The Bedtime Pass

Objective: To evaluate a novel intervention for bed-time problems

Design: We used an ABAB withdrawal-type experimental design

Setting: The intervention was prescribed in an outpatient primary health care context and evaluated in the home setting

Participants: Two normally developing boys aged three and 10 years were primary participants. Twenty parents and 23 practicing pediatricians rated acceptability of the intervention

Intervention: A bedtime pass, exchangeable for 1 excused departure from the bedroom at bedtime

Main Outcome Measures: For both primary participants, instances of crying and/or coming out format he bedroom after bedtime; for the 20 parents and 23 pediatricians, comparative ratings of acceptance for the pass 2 other commonly used approaches to bedtime problems (ignoring crying and letting children sleep without their parents)

Results: Crying and coming out from the bedroom reduced to zero rates in both children. Pediatricians rated using the pass as significantly more acceptable than letting children sleep with parents and equivalent to ignoring. Parents rated the pass as more acceptable than either alternative

Conclusion: The bedtime pass provides pediatricians with readily usable, potentially effective, and highly acceptable novel intervention for bedtime problems, one of the most common complaints in outpatient pediatrics.

Participants and Methods

Participants

The participants were 2 normally developing male siblings, aged 3 and 10 years. Their father was a professional educator, and their mother was a full-time graduate student in psychology. For both children, the referral concern involved frequent crying out and leaving the bedroom after bedtime. These problems had been occurring for some time, but increased demands on the mother's schedule increased the importance of an orderly bedtime. The parents' (mostly mother's) typical response to the bedtime problems was to ignore them or to issue a stern warning. Both parents agreed their strategies were ineffective.

Procedures

At baseline, the parents responded to bedtime problems in their usual fashion. During intervention phases, the bot were given 13 x 18-cm (5 x 7-in) card with their name embossed at the top and were told they could exchange it without penalty for 1 visit out of their room after bedtime. The visits were to be short and to have a specific purpose that could be satisfied by and action (eg. Obtain a drink, receive a hug, visit the bathroom). Following the action, the children were required to surrender the pass to the

parents until the following night when the process was repeated. Parents were instructed to ignore all crying out and to return the children to the room, without providing attention (ie, eliminate eye contact and verbal responses), of the child left after the pass was surrendered.

Measurement and Research Design

The dependent measure was the rate of crying out and leaving the room per night. An instance involved crying out from the bedroom or leaving it after the parents has said good night and left. A long cry was counted as 1 instance. A short call (eg, "Mommy") also counted as 1 instance. Leaving the room was defined by the child walking through the bedroom door. The mother was the primary observer. Her reliability was established with 14 simultaneous but independent observations from the father. Their agreement was 100%. An ABAB withdrawal design (A, baseline,: B, intervention) was used to evaluate the effects of the pass

Treatment Acceptability

A questionnaire asking for acceptability ratings (1 indicates not acceptable; 5, highly acceptable) of 3 behavioral options for managing bedtime problems (ie, ignoring, letting children sleep with parents, and using bedtime pass) was distributed to 2 groups of adults for whom children's bedtime problems were a potential concern. The first group was composed of all elementary, middle, and high school teachers from a small Nebraska school system who were also parents of preelementary and/or elementary school-aged children (n=wo). The second group was composed of practicing pediatricians from in and around the Philadelphia area who were attending a series of continuing education classes focused on developmental and behavioral problems (n=23). There were no refusals to participate from either group.

Resistance to bedtime is one of the most common child problems addressed in outpatient pediatrics. Prevalent forms of bedtime resistance include crying out from and leaving the bedroom. Frequent approaches for these problem behaviors include prescribing soporific drugs, letting children sleep with their parents, and ignoring bedtime crying. Each of these interventions may reduce bedtime problems, but may also produce adverse effects that limit their acceptability to parents. We evaluated the use of a procedure to reduce bedtime crying out and leaving the room while minimizing the likelihood of a temporary increase in problems.

Results:

Providing the bedtime pass reduced instances of crying and coming out of the bedroom for both boys, with zero rates achieved during the second intervention phase that were maintained at 3-week follow-up (figure). The contrast in data rates and trends between baseline and intervention phases indicate experimental control. As indicated by the plus signs on the Figure, the bedtime pass was used by the 3-year-oldonyl once in each intervention phase and by the 10-year-old boy 5 times in the first intervention phase and 3 times in the second.

Multiple *t* test comparison of the acceptability ratings showed the mean parent rating for using the bedtime pass (4.1) was significantly higher (P<.001) than those for ignoring (2.2) and for allowing children to sleep with their parents (2.1), which were not significantly different from each other (P=.81). Comparisons of the pediatrician ratings showed no indifference (P=.35) between the means for using the bedtime pass (3.7) and ignoring (3.3), and that both were rated as significantly more acceptable than the mean rating for letting children sleep with parents (2.5) (sleep with parents vs pass, P=.003; sleep with parents vs ignoring, P=.04).

Comment: Treatment of bedtime problems is often impeded by adverse effects. Soporific drugs can have diurnal carryover effects and rebound when they are withdrawn. Letting children sleep with parents can complicate marital relationships and delay development of independent bedtime skills. Ignoring children's crying after bedtime can lead to increased crying and coming out from the bedroom. In our study, the bedtime pass reduced the frequency of bedtime problems to zero rates in the 2 primary participants. The acceptability data from parents are important because parent nonacceptance often leads to treatment noncompliance and a perpetuation of bedtime problems. The acceptability data from pediatricians are important because their ratings of using the bedtime pass and of ignoring were equivalent, whereas parents rated ignoring as unacceptable. The difference in ratings between parents and pediatricians may be due to pediatrician reluctance to fully endorse nonemprically supported interventions. The effectiveness of bedtime procedures involving ignoring are well documented, whereas, to our knowledge, this report is the first documentation of the effects of the pass. Systematic replications of this study may be sufficient to increase acceptance of the pass by pediatricians beyond their acceptance of ignoring.

How the pass produced such positive results is unclear, but a number of possibilities exist. The pass may have functioned as an equivalent, although less effortful, means of accessing paternal attention. The absence of increased misbehavior that typically occurs when children bidding for attention are ignored suggests that using the pass is less aversive than ignoring alone. Ignoring a child upset about bedtime is a difficulty yet often necessary part of bedtime training. Using the pass allows parents to supply and children to received 1 "dose" of attention on an as-needed basis and may make any ignoring that is necessary easier for parents to conduct and for children to accept.

There are developmental and behavioral considerations for successful use of the pass. For example, the older child used the pass 5 times in the first intervention phase and 3 times in the second, whereas the younger child used it only once in each phase. This disparity in use was probably due to the disparity in the developmental levels of both boys. The developmental literature and our clinical experience with the pass suggests that 3 years of age is the lower limit of its utility. Bedtime problems in children older than 10 years are probably best addressed with more sophisticated contingencies. In addition, our success with the pass has been limited with children who are not under good instructional control during the day (not the case in this study). A general guideline for pediatricians is to use more comprehensive procedures for bedtime problems exhibited by children who score more than 1 SD above the mean on behavior problem checklists such as the Eyberg Child Behavior Inventory or Child Behavior Checklist.

There are some limitations to consider when interpreting our results. For example, the study included only 2 children, and whether such positive results would be seen in larger groups of children is a topic for future research. In addition, the presence of 1 high data point during the first phase of the intervention with the younger child creates some expereimetnal ambiguity for that phase. The mother reported tha the younger child was put to bed early and that she worked late in the adjeacnet room on the night the high data point emerged. This unique combination of influences could have neutralized the effect of the pass that night. These limitations notwithstanding, this study supplies pediatricians with a potentially effective, highly acceptable, and novel approach to one of the most common problems presenting in their outpatient offices.