



THE EFFECTS OF SLEEP
MANAGEMENT
ADVICE ON CHILDREN'S SLEEP
BEHAVIOUR



AN EVALUATION OF THE SURE
START SLEEP ADVICE SERVICE

THE EFFECT OF SLEEP MANAGEMENT ADVICE ON

CHILDREN'S SLEEP BEHAVIOUR AND FAMILY WELL-BEING

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ABSTRACT

The research question explores the effect of sleep management advice on children's sleep behaviour and family well-being.

A qualitative study using semi-structured interviews was carried out on parents who had received one-to-one sleep advice from the Sure Start health worker.

The research strategy was effective in collecting data about perceptions, but not about objective changes in sleep behaviour. There were difficulties in accessing the target population and in obtaining detailed information from the sample due to issues of trust and availability. Colloquial language and time elapsed since the therapeutic intervention made data analysis problematical.

100% of the children treated, learnt to settle satisfactorily within 3 days –2 weeks of the behavioural intervention, with a comparable reduction in frequency and duration of night waking. The level of parental motivation, the family centred approach, and the availability of advice at the time when the problem was greatest, were crucial to a successful outcome. All parents perceived an improvement in family well being once the sleep problems were reduced.

It is recommended that Sure Start Ravensdale continue to offer this advice service and to publicise it to local families and agencies.

1 BACKGROUND

This study was commissioned by the Sure Start Health worker who delivers sleep advice to assess the efficacy of the intervention on the child's sleep behaviour and the usefulness/appropriateness of the workers delivery method to our particular client group.

Previous research on sleep problems focuses on the success of behavioural management programmes delivered in a clinic or group situation. This study aims to fill gaps in knowledge by assessing the effect of sleep advice given to parents on a self-referral basis in the home environment (at the time when sleep behaviour is perceived to be problematic by the parents).

It seeks to build on research that shows that the level of parental motivation influences the parent's capacity to seek out and implement advice, and that success can be measured as much by parental satisfaction with the outcome as by actual change in the sleeping behaviour.

It develops theoretical knowledge by investigating factors, which parents perceive to impact on their capacity to carry out the intervention.

It examines the effect of intervention on families in a disadvantaged area who would not normally access formal referral systems or treatment programmes provided by mainstream services, and are therefore not usually included in formal research studies.

2 LITERATURE REVIEW

Richman et al (1982) found that night time settling and frequent waking is a problem with over half of 1-2 year olds and a third of 3 year olds. (In Wilson 1996). Whether this is problematic for parents depends on what they believe to be normal. Skuse (1994) in Sutton (2000) found that 10% of parents did not see nightly waking of one year olds as problematic whilst 37% of parents whose children woke less frequently did.

Parental perception is clearly instrumental in defining the sleep problem, and this is dependent on lifestyle and cultural factors determining what is both normal and acceptable. Sutton (2000)

Child sleeplessness can seriously impair family well-being. Levels of maternal depression and marital satisfaction are both shown to improve when the sleep problem is resolved Wilson (1996). Relationships with the child are less strained Szyndler and Bell (1992), Simcock (1999.) and the child's daytime behaviour improves- including improved concentration and mood and reduction in aggressive behaviour and temper tantrums. Simcock (1999). Bates et al (2002) found poor sleep patterns to be associated with poor adjustment in pre-school, even after accounting for family stress and parenting practices. Better sleep routines are associated with less family stress. The child's behaviour impacts on the parent and the parents on the child in a complex interdependent relationship.

Ranchandani et al (2000) carried out a systematic review of 9 drug and behavioural treatments for settling problems and night waking in young children. They report that whilst drug treatments are effective in the short term, behavioural techniques had a positive impact in both the short and long term.

These techniques involve changing children's sleep associated behaviours.

First, a positive bedtime routine is encouraged, providing appropriate cues, such as tidying up toys, going upstairs, putting on pyjamas and reading a story.

The child is then encouraged to settle to sleep without the parent's presence. This is achieved in one of several ways

In graduated extinction the parent kisses the child goodnight and leaves the room. When the child starts to cry the parent returns after a preset time repeats the kiss and leaves. No interaction, cuddles or comfort are offered. The interval between each intervention is increased each night.

In systematic extinction the parent checks the child is all right when it starts crying then leaves the room and ignores the crying; only returning if the child has got out of bed. This process is continued throughout the night.

Ranchandani (2000. p.212) reports that systematic extinction 'seems to have achieved clinically useful effects more quickly but had problems of 'compliance and acceptability' for parents'.

In Wilson's 1996 programme the 'fear' factor of 'controlled crying' experienced in extinction techniques, was not encouraged. Instead the bedtime routine was extended by parents offering a kiss and promising to return in a minute, but coming back sooner. The parent returned each time the child began to cry, gave a kiss and moved gradually away, until the child accepted their departure quietly. This method reported 59% success rates over one month, with a parallel reduction in night-time waking.

Sleep clinics in Cardiff had 86% success over 12 weeks (Richards 92) using positive routines and graduated extinction. Szyndler and Bell (1992) found 60% improvement in children with severe sleep problems, using individually tailored programmes, devised by parents who attended a sleep education group.

Although parents complain about sleep problems many enjoy having a small child to cuddle in bed and like to check on them in the night. Unless they are highly motivated to change the situation, parents will not take up treatment suggested by a health professional.

Richards et al (1992) found that from 380 families referred by health professionals 32% did not attend first or subsequent appointments. Of the rest only 45% attended 2 or more appointments, and overall the improvement in sleep behaviour was 21.8%.

Poorest attendance and success rates were in the most disadvantaged socio-economic areas. The authors wonder how 'sleep management techniques can best be offered to families who are not highly motivated to applying any systematic change in their family life'.

In Simcock's (1999) study weekly treatment at a sleep clinic was terminated when parents were satisfied with the change in sleeping pattern, so a subjective success rate of 100% was achieved. Analysis of sleep diary data indicated 70% success in changing actual sleep behaviour. All parents perceived their child's sleep problems to have improved despite any objective evidence.

In this case Simcock believes that increased tolerance and 'a modified approach to engagement with the child 'had resulted from the 'non-specific aspects of the therapeutic process.' Simcock (1999 p.128). Parents saw having the opportunity to talk about the problem, feeling that they were being heard and liking the therapist as equally important as the behaviour management skills learned. 73% of parents in this study said they were familiar with the behavioural techniques suggested but were unable to employ them without 'the support and motivation received at the sleep clinic' Simcock (1999, p.129)

Similarly 100% of mothers in a sleep management group found that meeting with other parents with comparable difficulties was useful or very useful. These parents felt more in control, more able to develop their own solutions, and less inadequate as mothers.

Szyndler and Bell (1992)

Key factors in successful interventions are parents clearly defining the changes they wish to see in the child's behaviour, learning skills to achieve this and having sufficient support, motivation and commitment to implement the plan. (Wilson 96, Szyndler and Bell 1992)

Socially excluded groups in disadvantaged areas are less likely to seek help and sustain commitment to formal treatment programmes.

This study examines such families who have received advice on a self-referral basis at the time when they perceive the sleep behaviour to be a problem.

Research Aim

To explore the effect of sleep management advice on children's sleep behaviour and family well being.

Objectives

1. To record the outcome of the sleep intervention on the child's sleep behaviour.
2. To identify the factors which have had an impact (positive and negative) on the parent's capacity to carry out the sleep management programme.
3. To examine the effect of the child's sleep behaviour, the support given by the health worker and the outcome of the intervention on the family's perception of well being.

3 METHODOLOGICAL STRATEGY.

3.1 The sample group are part of the target population of a Sure Start initiative based in an area of social and economic disadvantage. We seek to support families with children under 4 by developing innovative services, which best meet their needs, through informal intervention and through the provision of locality-based public services.

3.2 The purpose of the study was to test the impact, on children's sleep problems and family well being, of an informal advice –giving process with Sure Start families, and to investigate factors, which influence parental capacity to implement a sleep management programme.

3.3 Because the study was exploratory, a semi-structured interview was used. This format allowed respondents to raise issues not yet known by the researcher, whilst ensuring that key questions were answered.

The private and emotive nature of the topic precluded the use of focus groups. A formal questionnaire was unsuitable because many instrumental factors were as yet unknown. However in order to build on previous research an unstructured interview was also unsuitable because key questions needed to be asked.

3.4 The research question was specifically concerned with perceptions and feelings about an emotive and sensitive topic. In a population with low levels of social confidence and trust, a cautious approach was necessary. At all times the priority was to retain the therapeutic relationship between the participant and Sure Start.

3.5 The sample group are parents of children under 5, who have received sleep advice from the Sure start health worker over the last 2 years. Only 12 families were contactable so all those who were available were seen. 6 mothers were interviewed.¹

3.6 A letter² was sent to all families describing the research and inviting them to participate. A photograph of the researcher was included to provide forewarning of the person they would be meeting (to create equity and trust) and some reassurance of my authenticity as a Sure start worker and thus my suitability as a potential guest in their house. (To protect them and their children from potentially abusive situations).

3.7 Telephone contact was made after a week, allowing time for families to decide if they wanted to participate, and mutually convenient appointments were made.

3.8 Childcare expenses or childcare by Sure Start staff was offered, as was a choice of venue. This was designed to make families feel that they had some influence over the process and to make it easy for them to participate. Interviews were held either at the family home or at the Sure Start centre.

¹ No fathers were interviewed. Whether this was their choice or the mother's decision is unknown.

²Copies of the letter, research documents and the research tool can be found in the appendices.

3.9 The research tool comprised 33 questions covering the nature and context of the problem, the referral and advice process, and the action taken and the outcome achieved. Each of the research questions was addressed through several lines of enquiry in each section of the interview schedule.

The questions were checked for intrusiveness, relevance and ease of understanding. by the Health worker, the Community Development Worker and the Family Support worker before use.

3.10 At the beginning of each interview, the research purpose was explained and a consent form given to the participant to read and sign. This covered the right to withdraw, to veto anything in the final report pertaining to them, the opportunity to be debriefed and the way their information would be used.

3.11 The researcher briefly mentioned her job role and her status as a mother of young children who had received advice from the health worker; in order to build rapport, trust and a willingness to participate fully.

I had decided in advance that reciprocity would be necessary and gave reassurances and shared experiences when asked.

3.12 A Dictaphone was used in 4/6 cases, where respondents gave permission. The interviews took between 40 -90 minutes to complete and aimed to address all the questions on the interview schedule.

3.13 Since there were no contemporaneous records of the child's sleep pattern or the family's perceived well-being before or after the intervention, all data collection was necessarily based on respondent's perceptions at the time of the interview.

3.13 Data was transcribed for each case as a narrative in questionnaire order, then responses to particular questions collated thematically by the 3 research questions - outcome of intervention on sleep, factors influencing capacity to act and effects on family well-being.

3.14 Data was analysed thematically by examining particular questions. (see 3.13). This gave an incomplete picture of the data as much of the relevant information was given as comments on other questions, or at the end of the interview. Comprehensive data treatment and constant comparative methods (Silverman 2000) were applied to the transcripts to resolve this.

4 RESEARCH RESULTS

4.1 Efficacy of the Sleep Management Programme

86% of children had settling problems and 100% were waking at least twice in the night, every night.³ This behaviour had lasted between 2 months and 4 years
83% of the children treated had never had an established bedtime routine

Each respondent had agreed an individual action plan with the health worker (Sue), based on a positive bedtime routine and controlled crying.

100% of those treated, learnt to settle satisfactorily within 3 days –2 weeks of the behavioural intervention with a comparable reduction in frequency and duration of night waking. Parents found that children were going to sleep earlier and waking less often and at later time during the night.

One mother of a 2 year old exclaimed

“She settled so easily I can’t believe I’d not done it before. Someone should have said now its time to get into a better routine with bedtime and feeding.”

2 parents felt the outcome was completely successful, 3 wanted to see further reduction in the night waking and one had not implemented the plan.

Case study: Impact of establishing a bedtime routine.

Richard slept in his own bed for a year then started having nightmares and became scared of the dark.

He wouldn't settle when mum took him up to bed. He woke up in the night and climbed in the bottom of the bed with mum. When she tried to put him back to bed he would scream and end up back in her bed. This went on for 2 years.

By this point Richard was 3 1/2 and mum had a 2-month-old baby. Dad was working 2 full time jobs, leaving home at 5.30 in the morning and coming back at 10.30 pm.

Mum's goal was for Richard to go to bed on his own without arguing, have a story, and say *'night-night mum'*.

Mum had been bathing the children, putting their pyjamas on, and then coming downstairs to have tea. Richard would then watch TV whilst she rushed about doing bottles and when she said it was time for bed he would refuse and shout He complained *'you never let me do nothing ...can't watch nothing'*. This arguing would go on till 11 at night till mum gave up and went to bed.

After talking to Sue, mum changed the bedtime routine. She served tea, turned off the TV, tidied up the toys, went upstairs, had a bath and then read a story to Richard in bed. She would kiss him good night and promise to come back in 5 minutes, then go in her bedroom and watch TV with the baby (to keep him quiet).

'It took a couple of weeks and then it started working. He settled into the routine of going to bed and got more sleep. Sue got it straightened out for me'

³ 1 child was a 4 month old infant who would be expected to wake at least once during the night, but who was waking every hour.

Before the intervention Richard would come into mum's bed about 12-1am. Afterwards he came in at 5-6ish (more or less morning). He was going to bed a lot earlier because they weren't arguing all evening and sleeping longer through the night.

Mum reported that before the intervention she and Richard hated each other. He was grumpy and cheeky; she was depressed and 'nasty'. Afterwards she was more relaxed, in a better mood and had more energy to do things. Richard was also '*better and not so angry*'.

4.2 Capacity to carry out the Behaviour Intervention.

MOTIVATION.

Parents only sought advice when they felt they could no longer cope with the sleeplessness. Desperation was a common emotion to all those who took action.

"I got so low that I needed help"

In 4 cases, action was stimulated by a change in family circumstances- a new baby (2) return to work, (1) starting job training (1). One mother had sought advice continually since her child was 6 months old and, hearing that help might be available, felt she "*had nothing to lose by talking to Sue*"

The other mum did not feel her child's sleep was a problem but her partner did. He attended the advice session and tried to implement the action plan. Mum told me that her lack of motivation had undermined it and this child continues to sleep in the parental bed.

COMMITMENT

Simcock (1999) found that individually tailored plans are effective in sleep intervention. Parents are empowered to define the problem and the solution and given the skills and

confidence to act. This creates a greater 'ownership' of the process and commitment to it, which is confirmed in this study.

One parent summarises a general view.

*'I talked to friends but they were all in different situations to me. The Health Visitor gave advice but didn't see **my** point. She kept saying you've **got** to do this you've **got** to do that. I think Sue understood how it was. She was asking what **I** wanted, set the plan to suit **my** family'.*

Another respondent who had sought advice from GPs and Health Visitors over 4 years said

*'The advice conflicted. It was abrupt and impersonal. The Health Visitor said 'if you've not kept exactly to the sleep programme you need to go away and do it again'. Sue suggested options and asked if **I** thought they would work'.*

Because the action plan was 'acceptable' (Ranchandani et al 2000) and specific to the family, parents felt **committed** and motivated to carry it out.

When asked which factors affected their capacity to carry out the intervention parents emphasised **domestic circumstances** and **personal commitment in the face of fatigue**.

FATIGUE

The hardest aspect was balancing the (immediate) need for sleep against the (long term) commitment to problem resolution.

'Ignoring the crying was probably the hardest bit'. When I was knackered or I'd got to get up and go somewhere it was tempting to give him a feed so we both could sleep'.

'Stan [the husband] he'd sit at the end of the bed with his head in his hands saying - I can't take it any more' [mother mimes a rocking movement]

DOMESTIC CIRCUMSTANCES

Factors which made carrying out the action plan more difficult were:-

- working parent's shift patterns,
- the absence of a supportive partner or the presence of a non-supportive partner,
- insufficient space for each child to have their own room,⁴
- trying to settle an older child whilst looking after a baby.

Helpful factors were:-

- the presence of a supportive partner,
- support from nursery during the day,
- grandparents offering occasional respite,
- school or nursery routine.

Case Study: Impact of domestic Circumstances

In this case jealous siblings, an uncooperative father, mum working night shifts and not enough bedrooms combine to create a waking nightmare for the family.

Fiona (aged 21/2) wouldn't accept her baby brother Ben sleeping in her room. He would go to bed and then Fiona would refuse, shout, scream and have tantrums up till 11pm. Once in her room she would throw things at her brother till he woke up and cried too. So instead the parents settled her to sleep in parental bed at about 8.30pm, lying with her till she fell asleep. (Mum had done this before Ben was born) Then they carried her into her own bed when the parents came to bed. Fiona would wake later in the night and cry and throw things at Ben till he cried.

"Then we'd all be up, shouting and arguing, one of us storming out of the house, sometimes. One of us would end up on the sofa or all four of us in my bed. I was working nights and getting no sleep at all day or night."

Stan (the husband) had 'a bad attitude towards it' (the sleep problem)

'So I decided to do it myself. He wanted it sorted but didn't want to keep going up and downstairs'.

⁴ As part of the sleep advice role, Sue provided practical support to families before they tried to resolve the problem. E.g. helping to make a child's room safe and suitable, removing junk, ensuring a bed was available.

After the initial sleep intervention Ben started settling OK. Then a pipe burst and the flood meant that everyone had to change bedrooms. The problem restarted with Fiona waking everyone else.

Mum gave up her job and shortly after wards she and Dad split up. Mum and the children went to stay in a hostel. Ben slept fine there but Fiona insisted on sleeping in mum's bed (all in the same room anyway.) Mum was finally re-housed by the Council into 3-bedroomed home. Now the kids have got a room each. Mum then went through the action plan again.

'Ben, he'll go up, put his light on and say 'Good night mum'. Then don't I hear a peep out of him till 7 (on the dot) next morning. At 7pm Fiona goes upstairs and has a story. She can sometimes be left to go to sleep on her own or I sit with her. Shouting doesn't wake her up. I came back to Sue and told her about them settling in their own rooms'.

SUPPORT NETWORKS.

Feelings of isolation and inadequacy, even guilt are common in parents whose children have sleep problems. Szyndler and Bell (1992)

50% of interviewees had sought advice from the Health Visitor or Doctor, which had not resolved their situation.⁵ When asked if they had the support of family, most mothers reported that the family gave some respite by looking after the child for an hour or a night . However most felt that the family were judging them to be inadequate parents because the child wouldn't sleep. Similarly many mums had talked to friends, whose situations differed and had felt that they were being judged. One mother said

'When they ask if he's a good baby I just say yes because that's what they expect to hear'

Another mother summarises the feelings of isolation and inadequacy

"I used to blame myself because I worked. At the time the majority of my friends had kids who'd sleep through. I felt they were critical of the way I treated him....."

Carl [the husband] felt I should leave him to cry- but then in the night he'd get overtired and give anything to get a good night's sleep.

My mum had Jake while I worked, so I couldn't ask her at other times. A lot of the time you try and deal with it yourself.

It's a vicious circle. When you don't get any sleep it makes it 10 times worse.

My mum says he needs a good nights sleep!' (shakes her head in disbelief)

Szyndler and Bell (1992) reported that mothers who attended a sleep advice group reported feeling less inadequate and isolated. In this study, one participant suggested that such a group might be useful. When asked, the other interviewees felt that a group would be competitive, that they would continue to feel inadequate because their problems were different and that if they couldn't sort out the sleeping problem they would be seen to have failed yet again. These 3 mothers said they would not attend such a group.

4.3 Perception of Family Well-being.

The findings of this study are consistent with previous research; that child sleep problems are related to increased levels of stress, maternal depression and marital discontent, poor relationships with the child, poor child behaviour and extreme fatigue. One mother felt that the sleep problem had played a major part in the break up of the marriage.

"I was tired, arguing all the time. It was just a nightmare. One of us would end up on the sofa. I felt guilty every morning."

Another mother said of her husband.

"there were days when I hated the sight of him...-jealous that he'd not got up to Jake" [in the night]

Resolving the sleep problem had a major impact on the perception of family well-being.

⁵ See section on Commitment p13

"It felt different, brilliant. I can sit on the sofa and watch what I like on the telly and kick my legs up on the sofa."{Mum does this action and grins}

"All our focus was on Emma, now we have more time for each other."

Two mothers and a father describe how they felt before and after the intervention.

Before:

"tired, agitateda nightmare"

'terrible, I was getting depressed and nasty towards Richard. Me and Richard (the child) hated each other.'

'Arguing, tired all the time. Just want to go to sleep, too tired (for sex)'

After:

'more energy, fresh, ready to get on with the day"

'Getting more sleep, more willing to get up in the morning, more relaxed. Energy to do things and be in a good mood.'

'She don't argue so much or shout at me all the time.'

4.4 Effectiveness of the advice and delivery method.

REFERRAL.

The referral process consisted of a parent asking for advice, or being signposted by a friend or Sure Start worker.

"I was down at Sure Start and someone suggested seeing Sue. They said 'she's in now- we'll get her"

No forms were filled in; just a verbal request for support and a mutually convenient appointment was made. Interviewees appreciated:-

- the immediacy of the response,
- the health workers willingness to meet in a venue of the mother's choice
- and at an appropriate time.
- the offer of childcare whilst the adults talked

“She came late, after hours so that Sam could meet her....She said I’ve not come to look at the house”.

Since these families would not usually access formal processes, this approach ensured that they received support in a way and at a time when the sleep problem was a priority for them.

ADVICE PROCESS.

The Health worker asked parents to describe the nature of the sleep problem, and then went through an advice process common to other Health visitors in the locality, using sleep pattern analysis sheets and a sleep diary sheet.⁶ Parents were then asked to fill in a Bedtime behaviour plan describing their child’s current bedtime routine and to define the outcome they wanted.

A plan of action was negotiated around family circumstances and lifestyle. Most parents implemented the plan that same night (showing how serious the problem was) although one couple waited till their shift patterns coincided in order to support each other. Mothers appreciated the time taken by Sue to find out about their specific circumstances and to support them to find their own solutions.

“She didn’t criticise what I was doing – suggested ways to change it”

SLEEP PROGRAMME.

The positive routine proposed by Sue⁷ included tidying away toys, turning off the TV, having a quiet bath and a story, kiss goodnight, then leaving the child (to cry if necessary).

Mothers found it difficult to leave their children to cry but were motivated to do it by the severity of the problem. The mother who had not implemented the plan felt it was too cruel to leave the child to cry.

6 & 7.copies in the appendices

Mothers were happy with all aspects of the positive bedtime routine except for the quiet bath time. Whilst they understood the need for a calming down period before bed, they all felt bath time with toys was a positive, happy play experience for all involved and it was a shame to lose it.

ONGOING SUPPORT

The Health Worker offered to phone families to see how the plan was progressing or for them to phone her for support. Two mothers reported their progress to Sue, and 50% of mothers commented that it was good to know that support was freely available from Sure Start. However they generally were reluctant to discuss progress in case the Health worker would judge them to have failed.

One mother was keen to know whether Sue had any children. She commented that she would have been more comfortable with Sue had she known she was a mother. The credibility of the advisor is thus shown to have an impact on how well the advice is received. (as discussed in Finch 1993)

Summary of findings.

The support of the Health Worker increased parental capacity to act. By hearing the problem, enabling parents to define the goal and providing behavioural techniques to solve it, the worker facilitated the solution.

Capacity to carry out the behaviour intervention was affected by levels of motivation and commitment to the process. A change in family circumstances was commonly the stimulus for taking action, but domestic circumstances were also instrumental in causing the problem in the first place and making it more difficult to solve.

Positive changes in sleep behaviour were what improved perceptions of well-being..

Families were reassured by the knowledge that they could seek further support from Sure start should they want to.

5 METHODOLOGICAL CRITIQUE

This critique will focus on the methodological issues that relate to the context and consequences of this research study.

5.1 Ethical Issues.

Trust.

In order to gain access to interviewees and elicit maximum participation I used the strategies indicated in 3.6-3.11. I 'placed' myself as a recipient of sleep advice 'with whom they could share experiences' Finch, in Hammersley (1999 p. 173) and traded on my identity as a woman/mother/Sure Start worker to build rapport and trust. Like Finch I found my motives were accepted and respondents were unconcerned about issues of consent and anonymity. This leaves me with a responsibility not to exploit their trust, particularly in terms of consequentiality

Consequentiality and Politics.

My primary motive was to influence Sure Start and the NHS to make services more accessible and appropriate to families. In doing this I shared Finch's view 'that taking peoples experiences seriously is essentially a political activity'. Hammersley (1999 p.178). Representing the results of this research to relevant health professionals may well 'reinforce the view that working class women are inadequate and incompetent child rearers' Finch in Hammersley (1999 p. 176). This was in fact the view the women held of themselves.

It would be useful to present a workshop on 'instrumental factors in the success of the sleep management process' to relevant health professionals; followed by a discussion of the implications for their practice, in the light of their own priorities and resources.

Using this approach I hope to avoid over emphasis on the failings of the health service and/or the respondents.

5.2 Credibility

Seeking social meanings in retrospect is problematic in terms of reliability. Respondent's answers were not well articulated and were subject to reactivity and cultural prohibitions

of loyalty. I was able only to measure perceived rather than actual changes in sleep behaviour. Memories of the process and its problems would have been rationalised over time.

In order to be credible to the NHS further research will need to be conducted in conjunction with the therapeutic intervention.

Before advice is given participants should fill in a sleep diary over a short period. Details of family circumstances and perceptions of the family well-being should be collected.

This process should be repeated at an agreed time after the behaviour programme is implemented.

Examples of possible formats are available in Sutton (2000) or Szyndler and Bell (1992) or an amended version of the research tool could be used. Imposing this level of formality on the process will need to be done with care, as it has been the immediacy and informality of the process that has ensured its welcome within the Sure Start population.

5.3 Validity and Reliability

Data analysis was subject to my interpretations based on personal and professional experience on the subject and on the expectations raised by the Literature review.

Whilst I had asked the same questions of all participants, the wording and order differed to maximise access to the thought processes the participant was using. Mason (1996) notes that to achieve data that are comparable and valid this approach can be appropriate.

Like Finch (1993 p.169) I found the interview to 'take on the general character of an intimate conversation' but noticed a puzzling reluctance for respondents to comment on certain issues

Closer examination showed that the inconsistencies appeared during discussion of the relationships between the interviewee and her partner and between interviewee and the health worker.

When asked how their partners were affected by the sleep problem respondents reported that partners were equally committed to problem resolution. However on closer

examination several women had made aside comments that contradicted this.

"I read a story Sam - never would".

In talking about the health worker all participants gave a positive response about the advice process but clammed up when I asked about support during the intervention. Re-examining the transcripts showed that they were uncomfortable with having to answer questions from the health worker about their progress in case they were judged to have failed. This appeared to be a reflection of their lack of confidence rather than the inapproachability of the worker, but more research is necessary to explore this further.

The recency of the intervention significantly affected the interviewees' responses. Those still actively engaged in the process answered the questions in the order of presentation, clearly and with detail. Those whose problem was further in the past took a while to warm up and incidents were 'not clearly ...formulated in [their] minds.

Usefully, for the validity of the study their perceptions (which were the focus of the research) were startlingly similar. Desperation, isolation and inadequacy commonly featured in their accounts.

5.4 Social and cultural context.

Characteristic features of the target population made the data collection and analysis more difficult.

1 The non-specific, colloquial speech style was difficult to interpret with precision. Non-descriptive half sentences 'well you know....' predominated. Where I sought clarity by reflecting meanings or offering adjectives 'you mean that you felt embarrassed?' I was met with withdrawal: - blank stares and loss of eye contact.

2 This reflects the second feature of this population- distrust of outsiders and loyalty to ones own community. If I were one of them I'd understand - if I weren't then I had no right to ask.

3 Unreliability was another problem. Appointments were made, then forgotten or cancelled. The population was therefore not fully represented by those interviewed, as some 'hard to reach' families were too hard to reach within the time available⁸.

As a researcher these cultural 'blocks' frustrated me, but as a Sure Start representative I had a responsibility to maintain the therapeutic relationship with these families, and could probe no deeper.

5.5 Summary.

As an exploratory study the research design worked as well as I had hoped. The research was valid in that it effectively measured the perceptions of the interviewees, within the limits of what they would allow me to know. Whether the interview responses gave direct access to experience or as actively constructed narratives Silverman (2000 p. 36) they were consistent enough to reveal common patterns of perceptions. These are comparable with previous research and suggest key explanatory factors in the process of sleep management, which could be used to inform local family support services.

⁸ This is an ongoing issue for our work at Sure Start.

6 CONCLUSIONS.

The research question assessed the effect of sleep management advice on children's sleep behaviour and family well-being.

It was found that

1. The level of parental motivation (which was often desperation) was a key factor in the success of the sleep programme.
2. Sleep problems were ongoing. A change in family circumstances was often the stimulus that led parents to seek advice or discuss the problem with friends.
3. The availability of support from the health worker at the time when the problem was greatest was crucial to solving it.
4. Listening to parents, enabling them to set their own goals and giving them the skills to carry out the sleep programme made the parents feel valued and raised their confidence, commitment and capacity to deal with the situation.
5. The health worker's reassurances that the process would only take a fortnight, created a perception of a manageable time frame.
6. Parents found the positive bedtime routine acceptable, apart from a quiet bath time.
7. Parents did not seek ongoing support from family or friends or the health Worker for fear of being judged inadequate.
8. Practical circumstances such as lack of space, beds and awkward shift patterns were influential in causing the sleep problems and making solutions more difficult. Supporting the families to change these circumstances may be necessary before the sleep behaviour is tackled.
9. Where partners were actively supportive or were absent, mothers were better able to implement the sleep plan than when a non-supportive partner was present.
10. The majority of children had never had a positive bedtime routine. Once this was implemented, night waking problems were reduced considerably.
11. All families perceived an improvement in family well being once the sleep problems were reduced.

7 RECOMMENDATIONS

The research design reliably produced data about perceptions, but not about objective changes in sleep behaviour.

Further research is indicated which would

1. Look in more detail at the influence of relationships and domestic factors in the sleep management process.
2. Objectively measure changes in perceptions and actual sleep behaviour before and after behavioural intervention.

Action Proposed

3. That Sure Start Ravensdale continues to offer sleep advice using this informal one to one approach, and that this service is publicised.
4. That discussions are held with local Health Visitors to enable us to share experiences, work better in partnership, and provide mutual support.

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APPENDICES

Letter of introduction

7/11/2002

Dear

Sure Start Sleep Advice

As Evaluation Officer it is my job to find out how effective our services are; to see what is useful to families, and how we can improve what we do.

Some time ago you met with Sue MacDonald from Sure Start Ravensdale to talk about your child's sleeping pattern.

I would be like to find out

1. How useful was the advice Sue gave you.
2. If you carried out the plan you agreed.
3. How well the plan worked.

I would like to meet with you for about 1 – ½ hours to talk about the sleep advice you received. I will phone in a week or so to arrange a time and a place that is convenient to you and your family.



Childcare:

If you want me to visit you at home I can pay childminding expenses if you have a friend or relative who will look after the children. Alternatively I can bring someone to play with the children whilst we talk or we could meet at The Sure Start Centre when there is a creche on.

I hope you will be able to meet with me. This will help us improve our services to local families and to influence larger organisations such as the NHS to make their services more family friendly.

Yours Sincerely
Andrea Sharp, Training & Evaluation Officer

Consent Form

SLEEP ADVICE STUDY FOR SURE START

This study will help us improve our services to local families and to influence larger organisations such as the NHS to make their services more family friendly.

The information I collect will be written up under different headings e.g. Factors that help parents to change their child's sleep behaviour. This will provide information in a way which will not identify you or your family.

I may want to write some case studies that describe how individual families have been affected by their child's sleep problem. These will be used as examples to show workers the kind of issues that are involved. Names will be changed so that you cannot be identified.

I will also be writing a report on the way that I have carried out this research, for Nottingham Trent University. This will not identify you in any way.

You have the right to see any report I write resulting from this interview and to make changes to the parts that affect you. You also have the right to withdraw your information from the study at any time.

If after talking to me you think of anything else you want to discuss please phone me (or one of my colleagues if that feels better).

I have read and understood the terms of this study and am happy to take part

Name/s.....
.....

Date.....

Research Tool.

Sure Start Sleep Advice Questionnaire

Parent's name

Child's name

Nature of the Problem

1. How old was the child when their sleeping behaviour became a Problem ?

.....
.....

2. Child's sleeping context (cot, own room, bedtime, change in Circumstances, parents circumstances)

.....
.....
.....

3. What was the nature of the problem?
Settling/night waking/tantrums/wakefulness/other (please delete as appropriate) If other please state:

.....
.....
.....

Number of times woken per night.....

4. How often was this happening each week, on average?

.....
.....

5. What was the effect of this on your family life?

Mum

.....

Dad

.....

Siblings

.....

The child himself

.....

6. How long had it been going on before you sought advice?

.....
.....

7. What was it that made you decide that something needed to change?

.....
.....
.....

8. Who did you think of asking for advice?

Family /Friends / Doctor / Health Visitor / Sure Start / other

.....
.....

9. How did you identify Sue as the person to ask (process e.g. Friend - Paula – Sue)

.....
.....

The Advice

10. How long did you have to wait to talk to Sue?

.....
.....

11. When did you see her? (month/year)

.....
.....

12. Context: Where and who was involved? Were the Children Present?

.....
.....
.....

13. How did this feel?

.....
.....

14. What did you think about the process Sue took you through? What did you think of the advice she gave?

.....
.....
.....

15. What was the goal you set?.....

.....
.....

16. Did you understand what Sue said about waking patterns and how you would have to change how you reacted to the child?

.....
.....

17. Sue is very direct, did you find this useful or not?

.....
.....

18. Did you feel you could do everything she suggested?

.....
.....

19. Did you have anyone to support you with the sleep programme?

.....
.....

20. If you had been given the leaflet on its own (show leaflet) – do you think you'd have understood it? (followed the advice)

.....
.....

21. What things/factors helped you to be able to carry out the sleep programme?

.....
.....
.....
.....

22. What factors got in the way?

.....
.....
.....
.....

The Outcome

23. How long was it before you put the plan into action?

.....
.....

Were there other things you had to do first?.

.....
.....
.....

24. What action did you take as a result of your consultation with Sue?

.....
.....
.....

25. Which bits did you do and which did you not? If not why?

.....
.....
.....
.....

26. How easy/difficult was it?

.....
.....

27. What Happened?

.....
.....
.....
.....

28. How long did you stick with it?

.....
.....

29. Did Sue give you any support during this time?

.....
.....

30. Did the child's sleeping behaviour change in the short term or in the long term?

.....
.....

31. Did you achieve what you set out to do?
Yes/No/Partially (please delete as appropriate)

32. What have been the effects on your family life?
Of the support by Sue
The outcome of the action

Mum

.....

Dad

.....

Siblings

.....

The child himself

.....

33. If a friend had a similar problem with her child, what would you advise them to do?

.....
.....

Child's age at action	Settling problem	Night waking	Frequency	Duration of problem	Stimulus for seeking advice	Date seen and wait	Any support with action?	When plan Started?	Successful outcome?
2 RICHARD	Yes	Yes	Every night	18 months	Young baby, needed sleep.	2001 April 2 days.	Sue	Same day	Yes
4mths JOEL	Yes	Yes	Every night	2 months	Needs to go back to work	Sept 2002 Then and there	No, mum and sister have an hour in the day	That night	Partially
26 mths ELLEN	Yes	Yes	Every night	Always	Mum and dad both studying/working. Child in nursery 5 days all day	October 2002 2days	Partner. Nursery have stopped Ellen having a daytime nap.	3 weeks- waiting for shift patterns to coincide.	Partially-ongoing.
14MTHS JOSEPH	Yes	Yes	Every night	4mths	Fed up with him in our bed, dad	November 2001 A week	Not really. Mum could take him out for a bit of space	A week, dad when mum went out.	Not yet
4 ½ JAKE	No	Yes	Every night	Always	Just started school. Visit by Trent Surveys suggested help available.	Easter 2002, within a few weeks of survey	A little from mum and sister. Husband supportive but needs his sleep	Same night.	Partial
2 ½ FIONA 6mths BEN	Yes	Yes	Every night	Always 1 year 1 mth	Putting Ben in the same room caused bedtime 'night mare'. Sister refused to settle or sleep. Mum working nights	April 2000 Couple of days and September 2000	Mum and dad had Fiona over night sometimes	That night	Yes with Ben. Fiona's problem resolved 18mths later when she got her own room after parents split up.

Sleep Diary Sheet

Sleep Pattern Analysis Form

Devised Bedtime Behaviour Plan

Bedtime routine