morning nap, it may have to be moved earlier as well to allow for the afternoon nap. If your child has passed her first birthday, she may be able to give up the morning nap altogether.

Sometimes the afternoon nap may only be a little late, perhaps starting at 2:00, or last a bit too long—for three hours let's say—yet still be enough to affect your child's ability to go to sleep at bedtime. It will be relatively simple for you to find out by starting the nap a little earlier or by waking her after only two hours.

TOO MANY NAPS By the second year of life most children have given up their morning nap and sleep in the daytime only in the early afternoon. If your child continues to nap twice a day, it may cut into her nighttime sleep. The amount of sleep she gets in a twenty-four-hour period will be unchanged, but more of it will be shifted to the daytime.

If the morning nap is very early, she may begin to have early-morning wakings. If the naps are later, however, your child may not get sleepy until the late evening. Shifting the naps will just shift the problem. You may have to try to eliminate the morning nap and move the afternoon nap earlier, to right after lunch. If this is difficult to do all at once, then do it gradually. Try delaying the morning nap, and shortening its length about ten minutes each day until it can be stopped completely. Some parents prefer to gradually postpone the morning nap into the early afternoon, while decreasing the length of the afternoon nap until it has been eliminated.

NOT ENOUGH NAPS We might assume that if too much napping will make it difficult for a child to fall asleep or lead to early-morning wakings, then decreasing or eliminating naps will always lead to easier bedtimes and better sleep. However, that is not the case.

Simply making a child sleepy will not always make her sleep better—in fact it may have the opposite effect. When your child is overtired she is stressed, she may become irritable and overactive, and her behavior may worsen. In this state she may find it difficult to relax at bedtime, she may struggle against going to sleep, and she may be awake longer than she should. Even if she does fall asleep promptly, the overtired child may also have increased wakings at night and is more likely to have sleep terrors and other partial arousals (see Chapter 10).

Helen was two and a half years old and refused to go to sleep until at least 10:00 P.M. Her parents said that she used to sleep several hours each day in the late afternoon, but they had cut out her nap, trying to improve her bedtime. When they did this, however, several new problems developed. Helen continued to be sleepy in the late afternoon and her parents had to work hard to keep her awake. She seemed quite unhappy at this time and wanted to sleep. If she happened to be in the car at that time she would always fall asleep and be difficult to wake. Dinner became unpleasant because Helen was so irritable. After dinner, when it was time for Helen to go to sleep, she got a "second wind." She seemed almost overcharged, and putting her to bed at 8:00 P.M. was impossible.

I told Helen's parents that she was overtired. She had to have an afternoon nap, but at an appropriate hour. We started with a late nap when Helen got tired and gradually made nap- and bedtimes earlier. She now is napping an hour and a half in the daytime after lunch and sleeping several hours more at night. Her problem was not that she didn't need much sleep, it was that she wasn't getting enough. With

the extra sleep, she became much happier during the day and settled down easily at bedtime.

With younger children, you may have a similar problem if you eliminate the morning nap too soon, especially if your child's nighttime sleep does not increase proportionally. Older children who no longer need a nap may also have bedtime difficulties when they are overtired because their bedtimes are too late.

If you wait until your child seems very sleepy before you put her to bed you may be waiting too long. Try an earlier bedtime with a nice bedtime ritual and you will probably find she falls asleep quickly. She will get more sleep and her behavior in the daytime may improve.

If your child never seems tired at bedtime and if you have explored all the causes of bedtime difficulties and nothing seems to fit, it could be that your child is an "owl." She will be at her best late in the evening and always have trouble waking in the morning no matter how much sleep she gets. Even if she stays on a fairly regular schedule, she may have difficulty falling asleep at the proper bedtime. This pattern is common in adults, but happens less frequently in children. Children fall asleep much more easily than adults. If your child has this tendency to "wake up" near bedtime, you should still be able to avoid major problems, but you will have to keep her on a very regular schedule. You must be especially sure that she wakes at the same time every day. And you should plan her bedtime routines with care and assure that they are not rushed.

3. Nighttime Wakings

Regular schedules are not usually a *cause* of nighttime wakings, although a child who is not getting enough sleep may wake repeatedly during the night as well as, or instead of, having bedtime struggles. A more common way in which regular schedules can lead to nighttime wakings is through regular nighttime interruptions. Recurrent feedings at night are the most common cause of this (see Chapter 6). Sometimes a child may get other reinforcement for waking at night. If you make the nighttime waking time very pleasurable for your child—by going in and playing with her—then she will be motivated to continue waking. In this case you must eliminate the play if you want your child to learn that there is no point in waking during the night. Even if you scold or punish your child during the night wakings, the wakings may still be reinforced by the attention she gets. This is especially likely if your child gets too little attention during the day, and particularly if she spends too little time with you alone. If you think

this might be the case, do your best to set aside special times for her in the daytime. When she feels less needy she will not demand attention at night. If you find that you are unable to provide extra time for her, or if she seems very needy even when you do, then you should consider seeing a counselor to help you decide what the problem is and how best to proceed.

Normal Sleep, Abnormal Expectations

You may be dissatisfied with your infant's or toddler's sleep patterns, but they may be completely normal. Perhaps you like the time after 7:00 in the evening for yourself and also like to sleep until 10:00 in the morning. If your child falls asleep at 7:00 P.M. and wakes at 6:30 A.M., or if she won't go off to sleep until 10:30 P.M. but sleeps until 10:00 A.M., you may be irritated with her. But be mindful of the fact that your child only needs a certain amount of sleep, and you will have to consider her schedule as well as your own. Most children simply cannot sleep for fifteen hours. If your child is sleeping ten to twelve hours at night she is quite normal; it is your expectations that need to be adjusted. You can't have it both ways: with your child going to bed early and waking late. But you can make her schedule more convenient for you. Observe how much sleep she gets, then adjust her present sleep period so that it best fits with your schedule (see Chapter 9). But you will have to make concessions: you will have to be up with her later at night or you will have to get up with her earlier in the morning than you might like.

This problem is not limited to young children. Gregg, for example, was twelve years old and his parents complained that he would not go to bed at bedtime. He would stall for two hours and his parents would get very angry. Gregg had any number of excuses—he was thirsty, he had to go to the bathroom, or he wasn't tired. The last of these was quite accurate. His parents expected him to go to bed at 8:00 P.M. and get up at 7:00 A.M. But eleven hours was much more sleep than Gregg needed at night. The 8:00 bedtime was unrealistically early. When the parents agreed to move the bedtime to 9:45 P.M., the problems disappeared and Gregg fell asleep quickly.

It may also be that bedtime is not a problem but your child has difficulty waking in the morning. Ten hours of sleep may seem reasonable, but perhaps your child needs twelve. She should have an earlier bedtime. If she is an adolescent and still needs twelve hours of sleep at night, however, you may have problems. Most teenagers wouldn't consider going to bed at 6:00 or 7:00 P.M. Your child may have to be

somewhat sleep-deprived during the week and try to make up for it on the weekend. It is a compromise, but it may be the best solution.

The chart on page 19 is a guideline for how much sleep children need at each age. Each child is different, however, and estimating your child's sleep requirement is not always easy. You can usually get a good idea by watching her sleep patterns. Chart her sleep for one to two weeks and see how much sleep she now gets, especially when she does not have to be waked in the morning, and see if she seems tired or irritable in the daytime. If your child needs more or less sleep than the chart suggests, you may have to adjust your expectations accordingly.

Chapter 9

Normal Sleep at the Wrong Time— Sleep Phase Shifts

By now you know that your child's ability to fall asleep and to be awake varies throughout the day. This rhythm is closely synchronized with his or her other body rhythms, especially with the rise and fall of body temperature. There are definite sleep and waking periods in the daily circadian rhythm (see Chapter 2) which allow your child to fall asleep easily and wake naturally. If you try to put him to bed in the waking phase you may find he seems "unwilling" to go to sleep; but the fact is he simply is not sleepy. And if you try to wake him up in the sleep phase, you again may find he seems "unwilling," this time because he really isn't ready to wake.

The same holds true for you. Let's say you usually sleep from 11:30 at night until 7:30 in the morning and that you fall asleep easily and wake without an alarm, feeling rested. The sleep phase of your sleep-wake cycle clearly runs from 11:30 P.M. to 7:30 A.M. Now think for a moment what will happen if you try to change your bedtime or your time of waking.

- *If you go to bed early, let's say at 8:00 P.M., before the start of your sleep phase, you will have difficulty falling asleep—even if you do doze, you certainly won't sleep through the night.*
- *If you try to wake early, perhaps at 4:00 A.M., before your waking phase begins, you will be very sleepy and have much difficulty getting out of bed. You may feel terrible for several hours, but then near the hour you would normally wake, you will start to feel ready to face the day.*
- *If you go to bed late after your sleep phase begins, possibly at 2:00 A.M., you will fall asleep easily but you will wake "early,"*

that is, close to your normal waking time when your wake phase begins. Thus you will get less sleep than usual and you may feel tired during the day.

- If you try to sleep late, into your waking phase, perhaps until 10:00 A.M., you probably will be unable to do so. Or at best you will doze on and off for the last few hours.

As you recall from Chapter 2, our basic daily rhythms tend to cycle every twenty-five hours and we reset them to twenty-four hours by our daily routines. Because of this, we have a tendency to stay up a little later each night and get up a little later each morning. Thus, the third and fourth schedule changes described above—going to sleep later and waking later than usual—are easier to do than going to sleep early or waking early.

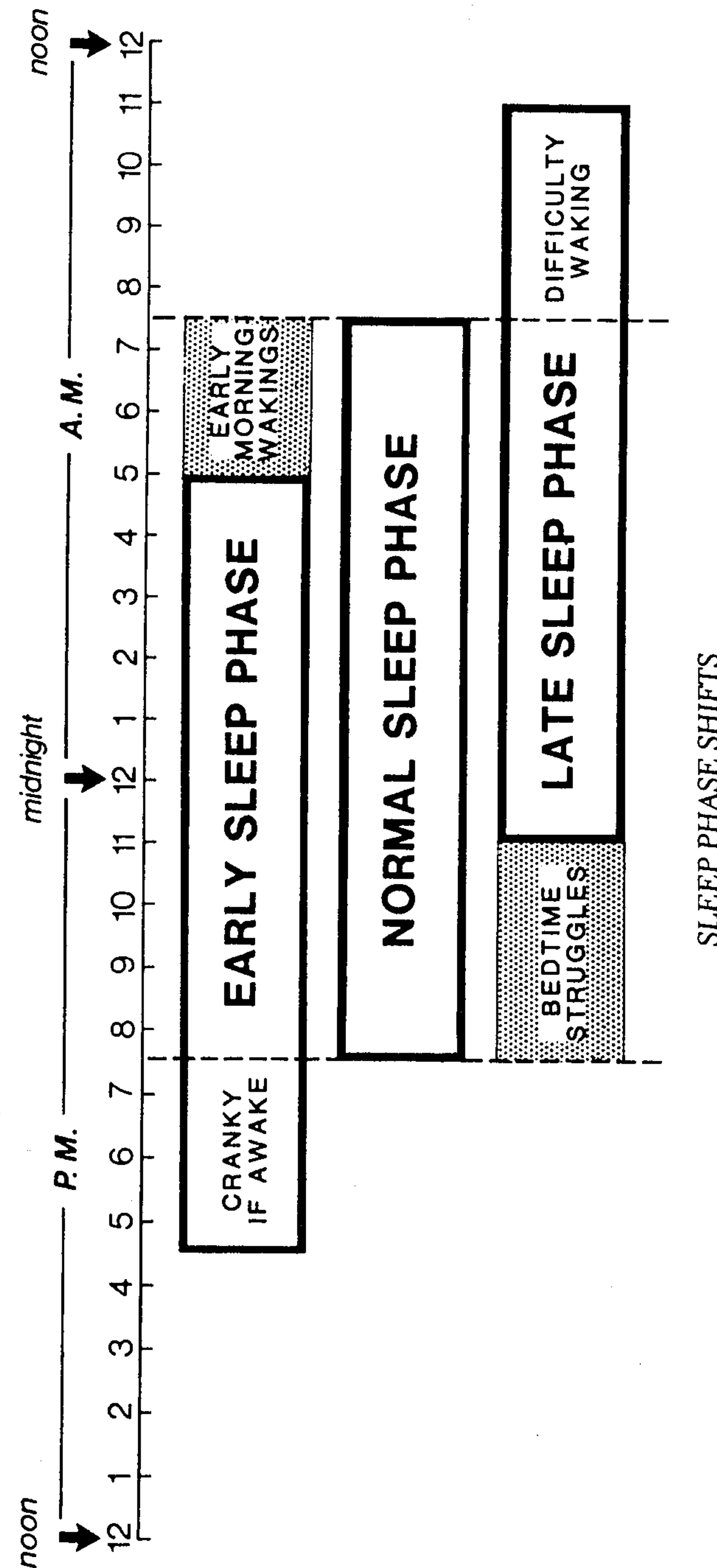
These examples describe what happens if you try to go to sleep or wake at times that do not coincide with the beginning and end of your sleep phase. The same is true for children. When their bedtimes or times of waking do not match their sleep-wake rhythms, they may have trouble going to sleep at night and difficulty getting up in the morning, or they may have problems staying awake until bedtime in the evening and then may wake too early in the morning. When this happens, it means that the sleep phase of your child's sleep-wake cycle is not where you want it to be—it has *shifted*. It may be too early—an *early* sleep phase—or it may be too late—a *late* sleep phase.

Early Sleep Phase

Your child has an early sleep phase if his natural sleep period—the time from when he falls asleep at night to when he wakes in the morning—occurs earlier in the twenty-four-hour day than you would like (see Figure 9).

Nina was eight months old and her parents were bothered by her sleep schedule. She went to sleep at 5:30 P.M., slept well, and woke at 5:30 A.M. Her two naps started at 8:30 A.M. and 12:30 P.M. She had her meals at 6:00 A.M., 11:00 A.M., and 4:00 P.M. Her parents' main concern was her 5:30 A.M. waking. They wanted her to sleep until 7:00 A.M. Yet when they tried keeping her up until 7:00 P.M., she became very fussy and she still woke at 5:30 A.M.

Although Nina was eating and napping early, she was getting twelve hours of sleep at night. The early feeding and nap were not causing the waking. In fact, Nina's whole schedule—sleeping, waking, and eating—was completely normal, except that it had shifted so that



This chart shows where in the 24-hour day a young child's sleep phase may fall. Here a normal phase is assumed to run from 7:30 P.M. to 7:30 A.M. An early sleep phase occurs when the phase shifts to earlier hours, and a late sleep phase occurs when it shifts to later hours. Of course, the position of the "normal" phase depends on the particular schedule required by your child and your family. For an older child, the length of the normal phase will be shorter and will begin later.

everything happened about an hour and a half too early. Her sleep phase began and ended ninety minutes before her family wanted it to. So if we could delay the timing of her sleep phase by ninety minutes, everyone would be happy.

How to Adjust an Early Sleep Phase

Although it was only Nina's time of waking that annoyed her parents, they agreed it would be more convenient if her meals, naps, and bedtime could be adjusted to coincide better with their schedule. I told them that we would have to intervene gradually. Simply keeping Nina up late for one or two nights would not help, because that did not allow enough time for the sleep phase to shift to a new time. Furthermore, changing the bedtime and not changing the rest of the daytime schedule was not enough.

When Nina's parents understood what was happening, they agreed to change her complete schedule a little at a time. Nina's bedtime, meals, and naptimes would be moved ten minutes later each day. After nine days she would be going to bed at 7:00 P.M., napping at 10:00 A.M. and 2:00 P.M., and eating at 7:30 A.M., 12:30 P.M., and 5:30 P.M. Things went very well. As often happens, the changes in morning waking lagged behind the other changes, but after two and a half weeks this too had improved. Nina's overall schedule was now the same as before—but at a better time of day. The problem had been resolved and Nina's sleep phase was no longer early.

An early sleep phase is less common than a late sleep phase, because our natural tendency is to shift later, as you will recall in our discussion of the inherent twenty-five-hour cycle (see Chapter 2). But an early sleep phase occurs often enough—especially in very young children. Although toddlers are less likely than infants to try to fall asleep earlier than you think they should, some of them may, and if they are frequently allowed to do so, their sleep phases may shift in an early direction.

If your child has an early sleep phase, it will be fairly easy to recognize the problem and gradually correct it. Remember, it often takes at least two weeks to shift and fully stabilize sleep rhythms even by as little as one and a half to two hours. And don't forget to examine your child's entire daily schedule, not just his bedtime. You may have to alter nap- and mealtimes as well. And like Nina's parents, you may have to make a compromise. You will have to decide where you want the sleep phase to be, realizing that *a later waking means a later bedtime*. If your child is already getting the amount of sleep he needs,

you can change the time of day he sleeps, but you cannot substantially increase the number of hours.

Late Sleep Phase

If your child's natural sleep period occurs later in the twenty-four-hour day than you would like, he has a late sleep phase (see Figure 9). This problem occurs in children of all ages and is very common.

I first saw Matthew just after his first birthday. His parents described problems with him both at his 7:30 P.M. "bedtime" and again in the middle of the night. At bedtime they tried to rock him to sleep, but he did not seem tired. He fussed and cried and did not settle. Generally his parents simply gave in, let him play for a while, and then tried again later to help him get to sleep. Most nights Matthew finally fell asleep at about 10:00 P.M. He slept fairly well at night except for one waking at about 3:00 A.M. Although he would be crying, he did not seem wide awake, as at bedtime, and he could always be rocked back to sleep quickly. In the morning, because Matthew had fallen asleep so late and his parents felt he should catch up on his sleep, they left him until he woke on his own, about 10:00 A.M. Also, his mother found that when she did have to wake him earlier, for example at 7:00 A.M. for errands or a trip, Matthew was difficult to wake and he remained cranky for several hours. Matthew napped twice a day, once at noon before a 1:00 P.M. lunch and again at 4:00 P.M. Matthew had a late sleep phase. His sleep phase ran from 10:00 P.M. to 10:00 A.M., but his parents wanted him to have one that started at 7:30 P.M.

Vanessa was seven years old. Although six years older than Matthew, she suffered from the same basic problem. Despite the fact that she behaved well during the day, her bedtime at 8:30 P.M. had become the source of major struggles and was quite unpleasant for the whole family. Vanessa resisted the bedtime routines, and tension would start to build by 7:30 P.M. Like many children, she had a variety of excuses for not wanting to stay in bed: She was thirsty, her stomach "hurt" (sometimes "so much" that she cried), and she didn't feel tired. Often she said she was frightened and wanted the light turned on, the shades pulled, and her closet door shut. She never fell asleep before 11:00 P.M.

Her parents were very upset, confused, and concerned about her behavior and had tried many ways to improve things. At first they thought they were being "too soft," so they refused to go along with her extra requests. Then they tried punishing her by taking away privileges and occasionally with spankings. All of this only seemed to

make matters worse. They became concerned that Vanessa might really be suffering from a stomach ailment. Although the doctor reassured them that Vanessa was healthy and that stomach pains which occur only at bedtime are not a cause for alarm, they had lingering doubts. And they remained concerned about her nighttime fears. They talked to her at length about her problem getting to sleep and asked whether she was upset about something, but she claimed not to be. They spoke to her teachers. Everything in Vanessa's life seemed quite normal, except bedtime. Finally they came to believe that she did not have a significant emotional problem, but they remained mystified as to what might be keeping her from falling asleep. In the morning they always had to wake her for school and always with great difficulty. She was grumpy in the morning, slow to become fully alert, and did not feel like eating breakfast. Now and then she seemed so tired that they let her stay home rather than go to school.

At this point in our initial conversation I was already suspicious that Vanessa's main problem was a late sleep phase—that her "natural" times of falling asleep and waking were too late. After we talked a bit more, I was sure. On weekends or vacations Vanessa slept late, till about 10:30 A.M., unless there was a very important morning activity. On waking at that hour she would be in good spirits and want to eat breakfast. And I discovered that Vanessa always fell asleep between 11:00 and 12:00 P.M. no matter what time she was sent to bed. There was nothing her parents could do to make her fall asleep earlier. Even if they sat with her, she would be up for a few hours. But *when she got to stay up late*—perhaps to 11:30 P.M.—after a family outing, on a special occasion, or on vacation, *she went to bed without objections*, without stalling, without stomachaches, and without feeling afraid. And she fell asleep quickly. There was *no problem when she went to bed when she was ready to fall asleep*.

For Vanessa, and other youngsters like her, having to stay in bed unable to sleep for several hours is unpleasant. She would lie there, toss and turn, and *think*. It was hard for her not to have scary fantasies in bed, wide awake, alone, in a darkened room, without distractions. It is really not so surprising that Vanessa objected so vehemently to going to bed. She faced a dilemma each night. Either suffer alone in bed or get up and have her parents angry at her.

Both Matthew and Vanessa had a late sleep phase. And both of them had all of the main symptoms:

1. Bedtime struggles or difficulty falling asleep at the expected bedtime, regardless of bedtime rituals or punishment.
2. Difficulty waking at a "normal" hour.

3. Consistent (but late) time of falling asleep.
4. No bedtime struggles or sleep difficulty when bedtime is near or later than the usual time of falling asleep.
5. Amount of sleep is normal when morning wakings are allowed to occur spontaneously.

If your child suffers only from a late sleep phase, then he will not have nighttime wakings. Matthew, however, did wake at night because in his parents' efforts to get him to sleep they had inadvertently taught him to associate rocking with falling asleep. And in some ways Vanessa was like a child testing limits or with exaggerated fears. But these symptoms proved to be secondary to her inability to go to sleep early. They were not causing the problem.

How Late Sleep Phase Begins

Late sleep phase shifts occur for a number of reasons, but the most common underlying factor is the natural tendency of the sleep cycle to drift later unless held in check by an appropriate and regular schedule. For example, if your child doesn't have a regular schedule and is allowed to stay up late at night and to sleep late in the morning, his cycle will gradually drift on its own. If he goes through a period in which temporary fears, excitement, a trip, or an illness interfere with his falling asleep, and at the same time he is allowed to sleep late, his cycle may also shift. Then, even when conditions return to normal, he may have a problem falling asleep at the old bedtime.

Also, some people seem more prone to develop a late sleep phase than others. As discussed in the last chapter, so-called "owls" like to stay up late; they feel energetic and productive at night but have difficulty waking in the morning regardless of the amount of sleep they have had. At the slightest opportunity they allow their sleep-wake schedules to begin moving later and later. But "larks," as you remember, do not feel very alert in the evening; instead they wake early in the morning full of energy. Larks will be much less likely to let their sleep phase shift late, even on vacations.

We don't know at what age these differences develop in children or if they carry these early tendencies into adulthood. And we don't know if these differences are inborn or if they arise primarily from environmental influences, such as growing up on a farm or having parents who work at home and maintain late schedules themselves. But we do know that many children—infants, toddlers, school-aged children, and certainly adolescents—already show a preference for either early mornings or late evenings.

In any case, family patterns may be important in determining how a late phase develops. If you like to sleep late, are happy if your child sleeps late, and are not tempted to wake him regularly at an earlier hour, then his sleep phase may begin to drift. But if you are an early riser, like to get up and out, and are unwilling to sit around waiting for your child to wake on his own, it is less likely his sleep phase will become delayed.

You may be wondering how Vanessa's sleep phase had drifted when she had to get up early five days a week. It was really the weekends that were keeping Vanessa in trouble. Sleeping late even one or two mornings a week may be enough to allow a sleep phase to drift late or to prevent it from being pushed back, earlier. It is not difficult to imagine how Vanessa must have felt. Many of us stay up late Friday and Saturday, sleep late Saturday and Sunday, and find that we have trouble going to sleep early Sunday night and can hardly get out of bed Monday morning.

How We Solve the Problem

Once you recognize that your child's problem is due to a late sleep phase, treatment is relatively straightforward. The easiest way to treat a delayed sleep phase is to begin with a schedule that fits his present times of falling asleep and waking, then gradually advance the sleep phase by making the bed- and waking times a little earlier each day.

If you are going to adjust your child's sleep schedule, allow him—for now—to stay up until about the time he normally falls asleep so that you can be assured he will fall asleep fairly easily. Thus you will eliminate the bedtime arguments. Bedtime can then become a pleasant period rather than one full of tension, bickering, anxiety, and frustration. If your child is old enough to understand, he will be relieved to learn you are no longer angry with him for not settling down earlier and that you agree that, at least for a while, he should be allowed to stay up much later.

Next you must decide when you want your child to sleep. If you and he do not have to be up and out at an early hour, then you have some choice. For example, I told Matthew's parents that he could sleep about twelve hours, starting any time between 7:00 P.M. and 10:00 P.M., but they would have to choose. Vanessa's family had less choice; Vanessa had to get up for school.

Now you can begin to adjust his schedule. To move his sleep phase earlier, you must begin in the morning. You cannot *make* a child fall asleep, but you can make him wake up. If your child does not have to

be up and out of the house early because he is not yet in school or day-care or because he is on vacation, then you can begin with his natural time of waking. Every one or two days wake him about fifteen minutes earlier. For example, Matthew, who usually woke at 10:00 A.M. was awakened for two days at 9:45 A.M., two days at 9:30 A.M., and so on. After the waking has been moved up by thirty to sixty minutes, so that your child is mildly sleep-deprived each night, you can begin making his bedtime earlier too. For Matthew this meant going to bed at 9:45 P.M., then 9:30 P.M., then 9:15 P.M. and so forth. Once you have reached the desired morning waking time, you may have to continue to advance the evening bedtime somewhat because you started the morning changes first. At this point you may also have to make other small adjustments in sleep times and daily routines to insure a sleep pattern that is both satisfactory and convenient. If your child's nap- and mealtimes are late, as they were with Matthew, you will have to change these gradually as you advance bedtime and waking.

You may find that when you begin to advance your child's hour of waking in the morning he will be a little more tired during the day and will have a natural tendency to add fifteen to thirty minutes to his nap. Don't allow this to happen. If he has been napping for an hour and fifteen minutes, hold him to that schedule so that he will need to go to sleep a little earlier at night.

If, like Vanessa, your child is already getting up early for school five days a week, you will have to work with the bedtime schedule. You will not be able to let him sleep late and begin waking him progressively earlier. You should still start with a late bedtime but you must wake your child at the same early hour *every day*, including weekends. We did this with Vanessa. I knew at first this would leave her a bit tired each day, but as long as she didn't nap, it would be easier for her to fall asleep at the earlier hour once she started to advance her bedtime. I suggested to her parents that they allow Vanessa to have an 11:00 P.M. bedtime for two weeks to give them all a chance to enjoy peaceful bedtimes, an experience they had never had. Then they should move Vanessa's bedtime about fifteen minutes earlier every week. There was to be no rush about moving up the bedtime. We wanted to avoid having Vanessa lie awake in bed for long periods. If the family could keep the earlier morning waking consistent, then Vanessa would gradually be able to go to sleep earlier. It took about three months to get Vanessa's bedtime to 8:30 P.M. But they were three easy months. Bedtimes were pleasant. The main problem for the parents was having to get up early on Saturday and Sunday so that there

wouldn't be any setbacks in Vanessa's progress, but they both agreed it was worth the inconvenience.

You will know that you've really solved your child's late sleep phase problem when he begins waking on his own at the right time in the mornings, especially during the week when the wakings are for school and not for cartoons. This is the most telling sign that his sleep phase is now appropriately positioned within his twenty-four-hour day.

In Matthew's case, advancing the sleep phase was complicated by his associations of being rocked with falling asleep, which also needed to be corrected. We had three choices: correct the sleep phase and the association at the same time; correct the association first and the sleep phase second; or advance the sleep phase, then stop the rocking. Any of these would work. I believed that since Matthew actually went to sleep fairly easily at 10:00 P.M. and only had to be rocked briefly once during the night, this association could be broken within a few days. The parents kept the 10:00 P.M. bedtime for the three days it took to break his association to rocking. Then they began waking him in the morning and putting him to bed at night ten minutes earlier every other day. In less than three weeks Matthew was sleeping well and at the appropriate times.

I must stress again how important it is for you to know exactly what is causing your child to sleep badly before you try to correct the problem. With Vanessa, for example, the ongoing bedtime battle would certainly have become worse if she had simply been made to stay in bed from 8:00 P.M. until she fell asleep, and her nighttime fears and physical complaints would only have increased. But by allowing her to start with a later bedtime, the nightly fights with her parents disappeared, and Vanessa fell asleep rapidly. Admittedly she did not enjoy having to wake early on weekend mornings, but this unpleasantness progressively lessened as her sleep phase moved earlier and, in any case, was minor compared to what the nighttimes had been like for her in the past. She cooperated fully, and she and her parents were delighted with the results.

Late Sleep Phase in Adolescents

Adolescents often have problems with a late sleep phase and they are more difficult to treat. On the weekends, teenagers frequently stay up late and then sleep until noon or later, and their sleep cycles can shift profoundly. As a result they may well be very sleep-deprived during the week when they most need to be alert.

Arthur, a fifteen-year-old high school junior, had trouble falling

asleep early and difficulty waking for school for many years; but over the summer before he came to see me, the situation developed into a major problem. By the start of school he was going to bed at 11:30 P.M. on weeknights but was unable to fall asleep until 4:00 or even 5:00 A.M. He would listen to the radio and occasionally get up to get something to eat. Needless to say, he had great difficulty getting up for school at 6:30 in the morning and in fact had missed many days.

His parents were becoming angry with him and there were battles every morning when they had to try over and over again to wake him. On the weekends Arthur would often stay up very late watching television and not even bother getting into bed until 3:00 or 4:00 A.M. On weekend mornings and when he missed school, he would sleep until noon or 1:00 P.M.

Arthur's problem is a bit more complex than that of younger children with a late sleep phase because it is much more difficult for a parent to assume control over an adolescent's sleep cycle. Even if your teenager understands the importance of maintaining a regular sleep schedule, he may be unwilling to do so. Pressure from friends is very strong in these years and most adolescents love to stay up late watching television, talking on the phone, or listening to music.

Arthur was an average student. Although he didn't particularly like school, he did want to attend and graduate. He was quite upset about having so much trouble falling asleep at night and he hated getting up in the morning after only two hours sleep, feeling tired, listless, and in a fog. When he was in school he was so exhausted that he had a great deal of difficulty paying attention. He was happy when I told him that I understood what was wrong and that we could solve his sleep problem. He found it reassuring to learn that I sympathized with his difficulty waking in the morning, that I knew he was not just "lazy," and that I agreed that he *couldn't* fall asleep early, at least not yet.

Like Matthew and Vanessa, Arthur had a late sleep phase, but his was a very late sleep phase, with a delay of five or six hours. His sleep phase ran from about 4:30 A.M. to 12:30 P.M. Although theoretically Arthur could have changed his sleep phase by getting up early seven days a week and not napping, I knew that, in practice, such a five- or six-hour shift in a fifteen-year-old would be very difficult to achieve by that method. All the time he was shifting he would be getting much less sleep than he needed. He would be tired, his motivation would fail, and he might sleep late occasionally, especially on the weekends. If he could not stick to the planned time of waking every day, then the treatment would not work.

So for Arthur we needed a somewhat different approach. First of all it was important that he assume control over his bedtime and wakings. In particular he should be responsible for getting up in the morning. He was not to rely on his parents; he had to take over that job himself. He bought a clock radio, set it to a loud morning talk show, and had a second backup alarm clock across the room just in case. Also, he was to stop listening to the radio in bed when it was time to go to sleep. Although it is more pleasurable to listen to the radio than just to lie quietly, if you are interested in the radio show it is harder, not easier, to fall asleep.

To correct the timing of Arthur's sleep phase the quickest and easiest way possible, he had to go to bed later each night. Yes—*later*. Instead of struggling to make his sleep phase earlier, Arthur was to delay it further each night until he had gone around the clock to the times he wanted—for example, until he was going to sleep at 11:00 P.M. and waking at 6:30 A.M. At that point the morning waking time would become key. Once he was sleeping at more normal hours, he would be able to maintain his sleep phase by getting up at the same time every morning, even if he stayed up later on the weekends. I felt that Arthur would be more likely to follow through with the plan if he were allowed to stay up late some nights. And as long as he got up by 6:30, or perhaps 7:30 at the latest on the weekends, the occasional late bedtime would not cause his sleep phase to shift later again. He also agreed to chart his sleep patterns so that he and I could follow his progress.

Arthur was to go to sleep and get up three hours *later* each day until he reached the desired times for bed and waking (see Figure 10). For example, the first night he was to go to sleep at 7:00 A.M. and plan to wake by 3:00 P.M. The next day he would go to bed at 10:00 A.M. and get up at 6:00 P.M. He was to continue this pattern of progressive change until he arrived at an appropriate schedule. If he overslept while making the shift it would help to speed up the process, but once he began to near the correct times, he had to be sure that he did not sleep past 6:30 A.M.

If you have a teenager with a late sleep phase, you will find this adjustment is fairly easy to make, it means that during the period of change your child is falling asleep quickly, getting enough sleep each night, and not having difficulty waking. Because of this he will lose any unpleasant feelings he may have learned to associate with just being in bed. Also, this schedule goes in the same direction as the natural tendency of his circadian rhythms—a little later each day. Within a week he should be sleeping and waking at the desired times.

Then, as long as he keeps his morning wakings constant, his sleep cycle will remain regular and become progressively stable. During this program he may have to miss one or two days of school but this can be kept to a minimum by starting the program in the early hours of a Saturday morning. If this is done, he will be sleeping during the morning on Saturday, Sunday, and Monday, but by Tuesday or Wednesday he won't be going to sleep until after school (see Figure 10). And once his sleep schedule is adjusted, his attendance should be even better than it was before.

If your teenager's sleep phase is only one and a half to three hours late, however, it makes more sense first to try and correct the phase shift by starting with the late bedtime and then moving it progressively earlier while keeping the time of morning waking early every day and avoiding naps. You cannot do this for him. You can explain to him the "why" and "how," but *he* must want to change things and *he* must be willing to get himself up each morning.

A "Desired" Late Sleep Phase

There is one other form of late sleep phase that we see mainly in adolescents. Some teenagers actually want a late sleep phase, although they may not be willing to admit it. It is important that you be able to recognize this problem because it won't get better by the types of schedule changes described here.

Susan was fourteen years old and, like Arthur, she had a very late sleep phase, but with several important exceptions. Instead of her problem being worse in the summer, when she didn't have to get up for school, it improved. In fact in the summer she slept from 1:00 A.M. to 9:00 A.M. But during the school year, Susan usually fell asleep at 5:00 A.M. and woke at noon. The school made special allowances so that she could come in at 12:30 P.M. for a half-day, but shortly afterwards Susan became unable to fall asleep until 7:00 A.M. or wake before mid-afternoon. When I saw Susan she had missed most of the first semester. Her parents tried to get her up in the morning but they had to go to work, and Susan usually went back to sleep when they left. Although Susan's problem had only been severe since she started high school, she had always fought going to school and was absent frequently. Her family situation was tense, unhappy, and unsupportive; and Susan's feelings about school had never been resolved. She was depressed, she had no close friends, and she hated school. Because she was unable to fall asleep until morning and could not wake until the afternoon, she missed a great deal of school, and she had

	Bedtime	Waking
<i>Sleep phase BEFORE starting program</i>	4:30 am	12:30 pm
Saturday	7:00 am	3:00 pm
Sunday	10:00 am	6:00 pm
Monday	1:00 pm	9:00 pm
Tuesday	4:00 pm	midnight
Wednesday	7:00 pm	3:00 am
Thursday	10:00 pm	6:00 am
Friday	11:00 pm	6:30 am
<i>Sleep phase AFTER finishing program</i>	11:00 pm	6:30 am

FIGURE 10 A Sample Routine for Around-the-Clock Sleep Schedule Change to Correct a Late Sleep Phase

little opportunity to spend time with other children her age. But that was what she really wanted. Susan allowed her sleep phase to shift because it gave her an excuse to stay home, to miss school, and to avoid being with her peers. She convinced her family and herself that she "wanted" to have a more normal sleep schedule but just "couldn't." This was partially true. She *couldn't* fall asleep early once her sleep phase had shifted, but she also didn't *want* to.

Adjusting Susan's sleep phase, either by gradual advance or progressive around-the-clock delay, would not work, because she would never cooperate. We tried a progressive delay just to be sure, but she did not follow through at all. Although she had previously complained that she couldn't fall asleep before 7:00 A.M., she now said she was "unable" to stay up later than that, but she never really tried. Instead, before 7:00 A.M. ever arrived, she would get into bed and turn out the lights.

Susan was depressed and isolated with very little self-esteem. Most of all she hated going to school. If she did not have to go to school, her sleep problem would have largely corrected itself.

For Susan and other youngsters like her there can be no direct treatment of the "sleep problem" because the sleep isn't really the problem. The late sleep phase is only a symptom of an emotional problem and the proper treatment is psychotherapy. In situations like Susan's I always recommend psychological evaluation and counseling. Often family therapy is the best approach because the problems are usually long-standing and intimately tied to the child's relationships with other family members. Sometimes a child may even feel an obligation to stay home during the day to care for a parent who is feeling depressed and isolated. Here the parent is actually providing subtle encouragement for the child to maintain a late sleep phase. Since neither of them really wants anything changed, the recommendation for counseling is often turned down.

If the family does follow through and obtains the needed counseling, things will improve and the sleep problem will usually resolve on its own without carefully planned schedule changes. If it does not, the necessary adjustments can be made later.

Susan and her parents were initially quite reluctant to seek any form of counseling. But, after a few months they finally agreed to give it a try. At first they found it difficult to discuss matters openly. Very gradually, however, they began to understand many of the problems they previously denied even existed. Although many issues remain to be settled, the family has already made much progress. Susan still does not like school, but she is attending regularly. She is not outgo-

ing, but she has made a few tentative efforts toward making friends and is clearly happier. Family relationships have improved. And though she still tends to stay up until about 1:00 A.M., her sleep phase is now much closer to normal than it was before. If Susan and her family continue to take advantage of the help they are receiving as they work out their problems, I am confident that things will continue to improve even further.

Part Four

et al.

INTERRUPTIONS DURING SLEEP

Sleeptalking, Walking, Thrashing, and Terrors—a Spectrum of Sudden Partial Wakings

Lisa, at eighteen months, was a happy baby, but every night, a few hours after falling asleep, she woke crying and rolling about in her crib and could not be comforted. Eldridge, at two and a half years, would wake two or three hours after falling asleep and thrash and yell in a bizarre manner for fifteen to twenty minutes. Marcy, at age four, would often moan, babble phrases that were difficult to understand, and move about her bed restlessly for a few minutes about two hours after falling asleep, but she always went back to sleep on her own. At age six, Christopher began to walk in his sleep, quietly and calmly, with a blank expression on his face. By the time he was eight he would sit up at night, scream out, and appear frightened. Shannon was a twelve-year-old girl who would jump out of bed and run about her room or even thrash on the floor frantically almost every night. David, seventeen, would suddenly leap out of bed after sleeping for two or three hours and run around so wildly in apparent terror that he actually injured himself.

You may wonder what all these youngsters have in common—a baby who wakes crying, a toddler who wakes thrashing bizarrely, a young child who talks in her sleep, an older child who sleepwalks and wakes apparently frightened as if from a bad dream, a pre-adolescent who runs or thrashes frantically at night, and an adolescent who runs about wildly in terror and sometimes injures himself. All of these children do have a similar sleep problem, however—an incomplete waking from deep *non-dreaming* sleep. The specific characteristics and the significance of these arousals vary depending upon the age of the child and upon certain physiologic and emotional factors.

While sleeptalking is so common that it can hardly be considered

"abnormal" or even a "sleep problem," sleepwalking has always been one of the most curious sleep disorders, one that is well known, and one that has been worrisome to parents and fascinating to sleep specialists and poets. Sleep terrors are perhaps the most dramatic of all sleep disorders. They are certainly the most frightening, at least to the family members who observe them. However, most people know little about them and do not realize that many children have them. Less intense but more long-lasting periods of confused thrashing can be equally if not more frightening to parents. Doctors and parents often misinterpret these episodes as bad dreams, from which the child should be waked, or as epileptic seizures needing medical treatment.

What Happens During These Partial Wakings

As you recall from Chapter 2, the onset of sleep is followed by a rapid descent into Stage IV, the deepest stage of non-REM sleep. In this state, the system seems to be on "autopilot," with very stable regulation of heart rate, respiration, and other functions. At the end of the first sleep cycle, usually sixty to ninety minutes after falling asleep, there is a brief arousal to a lighter stage of sleep and perhaps even a brief waking. In children this is usually followed by another fairly rapid descent back into Stage IV sleep for the second sleep cycle, though adults may have a brief nondescript dream at this time. The second sleep cycle ends similarly to the first, and most of the rest of the night is spent alternating between lighter non-REM sleep and REM. Just before morning, children often descend once again into Stage III or Stage IV sleep before their final waking, but this is not as deep as the Stage IV early in the night. The REM periods that appear toward morning tend to be longer, more intense, and are associated with more interesting and exciting dreams, occasionally even scary ones (true nightmares, see Chapter 11).

We know that the episodes described in this chapter could not possibly occur during the dream stage, since the near-paralysis which occurs during REM sleep effectively prevents us from acting out our dreams. You cannot sit up, you cannot thrash about, you cannot walk, you cannot scream, you cannot run. But during non-REM sleep you can move, and you usually do, at least during the transitions between sleep cycles. Most often these movements are minor and brief. But minor or major, basically the same thing is occurring. You will see that even thrashing, sleepwalking, or screaming are really quite similar to the quieter behavior that happens normally at the end

of a period of deep sleep. They just may be more sudden, intense, complex, long-lasting, and dramatic.

The events I am describing here happen most frequently about one to four hours after falling asleep, at the end of the first or second sleep cycle during a partial waking from Stage IV non-REM sleep. The end of a period in Stage IV usually occurs suddenly. Even when we monitor a child in the laboratory, we find nothing to tell us that a change in state is about to occur. Suddenly and without warning, the child moves. He or she may turn over in bed and will often briefly open and close his or her eyes before descending again into deeper sleep and beginning the next sleep cycle. This arousal is only partial. Full waking does not occur. The brain waves show a mixture of patterns, including those from deep sleep, those seen during transitions toward waking, and some patterns from the drowsy and waking states themselves.

Sometimes, however, your child may not make this transition rapidly. Instead, she may moan, speak in a mumbling and incomprehensible manner (here, not during dreams, is where most sleeptalking occurs), and move about restlessly for several minutes, as Marcy did each night. She may lift her head, grind her teeth, and even sit up briefly and look about in a confused manner before returning to sleep.

What we are seeing is apparently the simultaneous functioning of both the child's waking and deep sleep systems. Both processes seem to be going on together and, in fact, your child shows evidence of being awake *and* asleep. She may appear to be "awake" since her eyes are open, she may speak, and she may move about, but she can't manage complex actions requiring higher levels of mental functioning such as reading a book or even forming memories. She may behave oddly, seem distressed, confused, and disoriented; and she may not recognize you or her surroundings.

If her arousal is a bit more intense (see Figure 11, page 138) your child may begin to crawl about the bed in a somewhat confused manner as though she were looking for something, or she may even get out of bed and walk around. Although her eyes are open and she can make her way about the room or house, she has little awareness of the world about her. Even though she probably won't seem to recognize you, she still may come to wherever you are. Then she may stop and simply stare, but "through you," not "at you." Especially if she is beyond the toddler years she may seem to be looking for something and may mumble phrases that are difficult to understand. She may walk down the stairs and may even try to leave the house. If she is

FIGURE 11:
**Spectrum of Behavior in Children
 at the End of a Period of Stage IV Sleep**
 LISTED IN ORDER OF INCREASING INTENSITY

Normal termination of Stage IV (brief body movements; perhaps eye opening, mumbling, chewing)

Sleeptalking

(Enuresis)*

Calm sitting up in bed, looking about, blank expression

Calm sleepwalking (semi-purposeful; child may appear to be looking for something and/or may walk towards parents or light; actions may seem to be to fulfill a need such as hunger or urge to urinate; inappropriate urination common, e.g. into closet or shoe)

Agitated sleepwalking (trying to get out of room, possibly "away from something")

Extended periods of confused wild thrashing (thrashing, moaning, yelling, kicking, screaming; may be prolonged, child may act bizarrely or seem "possessed")

Sleep terror (terrifying "blood-curdling" scream, look of fear and panic, eyes wide open, heart racing, sweating profusely)

Full-blown sleep terror (scream with look of fear and panic, leaping out of bed, running wildly "away from something," significant chance of accidental injury)

**It is unclear where enuresis should be listed on this spectrum or even if it should be considered truly a part of this spectrum at all (see Chapter 12).*

very calm she may respond to your simple questions ("Are you okay?") with single-word answers ("Yes"). If you tell her to go back to bed she may, or she may let you guide her back to bed, perhaps with a stop in the bathroom to urinate. Sometimes, because of confusion, a boy (or less frequently a girl) may urinate in the wrong place. If so, it may not simply be in the middle of the floor, but more likely he will urinate into a boot, a wastebasket, or even into the closet. Once back in bed, younger children will usually return to sleep without ever completely waking. Older children and adolescents may wake briefly and feel embarrassed at finding themselves in unexpected places with people staring at them, but they too usually return to sleep promptly.

If your child's partial arousal is more pronounced, she may continue to walk in her sleep but no longer calmly and quietly. She may jump out of bed and hurry about the room or house in an agitated manner. She may appear upset, confused, and disoriented. Perhaps she will feel along the wall for the doorway leading out of her bedroom. She may yell out angry phrases such as "Get outta here!" She may even seem almost frantic. Still, although she appears somewhat apprehensive, she does not seem to be really terrified. In this agitated state she is unlikely to respond to your questions. She will not recognize you, and if you try to hold her she will only become more upset and push you away. You can't wake her, but after one to forty minutes (usually between five and twenty) she calms down, wakes briefly, and goes back to bed. She will remember little or nothing of the preceding period and will not describe any dream.

Infants and very young children are unlikely to show the same type of agitated sleepwalking, but some of their more intense arousals can seem even more bizarre and may be quite frightening for parents. The toddler or young child may arouse with prolonged moaning, then begin to cry, sob, or even scream. She may then thrash around the bed wildly with eyes open and with a peculiar look on her face. She will sweat profusely and you may notice that her heart is pounding. She may continue to moan, cry, and thrash for up to forty minutes, and on rare occasions for as long as an hour. The thrashing and rolling about may be very strange, unlike anything you have ever seen when she is awake, and unlike the behavior you may have come to expect for her nighttime wakings. You may assume she is having (or has had) a bad dream. However, she does not calm when you walk into her room and she may seem unaware that you are even there. She is not comforted when you try to hold her, and instead of clutching you tightly, she may even push you away. If you try to wake her by shaking her or by putting cold water on her face, the thrashing may get worse.

Some parents become so frightened that they rush their child to the hospital, only to have the episode end before they get there.

These episodes are commonly known as "night terrors" or "sleep terrors," but these terms are misleading, since your child doesn't appear to be "terrified." She does not even appear to be in pain. She looks agitated, confused, and upset. Many parents say that during these episodes their child looks "possessed," because of the very strange facial expression, the wild thrashing, and the lack of response when they try to help. After about ten to forty minutes your child will stretch, yawn, and lie back down. If she is sitting, she will now let you help her to a lying position and tuck her back in bed. If she wakes fully, she will be calm and want only to return to sleep. Only if you insist on trying to keep her awake, perhaps to be sure she is all right, will she remain awake for more than one or two minutes. She will not have any memory of the episode or of any dream either then or in the morning. She is fine, although you may still be upset.

A similar partial waking with extended crying and inability to be calmed may also occur in infants, appearing perhaps as early as six months of age. These episodes don't seem so strange at this age, because the thrashing is less wild and because we tend to expect infants to have some periods of uncontrollable crying. Many parents of babies with these episodes simply assume their child has had a bad dream. This is an easy mistake to make, especially since their child is too young to deny it.

These "wakings," in infants and toddlers, are important to recognize, however, because they are different from all the ones I discussed in Chapters 5 through 9. They have nothing to do with habits, associations, or limits, and the treatment for them is much different. Sleep schedule considerations, however, may be important.

In some children we see very intense arousals, which do perhaps deserve to be called "sleep terrors." They happen most often in adolescents, although pre-adolescents may show mixtures of patterns—extended wild thrashing along with screaming and a look of terror. Typically a sleep terror will start very suddenly. Your child lets out a loud "bloodcurdling" scream and sits bolt upright in bed. She looks terrified—her eyes are bulging, she is sweating, and her heart is racing. She may yell out phrases that suggest fear of attack or entrapment: "It's gonna get me" or "The ceiling is falling." These episodes are usually shorter than the extended thrashing of younger children and often end within one to five minutes. Your child then wakes briefly but quickly returns to sleep. Most often on waking fully she will have no recollection of anything frightening, although sometimes she

may have a vague "memory" of something that seems to fit the phrases she mumbled during the episode itself. Thus, your child may say that "something was going to get me." Nevertheless, she cannot describe this in any of the detail that you would expect if she had actually been dreaming. In the most intense episodes your child may jump out of bed and begin to run wildly. She will act as if she is trying to get away from someone or something, and she will seem to be in a real panic. She may knock over furniture or even people, break lamps or windows, and fall and injure herself. The major part of the event may be over in less than a minute, though your child may remain confused for some minutes more.

The Significance of These Arousals at Different Ages

All of these events occur during a partial waking from non-REM sleep. The more intense or long-lasting ones almost certainly arise from Stage IV. Until age five or six most of these episodes are "developmental." This means that they are not usually caused by physical or emotional problems but instead are only reflections of the normal maturation of your child's sleep stages. Because Stage IV non-REM sleep is very deep in young children, deeper than in older children and much deeper than in adults, it is likely that stimuli triggering arousal at the end of the first or second sleep cycle are sometimes insufficient to fully break the grip of the ongoing deep sleep state. As a result the child is left in a mixed state, half asleep and half awake. The triggers themselves are probably only the normal inherent mechanisms that control the end of one period in Stage IV sleep and the start of the next sleep cycle. These are part of your child's biological rhythms which are controlled by her "internal clock." Occasionally the triggers are external, for example an episode may begin when you make a noise walking upstairs or when you cover your child with a blanket. This is most likely to happen if you disturb your child near a time that a period of Stage IV sleep is about to end anyway. Ringing a loud buzzer an hour after sleep onset may trigger a sleep terror in susceptible children. Similarly, many children, even those who were not previously sleepwalkers, can be made to do so simply by lifting them up at this time and placing them on their feet.

Under age five or six, therefore, most of these episodes are of little significance, physically or emotionally. When they begin in or persist into the middle childhood years or adolescence, however, they may show different characteristics, be of different significance, and have different causes. Sleepwalking may look the same at any age, but the

seemed happy during the day and would wake in the morning in good spirits, at the nighttime waking she would cry and thrash about in her crib. Her mother or father would go in and lift her up, but she would not seem to be comforted. Instead, the thrashing increased in intensity, she would arch her back, kick, and could not be calmed. At times her parents noticed Lisa's heart seemed to be beating rapidly, she would be sweating, and her eyes would be wide open, but she looked more uncomfortable or frustrated than truly frightened or panicky. They would generally try walking her, talking to her, or shaking her in an attempt to wake her, and on a few occasions even tried cold compresses or screaming at her. Regardless of what they did, it would usually take ten to fifteen minutes for her to calm down. At times the episodes lasted twenty to thirty minutes. Eventually Lisa would begin to quiet, stretch, and yawn; and now her parents found they could wake her into a more normal state and reassure themselves she was in fact all right. After doing this, however, they found they might have difficulty putting her back down, and she was reluctant to go back to sleep for some time. Once back asleep, she would usually sleep through until morning. These episodes occurred four or five times a week.

Lisa's parents were concerned. They wanted to help her, but what they were doing was only making matters worse. They, like most parents, were filled with a desire to do something." However, the best response would have been to do nothing. They were interested to learn that Lisa was not crying in the midst of a bad dream. Crying occurs *after* a bad dream, not during it (see Chapter 11). And, she was not crying after waking from a bad dream either. In fact she was not awake at all and she was not frightened or in pain. Her parents came to realize that if she were awake and scared or in discomfort, she would want to be held and would let herself be comforted. Lisa was having partial wakings from deep sleep and there was little her parents could do to help at the time. And in fact there was no need to. Nothing worrisome was happening to Lisa.

Once Lisa's parents understood this, they were able to watch the crying spells without interfering, and without feeling guilty. I told them to go in, respond to her only if she wanted to be held, but otherwise just watch. They were to "keep their distance." Once Lisa stopped crying they were to help her lie down and cover her, but that's all. They were not to try and wake her fully. There was no need to see if she was all right. She was.

Lisa's parents noticed two improvements almost immediately. Although the "wakings" continued, they were shorter-lasting, because

her parents simply let them run their course without intervening, which actually had seemed to make the thrashing last longer. Secondly, after each episode ended, Lisa went right back to sleep. This is what one would expect. In the past, however, her parents had insisted on waking her after the events subsided. She would reach such full waking, and be the center of so much attention, that she was unable or unwilling to return to sleep immediately. Soon the wakings ceased to be a problem. Because the parents usually did not go to bed until after the episodes occurred, their own sleep was not disrupted. Eventually most of the "wakings" were fairly mild, with only a little whining and thrashing, and Lisa's parents didn't even find it necessary to go to her at all.

Eldridge, almost three, had been waking frequently at night for the past year. Although his bedtime was about 7:30, there was always a prolonged period of stalling and he would not usually get to sleep before about 9:00 P.M. Within two to three hours he could be heard moaning and moving about. Soon he would be screaming, crying, sobbing, and sweating profusely. He would toss, turn, and thrash wildly about his bed, get caught in the sheets, bump the wall, and sometimes do somersaults. Occasionally he would stiffen, although never rigidly. The events were similar from night to night but never identical. Eldridge did not seem to be frightened or in any discomfort but rather appeared quite confused or, as the parents put it "out of it." He might mutter a few phrases such as "I don't want to" or "Go away," but much of his speech could not be understood. Much to his parents' concern and frustration they were unable to comfort him at these times. In fact, he did not seem to recognize them and he would push them away when they tried to hold him. Although worried, they sometimes became angry when Eldridge pushed them away as they were trying to help. Even though they could not comfort him, they would continue trying to wake him by calling loudly to him and shaking him until the event finally ended. Eldridge's episodes usually lasted only a few minutes, although some nights the thrashing continued for fifteen to twenty minutes. Then he would relax completely, stretch, and yawn. When the parents persisted they could wake him at this point, but he was quite sleepy and only interested in returning to sleep. He always was unaware that anything unusual had occurred and he would return to sleep promptly. Sometimes Eldridge would have another episode an hour or two later, but it was almost always shorter-lasting and less intense than the first. The rest of the night was usually quiet. He occasionally had a similar arousal during the day after he had been napping for about an hour. Shortly before they

older child may show more agitation. Extended periods of wild thrashing become uncommon with increasing age, but in an older child the more clearly defined sleep terrors may appear. Also in an older child, these events can no longer simply be thought of as "developmental." Underlying emotional factors now are likely to be relevant, especially if the arousals are frequent. But before we discuss these matters more fully, it will be helpful for you to have a basic understanding of what this state of partial waking is all about.

More About "Partial Wakings" from Deep Sleep

Stage IV is a state with some paradoxes. It seems to be the state furthest away from waking. People waked from Stage IV sleep report no dreams and little or no memory of any ongoing thoughts. Generally it is a state from which it is difficult to be waked, even with meaningful words ("Fire!") or noises (crying, crashes). Trying to wake a child from Stage IV may seem almost impossible, even with vigorous stimulation. As mentioned in Chapter 2, if such a child falls deeply asleep in the car or at a neighbor's, she can often be carried back home, undressed, and put to bed with only a partial waking and no memory of being moved.

As difficult as it may be to wake someone fully from Stage IV, we have already learned that such a period usually ends suddenly, although this does not lead immediately to full waking. Under any circumstances, a full transition from Stage IV to waking takes time, especially in children. What does happen rapidly and more easily is a change from Stage IV to the start of the transition to waking, that is to a state of partial waking. This state is intermediate between sleep and waking and has some of the features of full waking and some of deep sleep.

Most often this transition is brief. Your child wakes slightly, turns over, pulls up the blanket, and goes back to sleep with little or no awareness of waking. But sometimes all does not go so smoothly. Your child may wake partially, then walk, thrash, scream, or run. If she does, you might like to know what she feels like at the time.

What a Sudden Partial Waking Feels Like

It may help you to understand if you imagine that, one hour after you fall asleep, there is a loud alarm, a gunshot, or a terrifying scream. You "wake" instantly. But your head will still be filled with "cobwebs"

and you will have some difficulty figuring out what is happening. If you wake with the fire alarm ringing, you may find your heart racing, feel yourself scared, and know that you have to do something. Yet you still find that it takes several seconds (or longer) to become clear-headed enough to act appropriately. That period of a few seconds during which you feel yourself afraid but are foggy and not fully alert, is an *approximation* to what children experience during a sleep terror.

If you have to get out of bed two hours after going to sleep to give your child medicine, the alarm clock may "wake you," and you get up calmly and walk into the bathroom. But instead of getting the medicine, you use the toilet and then start to return to your bedroom. You may then feel that there is something else you are supposed to do, but you are confused. You may stop and look about with a blank or dazed expression on your face. Still you are not sure what it is you are looking for, where you should be looking, or why you are even out of bed in the first place. Finally you wake more fully and remember all about the medicine. But what you had been doing before this, from the moment your alarm went off until you were finally able to think clearly, is perhaps an approximation to what your child experiences as she walks in her sleep.

Even though you may not be clear-headed during these partial wakings, you are closer to full waking than your child when she is sleepwalking or having a sleep terror. You are forming memories, and your behavior, although possibly comical, is unlikely to be bizarre. This is because your Stage IV sleep is lighter than your child's. However, if you went to sleep drugged with sleeping pills or alcohol, then waking would be more difficult for you and what you did on "waking" might be more similar to your child's sleepwalking or sleep terror episodes. And you might well return to sleep without much of a memory of the waking.

Now we can come back and talk in more detail about the different characteristics, significance, and causes of these events at different ages. If your child shows nighttime behavior similar to any of the children I will describe, it should now be easier to understand and you will learn how you can best deal with it.

Partial Wakings in Young Children

Let's take a closer look at two of the children I described at the beginning of the chapter. Despite an easy bedtime, Lisa, a one-and-a-half-year-old girl, would wake several hours after going to sleep, usually about the time that her parents were retiring. Although she generally

brought Eldridge to me his parents tried eliminating his nap in hope of improving his sleep, but the nighttime wakings only became worse. During the day Eldridge was happy and well behaved and I found the family situation to be stable and supportive.

Eldridge, of course, had the same problem as did Lisa, except that his arousals were more intense. He was bigger and could thrash about more, and at his age his failure to respond to his parents or to talk meaningfully seemed more unusual. His parents also had not known how to handle the problem. They always tried to "snap him out of it," and because the episodes did end in a few minutes, they thought they were "finally waking him" from the midst of an ongoing bad dream.

I gave Eldridge's parents the same advice I gave Lisa's—to keep their distance during the arousals, and then let him go back to sleep without questioning him. I suggested they go into his room when he was having an episode just to be sure he didn't hurt himself. They did not have to worry about "spoiling" him, as some people had warned them, because they were not going in to meet the demands of a wakeful youngster. And they should not question him about the events, then or in the morning, since he would have no memory of them, and their questions could only make him anxious. He would realize that he was doing something at night about which he was unaware, over which he had no control, and about which his parents were concerned. Anxiety over these partial wakings conceivably can lead to an increase in their frequency. It certainly will not help. Now Eldridge's parents felt less upset about getting up at night and they no longer felt angry. They were not involved in struggles with their son and getting rebuffed. Still, the partial wakings continued, so we decided to make two other changes. Eldridge was encouraged to begin napping again and his parents began to enforce the 7:30 bedtime after a pleasant bedtime ritual. Now that he was getting enough sleep, he was no longer overtired at night. The frequency and the intensity of the nighttime partial wakings decreased considerably and over the next few months the arousals disappeared almost completely.

In youngsters up to about age six, and less frequently in older children, assuring adequate amounts of sleep at night may be the most important treatment. You might expect an overtired child to sleep better than usual, but paradoxically such a child is more likely to sleepwalk or have sleep terrors. This happens because a sleep-deprived child has a greater need for deep sleep. This need or drive may prevent the deep sleep system from giving way at the end of the first or second sleep cycle, and a mixed state of partial waking may occur.

It is also important to insure that your child is on a regular schedule.

If your child is having episodes of partial waking at night, do everything you can to keep her nap- and bedtimes regular. Her biological rhythms will become more stable and can work in harmony. The timing of her arousals at the end of the first and second sleep cycles will be more appropriate. Now she will stir when deep sleep is "ready" to give way to a lighter state, not before.

Assuring adequate sleep, providing a normal schedule, and keeping your distance are the best ways to treat arousal problems in young children (see Figure 12, page 148). Please understand, however, that although these remedies *may* help, they won't always do so. You may just have to learn to live with your child's nighttime wakings. I find that once parents understand what is happening, they can accept the inconvenience much more easily. Some medication will alleviate the problem, but the side effects generally outweigh any possible benefits. I usually recommend the use of medication for children only if they seem at risk of injuring themselves, and this is unlikely before late childhood or adolescence.

When it is said that "sleep terrors" are most common at age three to four, what people are speaking of are the kind of events seen in Lisa and Eldridge. They probably occur with similar frequency in younger children but when they occur in infants they are more likely to be dismissed as "bad dreams." In most cases children outgrow them by age five or six.

Psychological factors are rarely relevant at this age, but they can be. If there is significant ongoing stress in your home, or if the episodes began after some specific stress such as a divorce, death in the family, or after a family member's hospitalization, then you should probably consider consultation with a professional counselor.

Partial Wakings in Older Children

The situation in older children and teenagers with frequent sleepwalking or sleep terrors is different. Here psychological factors are usually relevant. There is no specific age below which all such arousals are "developmental" and above which all are "psychological." But if your child is beyond six and her nighttime wakings persist, recur, or appear for the first time, there likely is a psychological component to her problem. This does not necessarily imply that she has *major* emotional problems. In fact, this is usually not the case. Emotional problems are most often minor and have to do with how your child has come to deal with her feelings. Typically she will be a well-behaved youngster

FIGURE 12 Sudden Partial Wakings

Behavior	Typical Age	What To Do	General Suggestions
Extended periods of crying, sobbing, moaning with wild bizarre thrashing	6 months-6 years, occasionally in older children	<ul style="list-style-type: none"> Go in to be sure your child does not injure herself. Let the episode run its course. Keep your distance. Don't forcibly "help." Only hold her if she recognizes you and wants to be held. Do not shake her or otherwise vigorously try to wake her. Watch for the relaxation and calm that signals the end of the episode. You may then help her lie down and you may cover her. Let her go back to sleep. Do not wake her or try to ask her what was wrong or what she had been dreaming about. Similarly, don't question her in the morning. Don't make her feel strange, different, or bizarre. 	<ul style="list-style-type: none"> Make sure your child gets sufficient sleep. Consider an earlier bedtime. Restart a nap if it was abandoned without good reason. Make sure that her sleep and daily schedules are fairly regular and consistent. Counseling may be considered if events are frequent and if they began around known stresses, or if significant ongoing stresses are present, or if your child is older than age six (since by middle childhood psychological factors are frequently relevant). Professional consultation may help in this decision.
Calm Sleep-walking	Any age from the time the child learns to crawl or walk	<ul style="list-style-type: none"> Talk quietly and calmly to your child. She may follow your instructions and return to bed herself. If she does not seem upset when you touch her, you should be able to lead her back to bed calmly. She may want to stop at the bathroom to urinate. Although you might be able to wake her, nothing is gained and there is no point trying. If she spontaneously wakes after the episode (which older children and adolescents commonly do), she will likely be embarrassed. Do not make any negative or 	<ul style="list-style-type: none"> For young children, insure adequate sleep and a normal schedule. Occasionally this will help older children as well. Make the environment as safe as possible to avoid accidental injury. Floors should not be cluttered, objects should not be left on the stairs, hallways should be lit. If your child's walking sometimes goes unnoticed, put a bell on her door so you will be aware whenever she leaves her room. Young children may need a gate by their door or at the top of the stairs. If your child tries to leave the house, an extra chain lock above her reach should be in-

Behavior	Typical Age	What To Do	General Suggestions
Agitated sleep-walking	Middle childhood through adolescence	<p>teasing comments. Don't mention it in the morning either, unless she asks. Don't make her feel peculiar or strange. Treat the sleepwalking matter-of-factly and let her go back to bed.</p> <ul style="list-style-type: none"> If the agitation is marked, restraint will only make the event more intense and longer-lasting. Keep your distance. Only hold her if she is starting to do something dangerous. When she calms, treat her as you would a calm sleepwalker. 	<ul style="list-style-type: none"> Consideration for counseling as with extended thrashing. Same as for calm sleepwalking.
Sleep terrors (scream, look of panic and fear, possibly wild running)	Late childhood, adolescence	<ul style="list-style-type: none"> Let the screaming subside and then simply let your child return to sleep. Do not try to wake her. Do not question her in detail and do not embarrass her if she reaches full waking (as some adolescents may do). If there is wild running and risk of injury, you may have to intercede, but be careful. Both she and you could get injured. Talk calmly and block her access to dangerous areas, but actually holding her may be very difficult and can lead to even wilder behavior. 	<ul style="list-style-type: none"> She may be safer sleeping on the first level of the house or in a finished basement room. If there is threat of, or actual, window breakage, consider replacing the glass with Plexiglas.[®] Use the same general precautions as for sleepwalkers. Consult your physician for possible use of medication, especially if there is wild running. If medication is used, it should be viewed as a temporary solution used mainly for protection. Counseling should be considered. This is true even if psychological factors seem minimal but arousals are frequent, intense, and dangerous.

who finds it very difficult to express outwardly any feelings she might consider bad—anger, jealousy, guilt, hate.

You should, however, consider how often your child has nighttime arousals and in what context they occur. One episode of sleepwalking or other partial arousal per year is trivial and probably of little consequence. It should not raise concerns of possible psychological problems. And some children have thrashing or terrors only when they have a fever. Here their sleep disruption is caused by illness, not stress.

The more frequent and the more intense the episodes are, the more likely it is that a child is under some emotional stress, but the frequency and intensity of the episodes do not always correlate with the degree of emotional upset she is feeling.

The Arousal or the Terrors: Which Comes First?

There is a difference of opinion among researchers studying sleep terrors. Some believe the "terror" comes first and causes the sudden arousal. Others think that the arousal comes first and this leads to physiological changes usually associated with fear. This distinction is especially significant after the age of five or six, when emotional factors are more likely to be relevant.

Thus, some feel that the arousal is triggered by a frightening thought, idea, urge, or image that suddenly enters into "consciousness" during the deep sleep state when a child's emotional defenses are down. This fearful thought would cause the child to scream and have a partial waking. However, this theory does not explain why a sleep terror can be triggered by a noise. And it does not explain why sleep terrors tend to occur at the *end* of the first or second sleep cycle rather than interrupting an ongoing sleep stage prematurely.

Others maintain that the arousal comes first, caused in some way by an underlying sleep disorder or even by a sound. Increased heart rate, sweating, and other bodily changes usually associated with fear occur simply as part of this sudden arousal from Stage IV. Thus a child wakes partially and finds herself sweating and her heart pounding, and *responds* to this agitated state by crying out, running through the house, or muttering incomprehensibly. She wakes with the *physical* symptoms of fear and quickly tries to find an explanation for it.

Think again how you feel when a fire alarm wakes you at night. You may find yourself with heart beating rapidly and a sensation of fear before you even know what has happened or if there is actually anything to be afraid of.

I believe that the latter explanation, which says that the arousal

comes first, best explains why children don't report having any definable thoughts and why, as the event ends and heart rate and other bodily functions return to normal, the child no longer seems afraid and in fact has no lingering fears. Yet this does not mean that emotional factors are not relevant; they are. But instead of directly triggering the events, as suggested in the first theory, I believe emotional stress acts indirectly. Emotional factors probably do not trigger the arousals but they may well affect how a child responds to arousals that occur normally during the night. The actual trigger to the arousals themselves remains the underlying biological system that controls the timing of sleep stages. This explains why the events occur when we would normally expect the first or second sleep cycle to end.

Thus in a sleep terror or sleepwalking episode it is likely that the child's emotional state affects how she responds to finding herself in a state of partial arousal rather than triggering the arousal itself. This differs from a true nightmare, in which stressful daytime events may appear in a dream in symbolic form and generate enough anxiety to wake the child. After such a nightmare a child will still feel fearful and can usually remember the dream.

How Emotions Affect Nighttime Arousals

I want to help you understand more clearly how a child's psychological state can affect her nighttime arousals. Imagine exploring an old cemetery on a dark drizzly night. You cannot see around you well; you do not know who or what is there. You feel defenseless and nervous. Then you hear a sudden unexpected sound. You may jump, cry out, and feel quite frightened. You might even run without ever learning if there was really anything to be afraid of. If you believe in ghosts, you may decide that you heard one, but you could not describe anything in detail. You "made up" the ghost to fit your feelings of fear at the time. Yet the same sound, if it occurred in the daytime in the security of your own home, might not have startled you at all. The sounds were the same in both settings but your psychological state was not. It was your state of mind that determined your different manner of response.

What happened in the cemetery occurred despite the fact that you were awake and clear-headed to start with. If something similar could happen in sleep, you might only reach partial waking, and a sleep terror or sleepwalking might result.

Now imagine yourself sleeping comfortably in your own bed. You have not been feeling particularly worried about anything. An hour

after you fall asleep there is the noise of a twig breaking outside. Although this may trigger a brief arousal, neither you nor anyone else (unless you were being monitored in a laboratory) would likely be aware of it and you would return immediately to deep sleep. But what if, instead of being at home, you are in battle surrounded by an enemy over whom you have *little control* and against whom you are *on constant guard*? In a moment of apparent calm you fall deeply asleep. One hour later the same twig breaks. Now it is unlikely that you will ignore the noise and return to sleep after a momentary lightening of your sleep stage. Instead, you might bolt upright and find yourself intensely panicked. Initially you would be confused and you might even cry out.

The difference between these two situations was your psychological state when you fell asleep. Fearful thoughts did not trigger either arousal; the noise of the twig snapping did. However, in the second situation you knew that by going to sleep you were letting down your guard, and you responded to the arousal much differently.

Calm sleepwalking would occur for similar reasons, except that in this case the threat of letting down one's guard at night is not so great. Imagine this time that you are still on guard, but for something important rather than dangerous. Perhaps you are a biologist waiting at night in the woods for the arrival of a certain rare species of bird. You fall asleep and one hour later you hear unusual sounds, perhaps of a bird, perhaps not. Ordinarily these would not wake you, but in this setting you sit up promptly and begin to look about, even though you are initially very confused and are not even sure what it is you are looking for. You may not even remember hearing the sounds that woke you. In the first few seconds you may react very inappropriately, possibly making noise instead of remaining absolutely silent. During this time you feel the need to get up and to look for something but are not yet awake enough to think clearly or understand what is happening. This is probably quite similar to what a sleepwalker experiences. Here too the only reason the sound had any real effect on your sleep was that you went to sleep prepared to arouse, because you were still on guard.

In younger children, extended thrashing episodes or sleepwalking usually mean the child is having difficulty making a smooth transition from one period of Stage IV sleep to the next sleep cycle. This difficulty almost always results from the depth of Stage IV sleep characteristic of a young child's level of development. But in older children who should be able to make this transition smoothly, their exaggerated response to the arousal is more likely based on psychological factors.

These older children often are in situations in which things they do not want to happen are occurring *outside of their control*. There may be moves to new neighborhoods, changes to new schools, and especially losses—a divorce, separation, or death in the family. Even if the family is intact, there may be loss of warmth, love, and nurturance. Parents may be rigid, demanding, and uncompromising, with high expectations for their child's behavior, school performance, and athletic success. The child is often quite angry about the circumstances but doesn't express the anger outwardly. Instead, she remains *on guard*, probably feeling that expression of her feelings may only be followed by more unpleasantness in her life. She may already blame herself for her parents' separation or other family problems. And she may carefully avoid causing her parents any displeasure. Such a child often will appear to be extremely pleasant and well behaved—if anything, too well behaved. Occasionally her anger will show in passive ways that feel safer to her. She may stay in her room after school and not talk at mealtimes. Or she may do poorly in school when she could do well. Such children expend enormous quantities of energy during the day guarding their emotions, which they view as the enemy, and keeping them in check. At night, in sleep, these defenses must be relaxed.

It is perhaps somewhat easier now to see how such a child might react to a partial arousal after the first or second sleep cycle. Like the soldier in battle who wakes suddenly at night, she finds herself confused and out of control with her defenses down. Before she knows what is happening she feels very fearful. This fear response is generated at a low level in the nervous system and does not require complex thought processes for it to occur. If this is true, then ultimately the solution is for the child to learn to be able to go to sleep without being on guard so that normal nighttime arousals may be handled in stride. She must learn that her feelings are not dangerous and that there is no need to guard against expressing them. Accomplishing this goal is no easy task and often requires a period of psychotherapy or counseling.

Treating Emotional Causes

The decision as to whether or not a child needs counseling is *thus* based on several factors. If a child seems to be feeling a great deal of stress, then she should have help regardless of the degree of nighttime disturbance. If your child has several major episodes each week, then psychotherapy may be helpful even if she doesn't appear to be under

much stress otherwise. If your child's nighttime episodes are dangerous, then treatment is urgently needed and psychotherapy, at least an initial evaluation, should be part of it. This is true even if no stresses seem apparent and your child seems to express her feelings openly. If therapy helps reduce the arousals, then it will certainly be worth it, even if you feel that your child is very happy and without any significant "psychological problems."

Christopher, you will recall, was an eight-year-old boy who had been having abnormal nighttime wakings for almost two years. Christopher had been a good sleeper until, two months after his father's death, he moved to a new neighborhood. At that time he began to get up two or three times a week and walk about several hours after his 9:00 P.M. bedtime. He wandered about calmly and quietly without any crying, talking, or signs of agitation. He would have a "strange look" on his face and was not very responsive to his mother's questions. Usually his sleepwalking appeared to have no purpose, but on some occasions he seemed to be "looking for something." Although he did not seem to recognize his mother, he would let her lead him back to bed, usually after a stop in the bathroom, where he would urinate. On two occasions he urinated in his room, once into the wastebasket and once into a shoe in his closet. Twice he actually walked out of the house and was led back home by neighbors. Over the next year his nighttime wakings stayed the same, although he faced considerable new stresses. His mother was away for two weeks because of emergency surgery, and shortly after that she remarried and his family moved again. Finally his mother became pregnant, and shortly before the birth of his sister, Christopher's nighttime episodes became more intense. Instead of happening a few times a week, they were now occurring several times a night and the initial event was of a different character.

About one hour after falling asleep, Christopher would sit up suddenly, cry out briefly, and appear frightened. He would not respond to his mother, did not want to be touched, and muttered incoherently. He would calm in a few minutes, then allow himself to be coaxed back down into bed and would fall asleep rapidly. A similar event would occur one hour later and a third an hour after that. Once Christopher calmed after the final episode, he would get up and begin to walk about the house as he had when he was younger. Several more episodes of quiet sleepwalking might occur over the next few hours. After 4:00 A.M. his sleep seemed to be deep and arousals were rare.

When I saw Christopher he was a nice quiet youngster, but despite his calm exterior he seemed very tense and anxious. I learned that his

father and stepfather were alcoholics and there was some violence within his home. He had many angry feelings toward people around him but was afraid to express them. He was quite frightened at his lack of control of the world about him and was surely distraught that his parents could not seem to control themselves. He devoted much of his own energy toward rigid self-control. He worried that if he did not control his feelings, there would be dire consequences.

Christopher and his mother both needed counseling. In the meantime I suggested that the family put a lock high up on the front door so that he could not walk out of the house. I explained in detail what happens during nighttime arousals so that other family members would be less angry at Christopher.

In the beginning Christopher's mother was not able to be supportive. She was still angry at Christopher for waking her. For this reason I decided to try to reduce the episodes until their therapy had gone further. Usually I would not recommend medication, but I felt it would help in this case. I prescribed imipramine (Tofranil) for Christopher, a drug that is sometimes, but not always, helpful. His nighttime arousals disappeared almost completely. Three months later he and his mother had made real progress in therapy and the tensions at home had eased, so we stopped the medication. The nighttime arousals returned, but they were much less frequent and Christopher never had more than one per night. His mother now felt that she could deal with them without anger. Over the next nine months his arousals decreased even further and now, at nine, he has episodes only occasionally.

Christopher's daytime behavior was typical of many children with emotionally induced sleepwalking or sleep terrors. He was a nice youngster who did not yell and scream but kept his feelings inside. His nighttime arousals varied within the spectrum described in Figure 11 (page 138) from calm sleepwalking to episodes close to full sleep terrors. And the progressive increase of symptoms after age six did suggest that psychological factors were involved, although the stresses Christopher faced were unusually severe. As he learned to handle his daytime stress in an appropriate manner, he showed a progression toward the milder end of the spectrum, with calm walking instead of screaming, sitting instead of walking, and so on.

Shannon's nighttime arousals were even more striking than Christopher's. At age twelve she had been having them for just over three years. Although there had been periods of up to several weeks without any episodes, they usually happened nightly. She had not had any major problems when sleeping at a friend's home, although that pos-

sibility continued to worry her. She would go to sleep at 10:00 P.M. but about an hour and a half later would sit up and cry out with a single long guttural scream. She would then get out of bed and run about frantically and hysterically, touching the walls and furniture like a blind woman trying to get out of a burning room. At times she would even fall on the floor and thrash, kick, and roll about. Sometimes she would run wildly out of her room and even downstairs. Her mother had noticed that she could trigger one of these wakings if she disturbed Shannon in any way sixty to ninety minutes after she fell asleep. For this reason she was careful to stay out of her room at that time and not even attempt to cover her with a blanket.

Her family felt that although Shannon did seem somewhat frightened during some of these events, she did not seem truly terrified. Instead she seemed more to be angry, frantic, and very confused. She would only push people away if they tried to hold or restrain her. She even seemed to get angry when spoken to, replying "Don't bug me" or "Leave me alone." She had tried to leave the house once or twice, but never successfully. Infrequently the events were less disturbing, with simple talking and sitting in bed and hardly any signs of agitation.

When Shannon was nine, these events lasted up to half an hour, but by age twelve most were over within five to ten minutes. Toward the end of the episodes she would calm, urinate in the bathroom, alert in a sleepy fashion, and return to sleep. She had no memory of the events at that point or in the morning.

Shannon's family tried to be supportive, but her parents were preoccupied with their own problems, which they were beginning to solve with the help of a marriage counselor. Shannon had recently started seeing a psychologist as well. She did not seem to have significant emotional problems and, at least outside of the home, she was extremely well behaved. However she was not a spontaneous youngster. She seemed angry at her parents for the tensions at home and she felt a lack of warmth and nurturance. She had difficulty expressing these feelings and was afraid that if she did, matters would only get worse.

Shannon's arousals fell somewhere between angry agitated sleep-walking and full sleep terrors. She also had episodes of extended thrashing. Although psychological problems were not major, they could clearly be identified and the family had already sought help for them. I helped the family most by reassuring them that Shannon was physically normal and by telling them that these types of arousals were common. Except for prescribing medication, there was little I could do promptly to reduce the frequency of wakings. But I preferred to

avoid the nightly use of drugs and the family agreed. Instead, we decided to find a dose of medicine that would prevent these episodes and allow Shannon to take it only when she slept over at a girlfriend's home, when a friend slept at her house, or when she went to camp. Otherwise the events would be allowed to continue. We were hopeful that as she continued to work with her psychologist, and as her parents continued to resolve their own problems, the wakings would gradually decrease. In fact, they did diminish, but very slowly. I was prepared to start regular medication if her arousals intensified to the point that she became in danger of hurting herself. Fortunately this never occurred.

I did not expect Shannon to hurt herself, because that would be unusual for a twelve-year-old, unless she tripped over something left on the floor. I would have been more concerned if the same symptoms were present in a child several years older, because injury occurs most often in teenagers.

David was seventeen and during the eight years before I met him his parents had divorced, then each had remarried. At the time that his parents separated David was known to talk in his sleep frequently. He did not begin to have intense arousal episodes until he was twelve, when his father remarried. Then about once a month he would leap out of bed suddenly about midnight and begin yelling. His mother would find him standing in his room, apparently upset, as if "something was going to happen to him." He did not seem to be terrified, although he occasionally mumbled phrases such as "I've got to kill him." David's mother could not wake him, and within three to four minutes he would return to bed and fall rapidly back to sleep. When David was fifteen his mother remarried and his arousals became more intense. Now they would start with a "bloodcurdling scream." David would jump out of bed, knock over furniture, and run about as if trying to "escape from something." He no longer simply looked upset. Now he appeared truly terrified. He injured himself a few times, although usually the scrapes and bruises were very minor. However, on a number of occasions his mother saw him head toward the window. Once he leaned out the window and another time broke a window-pane, cut his hand, and required several stitches. At the end of each episode David would wake fully and was always quite embarrassed to find himself in a disarrayed room with his family members staring at him.

David's parents described him as being "very controlled," "holding things in," and "handling things too well." He did not seem to be working up to his potential in school. I found David to be pleasant

and cooperative but somewhat depressed. He was easy to talk to and, in fact, he was able to express some of his feelings, though he clearly was not fully in touch with all of them, particularly those of sadness and anger.

Although David's episodes occurred infrequently, their character was quite worrisome. I felt that he might injure himself seriously. I have treated other adolescents like him who had actually jumped through windows. In David's case I recommended medication without much ambivalence. I chose diazepam (Valium) which was the drug I felt most likely to suppress his arousals. When David was on the medication, the arousals stopped completely, but I viewed this as only a temporary measure to assure David's safety. In the long run we wanted to have David sleep at night, calmly and safely, without drugs. To this end psychotherapy was recommended and begun even though David was not seriously disturbed. But his psychological characteristics, taken in the context of his nighttime symptoms, were enough to justify this approach. Our plan is for David to remain on the medication until he has had more time to benefit from the counseling. Then we will gradually decrease the medication, hoping that the arousals will not recur, or if they do that they will be milder and not require medication at all or only a small dose.

Variability of Arousals

As you have seen in the cases I have described, a child's nighttime arousals may be different on different nights or at different times in her life. Often a child shows a progression along the continuum described in Figure 11, from quiet arousals to major sleep terrors, usually because of changes in current life stresses and the manner in which she deals with them. But day-to-day changes in a child's life may be subtle and difficult to recognize and night-to-night changes in the occurrence or intensity of arousals may occur without any identifiable change in daytime stress. In fact, nighttime symptoms usually tend to wax and wane over weeks and months without any recognizable daytime changes. Therefore, it is not easy to predict when a child will have nighttime episodes, based only on the knowledge of what current stresses she seems to be facing—an upcoming examination, an operation, or perhaps a separation from the family. In fact, nighttime episodes may actually *decrease* at a time when your child starts to misbehave, have outbursts of temper, and become uncharacteristically uncooperative during the day. When she allows herself to express her feelings in the daytime, even inappropriately, she will have less

need to guard against these feelings at night and will have more continuous sleep.

What About Other Causes?

It is certainly possible that hormones or other biological factors affect the character of the nighttime arousals. Also many children with these sleep disorders have close relatives with a history of similar nighttime arousals. In very young children this may explain the occurrence of the arousals entirely. In older children, a family history of the disorder may explain why only some children who struggle to avoid expressing their feelings develop these sleep problems. It is likely that after about age six, a child needs both a biological and an emotional predisposition for frequent sleep terrors or sleepwalking to occur. Just as stress is more likely to lead to an ulcer in a person with a familial predisposition to ulcers, sleep terrors or sleepwalking are more likely to occur in a child who not only has difficulty dealing with and expressing her emotions but who also has close relatives known to walk, thrash, or scream in their sleep. Similarly, it is likely that the specific type of arousal shown by a child—that is, where on the spectrum of increasing intensity it occurs (from sleeptalking to terrors)—also involves both psychological and inherited factors.

Some Final Words

The state of extended confusion or sleepwalking is unusual and has many features otherwise seen only during epileptic seizures (which these events clearly are not). Specifically, a child's unusual and confused behavior goes on over an extended period of time during which she has little ability to respond to people or events in the environment. She does not seem capable of rational thinking, and she forms little or no memory of the events. What seems even stranger is that no amount of stimulation can shorten an episode, at least a major one, and bring the child to full waking. It will simply run its course and usually will only be intensified if one tries to hold or otherwise restrain the child. The child seems to perceive any intervention as threat or attack instead of help. Perhaps this is so because she feels her parents closing in on her but she does not recognize them.

You should now understand these unusual phenomena more fully. However, I cannot entirely explain why some of the arousals should be so extended in time or why forceful waking is usually impossible. But whatever the reason, try to be content to wait. All episodes, re-

ardless of their length, will eventually end fairly suddenly and on their own. You can learn to recognize when your child reaches this point. There is a general relaxation, stretching and yawning, and readiness to return to sleep rapidly. At this time older children may wake fully, either spontaneously or in response to your efforts. Not only will they have no memory of the preceding event, but they will seem calm and usually unperturbed. If your child seems upset at this time it is usually because she sees that you are or she is embarrassed that she has done something strange again, something that her family regards as "bizarre," and something over which she seems to have no control.

It is for this reason that such a child may become quite angry when questioned repeatedly about the nature of her "dream." She is concerned about loss of control during the day and finds out that she has acted without any control during the night. This knowledge can cause her even more anxiety, increase her worries at bedtime, and possibly even lead to more arousal events. This is one of the reasons I recommend you do not try to wake a child after one of the events and certainly do not question her at that point or in the morning. In fact, it only makes sense to tell your child about them on a regular basis if she is asking or if she is old enough to make her own decision as to psychotherapy and medication.

The children you have read about in this chapter represent only a small number of those I have seen with similar problems. This sleep problem is not as unusual as you may think. However, because the disorder is not often discussed among parents, or between children and their friends, some parents view their children as "strange" or "abnormal," and some children worry that they themselves are weird. You and they should be relieved to know these episodes are very common and are usually outgrown.

Most toddlers have occasional confused partial wakings of varying intensity. The actual number of children who have extended thrashing spells, sleepwalking, and full night terrors is not known, but at least 15 percent of children have had at least one sleepwalking episode. Extended partial wakings and thrashing in children are probably much more common. Of course, fewer children have very frequent and intense episodes, but wild sleep terrors with running about are by no means rare.

It is relatively easy to feel empathy for a child who wakes at night in distress and accepts your efforts of comfort. But when you attempt to help your child and she only pushes you aside, you may react with anger if you do not understand what is happening. If you watch your

child thrash about for an extended period of time as if "possessed," you may become extremely frightened. It is important that you understand what is happening during these partial arousals so that you will not react hastily to your child out of anger or fear. Now you should be able to simply watch the episodes proceed, realizing that nothing serious is happening. Do your best to avoid overreacting, and control your urge to try and wake your child forcibly. And don't question her, since she will not have any memories to describe.

If your child seems susceptible to these episodes, pay attention to their frequency and character and try to identify any stresses she might be under. The infant or toddler who has occasional thrashing episodes doesn't need treatment. Just keep your distance, let the event run its course, and then allow your child to return to sleep. Make sure your child gets enough sleep and has a regular schedule. Drug treatment is almost never advisable.

Sleepwalking is similar. You can often lead a calm sleepwalker back to bed; but if she is agitated, you may have to first wait until she calms. For her safety, remove any obstacles on the floor and stairs. If your child is young, a gate may be necessary by the stairs and possibly across her bedroom door. If your child is older and she tries to leave the house, put an extra chain lock high up on the door, and you may want to attach a bell to her bedroom door and to the outside doors to let you know if they are opened. Although injury is unusual during calm sleepwalking, it certainly can occur. It is more likely if there is agitation. Leaving the house, of course, is especially worrisome.

Even full sleep terrors should be allowed to run their course if possible. However, if your child is about to hurt herself or others or to damage the furniture or walls, then you may have to intervene. But do so as gently and with as little physical restraint as possible. Trying to restrain an agitated seventeen-year-old could lead to everyone's getting hurt.

If you are worried that your child's episodes are unusually frequent, intense, or dangerous, by all means consult your doctor. Very rarely medical problems may be responsible for some of the arousals—pain from heartburn (acid moving up out of the stomach into the esophagus) or middle ear disease. But when medical factors are involved, the child will usually have wakings at other times as well, not just from Stage IV. She will have a more general sleep disruption, with only some of the arousals being sleepwalking or sleep terrors.

Very rarely nighttime epileptic seizures can mimic this disorder. You should be suspicious if your child's arousals are very different from those described in this chapter. If they occur near morning

instead of closer to bedtime, if they begin with full waking and your child's realization that something is about to occur, or if she has good memory of the entire event or of its beginning instead of its end, she should be seen by a physician. If the episodes are always exactly the same, if there is marked body stiffening with one arm extended and the head turned to the same side, or if there is prominent repetitive body jerking, you should also be concerned. Discuss these with your doctor.

Although I have prescribed medication for children having very frequent episodes—two or three every night—because of the disruptive effect in the household, I always do so reluctantly, because, in a sense, I am treating the family more than the child. However, the child who is having many intense episodes and who is at significant risk for self-injury, does deserve the most urgent intervention. With such a child it is important first to protect her by suppressing the nighttime episodes through medication. If your child is like this, you should see your doctor promptly. You should also consider counseling, although you need to understand that the therapy is needed to identify and treat certain psychological problems and not simply to cure the arousal events. Although stopping the arousals may be a prime goal, you cannot judge the success of psychotherapy simply by keeping track of the frequency or intensity of the nighttime episodes. Sometimes improvement in sleep follows progress in therapy very slowly. It may take some time for your child to learn new ways of dealing with important feelings so that she is able to go to bed without worrying about what may happen if she relaxes her emotional defenses in sleep. Similarly, a child who develops sleep terrors after surgery is like a soldier who develops sleep terrors during a period of battle. She may continue to have them for some time even after returning to the safety of home, where she no longer has to be on guard at night for nurses with needles or doctors with scalpels. Such a pattern, once learned, may be slow to change.

Chapter 11

Nightmares

What Are Nightmares and Why Do They Occur?

Nightmares are dreams—very scary dreams that wake your child and leave him or her feeling frightened, anxious, and with a profound sense of dread.

Although nightmares occur during sleep, for the most part they are caused by, and reflect, emotional conflicts that take place during the day. These are the usual struggles faced by all children at each stage of normal development. All children have nightmares at one time or another.

The specific content or "story" of your child's nightmares depends on several factors: his stage of physical and emotional development at the time; the particular emotional conflicts facing him at that developmental stage; and the occurrence of specific daytime events which seem particularly scary or threatening.

The anxieties that lead to nightmares during sleep are the same ones that may lead to fears at bedtime and during periods of wakefulness at night. These are discussed in Chapter 4. Concerns about separation are common in young toddlers. Your child worries about being away from you. He may have nightmares when he first goes to day-care, at a time when you must be out of town or hospitalized, after he is temporarily "lost" at a store, or when he feels that he "loses" you to a new brother or sister.

As your child grows a little older he is more concerned about loss of your love than about temporary separation from you. In his third year, for example, during toilet training, your child may struggle with his own impulse to soil while at the same time wanting to please you. He