Original paper

To learn how to sleep

A. M. Montserrat Gala[a], M. A. Fortes del Valle[b]

[a]BA in Nursing student. Universitat Rovira i Virgili. Tarragona. Spain
• [b]Associate professor. Department of Nursing, Universitat Rovira i Virgili. Tarragona. Spain.

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Ana M.ª Montserrat Gala:
anam.montserrat@estudiants.urv.cat

Abstract

Introduction: learning how to sleep in the first years, play an important role in the child's development. As healthcare professionals, we should try to provide parents with an appropriate guidance on child's healthy sleeping habits. The analysis of each case requires a solution adapted to each family for the night's rest. Nowadays, there are different methods in order to get good sleeping habits in the early years. For instance, Eduard Estivill, through his book *Duérmete, niño* and Carlos González in *Bésame mucho*. They have exposed two different styles of how to create correct child sleeping habits.

Materials and methods: this work is a qualitative research through the study of these methodologies and two families' evidences. We want to explore the benefits and difficulties of these two methods on the acquisition of sleeping well in children.

Results: the knowledge of both methods provides us with the opportunity to solve any situation related to sleeping habits in the early years. Moreover, the two families' interviews prove that both methods work successfully. To sum up, the most important issue is not the method.

Conclusions: the most important thing is being conscious that there are different stages that parents have to go through while teaching their children how to sleep well, and these stages could imply risky situations in parents and children health. Especially when it's their first child, with whom any situation is a challenge for the parents.

Keywords:
• Sleep
• Co-sleeping
• Routine
• Habits
• Rest

Aprender a dormir

Resumen

Introducción: aprender a dormir en la infancia tiene repercusiones relevantes en el desarrollo integral del niño. Como profesionales sanitarios, debemos ser capaces de proporcionar las directrices adecuadas para la adquisición de hábitos saludables en la necesidad de dormir de los más pequeños. El análisis de cada caso requiere una solución adaptada a cada familia para lograr el descanso nocturno. En nuestra sociedad actual, se utilizan diferentes métodos para la adquisición de buenos hábitos para dormir de forma saludable desde los primeros años de vida. Eduard Estivill, a través de su libro *Duérmete, niño,* y Carlos González, con *Bésame mucho,* han expuesto dos estilos diferentes sobre cómo crear correctos hábitos del sueño infantil.

Material y métodos: en este trabajo se realiza una investigación cualitativa a través del estudio de dichas metodologías y del testimonio de dos familias. Se quiere profundizar en los beneficios y dificultades que han aportado ambos métodos en el aprendizaje del dormir de los más pequeños.

Resultados: el conocimiento de ambos métodos nos enriquece, ya que incrementa las herramientas disponibles para solventar cualquier situación relacionada con los hábitos del sueño. Después de analizar las dos entrevistas, se comprueba que las dos metodologías fueron llevadas a término con éxito, al conseguir dormir a los pequeños.

Conclusiones: lo más importante no es el método utilizado, sino que los padres, ante la dificultad de enseñar a dormir a sus hijos, pasan por diferentes etapas en las que tanto su salud como la de sus niños pueden estar en situación de riesgo, sobre todo cuando se trata del primer hijo y cada situación es un nuevo reto.

Palabras clave:
• Sueño
• Colecho
• Rutina
• Hábitos
• Descanso

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INTRODUCTION

Sleep disorders are very frequent in children nowadays, and 25 to 84% of them tend to appear in early childhood in a period that can last up to three years of age[1].

All sorts of concerns and doubts are addressed in visits with paediatric nurses, with concerns in regards to sleeping being quite significant. Finding the right approach to manage the need to sleep is a challenging task for parents, and it can lead to very high levels of anxiety and worry in some families. When it comes to a firstborn, healthcare professionals become, more than ever, a reference point that may provide guidelines for the development of healthy habits. When families develop them spontaneously, we do not need to intervene.

In most cases, the advice that families seek has more to do with directions and guidelines for establishing habits than with an actual disorder. The recommendations vary depending on the family and its cultural background. Thus, as healthcare professionals, having different possible perspectives and solutions can help us understand the psychosocial context of the child and the different solutions that can be offered.

The importance of sleeping well is rooted in healthy child development, as physiological changes take place during the night. Sleep leads to activities that are very important for the physical and psychological balance of the individual; hormonal, biochemical, and metabolic changes take place that are essential for functioning well the following day. There are important functional changes at the psychological level too, such as restoring mental functions, learning, and the consolidation of long-term memory, information reprocessing, the unlearning of useless material, and brain maturation and restoration[2].

Objectives

- **General:** deepen our theoretical and practical knowledge of strategies to assist in the acquisition of healthy sleep habits in the early years of life.
- **Specific:**
  - Study in detail the sleep habits proposed by paediatrician Carlos González in his work *Bésame mucho*.
  - Study in detail the sleep-training methods based on cognitive-behavioural therapy proposed by paediatrician Eduard Estivill in his book *Duérmete, niño*.
  - Identifying the benefits and challenges experienced by families in applying each of these specific methods.

MATERIALS AND METHODS

We performed a qualitative study, as we explored in detail the experience of two families who have applied the different methods mentioned above. We wanted to get a detailed account of everything that these families had experienced from an anthropological point of view. We have explained each case and reflected the particular experiences of each family and taking into account the method they chose to establish healthy sleep habits in their children[3].

Our research design was done according to a series of decisions regarding the methods, techniques and procedures to be used for selecting the participants, collecting the data, and adopting the most fitting analytical approach.

Different criteria are used to categorise designs; in the health sciences, the most important criteria are epidemiological criteria, amount of manipulation (observational and experimental), their development in time (cross-sectional and longitudinal) and their purpose (descriptive and analytical).

Our study involved:

- Observational research, since a significant part of the information was obtained from observing the families.
- Cross-sectional research, as we observed and analysed each fact that had to do with the sleeping needs of the children. We did not follow up on the observed facts, so this design cannot establish causality.

- Descriptive research, as we give a detailed account of the characteristics of the epidemiological phenomena in terms of people, place, and time. Descriptive studies help us learn about the current social and healthcare challenges and needs.

Population and sample

We performed interviews with families, which we will henceforth refer to as "sources". The number of sources was two people or families (with one member representing both parents).

The selection criteria for sources were: a) age of mother ranging from 20 to 45 years; b) birth of the child in the last five years; c) use of at least one of the two methods (Doctor Estivill or Doctor González); d) first-time parents; e) family formed by a couple and their child; f) child with a minimum age of 18 months; g) absence of severe disease, surgery, and hospitalisation in the child; and h) family registered in the census and residing in Tarragona.

We used an emergent research design, as we made changes in the course of our study to adapt to unexpected needs as they arose with the perspective that each studied family was a distinct social reality[4].

Data collection techniques

The data collection techniques encompass the set of procedures, resources, and tools used to gather data; in our research we used participant observation and in-depth semi-structured interviews.

The in-depth interview[5] is a dynamic interaction process where two people communicate, the interviewer and the interviewee, and which is controlled by the former. By means of interviews with specific questions (semi-structured interviews) we analysed the experiences and phenomena that led these individuals to follow one method or the other. We took into account both verbal and non-verbal information, and established a two-way asymmetrical communication process (where one person makes the questions and the other one answers).

Thus, the interview was structured in that there was a list of subjects to be addressed in the course of the meeting, while it was possible to adapt the phrasing and order of the questions to the answers given by the interviewee. The key was to ensure that the essential points were discussed in a relaxed atmosphere.

Another characteristic we should mention is that the interviews were individual, which allowed us to communicate and understand deeply experiences associated to a problem or situation. The interviews were conducted at the home of each source. We needed a quiet and private place, as we were going to ask confidential questions about their personal lives. The ultimate purpose was to get information that would give us as clear as possible a picture of how their children had learned to sleep in the early years of life. Both interviews were recorded and then transcribed so we could analyse them meticulously to better compare the different sources. Being able to compare them was very important, since it allowed us to explore how each family felt throughout the process. The minimum length of the interview was two hours per person, in order to make the most of the information obtained in each interview.

With these interviews we hoped to learn how they had established their children's sleep habits. Key issues were who had given them advice, which books, articles, or sources of information they had read, and which expectations and experiences resulted from it. Which recommendations they would give to future parents, and which is the support they consider most fitting. We wanted to know how the family evolved in the process of child sleep training, and which significant aspects of their night-time lives they would identify as having changed.

We needed to get consent from all the interviewed individuals, so they signed an informed consent form that specified the reasons for the interview and for the research we were carrying out. We did not need approval from a bioethics board, as the interviews were not done in the context of providing healthcare services.

RESULTS

We did two interviews for this study. In one, we interviewed a family that followed the guidelines of Doctor Estivill, as described in his work *Duérmete, niño,* and a family that followed the recommendations of Doctor González, which he expresses in his book *Bésame mucho*. The person who described her experience with the Estivill method was Elena, and Marina told us about the González method. They are both first-time mothers of children born in Tarragona at full term and with no health problems.

Several factors stood out upon analysing the interviews. In Elena's case, she was aware from the beginning that her daughter had a sleep disturbance, as she had trouble falling asleep. Marina, however, did not report any difficulties, but during the interview we found out that she had made an appointment with Doctor Rosa Jové, who is a fervent advocate of the recommendations of Doctor González.

Regardless of the method chosen by the family, once the recommendations of each author had been implemented both children managed to fall asleep and sleep through the night, and have been in excellent health.

As for the implementation of each method by each family, there was a different level of difficulty in obtaining the same results in the children's nighttime sleep. In Elena's case, various difficulties arose when members of the family other than her had to take care of her daughter's bedtime, be it the father, or at times the grandfather.

Elena's father is Russian and comes for one- or two-month long stays in her house. During his last visit, he started introducing changes and as a result the girl did not continue to rest as regularly as she had been. In her interview, Elena commented: *"When my father came to help me in December, he started introducing his own changes, he started to pick her in his arms, and the girl started sleeping poorly. When the girl woke up he gave her her favourite toys or some water, and I had to tell him not to do that, that he had to ignore her, because otherwise she would establish an association and need it again. Children wake up several times and if she is expecting another stimulus each time she has to fall back asleep, she cannot do it. He started to ignore her and now she's sleeping fine".*

Elena also spoke of her husband and told us how introducing small variations made the method be less efficient on the girl. When she was working, her husband put the girl to sleep, but he had a hard time leaving as quickly as the method demands. She explained this in the interview: *"When I worked nights and my husband put her to bed, at first he felt sorry for her when he lay her in the crib and left, and he would stay a little longer, and when I took my turns and set her down to sleep in the afternoon I noticed that it was becoming increasingly hard for her to fall asleep. Then I started to look into things and I realised we were no longer applying the method correctly. I think one needs to adhere to the method just as the book specifies* (Duérmete, niño); *she needs to be left there and learn to sleep, to fall asleep, on her own".*

These two accounts show how in this case it was key for everyone to adhere to the same guidelines if the goal was to be achieved. The goal was none other than to get the girl to fall asleep by herself so that when she woke up at night she would be able to fall back asleep on her own. When her daughter woke up, she would need to have all the stimuli she had had to fall asleep the first time around.

In Marina's case, she and her partner always took care of the child's bedtime. They had practised co-sleeping from the time the child was three or four months of age after receiving advice during a visit to Doctor Rosa Jové. In the beginning, they were putting the baby in a crib by the bed. At the time of the interview they had a set schedule, as every day they put the child in the parent's bed at 10 pm. Once he had fallen asleep, the parents spent some time in the dining room and then went back to bed. These parents could use different routines to get the child to fall asleep in the bed. When bedtime came Marina took her son to bed, where she preferred to read him stories. On the other hand, the father preferred walking him in his arms until he fell asleep, after which he lay him in the bed.

This is how Marina explained it when we asked her about her son's bedtime during the interview: *"We put him to sleep directly in our bed, and later on we go to bed ourselves. What I do is bring a couple of storybooks, we read them in bed and I stay with him until he falls asleep. His father walks him around in his arms because he says this way he falls asleep faster. Each of us does it our own way".*

In this case, what matters is that either parent keeps the child company as he falls asleep, and that the child identifies the bed he shares with his parents as the place where he sleeps. This course of action makes the child feel relaxed and fall asleep easily. This method does not put much emphasis on following the guidelines strictly, as is the case with Elena; what matters here is to keep the child company at the time he is having difficulties (the time to fall asleep). Each parent can pick the way they feel is most suitable to get their child to sleep.

As Marina commented during the interview, she had tried with poor results: *"At first we did not want to put him in our bed because everyone keeps telling you not to do it because they will get used to it. At first, for like 3-4 months, we had him sleeping in the crib by the bed. It was a pain because he woke up all the time, you had to get up and pick him up, and then he would not let you put him back down, you'd be walking all over the house, until eventually I took him to bed and it was the easiest way".*

Marina says she can identify a before and after in her son's sleep. When they started co-sleeping bedtime became much easier.

Elena, too, noticed progress in sleep once they started using the Estivill method. She sought help, as it was a frustrating time of day in her family life. She did not know what else to try to get her daughter to fall asleep. She explained that she had learned about the method from a girlfriend, and that she subsequently read the book.

In the interview, Elena explained how there was a noticeable difference before and after applying the strategies of this method: *"Before, we used to do all sorts of things: we watched television until 2 am, we rocked her, we walked her to the end of the street as she cried away, we walked her up and down the hallway at home... because each time she woke up she'd cry and cry and we would not know what to do, we felt desperate... We applied this method for three days, and on day four she started falling asleep just fine (on her own)... In our case, she cried for 45 minutes on the first day".*

Elena's account shows how after three days her daughter started falling asleep on her own and quickly. After a year of crying and rocky nights for the entire family, there was calm. She told us how in practise she had to let her girl cry for 45 minutes on the first day. This is why the Estivill method is commonly referred to as the "cry it out" method. She speaks of its efficacy, as on the fourth night her daughter was able to fall asleep on her own and sleep through the night. Following the same routine every night and sticking to schedules for going into the room were the keys to success. It was a real challenge for her and for her husband, who could not bear hearing his daughter cry. Elena told us what she had to do with her husband the day she started using the method: *"My husband had to go walk the dog and when he came home he locked himself up in his room (to avoid hearing his daughter) and I was in charge of going in at the set times, speaking to her softly, soothing her without touching her, and then leaving the room again".*

Both methods, the one used by Marina as well as the one used by Elena, were effective, as upon implementing them they succeeded in getting their children to fall asleep and to be calm and not cry when they woke up at night, unlike before. What we think needs highlighting is that each method poses different challenges to the parents. A challenge that is manifested both in the skills that the parents need to develop and in the feelings they come to experience. The Estivill method requires adherence to a strict routine and showed results, in this case, by the fourth night, while the method of Doctor González was flexible in that each family member could follow a different routine, in addition to being efficacious from day one.

The families are satisfied with the evolution of their respective children following implementa-

tion of the different methods. This study observed a positive evolution of basic needs following implementation of these methods. Poor sleep did not only affect the family's wellbeing, but the child's also, and this is how both mothers perceived it:

Marina remarked: *"Before, when he napped in the crib, he might sleep for a half hour and then wake up, and then he was more tired and cranky. Now that he sleeps in bed with me, he is better rested and feels better".*

And Elena told us: *"We had changed the daily pattern because if she went to sleep at two in the morning she would not wake up until eleven, and you did not know what to do about breakfast, lunch, snack time..."*

Poor sleep habits had an impact on mood and all other basic needs; in Elena's case, one as important as nutrition.

DISCUSSION

Theoretical framework

Understanding the sleep needs of children involves knowledge of sleep physiology and the sleep-wake cycle. Sleep can be defined as a resting period for the body and the mind in which there is an interruption or inhibition of consciousness and most bodily functions. Sleep is a complex physiological function that requires full brain integration, and during which all physiological processes change[6].

Why is there a sleep-wake cycle?

The state of wakefulness is interrupted cyclically by sleep. Wakefulness is maintained by the action of the ascending reticular activating substance, and sleep is activated by means of brain structures that act in two ways: on one hand, the inhibition of the ascending reticular activating system, and on the other, the stimulation of the sleep-producing structures, which are located in the brainstem, in the thalamus, the anterior hypothalamus, and the preoptic area.

The different stages of sleep are regulated in two areas: a) in the brainstem, in which rapid eye movement (REM) sleep originates, and b) the diencephalon, which generates non-rapid eye movement (NREM). There are four stages in NREM sleep: stage I, wake-sleep transition; stage II, superficial sleep; stages III and IV (delta sleep), deep or slow sleep.

In 1937, Loomis[7] described the four stages in slow sleep (NREM), which amounts to 70 to 80% of the total duration of sleep. During NREM sleep there is a clear prevalence of parasympathetic nervous system activity, as the heart rate and breathing slow down, blood pressure and temperature decrease, while the brain cell protein structure is restored and secretion of growth hormone increases. In 1953 Aserinsky[8] described paradoxical sleep or REM sleep, which accounts for 20 to 25% of all night-time sleep and appears periodically in the course of slow sleep. REM sleep entails an abolition of muscle tone and changes in neurohormonal secretions, and while its duration increases with emotional problems and intellectual overload, a decreased amount of it may cause psychological problems. There is dreaming during most of REM sleep.

The maintenance of the sleep-wake cycle depends on the circadian rhythm, so there are certain neuronal structures in the suprachiasmatic region that function as an endogenous pacemaker for the circadian rhythm, responsible for the cyclical sleep-wake rhythm and other biological functions.

The sleep needs of children

The sleep-wake cycle depends on age. The newborn is sleeping all but continuously, with very short periods of wakefulness, and with no distinction between night and day. Toward the second month of life, the circadian rhythm starts to get established. At three months, when the NREM sleep is structured in consonance with the development of the cerebral hemispheres, sleep starts veering towards night-time guided by environmental and family stimuli.

Between three and six months of age sleep spindles and K-complexes appear, and stages II, III, and IV become distinct. The total amount of sleep decreases and the bulk of it takes place at night.

At six months of life, children need 14 hours of sleep on average, with two or three naps daily, despite having established a night-time sleeping habit that is not broken to nurse or drink formula. At 18 months, children require 11.5 hours of night-time sleep and two hours of napping on average. By five years, the average duration of night-time sleep is about 11 hours. In non-Mediterranean countries, the siesta (afternoon nap) is dropped between three and five years of age.

When children do not get enough hours of sleep, they show an alert attitude and experience the phenomena around them very intensely. They tend to have a shallow sleep during which they appear restless and vigilant, and the faintest noise wakes them up. They tend to be irritable during the day and to be heavily dependent on their caregiver[9].

Doctor Estivill's method

In the first year of life, the child learns several habits. Eating and sleeping habits are among the most important ones. Children learn to eat correctly according to the social norms of their environment. Western children eat seated on chairs, resting the plate on the table, and using utensils known as fork and spoon. In the East they eat sitting on the floor, holding bowls in the hands, and using chopsticks. Either behaviour is fine and is considered an appropriate habit. The same thing applies to sleep. Children can learn to sleep alone, accompanied by their parents, on the couch, in their own bed, in the parents' bed, and so forth, but the "norms" that surround the act of sleeping should be dictated by the parents and be consistent with the prevailing social norms[10].

The American Academy of Sleep Medicine performed a meta-analysis to review the evidence on the efficacy of behavioural therapies in the treatment of childhood insomnia due to poor habits. They selected 52 studies, the results of which showed that the most efficacious treatments for this disorder are extinction (and graduated extinction), bedtime routines, and preventive parent education. Graduated extinction consists in entering the room at periodic intervals that get increasingly longer. This was popularised in the United States by Dr. Ferber with his 1985 self-help book, and adapted in Spain by Doctor Estivill in his book *Duérmete, niño*. This author argues that it is essential that the parents come to the child at regular intervals to teach him how to sleep alone. This lowers the anxiety of the child and of the parents. According to this approach, if children are put to sleep by holding them, rocking them, singing to them, etc... they will associate sleeping to these elements and when they wake up at night they will demand what they believe is associated to sleep, such as a song, the parents' arms, or the bottle of water, based on the stimulus-response theory. The parents must leave the room where the child is while he is still awake, and the child must fall asleep in the absence of the parents. Children should not associate their parents with the onset of sleep.

Sleep routines or habits are all those norms that adults can teach a child to help him form the sleep habit correctly. A habit is formed through the repeated association of the same external elements and the attitude conveyed by the parents when they are teaching the habit. By repeating the same type of activity, without any changes, the parents convey their confidence, so the child perceives the behaviour he is being taught is the right one.

This routine should be a pleasant time shared by parents and child and should last between five and ten minutes. It consists of a soothing, affectionate exchange of information based on the child's degree of understanding, done in a place other than where the child sleeps, such as singing a soft melody, telling a short story, or else planning an activity for the following day. The child is continuously informed of the time that is left before it is time to sleep. Later on, the child is left in his room, in the crib or bed, and the parents bid him farewell. It is essential that the child be awake when the par-

ents leave the room. We must keep in mind that the child learns to fall sleep with whatever the adults give him, and that when he arouses at night he will demand those circumstances he has come to associate with falling asleep. If the child falls asleep on his own, he will fall back asleep on his own when he wakes up at night, but if he has fallen asleep in someone's arms or being rocked, he will demand the same stimulus that had helped him fall asleep.

If the routine is set up right, the child will look forward to his bedtime and will find it easy to part with the parents when they leave the room. Watching television before bed, even together, is not a suitable activity, because it allows for no interpersonal exchanges. Reading the child a story or doing any other soothing activity is much more advisable. Keeping a favourite plush toy, or a pillow is good for the child. It will make him feel more accompanied once he is left alone in the room and, more importantly, he will realise that they stay with him when he wakes up during the night. It is very important that the child's bedtime routine is followed consistently. When the routine is over, the parents leave the room and have to adhere to a schedule of waiting periods, which increase in length progressively, until the child manages to fall asleep alone.

According to Doctor Estivill, starting at 6-7 months of age a child should fall asleep on his own, without crying, and for an uninterrupted stretch of 11-12 hours. He may use a plush toy as an "accompanying friend" (transitional object), must sleep in his own crib, and the lights need to be turned off.

Doctor González's method

Sleep is a developmental process that adjusts to the needs of each stage of life. Each child has a schedule of his own and must not be compared to other children. The problem lies in the unfounded expectations the parents develop, where there is usually a mismatch between the work or social schedule of the parents, and the sleeping patterns of the child[11].

Doctor González advocates for co-sleeping as the best way to get rest for the whole family, and above all to help the child develop his autonomy when he is developmentally ready for it in a natural way. Co-sleeping is defined as the act of sleeping in the parental bed until the child stops needing it of his own accord. At present, co-sleeping is a widespread arrangement in most societies with the exception of Western ones, including technologically advanced societies like Japan.

There are many advantages to co-sleeping:

- It minimises the risk of sudden infant death syndrome (since the child's breathing becomes synchronised with the mother's, which serves the child as a reminder to keep breathing in cases of apnoea).
- It helps the mother remain asleep while she breastfeeds her child at night.
- It facilitates temperature regulation at night, as newborns cannot regulate their bodily temperature.
- Children feel accompanied and that their needs are being met. Stressful situations can affect falling asleep and waking up times, but if their attachment needs are met the brain can focus on structuring itself according to newly learned things and developing regular sleep patterns[12].

According to Doctor González, parents should abide by the following guidelines to avoid crushing the child:

- If the headboard has bars, it should be temporarily upholstered with fabric.
- Do not co-sleep if the adult is under the influence of alcohol or has taken sleeping aids, or if the adult is too obese.
- Do not use water mattresses nor furs (either natural or synthetic).
- Do not use heavy blankets and bedspreads, at least in the first six months (in the winter it is preferable to turn on the heat and use a light blanket).

- Do not smoke, as smoke greatly increases the risk of sudden infant death syndrome.
- One should never sleep with a baby in a sofa. There are too many cracks or corners where the baby could get trapped.

When the child wakes up while sleeping with the mother, he usually falls back asleep, soothed by her presence, and other times he breastfeeds. The mother may not wake up fully, and perhaps will not remember it the next day. When the child is awake but is not crying, we do not need to do anything to get him to fall asleep.

When children understand rationally that there is no danger, that their parents are in the room next door and will come if they need them, they are capable of falling asleep without crying. In families that practise co-sleeping, children start falling asleep by themselves at about three or four years of age, although they need to be coaxed to do it with some skill, encouraging them with sentences such as: "Now that you are big you will have a bed of your own...". Usually these kids ask to be told a story and be kept company until they fall asleep, and they continue to request it nightly until seven or eight years of age.

The González method requires the application of easier guidelines than those found in the Estivill method. For Marina, who followed the guidelines of Doctor González, the efficacy of the method is rooted in the spontaneity and flexibility of its actions. Each parent was able to adopt the most comfortable way for them to put the child to sleep: the husband walked him in his arms until the child fell asleep, while she would read stories to him. Doctor González expresses this in his book (p. 152): *"Our meals do not have to be the same every day, and neither do we need a routine to go to sleep. But if one were necessary, why not choose one that makes you and your child happier? Falling asleep in someone's arms, at the breast, with a lullaby, or in the parents' bed can also be routines, they would just need to be done the same way every day".*

The book *Bésame mucho* reflects the freedom that parents have to choose their preferred way to help their child sleep. In contrast, the author of the book *Duérmete, niño* describes a precise routine that must be followed by whoever is in charge of the child's bedtime in order for the latter to learn how to fall asleep alone. Another important difference between these two methods is that Doctor Estivill explains how to develop healthy habits when there are sleep disturbances, which are caused by poor sleep habits in 98% of cases.

Elena told us how the efficacy of the Estivill method decreased whenever there were changes in the bedtime routine of her daughter. This method is harder to implement, as it requires more effort from the parents. When she explains that the girl "only cried for 45 minutes" the first night and that her husband could not bear to hear her cry, she lets us see the challenges involved in this method, which are not limited to the correct execution of the routine set by Doctor Estivill, but also require managing the emotions that arise when parents hear their children cry. The method by Doctor Estivill is popularly known as "the cry it out" method, and there is a reason for it.

In the book *Duérmete, niño* he explains the routine as follows (p. 80):

"How to re-train the sleep habit

1. *Create a ritual around the act of going to bed (singing a song, telling a story).*
2. *This situation is not created to have the child fall asleep, but for the child to start associating it with having a pleasant time before going to sleep alone.*
3. *The parents must leave the room before the child falls asleep.*
4. *If the child cries, the parents must come in at short time intervals to reassure the child, doing nothing to get the child to fall asleep or be quiet, until the child falls asleep on his or her own."*

Time guidelines need to be followed at all times when the child is left to cry it out: the first day parents must enter the room after one minute, then after three minutes, then after five minutes, and then every five minutes until the child falls asleep ... As a mother, Elena felt compelled to act in re-

sponse to her daughter's difficulty in falling asleep. She chose the Estivill method, and feels happy when she recounts her experience, because on the fourth day her girl was able to fall asleep easily. That family was able to get rest, and what is more important, gained the necessary stability to guarantee the physical and psychological health of their daughter.

In the interviews we made we saw that both families were satisfied with the methods they used. This is certainly because their children have been able to rest and are currently in good health.

Every situation is different, as no two people are alike. Each family lives in a socio-cultural context all its own in which they have to operate based on their own views and which helps find the most effective path to the safety of those around them. Child rearing can vary widely within a single family, and it is not possible to make a generalisation about the best course of action. When it comes to a first child, the parents endure higher levels of stress. The acquisition of good sleep habits allows the family to rest and the children to grow up healthy.

Parents always want the best for their children and determining whether one author's approach is better than the other's is not what matters here. Talking to families and figuring out what activities they engage in prior to bedtime gives us information about the resources available to them to help their children sleep.

As healthcare professionals, when we are asked for information on the acquisition of good sleep habits we have to explain what each method consists of and plan the changes needed to achieve a good night's rest for the family taking into account their particular needs. Night-time sleep is part of the family's wellbeing for parents and children alike. Families are free to make their own choices, but at times they may need guidance to facilitate or redirect the acquisition of good habits.

CONFLICT OF INTERESTS

The authors declare having no conflict of interests in relation to the preparation and publication of this paper.

ACRONYMS

• **NREM:** non-rapid eye movements • **REM:** rapid eye movements.

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