

# Controversies in Behavioral Treatment of Sleep Problems in Young Children

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## KEYWORDS

- Sleep • Young children • Behavioral intervention • Age • Sleep aids • Pharmacologic agents
- Child and family outcomes

## KEY POINTS

- Behavioral interventions to treat sleep problems in young children are efficacious and should be tailored to meet the needs of the individual child and family.
- Evidence suggests that treatment strategies can be initiated after 3 to 4 months of age and may include a sleep aid as a noncritical component.
- Pharmacologic agents are not likely to be effective as the sole intervention, and behavioral strategies should be used as the primary treatment procedure.
- Behavioral treatments have not been found to have iatrogenic effects on the child, parent, or parent-child relationship.

Sleep problems are a common parent complaint, with estimates that approximately 30% of children experience some difficulty sleeping.<sup>1,2</sup> Trouble falling asleep and waking during the night are the most prevalent concerns for young children and occur in 20% to 30% of infants, toddlers, and preschool-aged children.<sup>3,4</sup> In addition, longitudinal studies have shown that sleep difficulties may persist for months to years and can become a chronic problem. For example, a longitudinal study of 359 mother/child pairs found that 21% of children with sleep problems in infancy, compared with 6% of those without, had sleep problems in the third year of life.<sup>5</sup> Furthermore, sleep problems can have a negative impact on mood, behavior, academic achievement, learning, and memory consolidation.<sup>6,7</sup> Untreated sleep problems are also a public health concern as insufficient and

inappropriately timed sleep has been linked to an increased risk of obesity and a considerable estimated economic burden.<sup>8,9</sup>

Treatment options and the implementation of intervention procedures may seem confusing and overwhelming to parents (especially to those who are sleep deprived). Practitioners also often look for guidance. This article seeks to address some of the most frequent controversial issues and common questions related to the implementation of behavioral interventions in young children, including (1) which behavioral techniques have the most empiric support, (2) what is the best age to begin to implement these strategies, (3) should sleep aids or transitional objects be used, (4) what is the role of pharmacologic agents as an adjunct to behavioral interventions, and finally (5) what are the potential negative consequences

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of implementing behavioral interventions on the child, parent, and the child-parent relationship.

### WHICH TECHNIQUE IS BEST FOR INFANT AND TODDLER SLEEP DISTURBANCES?

A variety of behavioral treatment methods have been shown to be efficacious in the treatment of sleep problems in young children and are both widely recommended in clinical practice and used by parents with or without professional guidance.<sup>3</sup> However, parents as well as practitioners may be overwhelmed with the variety of behavioral approaches and have difficulty choosing which intervention to implement.

Most behavioral strategies are based on the premise that difficulties falling asleep and frequent awakenings throughout the night are related to parental involvement at the time of sleep onset. If parents habitually assist their child in falling asleep at bedtime, the child may not be given the opportunity to develop the self-regulatory skills necessary to soothe him or herself to sleep. Arousals and brief night wakings are a normative part of the ultradian rhythm of sleep<sup>10</sup> and are not inherently pathologic. However, children who have failed to develop self-soothing skills are often unable to return to sleep independently after these naturally occurring wakings and require parental assistance to return to sleep. If parent intervention is not offered, prolonged night wakings with crying and protest behavior ensue. Behavioral treatment strategies are based on principles of learning and behavior and recruit the parent to act as the agent of change to decrease bedtime problems and frequent night wakings. These strategies include traditional extinction, variations of graduated extinction, and parental education regarding fostering healthy sleep habits.

Traditional or unmodified extinction<sup>11</sup> involves the parent putting the child to bed at bedtime and ignoring the child until a set wake time in the morning while monitoring for safety and/or illness.<sup>12–14</sup> The parent also ignores disruptive behavior that may be displayed by the child, including crying, tantrums, and calling out for the parent. An audio and/or video monitor can be used to ensure the safety of the child while implementing these procedures. It is thought that after the child protests, the combination of sleep pressure and the consistent absence of parental reinforcement will result, over time, in the development of self-soothing skills and the subsequent ability to return to sleep independently. This technique is often referred to as *cry it out* in the public domain.

Although extinction procedures have been demonstrated to be highly effective in teaching children to initiate and maintain sleep without

parental assistance, there are several limitations that have been noted in the literature.<sup>14,15</sup> Perhaps most important for parents is that disruptive behaviors (eg, crying, tantrums, calling for parent) typically increase in frequency and severity before improvement (*extinction burst*).<sup>16</sup> Parents must also implement this strategy with consistency and continue to ignore problematic behavior no matter how long the behavior lasts.<sup>14</sup> However, because this procedure can be stressful for parents, many caregivers are unable to use this method with the consistency that is needed to be effective. When implemented inconsistently, parents may actually inadvertently reinforce the disruptive behavior. For example, if parents initially ignore but then eventually respond to the child, thus allowing the child to escape the situation after a certain amount of crying, the child will learn to cry longer the next time to elicit the same response (intermittent reinforcement). Thus, reinforcing the inappropriate behavior may result in protest behaviors that are more severe and intense than before the initial implementation of the extinction procedures. Given the difficulties in implementing standard extinction procedures, there is often a high attrition rate and parental resistance to implementing such a strategy.<sup>17</sup>

Graduated extinction theoretically involves the same underlying process as extinction but involves a more gradual approach. This method is often referred to as *sleep training* or the *checking method*,<sup>18</sup> and parents are instructed to ignore undesired behaviors after bedtime for a specified duration of time while checking in at specific intervals.<sup>11,19</sup> Unlike traditional extinction, some graduated extinction procedures are only implemented at bedtime, and parents are permitted to continue to respond as they typically would if the child wakes during the night. The expectation is that the development of self-soothing skills at bedtime will generalize, making nighttime intervention unnecessary.<sup>20</sup> This strategy has a plethora of empiric support and has also been shown to have better parental adherence and less parental stress when compared with standard extinction.<sup>3,21</sup>

This type of intervention also allows the length of intervals and content of the check-in to be customized to the needs of the family (eg, how long they can tolerate the child's protesting) as well as the child's age, temperament, and developmental level. Check-ins involve the parents comforting the child for a brief amount of time, with a typical range of 15 to 60 seconds. Parents are also encouraged to minimize interaction with their child during this time and may be instructed to repeat the same phrase if they must speak to their child (eg, I love you; it is time to go to sleep).

This practice permits the parent to verbally reassure their child while minimizing attention, as the phrase remains consistent across each interaction. A fixed-interval schedule (eg, every 5 minutes) or a variable-interval schedule (eg, 5 minutes, then 10 minutes, then 15 minutes) can be used in which the interval progressively increases within the same night or across multiple nights. To date, there are no studies that have compared the efficacy of different checking schedules.

Finally, psychoeducational programs that may help to prevent sleep problems from developing provide instruction to expectant parents, as well as parents of infants less than 6 months old, regarding the development of bedtime routines, consistent sleep schedules, parental involvement during sleep initiation, and parental response after spontaneous awakenings during the night. Perhaps most importantly, most programs stress that babies should be put to bed *drowsy but awake* to help them develop the ability to self-soothe at bedtime, thereby enabling them to return to sleep independently after naturally waking during the night. To date, published reviews have concluded that preventative parental sleep education is efficacious and reduces sleep problems,<sup>3,16</sup> with specific studies noting improvements in sleep outcomes.<sup>22–25</sup> However, 2 recent studies found limited efficacy. One study found no impact of an education program provided by nurses in maternity units.<sup>26</sup> This study included an in-hospital education session, phone contacts, and an informational booklet. Note that an earlier pilot study by the same group did find that preventative education was efficacious.<sup>27</sup> Another randomized control trial of a parental intervention with follow-up at 6 months of 554 infants noted efficacy only for improvements in daytime sleep for frequent feeders.<sup>28</sup> This study included parental education provided in a booklet and a DVD with information on such topics as normal infant sleep cycles, crying patterns, and strategies to promote independent settling. No differences were found between the intervention group and a control comparison.

### **Summary**

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The behavioral treatments with the most empiric support are unmodified extinction, graduated extinction, and, at least in older studies, preventative parent education,<sup>3,29</sup> with no clear empiric support favoring one approach over another. These 3 strategies are likely most successful because each involves the goal of fostering the development of self-soothing skills in the child. Given the difficulties in implementation and parental acceptance, extinction is likely less often chosen by

parents or recommended in clinical practice. In contrast, graduated extinction and preventive education offer a wide range of options that permit a parent and/or treatment provider to customize a protocol to fit the specific needs of a family and to increase parental adherence.

### **WHAT IS THE BEST AGE TO IMPLEMENT BEHAVIORAL INTERVENTIONS?**

Because the sleep of infants changes so rapidly in the first year, practitioners and parents often wonder what the optimal age is for implementation of a behavioral sleep intervention. Furthermore, is there an age when intervention is not recommended (ie, is it ever too late)? Unfortunately, no studies have compared the efficacy or negative effects of behavioral interventions instituted at different ages, such as 3 months vs 6 months. Parenting books make various recommendations, from starting at 12 weeks<sup>30</sup> to letting the child determine when they want to sleep on his or her own.<sup>31</sup> Although there are no data supporting a best age for behavioral interventions for sleep, clinical experience suggests that between 3 to 4 months of age may be a perfect age to implement many aspects of behavioral interventions. For example, this is a good time to transition an infant from a bassinet to a crib, to institute a bedtime routine, and to begin the process of teaching an infant to fall asleep independently. There are certain aspects of sleep physiology that may relate to the timing of behavioral interventions. First of all, 3- to 4-month-old babies are essentially immobile. Although some can roll over, babies at this age are not yet sitting, crawling, pulling to standing, or walking. Thus, the potential disruptive impact of rapid acquisition of motor milestones on sleep is avoided.<sup>32</sup> Additionally, an infant becomes capable of sleep consolidation (ie, the ability to sleep longer stretches of time during the night) by 2 to 3 months of age. One longitudinal study of 75 infants found that sleeping for 8 consecutive hours was most likely to occur at 2 months and sleeping from 10:00 PM to 6:00 AM occurred at 3 months of age.<sup>33</sup> A review of the literature by this same group of investigators found that the greatest rate of change for the longest consolidated sleep period occurs in the first 3 months, with minimal change between 3 and 12 months.<sup>34</sup> They concluded that infants' physiologic ability to sustain sleep develops rapidly in the first few months and that further changes after this time point are related to self-regulation skills, that is, the ability to self-soothe.

In contrast, Douglas and Hill's<sup>35</sup> recent review of behavioral interventions for sleep problems in the

first 6 months of life concluded that “the belief that behavioral intervention for sleep in the first 6 months of life improves outcomes for mothers and babies is historically constructed, overlooks feeding problems, and biases interpretation of data.”<sup>35</sup> Their review of 43 studies, however, was a mix of a few intervention studies, with the majority being longitudinal studies of infant sleep. Thus, it may not be accurate to conclude that behavioral interventions are ineffective at this young age.

Although Douglas and Hill’s<sup>35</sup> review was titled “Behavioral Sleep Interventions in the First Six Months of Life Do Not Improve Outcomes for Mothers or Infants: A Systematic Review,” there actually do not seem to be any published studies of behavioral interventions for infants younger than 6 months with identified sleep problems; the only studies that have been conducted are preventative education programs. These programs are not intervention studies per se in that parents are provided with general information during pregnancy or during the first few early months of the infant’s life but are not supported in carrying out such interventions in real time.

It is almost never recommended that behavioral sleep interventions be implemented before 3 months of age. Physiologically, newborns may not be ready to sleep for long stretches, often need multiple nighttime feedings, and may not be capable of soothing themselves. In terms of too late, there never seems to be an age at which behavioral interventions are no longer effective and behaviorally based sleep disturbances are no longer malleable to intervention. Several studies have documented success with behavioral interventions with toddlers and preschool-aged children<sup>36–39</sup> and even with school-aged children.<sup>40,41</sup>

### **Summary**

There does not seem to be any research that clearly supports the best age to implement behavioral strategies for sleep disturbances during infancy, either from a preventative or an intervention standpoint. Before 3 months of age is not recommended. The authors propose that an excellent age to learn self-soothing is between 3 and 4 months, although this needs to be customized on an individual basis; overnight feeding should be determined based on the child’s growth.

### **SHOULD SLEEP AIDS AND/OR TRANSITIONAL OBJECTS BE USED AS AN ADJUNCT TO BEHAVIORAL INTERVENTION?**

Sleep aids (most often pacifiers) are objects used to promote sleep initiation and maintenance in infants younger than 6 months. Practitioners and

parents may question if these items promote or hinder independent sleep behavior. As children reach the ages of 6 to 9 months, sleep aids can be used as a transitional object to provide a sense of comfort and security in the absence of a parent and assist the child in transitioning between waking and sleeping independently. Common examples of sleep aids or transitional objects include pacifiers, blankets, toys, stuffed animals, thumbs for sucking, and/or a clothing item previously worn by a parent.

Cultures that emphasize a child’s ability to self-soothe and sleep independently have the highest utilization rates of sleep aids.<sup>42</sup> These items are most commonly seen in Western cultures, especially industrialized societies and in urban areas. It is estimated that 16% to 72% of children between 3 months and 5 years of age make use of a sleep aid to facilitate sleep,<sup>43</sup> and 44% of children between 6 months and 4 years of age use an aid or object specifically at bedtime.<sup>44</sup> Furthermore, the age of the child is also related to the use of a sleep aid, with use increasing from 1 month of age, peaking between 4 and 6 months of age when infants are most likely to sleep independently and be physically able to make use of a sleep aid, and decreasing by 12 months of age.<sup>45,46</sup> For example, one study found that the use of a sleep aid was used by 43% of children at 1 month of age and subsequently declined, with only 26% of infants at 12 months of age using a sleep aid.<sup>45</sup> In addition, of children who used a sleep aid at bedtime, the use of the same object after waking during the night tends to increase with age. That is, infants at 1 month of age used an identical sleep aid for fewer than 30% of awakenings during the night, whereas infants at 6 months, 9 months, and 12 months of age used an identical sleep aid during 60%, 40%, and 50% of wakings, respectively. Finally, the types of sleep aids that are used also changes with age. Infants at 1 month of age are more likely to use a pacifier than at any other age, and infants at 12 months of age tend to use a mix of objects or nothing at all.

It is possible that sleep aids can promote self-soothing skills.<sup>47</sup> Although these are older publications, several studies suggest that children exhibiting self-soothing skills are more likely to use a sleep aid and/or transitional object than children who rely on a parent to transition from wakefulness to sleep.<sup>44,47</sup> Further, infants who use a sleep aid at bedtime and after waking during the night are less likely to exhibit night wakings at 9 months of age.<sup>48</sup> However, an intervention study conducted by Burnham and colleagues<sup>45</sup> found that providing their mother’s shirt to 6-month-old infants did not significantly aid in self-soothing at bedtime. It is

possible that the tactile characteristics of this transitional object, which may be an important component in identifying an aid or object to promote sleep, were not acceptable. In older children, transitional objects can be quite positive and comforting. For example, a recent study found that a stuffed animal, the huggy puppy, was efficacious in reducing nighttime fears in a study of 104 preschool-aged children (aged 4–6 years).<sup>49</sup>

Clinically, there are potential drawbacks to promoting pacifier use, particularly in children younger than 6 to 7 months. Parents will likely have to replace the pacifier during normative night wakings until the child has the motor skills to retrieve and replace the pacifier during the night. This practice may be similarly problematic with other transitional objects. However, once past this point, sleep aids seem to be beneficial. Thus, parents need to decide what the benefits versus costs of promoting sleep aid use. Finally, the child may replace the pacifier with fingers or a thumb or have significant sleep disruption if the parent stops the pacifier use.

### **Summary**

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The use of sleep aids in young children is more common in those able to initiate and maintain sleep independently; however, there is no empiric support for the use of these items either causing or being associated with a change in behavior. Although sleep aids may be successfully used in conjunction with an empirically supported behavioral intervention, the independent presence of a sleep aid is not likely to foster the development of self-soothing skills.

Finally, it is imperative to stress the current recommendations from the American Academy of Pediatrics<sup>50</sup> regarding the sleep environment of a young child. It is advised that a child is put to sleep on his or her back on a firm mattress with a fitted sheet. Soft toys, pillows, blankets, and other stuffed objects or toys should be kept out of the crib. Parents are encouraged to select potential sleep aids with these recommendations in mind.

### **WHAT IS THE ROLE OF PHARMACOLOGIC AGENTS IN CONJUNCTION WITH BEHAVIORAL INTERVENTION?**

Although there are several effective and empirically based behavioral strategies used to treat sleep problems in young children as discussed earlier, pharmacologic interventions may also be used in conjunction with behavioral treatments, as sought out by parents or recommended by physicians. For example, a national survey of 670 community-based pediatricians indicated that the majority

had recommended nonprescription medication or prescribed a sleep medication to a child with a sleep problem within the previous 6 months.<sup>51</sup> Approximately 75% of respondents had recommended a nonprescription medication, with antihistamines, such as diphenhydramine, being the most common recommendation; approximately 50% of practitioners had recommended an antihistamine as a sleep intervention for children aged 0 to 2 years. Half of the responding pediatricians had prescribed a sleep medication, with  $\alpha$ -receptor agonists the most common prescription, although this was rare in very young children (2%) but more common in 3 to 5 year olds (10%). Overall, 40% of physicians recommended medication for typically developing children with difficulty falling asleep or staying asleep. Although pharmacologic agents are commonly used in clinical practice, it is important for parents and health providers to be aware of the evidence that supports or refutes the use of sedating/hypnotic medications as safe and effective in children.

There are few empiric studies to support the use of prescription or nonprescription medication in the pediatric population.<sup>52,53</sup> In addition, the Food and Drug Administration does not currently approve any medication for the treatment of sleep problems in children. As a result, there is a significant lack of knowledge regarding the effectiveness and safety of the use of these drugs in children. In addition to the obvious concerns regarding safety, there is limited empiric support for pharmacologic agents in the pediatric population, primarily because of a lack of studies. One clinical trial randomly assigned 44 young children aged 6 to 15 months to receive either a placebo or diphenhydramine approximately 30 minutes before bedtime.<sup>54</sup> The results indicated that the groups did not differ in ability to fall asleep independently, sleep latency, number of awakenings during the night, parental happiness or satisfaction, and parental belief that the medication was effective. Essentially, diphenhydramine did not play a role in treating the children's sleep problems; the trial was discontinued before completion. In contrast, an older study<sup>12</sup> evaluated the effects of combining extinction and sedative medication (trimeprazine tartrate), prescribed in a reducing dose over the first 10 days of extinction in a sample of 45 children, aged 7 to 27 months. The combined extinction/medication group was found to have abrupt improvements in sleep, whereas the extinction and placebo groups had slow improvements. Finally, a recent meta-analysis of the use of melatonin in the treatment of sleep disturbances in children with autism spectrum disorders found overall efficacy; but none of

these studies were conducted with children younger than 3 years, and most did not do so in combination with a behavioral intervention.<sup>55</sup>

### **Summary**

Behavioral treatment approaches for young children with difficulty falling asleep and/or staying asleep are well supported in the literature and should be the primary treatment modality in this population. The American Academy of Sleep Medicine's multidisciplinary task force on Pharmacotherapy in Pediatric Sleep Medicine stresses the importance and effectiveness of behavioral strategies as the primary intervention.<sup>52</sup> If pharmacologic agents are used at all, they should be as an adjunct to and in combination with empirically supported behavioral treatment. Only in specific situations, such as if the safety or welfare of the child is threatened, there is an acute stressor, or the family is too stressed to manage the implementation of behavioral changes, should medications be used to treat sleep problems in typically developing children. Additional studies are clearly needed to assess the role of pharmacologic treatments as an adjunct to behavioral interventions.

### **ARE BEHAVIORAL INTERVENTIONS MORE HELPFUL OR HARMFUL?**

Although no systematic negative effects of sleep training have been supported by research, the potential iatrogenic effect of behavioral approaches to childhood sleep problems continues to be a controversial area. Although there is a solid empiric foundation demonstrating that behavioral approaches improve children's sleep,<sup>3</sup> there continues to be discussion as to whether such approaches cause harm in other domains of child and family functioning. Reviews and opinion pieces representing both sides of the issue continue to be published and receive significant attention.<sup>56,57</sup>

Overall, there are few studies investigating secondary outcomes of behavioral approaches; no studies to date have started with a priori hypotheses that negative effects would occur. In the most comprehensive longitudinal study to date,<sup>58,59</sup> a follow-up study at 6 years of age was conducted following a randomized controlled trial of an individual behavioral sleep intervention delivered by nurses to infants (8–10 months) with an identified sleep problem and their mothers. Of the 326 initial participants, 225 participated in the follow-up at 6 years of age (63%). The overall findings were that behavioral interventions for infant sleep improve sleep in the short-term with no long-term negative effects. More specifically, there were no negative effects on child mental health, psychosocial

functioning, the parent-child relationship, maternal mental health, or parenting style in children receiving the behavioral intervention compared with the control group.

A recent article by Moore and Mindell<sup>60</sup> provides a comprehensive review of pediatric behavioral sleep intervention studies with inclusion of secondary outcomes (N = 35) and looked at the effects on the child, on the parent, and on the parent-child relationship. The conclusion of this review was that there were no systematic negative effects of any behavioral sleep interventions. If anything, only positive effects of these interventions were found. A brief review of the main outcomes is provided here.

### **Effects on the Child**

Studies including child-based secondary outcomes have included measures of mood, temperament, and daytime behavior/functioning. In terms of research on child mood following behavioral sleep interventions, research is scarce. One study with a pre-post design investigated infant mood in 33 infants who were part of an inpatient behavioral sleep intervention at 6 to 23 months of age.<sup>61</sup> At 2 months after the intervention, 15 of 19 infants who were initially described as "irritable" before the intervention were described as happier, more playful, calmer, more cheerful, and easy to please. The two studies that have assessed the impact of sleep interventions on child temperament, not surprisingly, did not find any impact.<sup>61–63</sup>

Most of the research on secondary outcomes of behavioral sleep intervention has targeted daytime behavior/functioning of the child. Although most studies have not included children with clinically significant behavior problems, several did describe positive changes in behavior. For example, Seymour and colleagues<sup>64</sup> found that sleep improvements related to positive changes in daytime behavior, including being happier, easier to handle, and less aggressive. France<sup>65</sup> found improvements in agreeableness, likeability, and emotionality up to 18 months after the intervention in 35 infants (6–24 months) compared with controls. Other studies have also found improvements in daytime behaviors, including both internalizing and externalizing behaviors.<sup>63,66</sup>

### **Parent Effects**

Although not the focus of this article, child sleep affects parent sleep; improvements in child sleep have been found to relate to improvements in parent sleep quality and lower fatigue levels<sup>38,67,68</sup> as well as decreased night wakings.<sup>20</sup> Studies have also found improvements in parent well-being (eg,

stress, distress, mood, marital satisfaction) with improvements in the child's sleep.<sup>63,68</sup>

### ***Parent-Child Relationship***

Both in the popular press<sup>69</sup> and in academic journals,<sup>56</sup> concerns have been raised about the impact of behavioral sleep training on the parent-child relationship. Studies have not only failed to support any negative outcomes but have also identified potential benefits. For example, following a behavioral sleep intervention with 8 to 10 month olds, one study found 84% of mothers reported that behavioral interventions had a positive affect on their relationship with their child.<sup>70</sup> Two studies have specifically looked at infant security as a primary outcome of a behavioral sleep intervention and found a significant improvement in security at day 3 of the intervention and further improvements notes at week 6 of treatment.<sup>12,65</sup> No improvements in security were found in controls or untreated infants. A third study compared 95 infants referred for a sleep problem with a community comparison and found significant improvements in security after the intervention.<sup>37</sup> Group differences in security (with infants with a sleep problem described as less secure) found at baseline were eliminated following the intervention.

### ***Summary***

Although behavioral sleep interventions may be difficult for parents to implement and, in some cases, may involve the child protesting in the short-term, no studies to date have found any negative effects on the child. Based on existing research, clinicians can confidently recommend behavioral interventions without fear of short- or long-term harmful effects in the child or family.

### **SUMMARY**

Sleep problems in young children are prevalent and may become chronic without treatment. Behavioral interventions are clearly effective; but questions still remain and controversies exist, which provide barriers to implementing these interventions. Overall, the results of empiric studies as well as clinical experience suggest there is no perfect or one-size-fits-all intervention but rather that these strategies need to be tailored to the individual child and family. Research does not support the best age to implement behavioral strategies, although the authors postulate that 3 to 4 months of age may be optimal in many cases. Parents should aim to improve sleep behavior as soon as a problem has been identified and when they feel comfortable using intervention procedures to

modify the behavior of the child. The practice of pairing sleep aids with an evidence-based behavioral treatment strategy also has some empiric support. However, there are few data supporting the use of sedative/hypnotic pharmacologic agents in children either alone or in combination with behavioral treatments; these agents should be used, if at all, with caution and only under the supervision of a health care provider. Finally, parents can be assured that research does not indicate a link between behavioral approaches used to improve the sleep in young children and any negative effects on the child, parent, or child-parent relationship outcomes.

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