Commentary: Empirically Supported Treatments in Pediatric Psychology: Bedtime Refusal and Night Wakings in Young Children

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Mindell’s review highlights the high incidence of sleep problems in young children and the diverse treatments used by clinicians and investigators in their attempts to solve this problematic behavior. In the detailed descriptions of the various studies cited by the author, a number of issues stand out.

None of these studies evaluated the efficacy of a specific treatment approach in relation to the etiology of different sleep disorders. This is puzzling since sophisticated criteria differentiate between dyssomnias (i.e., disruptions of the sleep process) and parasomnias (i.e., conditions in which sleep is disrupted because of an event happening during sleep) (American Sleep Disorders Association, 1990).

Even among children with dyssomnias, who make up about 85% of all sleep-disturbed children, there are clearly defined diagnostic subgroups (e.g., there is a sleep onset association disorder and a nocturnal eating disorder). These may well require different treatment approaches. Furthermore, even within each subgroup of these sleep problems, different etiologies may be found. For example, there is good evidence that children can have difficulties settling at night because their mothers are anxious and show an insecure attachment pattern (Benoit, Zeanah, Boucher, & Minde, 1992; Daws, 1989), while others may have trouble primarily because they have a difficult temperament (Carey, 1974; Minde, Popiel, Leos, & Falkner, 1993; Weissbluth, 1981). Sleep disturbances are also more common in premature infants (Wolke, Meyer, Ohrt, & Riegel, 1994), in children who sleep with their caregivers in one bed (Lozoff, Askew, & Wolf, 1996), and whose parents are present while they fall asleep (Adair, Bauchner, Philipp, Levenson, & Zuckerman, 1991).

The definition of a sleep disorder varies among authors. For example, Moore and Ucko (1957) defined a good sleeper as an infant who slept without removal from the crib from midnight to 5 a.m. for at least 4 weeks. Others demand 7 hours of continuous sleep, although even these investigators would call an infant who sleeps from 7 p.m. to 2 a.m. a “night waker” while the baby who sleeps from 10:30 p.m. to 5:30 a.m. is considered to “sleep through” (Scott & Richards, 1990). While others have very precisely defined criteria (Richman, Douglas, Hunt, Landsdown, & Levere, 1985), there is no indication that these factors have been taken into account in this review. This is clinically important since the treatment of one subtype of dyssomnia called “circadian rhythm or Sleep/Wake Cycle Sleep Disorder” is based on a disturbance of the biologically programmed pacemaker, which brings about predictable sleep/wake alternation periods. While dysfunctions of that circadian system can occur because of abnormalities in the brain (e.g., a hypothalamic tumor or blindness), most often difficulties appear because the child’s particular schedule comes into conflict with parental priorities. For example, some caregivers enforce excessively long nap times because they allow them “to do something for themselves.” However, a two-year-old who sleeps from 2–5 p.m. in the afternoon may not be ready for bed again at 7 p.m. for an 11-hour sleep period. Treatment of these conditions...
obviously consists of restoring the normal circadian system.

Another limitation of the literature is the fact that many of the investigations cited are based on small-size case studies. Whereas small case studies can be useful in an initial phase of exploring a new form of treatment, one would usually include them only in treatment evaluations that use a meta-analysis as the statistical tool for measuring treatment efficacy. Finally, this review is very focused on the efficacy of specific components within an overall treatment schedule for sleep disturbances. This is clearly an honorable exercise, yet it may have somewhat limited clinical relevance since there is increasing realization that many behavioral abnormalities require a multimodal treatment approach. In short, it may be unrealistic to hope for a “single effective treatment variable” because human behavior is multidetermined and treatment must take this into account.

In summary, there is no doubt that sleeping problems are often an early indicator of later relationship disturbances. There is furthermore no doubt that a multimodal treatment, including a dynamic understanding of parental fears and concerns, as well as biological givens of the child, can be effective in the majority of cases. The present review gives an indication of the effectiveness of specific measured treatment variables on the overall outcome of sleep disturbances but may have underestimated the generic effects each of these treatments has on a parent’s hope or readiness to take charge of his or her child’s behavior.

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References


