

The authorial model of the therapy used in night terrors and sleep disorders in children

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Summary

Aim. The article describes the authorial model of the therapeutic work with children and their families used in night terrors and sleep disorders in children.

Methods. The reported symptoms concerned children 7 to 12 years old and were based on difficulties in falling asleep without the physical proximity of a parent or waking up at night and the reported anxiety as well as the need of the presence of a parent. The presented model of psychotherapy was worked out by the author on the basis of many years of clinical practice as well as searching for a possibly quick form of helping both children and their parents. The psychotherapy was conducted with 15 families in the form of a family therapy in the systemic approach and an individual therapy with a child conducted in the cognitive-behavioral approach.

Results. In all 15 families, in which the described model of psychotherapy was conducted, the symptoms of night terrors and sleep disorders in children subsided.

Conclusions. The authorial model of the therapy with the use of a “night link” may be an example of an integrative therapy within the framework of which the remission of symptoms was only possible due to connecting individual and family interactions.

night terror / sleep disorders / psychotherapy

INTRODUCTION

In recent years, within the framework of the conducted outpatients clinical practice, I started to work more often with families that looked for help for their children who suffered from night terrors and sleeping disorders. The reported sleep disorders were based on the fact that children could not fall asleep alone or woke from sleep with anxiety and demanded presence of one of their parents. When having difficulties in falling asleep they needed physical proximity of their parents, came to their bed or called

them to come to their bedroom. In the cases of falling asleep unaided night awakening usually took place between 1 and 4 a.m. Awakening was sometimes accompanied by the feeling of breathlessness. The characterised situations concerned children 7 to 12 years old. Before the symptoms occurred for many years the children had usually fallen asleep unaided and slept without any problems in their bedrooms.

In the cases of the reported night terror and sleep disorders in children I was conducting the family therapy in systemic paradigm and the individual child therapy in the cognitive-behavioral approach [1]. While analysing the problem from the family perspective I distinguished three types of family situations in which a night terror and sleep disorders reported by the children occurred: the change of a family structure, the change of a place of living and atypical situations.

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The change of a family structure took place in five families and was usually caused by a parents' divorce or separation [2, 3, 4]. These types of causes of changes in a family structure could undoubtedly contribute to frustration or deprivation of satisfying a safety need and thus to disturbing the sense of security. In some families the change of the structure also included the reconstruction of a family that was based on one of the parents engaging in a relationship with a new partner. For the child – in case of a new relationship of one the parents under whose custody the child remained – this situation could be the source of various emotional difficulties that included among others the conflict of loyalty towards parents, a relationship with a new partner or anxiety connected with the status in a new family. The change of the family structure was also very often connected with changing the place of living.

Changing the place of living was the second family situation that preceded the occurrence of a night terror and sleep disorders. I treat distinguishing this type of a situation as an isolated situation which is not connected with changing the family structure. Changing the place of living usually concerned moving to a bigger flat or house. Before moving, the children had no problems with falling asleep and slept alone in a separate bedroom.

Atypical situations concerned families where the aforementioned changes had not taken place, that is changing the family structure or changing the place of living. Moreover, conversations with the parents and child did not indicate the existence of clearly perceptible factors which can be hypothesised to have a trigger character.

DIAGNOSTIC DILEMMAS

It is difficult to unambiguously classify night terrors reported by children and sleep disorders associated with them in the specific diagnostic category within the framework of ICD-10 classification as these types of disorders are not included in it [5]. The categories concerning the disorders of the developmental period, that is "behavioural and emotional disorders with onset usually occurring in childhood and adoles-

cence" (F90-F98) do not include the description of the discussed night terror.

The description of the reported symptoms could make the assumption about the separation basis of the disorders. However, the children with anxiety disorders I worked with did not fulfil the required criteria concerning separation anxiety (F93.0). Children's separation anxiety that is specific for the developmental stage is different from anxiety disorders in terms of significant intensification, excessively long lasting, coexistence of difficulties which hamper functioning [5].

The children I worked with did not fulfil the separation anxiety criteria because they did not worry about persons close to them. They also did not fear of dramatic situations, went eagerly to school, did not show fixed unwillingness to go to sleep because in the earlier period they had fallen asleep and slept without any disruption, had no problems with staying home alone during the day, did not report any night terrors, did not show any distress when separating from their significant others. The children also did not show symptoms typical for phobic anxiety disorders (F93.1), i.e. the anxiety focused on various objects and situations [5]. Although, the described disorder seems to be close to phobic anxiety diagnostic criteria because the children experienced symptoms such as shortness of breath and these sensations occurred only in a specific situation, they did not feel an anticipation fear and emotional tension or mental discomfort while discussing or visualising situations causing anxiety. The children calmly talked about the situation causing anxiety, often showing significant distance and even a sense of humour connected with the reported night terror. They also did not see a problem in the fact that they could not fall asleep or woke up at night without the presence of their parent.

Anxiety and sleep disorders in children reported by the families also did not fulfil the sleep disorder criteria described in the category: (F50-F59), "behavioural syndromes associated with physiological disturbances and physical factors" [5].

The disorders reported by the children cannot be classified as nonorganic sleep disorders (F51) because they did not fulfil the criteria of both the category (F.51.0) "nonorganic insomnia" and the

category (F51.4) "night terrors" [5]. The children did not complain about the problems with falling asleep or poor quality of sleep and the frequency with which their disorders occurred depended on physical availability of one or both parents. The children also did not worry about the effects of the disordered sleep and the interrupted sleep neither caused tension nor disturbed normal functioning during the day. My patients' disorders also did not fulfil the criteria in the category (F51.4) "night terrors". Night terrors are the episodes of an extremely intense panic attack accompanied by screaming, motor and autonomic nervous system agitation. The patient does not react to attempts to calm him or her down, is disorientated and usually does not remember the past episode [5]. My patients also did not complain about nightmares (51.5). The children did not remember whether they had had any dreams while sleeping.

On the other hand, in the DSM-IV classification one may distinguish the category: "anxiety disorders of childhood and adolescence". A night terror is classified in this category, however it does not include the description of the discussed form of anxiety.

The aforementioned diagnostic categories of ICD-10 and DSM-IV classification do not fully describe the problems reported by the families with children during the therapy. The disorders presented by the children approximate the criteria of categories such as separation anxiety or phobic anxiety disorders.

The type of the reported problems may be classified in the category: "factors influencing health status and contact with health services" (Z00-Z98) and within its framework in the category: "other problems related to primary support group, including family circumstances" (Z63) [5].

METHODS AND TECHNIQUES OF THERAPEUTIC WORK

In the cases of families reporting with a child to the therapy because of a night terror and sleep disorders I was conducting the family therapy in the systemic paradigm and the individual therapy in the cognitive-behavioural approach.

Within the framework of the cognitive-behavioural therapy of a child relaxation and systematic desensitization were the applied techniques [1, 6, 7]. Most child and adolescent patients quite fast experienced the feeling of muscle and emotional relaxation because of the developmental susceptibility to yielding to a suggestion. After the child gained the ability to experience relaxation I gradually introduced images relating to the symptom, that is a night and sleep. From the onset of the exposure to them the images did not invoke strong emotions in children. The work with a child based on relaxation and desensitization was usually conducted within the framework of 2 or 3 sessions and was emotional preparation for sleeping alone. Individual sessions usually took place once a week.

In the therapeutic work with a family I applied the systemic approach within the framework of which I put forward hypotheses relating to both the stage of a family life and its specific situation. In the case of focusing on stages of a family life I mainly took into account families with school-age children and adolescents [2, 8, 9]. I examined their difficulties and/or problems concerning:

- sharing parental duties connected with upbringing and school education of the child,
- natural loosening of a mother-child bond (especially when the child did not attend kindergarten before),
- establishing by the child a connection with a new system, that is school,
- mother's return to professional activity,
- adaptation of the family to the process of children growing up and their leaving,
- gradual adaptation of the family to the stage of the empty nest.

While analysing the specific situation of each family in most cases I concentrated on:

- rules regulating the functioning of the family system,
- communication in the family that included among others the parents giving their consent to expressing by the child the so-called negative emotions,
- emotional relationships among the family members,
- changes of marital relationships.

The most often used techniques in the work with the families included:

- circular questions,
- reflective questions,
- reformulation.

Circular questions concerned among others relationships in the family, differences in descriptions of these relationships presented by the particular family members. On the other hand, questions concerning the future enabled me to gain new possibilities of solving problems and preparing the family system to the forthcoming changes.

Reflective questions focused on identifying behaviors, events and models adverse for a family and aimed at triggering off changes in the system of family convictions concerning a problem.

Reformulation was connected with identifying positive aspects of a symptom and its function in a family life [1, 2, 4].

The therapeutic work with a family also included behavioural elements based on the suggestion of using positive reinforcements during the introduction of a prop which I called a "night link". Family sessions took place once a month and included 6 to 10 meetings, that is they usually lasted from half a year to 10 months. A method of the therapeutic work with a child and family, apart from the aforementioned specificity of the techniques applied within the framework of the cognitive-behavioural approach and the systemic paradigm, may also be considered from the integrative psychotherapy point of view [1, 10, 11].

INTRODUCTION OF A SYMBOLIC PROP – A "NIGHT LINK"

I was inspired to introduce a symbolic prop, which I called a "night link", by the beginnings of my work with families and their children reporting night terrors and sleep disorders. Night terrors manifested themselves by the fact that a child usually woke up at night and called a parent or both parents to his or her bed or came to the parents' bedroom saying that was afraid to sleep alone. In both cases when a parent came to the child's bedroom as well as when a child came

to the parents' bedroom the result was the same, that is both parents and a child slept together. The situations when a child reported problems with sleep and asked to go to sleep with a mother or both parents were more rare. On the other hand, in all cases for several years children had had no problems with falling asleep alone or slept the whole night before anxiety disorders occurred. I worked with children 7 to 12 years old and used a symbolic prop – a "night link". In all cases it was parents who noticed the problem and wanted to change it whereas children did not see any problem in the fact that they could not fall asleep alone or woke up at night with anxiety. Children even sometimes reported satisfaction with the results they achieved in connection with the symptoms. In all families parents met their child's expectations and slept together with him or her. In the result, when feeling the physical proximity of the parents the child's anxiety subsided and he or she slept the whole night without any interruptions.

1. The idea of a "night link"

The aforementioned situations became an inspiration to look for solutions that would give a child the sense of security and let him or her maintain emotional proximity with parents while keeping physical distance at the same time. I hypothesised that mental proximity together with keeping physical distance can make a child feel a bond. When searching for the appropriate form of verifying this hypothesis I took into account children's developmental capability, especially within the scope of abstract thinking and understanding symbolic meanings. The period of life from 7 to 12 is characterised by the stage of concrete thinking [12]. This means that the form of a symbolic bond introduced in the therapy should be at the same time a concrete prop. Thus, the manifestation of the bond should be a symbolic link and a simultaneous concrete "bond". Specific meanings are ascribed to the concepts of a bond and attachment in attachment theories constructed by authors such as Bowlby, Ainsworth or Schaffer among others where they describe children's relationships with significant others in early childhood [13].

For the purposes of the conducted therapy of night terrors I use the term “attachment” in the concrete understanding as a “connection” or “link” which may literally mean “tying”, e.g. by the means of a rope or string. Thus, I suggested strings and ropes as props used to “night linking” and “tying” children to parents. In this way the idea of a “night link” emerged. This prop was usually introduced during the first session of the family therapy after conducting desensitization with a child. During the first two or three meetings I worked with a child using desensitization which concerned visualising sleeping alone. After two sessions a child usually agreed on sleeping alone. The information about introducing a prop and calling it a “night link” was passed on to the parents as a task. The family was informed that a “night link” would be introduced between the child and parents and that it would help the child to be in contact with them any time he or she wished but without changing the place, that is without parents coming to the child’s bedroom or the child coming to the parents’ bedroom. The information about introducing a “night link” was passed on as a task to perform both for the parents and child. The proposal of using a “link” by the means of a string was usually a positive surprise and it never caused reluctance or skepticism.

2. Entering the contract while introducing a “night link”

In the case of incomplete families cooperation by the means of a “night link” took place between a mother and a child. On the other hand, in complete families a “night link” was assigned to parents alternatively, i.e. one night the mother had it while during the other one it was in the father’s hands. The parents took turns in tying one end of the string around a finger or a wrist while the child tied the other end of it to his or her bed or a night table in a way to have it within easy reach. I did not propose tying the string to a finger to children because of three reasons: firstly, due to safety issues, secondly, because of a sleeping comfort and the final reason was based on the assumption that the child was supposed to reach for the string, i.e. a contact with the parents, not to be tied to them but only when he or she wished or felt the need of such

a contact. Tying the string to the mother’s or father’s hand was necessary for the parents in order to react when they felt a “silent call” of the child, that is pulling the string. The parents’ task was based on answering the child by pulling the string a specific number of times which had been determined together with the child before. Using a “night link” was accompanied by the introduction of daily activities which were attractive for a child as a reward for accomplishing the task. The attractiveness of the introduced activities was usually based on spending time together with one or both parents. The type of activities and the way of performing them were discussed during the family session by the means of circular questions. The child’s withdrawal from the contract was connected with the resignation from the planned activities. I assumed the hypothesis that parents would be stimulated to perform the task by the remission of symptoms which would cause that both the parents and the child would spend the night without changing places. The clinical practice seems to corroborate this hypothesis as out of 15 families I worked with only in two cases parents did not keep the contract and temporarily withdrew from accomplishing the task which resulted in the recurrence of symptoms in a child. On the other hand, in all cases children kept the contract by pulling the string and neither calling the parents nor coming to their bed.

In all families, since the introduction of a “night link” children slept in their beds. In the case of most families using the prop lasted for several weeks after which children slept alone without using the string whereas the family therapy was continued and usually lasted from six to ten months.

3. Strategic functions of a “night link”

I assumed the following hypotheses concerning strategic functions of a “night link”:

A. The emotional bond with parents is kept with the lack of physical proximity.

Forming this type of a bond may perform a function modelling the child-parents relationship during the stage of a family with a child growing up or the empty nest stage.

B. The kept bond is accompanied by the distance essential for the course of separation. Without the emotional proximity with the simultaneous consent to remoteness it is difficult or impossible for a child to experience the separation from parents.

C. The function maintaining the symptoms, i.e. fulfilling child's expectations in terms of sleeping with parents, is interrupted.

D. Parents are "available" when a child needs it. In this way relationships typical for the stage of a family with a growing up child are modelled. The modelling runs during the course of a therapy according to terms established by a family in the contract.

E. The parents' engagement and entering the contract which states an equal share in the experiment of both a mother and a father is a situation modelling changes in a relationship with a child.

F. The proposal of using a "link" is a planned situation precisely determined by a therapist which reinforces the feeling of security of both a child and parents.

The clinical practice based on applying the aforementioned method for many years confirmed the effectiveness of the work with a child and parents which is based on using principles and functions of a "night link". In all 15 families, in which I used the presented model of work, problems with sleep subsided. However, the use of the model of work with a "night link" requires conducting a simultaneous family therapy which is adjusted to the structure, needs and problems of a family.

CONCLUSIONS

Out of 15 families I worked with according to the aforementioned model in 5 there was no divorce or move. In 5 families the move took place whereas five families experienced a divorce.

In the families where no formal changes had taken place the difficulties usually concerned marital problems or marital crisis as well as extending working time of one or both parents. Longer and longer time devoted to work was not only one of the marital problems but it also

caused in children frustration of the contact with one or both parents. There were also situations in which a parent or both parents, in spite of being physically available, were not emotionally available because they were engaged in professional work.

The children in these families experienced the lowering of the sense of security which resulted in night terrors and sleep disorders. Consequently, sleep problems in children contributed to the parents' integration in terms of searching for solutions and help. Parents cooperated with one another within the framework of the therapy which helped in the improvement of marital and parental relationships.

In the families where parents got divorced children lived with their mothers. In two cases the child lived only with the mother while in the three ones the family reconstruction took place, that is the mother was in a relationship with a new partner. In work with post-divorce families the problems concerning the child's loyalty conflict towards parents living separately were significantly important. On the other hand, in case of reconstructed families the additional problem was building a relationship between the child and the mother's new partner and the loyalty conflict towards the father connected with that.

Next, in the families which changed the living place working on a night terror concentrated on regaining the sense of security both by the child and parents. In these families parents were experiencing the feeling of uncertainty and concerns for removal as well as the change of financial situation connected among others with raising a loan, which very often accompanied the removal. During changing the place of living the child's sense of security was also lowered because of significantly smaller amount of time that the parents devoted to him or her during this period due to furnishing the new house and presenting it to friends.

In all three types of families the used therapy triggered off emotional relationship between the child and parents. Moreover, the parents very often reorganized their professional activity and changed the way of functioning in a family. These changes made the parents more emotionally available for children and thus they met the child's need of contact and security to a larger extent.

The model of therapeutic work with each family was similar, that is after the first diagnostic-consultative session I proposed desensitization connected with visualising a night and day to a child and then during the first therapeutic family session a "night link" was introduced and the contract concerning its use entered. I could observe exceptional effectiveness of how a "night link" worked after the introduction of which children slept the whole night in their beds in spite of the fact that at the beginning they sporadically woke up at night. In most cases a "link" stopped being used after several weeks and children slept the whole night without interruptions. During this time family systems therapy was continued and its duration as well as the number and type of verified hypotheses was adjusted to the needs and problems of the family.

The question concerning the contribution of factors that enabled achieving a therapeutic effect arises. In the studies devoted to curing factors in psychotherapy specific and non-specific factors can be distinguished [1, 10, 11]. The first group, that is specific factors, include a theoretical approach and psychotherapeutical techniques. The second group, described as non-specific factors, comprises among others a therapeutic relationship which gives patients the sense of security and support. As the authors emphasize, the condition for the effectiveness of each therapy and efficiency of specific factors is the contribution of non-specific factors [10, 14].

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