New Mexico Early Childhood Education & Care Department | Family Support and Early Intervention Division FAMILY INFANT TODDLER (FIT) PROGRAM

CENTER FOR DEVELOPMENT & DISABILITY

Early Childhood Evaluation Program – Technical Assistance & Consultation
Continuing Education series for NM FIT Providers

Sleep Issues in Infants and Toddlers

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Sleep and Sleep Issues in Infants and Toddlers



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University of New Mexico Health Sciences Center
Department of Pediatrics - Center for Development & Disability



Introductions and Housekeeping

- Today's ECEP Team
- We want to see you- cameras on!
- We want to hear you
  - Please use the chat or jump in with comments, ideas, and questions.
  - Goal is to share experiences and knowledge.



Remember: New and Improved Format!

- Topical Information and Background
- De-identified Case Example and Discussion
- Volunteer case consultation and questions!

***Please note this zoom platform is not HIPAA-compliant - please de-identify any confidential/case-related information.**



Objectives for today



- ❑ Identify typical sleep patterns and requirements
- ❑ Understand medical reasons why sleep is interrupted.
- ❑ Recognize behavioral impacts of poor sleep
- ❑ Become familiar with strategies to support families for children with sleep issues

How can we understand sleep challenges in toddlers?



A framework for observation, gathering key information, and ruling out concerns:

1. Rule out possible medical concerns/causes and establish typical behavior range
2. Consider/question what is happening – walk through the timeline of bedtime, to morning and identify patterns
3. Use strategies to track behavior (sleep log)) – Looking for "trends" over time
   - Always ask, What have you tried? and, For how long?
4. Consider an outside perspective – consultation or possible resources!

Sleep:

What is Typical?



The Centers for Disease Control and Prevention's recommendations for a healthy daily amount of sleep in every 24 hours: (including naps)

Infants (4 to 12 months): 12 to 16 hours

Age 1- and 2-year-olds is 11 to 14 hours

Ages 3 to 5, it's 10 to 13 hours every 24 hours

Adolescents (13 to 18 years): 8 to 10 hours

FYI for adults: 7-9 hours!

"The story of toddlers and sleep is really about a child's first introduction to self-regulation. It has been said that one of the best gifts we can give children is to help them learn to fall asleep independently. "



Dr. Lloyd, Mayo Clinic Sleep Specialist:

Not enough sleep ☹



Insufficient sleep means not getting enough sleep at night, which can cause several problems including decreased brain development, learning problems and more frequent negative emotions. It can also contribute to weight management problems, growth issues and increased frequency of illnesses. Insufficient sleep may also referred to as sleep deprivation.

Reference: Children's Hospital of Colorado

What are the symptoms of insufficient sleep



- Problems paying attention
- Hyperactivity and impulsiveness
- Low energy
- Poor mood regulation
- Decreased social skills
- Falling asleep at school or during short car rides
- Trouble getting out of bed in the morning
- Trouble falling asleep or staying asleep
- Family stress

Reference: Children's Hospital of Colorado

What do we mean by sleep problems



Sleep problems are a diverse set of problems, including:

- difficulties with insomnia (hard to fall asleep, stay asleep or get good quality sleep)
- sleep-related breathing disorders
- excessive daytime sleepiness
- circadian rhythm sleep disorders
- parasomnias
- sleep-related movement disorders (like restless legs and teeth grinding)

Sleep problems are more common in genetic and neurodevelopmental conditions



For Example:

Down syndrome: Due to craniofacial differences, low muscle tone and central respiratory differences, sleep problems are common (31-54 percent), including sleep apnea (31-63 percent) in these children

Angelman's Syndrome: estimates up to 70 percent with sleep problems.

Cornelia de Lange (CdeL) Syndrome: 50-70 percent

Autism Spectrum Disorder: 50-80 percent

FASD: Up to 80 percent report sleep difficulty; may be due to brain injury, environmental stressors, over-reaction to small amounts of stimuli

CVI: Differences in Circadian Rhythm, sleep/wake cycles and light sensitivity affect sleep.

Medical Considerations



- **GERD-** Signs may be hoarse voice, coughing after meals, frequent awakening at night, vomiting, irritability after certain foods.

OSA- Snoring with sleep interruption should prompt referral for a sleep study or ENT evaluation

Anemia- Low iron stores are associated with Restless Leg Syndrome (RLS) or Periodic Limb Movement, as well as with inattention. A routine finger stick may not show enough information for low iron stores.

Medication Side Effects-

Night time seizure disorder In toddlers, seizures that commonly present at night include frontal lobe seizures, which can manifest as sudden arousal, thrashing movements, bicycling leg motions, or other seemingly agitated behaviors during sleep; these are often associated with a type of epilepsy called "Nocturnal Frontal Lobe Epilepsy" (NFLE). Also, Benign Rolandic Epilepsy and Myoclonic Seizures

Medical Considerations



- Always consider abuse/neglect or exposure to trauma for any unexplained sleep problems
- Detailed pediatric history and examination
  - To rule out underlying medical cause, for example GERD, snoring and sleep apnea, anemia, growing pains,
  - Look for any additional signs of abuse or neglect (failure to thrive, unexplained injuries, bruising, etc.)

Nighmares vs. Night terrors



Night Terrors: A child with a night terror wakes up screaming and thrashing around, but they are still asleep and can't be comforted. They usually don't remember the night terror when they wake up. Night terrors are most common in children between the ages of 3 and 8, and they typically occur during the first few hours of sleep. Possible triggers include fever, lack of sleep, or emotional stress

Nightmares: A child with a nightmare wakes up from a bad dream and can remember it. Nightmares are more common than night terrors and can affect both children and adults. They usually occur during rapid eye movement (REM) sleep and are most common in the second half of the night. (Children can be woken from nightmares and are easily consoled) May begin as early as six months; peak 3-12 years of age.

Case Example #1

Difficulty falling asleep



Molly is a 30 month old girl who presents for developmental evaluation. She was born at term, estimated gestational age. There was no prenatal care. Prenatal exposures include methamphetamine, tobacco and alcohol in unknown amounts. Molly is in the care of her maternal aunt to whom she was discharged from the nursery.

Molly has seasonal allergies and asthma. She has a history of GERD, that improved after six months of age. She has grown at the 95th percentile for weight, 50th percentile for height and 50th percentile for head circumference. Her medications include seasonal allergy medication, albuterol and Flovent inhalers and nebulizers when she is ill, as well as steroid bursts.

Molly receives early intervention services based on environmental risk. She receives developmental special instruction and FSC. Vision and hearing are without concerns.

Molly's aunt notes that she has never slept well. It takes her 60-90 minutes to fall asleep. She watches TV in her room during that time. She has intermittent snoring and is a restless sleeper. She seems to wake up tired and can be irritable and inattentive during the day.

What more would you like to know?

What are Molly's risk factors for poor sleep



What more would you like to know?

1. Sleep hygiene questions…

- Where does she sleep
- With whom does she sleep
- What is the night time routine
- When did the sleep issues begin
- Has she always had a TV in her room
- When does she take her medications
- Does she have obstructive breathing with her snoring
- What have they tried
  - Melatonin
  - Weighted blanket
  - Lavender

Sensory Considerations



Sleep – Sensory Considerations

What's happening around bedtime? Is it stimulating or calming? Is the routine predictable?

Does she like lots of blankets, pillows and stuffed animals? Or does she sleep better under just a sheet?

Does he have specific clothing preferences? Maybe he's sensitive to the slight pilling on the sheets?

Were the sheets or his pajamas just washed with a new detergent?

She does she seem over-sensitive to every-day sounds when awake? Maybe she wakes easily with even very quiet sounds like a TV on in a different room.

Is there a streetlamp that shines in the room and makes shadows?

Does he get car sick or seem to avoid movement like swinging or sliding? Maybe he needs to sleep on a firmer surface.

What will you recommend?



1. No more TV
2. Consider that her prenatal exposures may leave her with less capacity to self regulate, and more sensory sensitivities.
3. Family should discuss sleep problems with her pediatrician
4. Establish a bedtime routine and sleep hygiene.
5. Consider OT consult within your agency
6. Consider a weighted blanket, warm bath, other calming strategies.

Interestingly, literature shows that sleep pamphlets are not as helpful as small group sessions

Case Example #2 Autism and sleep



Diego is a 33 month old boy who has been enrolled in your early intervention since 24 months of age when his pediatrician referred him for speech and motor delays. His MCHAT score is a 7 and he is on the wait list for an autism evaluation. You strongly suspect he will receive this diagnosis. He receives FSC, DS, SLP, and OT through your organization.

His family is struggling with his behaviors around sleep and everyone is exhausted. Diego falls asleep on the couch downstairs at night around 10 pm and then his parents move him up to his toddler bed. He wakes up and roams the house and will stay up for two to three hours before finally going back to sleep. Sometimes he doesn't go back to sleep at all. He is a safety risk at night as he has gotten out of the door once. He sometimes naps but overall never gets more than six hours of sleep in a 24 hour period.

Diego is otherwise generally healthy and he takes no medications.

The three most common sleep treatment approaches in ASD include parent/caregiver education, behavioral, and pharmacological.

Melatonin

Dr. Lloyd: from Mayo clinic

Before even thinking of melatonin, I recommend that parents get back to the basics, because in most developing children, it's all about routine, habits and limit setting. It seems silly that parents would give a toddler an unregulated supplement for a correctable behavioral problem, and there is little evidence that it helps developing children sleep. The American Academy of Sleep Medicine recently issued a statement advising parents to talk to their health care providers about melatonin before giving it to children. While it may seem benign because it is readily available and comes in child-friendly preparations such as gummies, it is not. It is a supplement and therefore not a regulated medication, so the amount administered can vary significantly from what's listed on the bottle. Ingestions have significantly increased — with hundreds of ICU admissions, some resulting in death.

Screens

Mayo Clinic

Avoid having too late a bedtime and avoid involving technologies — including audio bedtime stories on a tablet, which is the same as giving a child a screen because it still emits blue light and therefore suppresses the child's natural melatonin activity

https://www.childrenscolorado.org/conditions-and-advice/conditions-and-symptoms/conditions/sleep-deprivation/

https://mcpress.mayoclinic.org/parenting/why-wont-my-toddler-sleep/

https://pmc.ncbi.nlm.nih.gov/articles/PMC5424624/#:~:text=Introduction-,Individuals%20with%20intellectual%20and%20developmental%20disabilities%20(IDD)%20experience%20sleep%20problems,%2C%20%26%20Dunn%2C%201986).

Discussion



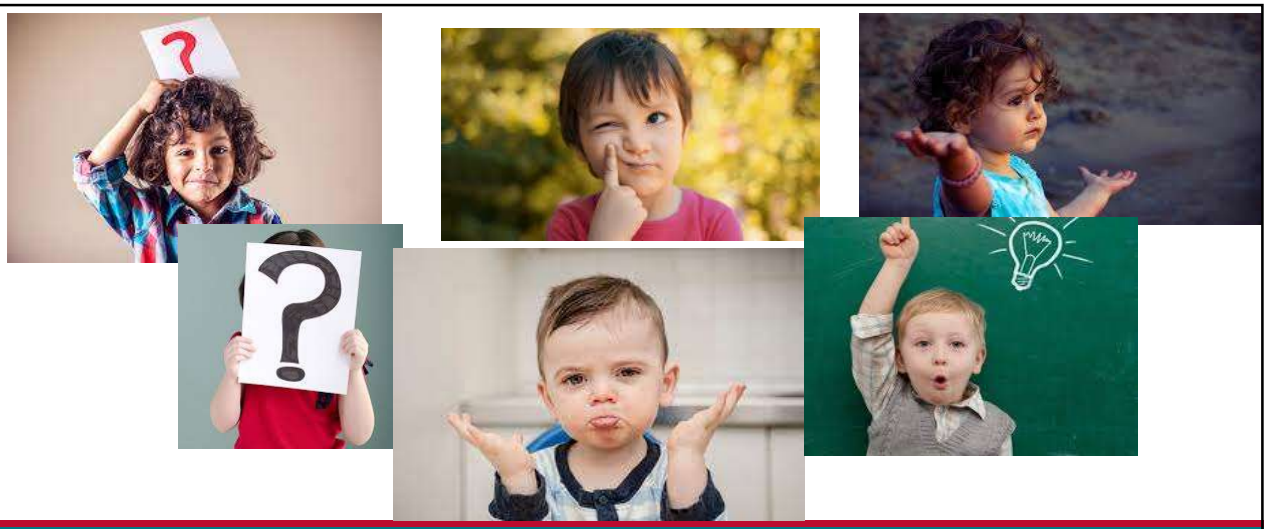
Case examples?

Successes?

Challenges?

Team considerations?

Next Steps?



Questions

Join us for more ECEP Office Hours in 2025!

Session 1:
January **, 2025



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Resources



Zero to Three

https://www.zerotothree.org/

Pathways

https://pathways.org/

CDC

https://www.cdc.gov/ncbddd/actearly/milestones/index.html

AAP Bright Futures

https://www.aap.org/en/practice-management/bright-futures

What to Expect

https://www.whattoexpect.com/

Resources



https://mcpress.mayoclinic.org/parenting/why-wont-my-toddler-sleep/

https://www.childrenscolorado.org/conditions-and-advice/conditions-and-symptoms/conditions/sleep-disorders-children/

https://www.childrenscolorado.org/conditions-and-advice/conditions-and-symptoms/conditions/sleep-deprivation/

Esbensen AJ, Schwichtenberg AJ. Sleep in Neurodevelopmental Disorders. Int Rev Res Dev Disabil. 2016;51:153-191. doi: 10.1016/bs.irrdd.2016.07.005. PMID: 28503406; PMCID: PMC5424624.

Jan JE, Owens JA, Weiss MD, Johnson KP, Wasdell MB, Freeman RD, Ipsiroglu OS. Sleep hygiene for children with neurodevelopmental disabilities. Pediatrics. 2008 Dec;122(6):1343-50. doi: 10.1542/peds.2007-3308. PMID: 19047255.