Provide a brief description of your child’s sleep problem (p. 1)

Describe your goals regarding your child’s sleep (p. 1)
Important assumption of **Behavior Analysis**:

Sleep problems are viewed as skill deficits which can be addressed by teaching relevant skills
Important assumption of Behavior Analysis:

Autism is not a life sentence of poor sleep and tired days
Good Sleep

falling asleep quickly

staying asleep through the night

rising without much trouble each morning

not feeling drowsy during the day
Why is Good Sleep Important?

Good sleep is restorative; without it, children are:

more irritable

more easily fatigued

more likely to suffer from unintentional injury

less likely to follow instructions

less likely to learn academic concepts

more likely to engage in problem behavior
  (meltdowns, self-injury, aggression, stereotypy)
Without good sleep, people with autism may be more likely to engage in **stereotypy**

![Graph showing the relationship between number of hours slept each night and mean baseline session rate of stereotypy. The graph includes a trend line with a correlation coefficient of $r = -0.484, p < 0.05$.](image-url)
Why is Good Sleep Important?

Persistent sleep problems in childhood are also associated with:

- childhood and adult obesity
- adolescent behavioral and emotional problems
- anxiety in adulthood
- sleep problems through adulthood
Why is Good Sleep Important?

Children’s sleep problems can lead to:

Maternal malaise and depression

Parental sleep problems

Erosion of the parent’s relationship with each other and with their children
How Prevalent are Sleep Problems?

Sleep problems are prevalent:

- 35 - 50% of young children
- 63 - 73% of children diagnosed with autism

Sleep problems are persistent—
they do not typically remit with time
Why So Prevalent?

Clash between our ancestral history (encoded in our genes) and existing cultural practices

we are built to sleep in a particular context

but

we are expected to sleep in a very different context
Treatment Options?

Parents are likely to consult with pediatricians despite only 5 hr of training on average.
81% of children’s visits to pediatricians, psychiatrists, or family physicians for sleep problems result in a prescription for a medication despite no FDA approval, no medication labeled for pediatric insomnia, no (or inconsistent) efficacy signal in literature
Baseline

Melatonin: 3 mg
Clonidine: 0.1 mg
Hydroxyzine: 4 ml

Behavioral Intervention

Melatonin: 3 mg
Clonidine: 0.1 mg
Hydroxyzine: 4 ml

0 mg
0 mg
0 mg

07:00 pm
09:00 pm
11:00 pm
01:00 am
03:00 am
05:00 am
07:00 am
09:00 am
11:00 am
07:00 am
09:00 am
11:00 am

Goal bid
goodnight time (09:00 pm)

Goal wake time (08:00 am)

Alice

Time

Nights
Treatment Options?

From: National Academy of Sciences, Committee on Sleep Medicine and Research, Board on Health Sciences Policy (2006)

“There have been no large-scale trials examining the safety and efficacy of hypnotics in children and adolescents. Other pharmacological classes used for insomnia include sedating anti-depressants, antihistamines, and antipsychotics, but their efficacy and safety for treating insomnia have not been thoroughly studied.”
Melatonin?

• There is evidence to suggest that:
  – It can decrease sleep onset delay without increasing night awakenings
  – The side effects of melatonin are less than any other prescribed or OTC drug for improving sleep
  – The smaller/younger the child, the higher the dose needed for an effect to be observed
  – Consistent long term use mitigates its effects (vacations from Melatonin are probably important to schedule)
  – In the absence of some other intervention, it alone will never solve a chronic sleep problem

• We surely do not know:
  – The dose that will work, if any.
  – The likelihood of its efficacy or for which children it will be effective

• If you use it, give it 45 min prior to bid good night and then turn down house lights
Behavioral solutions are recommended 22% of time (Stojanovski et al., 2007)

but the solutions are relatively weak antecedent-oriented approaches
  (e.g., positive routines prior to bed)

or not “behavioral” at all (candles and lotion)
**Assumptions Regarding Sleep**

- *Behavioral quietude / Falling asleep* are the behaviors of interest
- Can be influenced by past and present events in one’s sleeping environment
  - can be motivated (or demotivated)
  - can become reliant on environmental cues
  - can be affected by other reinforcers for other behaviors available at night
Looking at falling asleep.... through the lens of a contingency

• Conduct a contingency analysis:   EO + SD → R → Sr

• That which is known:
  – Reinforcer (Sr) for falling asleep is *sleeping*

• That which is unknown:
  – Everything else!
Looking at sleep.... through the lens of a contingency

EO + SD → Falling Asleep → Sleep

– What alters the value of sleep as a reinforcer?
Looking at sleep....
through the lens of a contingency

EO + SD → Falling Asleep → Sleep

– What signals that the reinforcer is available (and prepares the body to “consume” the reinforcer), and are those signals available when the child wakes up multiple times each night?
Looking at sleep.... through the lens of a contingency

EO + SD $\rightarrow$ **Interfering behaviors** $\rightarrow$ Sr

– What other behaviors are occurring before and after the bid good night that are incompatible with falling asleep (i.e., that do not allow for behavioral quietude)?
Looking at sleep....
through the lens of a contingency

EO + SD $\rightarrow$ Interfering behaviors$\rightarrow$ \textcolor{red}{Sr}

– What reinforcers are available for behaviors that are incompatible with falling asleep?
Looking at sleep.... through the lens of a contingency

**EO** + SD → Incompatible behaviors → Sr

– What alters the value of these other reinforcers for behaviors that are incompatible with falling asleep?
Looking at sleep.... through the lens of a contingency

EO + **SD** → Incompatible behaviors→ Sr

– What signals that these other reinforcers are available?
How do we assess and treat children’s sleep problem?

• Through a general understanding of the common factors that influence good sleep and sleep problems

• Using an open-ended indirect assessment to identify the personal factors influencing the sleep problem
  – SATT (Sleep Assessment and Treatment Tool)

• By encouraging parents to develop the intervention with us
  – we support parents in their implementation of the assessment-based treatment via phone calls and weekly visits.
Common Sleep Problems

Nighttime routine noncompliance

Sleep-interfering behavior

Delayed sleep onset

Night awakenings

Early awakenings
Your turn.

Nominate any relevant sleep problems (p. 1)
A typical case example

Ray

4-year-old-boy with Autism

Hyperactive

Parents tried multiple medications for sleep problems
<table>
<thead>
<tr>
<th>Sleep Onset Delay (min)</th>
<th>Baseline</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine 0.10 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melatonin 1-3 mg</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Interfering Behavior (min)</th>
<th>Baseline</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine 0.10 mg</td>
<td></td>
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<td>Melatonin 1-3 mg</td>
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<table>
<thead>
<tr>
<th>Night/Early Waking (min)</th>
<th>Baseline</th>
<th>Treatment</th>
</tr>
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<tbody>
<tr>
<td>Clonidine 0.10 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melatonin 1-3 mg</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Total Sleep (hr)</th>
<th>Baseline</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonidine 0.10 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melatonin 1-3 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sleep Onset Delay (min)

Baseline

Video Diary

Clonidine 0.10 mg

Appropriate Range of Sleep Onset Delay

Illness

Melatonin 1-3 mg

Interfering Behavior (min)

Clonidine 0.10 mg

Melatonin 1-3 mg

Night/Early Waking (min)

Clonidine 0.10 mg

Melatonin 1-3 mg

Total Sleep (hr)

Nights
<table>
<thead>
<tr>
<th>Sleep Onset Delay (min)</th>
<th>Baseline</th>
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</thead>
<tbody>
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<tbody>
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<td>Clonidine 0.10 mg</td>
<td></td>
<td></td>
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</tbody>
</table>
Sleep Onset Delay (min)

Baseline

Treatment

Clonidine 0.10 mg

Appropriate Range of Sleep Onset Delay

Illness

Melatonin 1-3 mg

Interfering Behavior (min)

Illness

Clonidine 0.10 mg

Melatonin 1-3 mg

Night/Early Waking (min)

Illness

Clonidine 0.10 mg

Melatonin 1-3 mg

Total Sleep (hr)

Naps

Nights
AN INDIVIDUALIZED AND COMPREHENSIVE APPROACH TO TREATING SLEEP PROBLEMS IN YOUNG CHILDREN

C. Sandy Jin, Gregory P. Hanley, and Lauren Beaulieu

Western New England University
# Social Acceptability Survey (Parents)

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Walter</th>
<th>Andy</th>
<th>Lou</th>
<th>Average (Range)</th>
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<td>6</td>
<td>7</td>
<td>6.7 (6-7)</td>
</tr>
<tr>
<td>2. Acceptability of treatment</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6.7 (6-7)</td>
</tr>
<tr>
<td>3. Improvement in sleep</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
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<tr>
<td>4. Consultation was helpful</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6.7 (6-7)</td>
</tr>
</tbody>
</table>

*Note: Likert scale: 1 to 7. 1 (not acceptable, not satisfied, not helpful), 7 (highly acceptable, highly satisfied, highly helpful)*
Step 1: Develop Ideal Sleep Schedule

Step 2: Routinize Nighttime Routine

Step 3: Optimize Bedroom Conditions

Step 4: Regularize Sleep Dependencies

Step 5: Address Sleep Interfering Behavior
Step 1: Develop Optimal Sleep Schedule

• Recognize of age-appropriate sleep amounts
• Recognize importance of current sleep phase and “forbidden zones”
• Recognize universal tendency to go to bed later and wake up later
Age-Based Sleep Averages:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total Sleep</th>
<th>Night Sleep</th>
<th># Naps</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>11 hrs 30 min</td>
<td>9.5 hours</td>
<td>1 (2 hrs)</td>
</tr>
<tr>
<td>3</td>
<td>11 hrs 15 min</td>
<td>10 hours</td>
<td>1 (1hr15min)</td>
</tr>
<tr>
<td>4</td>
<td>11 hrs</td>
<td>10 -11 hours</td>
<td>0-1</td>
</tr>
<tr>
<td>5</td>
<td>10 hrs 45 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>10 hrs 30 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>10 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>9 hrs 45 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>9 hrs 15 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>9 hrs</td>
<td></td>
<td></td>
</tr>
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</table>

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
<table>
<thead>
<tr>
<th>AGE</th>
<th>Total Hours of Sleep</th>
<th>Typical Range</th>
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<tr>
<td>1 week</td>
<td>16</td>
<td>14 - 18</td>
</tr>
<tr>
<td>1 month</td>
<td>14</td>
<td>12 1/2 - 15 1/2</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>12 - 14</td>
</tr>
<tr>
<td>6 months</td>
<td>12 1/2</td>
<td>11 1/2 - 13 1/2</td>
</tr>
<tr>
<td>9</td>
<td>11 3/4</td>
<td>11 - 12</td>
</tr>
<tr>
<td>12</td>
<td>11 5/8</td>
<td>11 - 12 1/2</td>
</tr>
<tr>
<td>18 year</td>
<td>11</td>
<td>11 - 12</td>
</tr>
<tr>
<td>2 years</td>
<td>11 1/2</td>
<td>11 - 12</td>
</tr>
<tr>
<td>3</td>
<td>11 1/4</td>
<td>10 3/4 - 11 3/4</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>10 1/2 - 11 1/2</td>
</tr>
<tr>
<td>5</td>
<td>10 1/2</td>
<td>10 1/4 - 11 1/2</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
<td>10 - 11</td>
</tr>
<tr>
<td>7</td>
<td>10 3/8</td>
<td>9 7/8 - 10 7/8</td>
</tr>
<tr>
<td>8</td>
<td>10 1/4</td>
<td>9 3/4 - 10 3/4</td>
</tr>
<tr>
<td>9</td>
<td>10 1/6</td>
<td>9 5/8 - 10 5/8</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>9 1/2 - 10 1/2</td>
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<tr>
<td>11</td>
<td>9 7/8</td>
<td>9 3/8 - 10 3/8</td>
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<tr>
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<td>9 1/4</td>
<td>9 1/4 - 10 1/4</td>
</tr>
<tr>
<td>13</td>
<td>9 5/8</td>
<td>9 1/8 - 10 1/8</td>
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<tr>
<td>14</td>
<td>9 1/2</td>
<td>9 - 10</td>
</tr>
<tr>
<td>15</td>
<td>9 1/4</td>
<td>8 3/4 - 9 3/4</td>
</tr>
<tr>
<td>16</td>
<td>9</td>
<td>8 5/8 - 9 5/8</td>
</tr>
<tr>
<td>17</td>
<td>9 1/2</td>
<td>8 1/2 - 9 1/2</td>
</tr>
<tr>
<td>18</td>
<td>9</td>
<td>8 1/2 - 9 1/2</td>
</tr>
</tbody>
</table>

- **nighttime sleep**
- **daytime sleep**
  
  *Divided into typical number of naps per day. Length of naps may be quite variable.*
Sleep Scheduling

**Cautions:**

Difficulty falling asleep, staying asleep, or complying with nighttime routines may occur if child is expected to be in bed too long

Difficulty waking up or day time tiredness may be related to child being in bed for too short of a time

**Implication:** Select the right sleep total for child
When should the bedtime be scheduled?

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
When should the bedtime be scheduled?

Adapted from: *Solve Your Child's Sleep Problems*, Richard Ferber, Simon & Schuster, 2006
When should the bedtime be scheduled?

Caution

Putting children to bed during the Forbidden Zone will increase the likelihood of

nighttime routine noncompliance,
sleep onset delays
and
sleep interfering behavior
When should the bedtime be scheduled?

We have a tendency to go to bed later and wake up later because of our 24.2 hr clock.

Artificial light and nighttime activity availability leads to a 25-hour clock.
When should the bedtime be scheduled?

At the beginning of sleep treatment:
set the start of the sleep routine slightly later than when the child fell asleep the previous night

Then gradually transition sleep phase earlier
if child falls asleep within 15 min move bedtime 15 min earlier
next night until desired bedtime is achieved (Piazza et al., 1991)
Extreme Sleep Phase Shift?

Consideration

Try **chronotherapy** if sleep phase is more than 4 hours past desirable sleep time:

Move sleep and awake times *forward* by 1 to 2 hours each night (larger leaps can be made with older children)
Your turn.

Determine your child’s sleep schedule at the start and end of treatment
(p. 2)
Step 2:
Routinize Nighttime Routine

Develop a nighttime routine that occasions “behavioral quietude”

Try to implement it consistently across nights
Step 2: 
Routinize Nighttime Routine

Some emphases prior to bid goodnight

Activities progress from active to passive
   Arrange choices on picture schedule
   Make gradual changes in fun factor
      avoid rich to barren context transition

Exercise/baths earlier in routine

Ambient light gets progressively dimmer

Light snacks without caffeine
Step 3: Optimize Bedroom Conditions

Cooler temperature

Indirect lighting only

Non-undulating noise

Best toys/preferred activities not visible
Nighttime Noncompliance Considerations

Tendency to not follow instructions or resist guidance to, for example, put on PJs, brush teeth, or get in bed

**Solutions:**

- Start routine just prior to natural sleep phase
- Promote instruction following during the day
  - *See steps on handout (e.g., name game, follow through, etc.)*
Individual Children

Beaulieu et al., (2013, JABA)
Individual Children

**Precursors**
- Responding to one's name
- Stopping activity, looking at teacher, saying, "Yes," and waiting until teacher says something.

**Compliance**
- Completing an instruction within 6 s
BL1

$U = 11, p > .05$

Individual Children

BL2

$U = 0, p < .05$

$U = 12, p > .05$

Control  Experimental  Control  Experimental

Group
Control
Experimental

M% Compliance

BL1

$U = 12$, $p > .05$

BL2

$U = 4.5$, $p < .05$

M% Precursors

$U = 11$, $p > .05$

$U = 0$, $p < .05$

Group

Control  Experimental  Control  Experimental
Nighttime Noncompliance Considerations

Tendency to not follow instructions or resist guidance to, for example, put on PJs, brush teeth, or get in bed

*Solutions:*

- Start routine just prior to natural sleep phase
- Promote instruction following during the day
  - See steps on handout
- Arrange big discrepancy in consequences for compliance vs. noncompliance to routine
  - Avoid DRA with extinction
Your turn.

Identify aspects of current pre-sleep routine or bedroom conditions that may inhibit sleep onset and commit to new routines more conducive with sleeping (p. 3)

Adopt strategies to promote compliance with the nighttime routine (p. 3)

and see pp. 9-10 after workshop for additional strategies
Step 4: Optimize Sleep Dependencies

Transitioning from behavioral quietude to sleep depends on stimuli associated with falling asleep.
Stimuli that set the occasion for sleep must be there through the night because children wake up often during the night.

FIGURE 3. TYPICAL SLEEP STAGE PROGRESSION IN THE YOUNG CHILD
Optimizing Sleep Dependencies

Transitioning from behavioral quietude to sleep depends on stimuli associated with falling asleep

Problems:
Things that occasion sleep are not present when the child wakes up during the night = Night Awakenings

Things that occasion sleep are suddenly removed or inconsistently available = Sleep Onset Delay and possibly sleep interfering Behavior

Examples: TV, radio, books, bottles, “full belly,” presence of another person, being rocked or patted, lights, fallen stuffed animal or blanket
Optimizing Sleep Dependencies

Occasion sleep with things that
don’t require your presence,
can be there in the middle of the night, and
are transportable
(e.g., for vacations or nights at Grandparent’s home)
Optimizing Sleep Dependencies

**Good dependencies:**
- pillow,
- blanket,
- stuffed animal (with bed rails),
- pacifier,
- sound machine on continuous

Eliminate or fade “bad” ones and replace with “good” dependencies
Your turn.

Identify current sleep dependencies and commit to new ones that are easy to maintain, can be continuously available, and are transportable (p. 4)
Step 5: Address
Sleep Interfering Behavior

SLIB = Behaviors that interfere with behavioral quietude necessary for falling asleep

The big four are:

- leaving bed (curtain calls)
- crying / calling out
- playing in bed or in bedroom
  (this includes motor or vocal stereotypy)
- talking to oneself
Step 5: Address (SLIB)

Be sure to first properly consider what the likely reinforcers are for the interfering behavior

Attention / Interaction

Food/drink

Access to TV or toys

Escape/avoidance of dark or of bedroom

Automatic reinforcers (those directly produced by the behavior)
Addressing SLIB

Part 1

Provide the presumed reinforcer prior to bidding the child good night
Addressing SLIB

Part 2

After bid goodnight, eliminate access to presumed reinforcer following IB

With socially mediated IB, options include:
Extinction, Progressive Waiting, **Time-Based Visiting**, Quiet-Based Visiting, Quality Fading, or **Bedtime Pass**

With automatically-reinforced SLIB, we use:
Relocation of relevant materials
Blocking
Addressing SLIB

Time-Based Visiting

Visit your child at increasingly larger intervals after the bid good night and across nights (hopefully before IB occurs); during visit re-tuck them, bid good night, and leave.

<table>
<thead>
<tr>
<th>Day</th>
<th>First visit</th>
<th>Second visit</th>
<th>Third visit</th>
<th>Fourth visit</th>
<th>Fifth visit</th>
<th>Sixth visit</th>
<th>Seventh visit</th>
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<tbody>
<tr>
<td>1</td>
<td>10 s</td>
<td>30 s</td>
<td>1 min</td>
<td>3 min</td>
<td>5 min</td>
<td>10 min</td>
<td>30 min</td>
</tr>
<tr>
<td>2</td>
<td>30 s</td>
<td>1 min</td>
<td>3 min</td>
<td>5 min</td>
<td>10 min</td>
<td>30 min</td>
<td></td>
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<td>30 s</td>
<td>3 min</td>
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<td>10 min</td>
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<td>30 min</td>
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</tbody>
</table>
Addressing SLIB

Bed Time Pass

Give your child a *bed time pass* to be used as needed after the bid good night to have one request granted.

If # of IBs was high before you try this treatment, provide more than one bed time pass initially and then fade out the number each night.
Results of Social Acceptability Questionnaire Administered to Parents who Implemented Three Strategies for Addressing Sleep Interfering Behavior

<table>
<thead>
<tr>
<th>Most Preferred</th>
<th>Gina</th>
<th>Sam</th>
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</thead>
<tbody>
<tr>
<td>Mom</td>
<td>Mom</td>
<td>Dad</td>
</tr>
<tr>
<td>Mom</td>
<td>Dad</td>
<td>Mom</td>
</tr>
<tr>
<td>Bedtime Pass</td>
<td>Time-based Visiting</td>
<td>Bedtime Pass</td>
</tr>
<tr>
<td>Extinction</td>
<td>Bedtime Pass</td>
<td>Extinction</td>
</tr>
<tr>
<td>Time-based Visiting</td>
<td>Extinction</td>
<td>Time-based Visiting</td>
</tr>
</tbody>
</table>

Ranking

1. Bedtime Pass
2. Extinction
3. Time-based Visiting
Just prior to bed, the children were allowed to choose the treatment for each night.

- **Bedtime pass**: Reinforcement only if handed a pass.
- **Extinction**: No reinforcement (period).
- **Time-based Visiting**: Reinforcement available according to time.
- **Blue Card**: Treatment-Correlated Stimuli
- **Green Card**: Treatments
- **Red Card**: Contingencies
Eliminating Interfering Behavior

My new favorite: The Combo+

Time-Based Visiting
and the Bed Time Pass
with dueling outcomes

+Hand in pass for something now or hold onto pass
and hand in at breakfast for something better
Your turn.

Identify possible reinforcers for interfering behaviors and identify a means of providing them in some way that will promote “behavioral quietude” (p. 5)
Addressing Night Awakenings

Should be resolved with appropriate sleep schedule and healthy sleep dependencies

If not, address issues related to temperature, food, light, noise, incontinence, nighttime reinforcers

If not, we actively teach child to know when it is okay to get up for the day

usually with moon/sun clocks
Key Considerations for Good Sleeping

- sleep schedule
- nighttime routines
- sleep contexts
- sleep dependencies
- reinforcers for sleep interfering behavior
Implications

Chronic medication use is not the solution for sleep problems exhibited by children with autism

(or for your sleep problems)
For you to consider...

Start on Friday
Exercise
Avoid caffeine

Reflect on the day and tomorrow *before* you are in bed

and
For you to consider...

Address sleep onset delay by:

1. Making your bedtime 1 hr. later than usual,

2. Only putting yourself to sleep in your bed,

3. Getting out of bed if not asleep within 10-15 min, and sitting in chair & reading a literary classic for 15 min or until drowsy,

4. Gradually adjusting sleep and wake times to desired times.
Freedom from sleep problems is possible and probable with:

**Individualized assessment**

**Individualized and comprehensive treatment:**

**Step 1:** Develop Ideal Sleep Schedule

**Step 2:** Routinize Nighttime Routine

**Step 3:** Optimize Bedroom Conditions

**Step 4:** Regularize Sleep Dependencies

**Step 5:** Address Sleep Interfering Behavior
Thank you.

Good luck with all that you do for all who you teach and provide care.

For more information go to: www.practicalfunctionalassessment.com

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