THE PARENTS' GUIDE TO PSYCHOLOGICAL FIRST AID

Helping Children and Adolescents Cope with Predictable Life Crises

EDITED BY
GERALD KOOCHER, PH.D.
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The Parents' Guide to Psychological First Aid

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Annette M. La Greca, PhD

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To the memory of our parents—who provided psychological first aid when we needed it

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G.P. Koocher
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INTRODUCTION

Every child will encounter bumps, scrapes, infections, and similar misadventures as part of growing up. Similarly, many psychological crises arise that are akin to these physical events and that will predictably challenge the emotional resilience of children and their caregivers. This practical guide brings together expert advice on promoting coping, resilience, and recovery when such events occur.

Each chapter covers a different "predictable crisis" that can challenge parents' and children's coping skills (and patience!), and includes pragmatic advice on how parents might deal with such situations. The advice provided is also appropriately tailored toward children's developmental level. We also suggest relevant books and websites for those seeking more information.

The chapters were prepared by expert professionals in mental health and education who not only work with parents and children in these problem areas, but who also conduct research to better understand the bases of child and adolescent problems and how best to prevent or treat them. Thus, the advice provided within each chapter draws on the "best evidence" we currently have on how to deal with the "normal" emotional crises of growing up.

You may find that we have omitted some topic of importance or have suggestions about how we might improve the next edition of this guide. If you do, please contact us by sending an electronic message to Koocher@gmail.com. If we use your idea, we will send you a free copy of the next edition.

Gerald P. Koocher and Annette M. La Greca
Boston, Massachusetts and Miami, Florida

In this book, authors strived to use gender-neutral language whenever possible, and refrained from referring to a child or adolescent as "he" or "she." However, on occasion,

this was not possible without creating an awkward or complicated sentence. Thus, on such occasions, authors refer to a child or adolescent as "he" or "she" with the understanding that they intend for the statements to be applicable to all children, regardless of whether they are male or female.

The Parents' Guide to Psychological First Aid

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PART ONE

Health Issues

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CHAPTER 1

Toilet Training

Patrick C. Friman

The phone rang at 8:30 A.M. and on the line a small voice reported a successful poop in the potty. The voice belonged to Ted, a 3 1/2-year-old boy, who had previously resisted toilet training. After a short program, however, he quickly began urinating in the toilet. Defecation took a bit longer, but when told he could call his grandmother if he had a success, he agreed to try harder, and the result: a poop in the potty and a happy phone call to grandma.

Full toilet training marks a critical developmental milestone. In some agrarian cultures, children actually achieve full training before their first birthday. Unfortunately for children and parents in fully industrialized cultures like the United States, complete continence before age 1 requires intensive daily training that takes months to complete. Few parents in the United States have that kind of time. Historically, children in the United States completed their training by an average age of 2 1/2 years. Currently, however, full training has become more delayed, and many children do not accomplish full success until the middle of their third year. We do not know all of the reasons for this shifted pattern, but changing cultural practices, parental attitudes, and the availability of highly absorptive underclothing (e.g., pull-up training pants) all partly contribute. Folklore about toilet training can also create an impediment to its progress. For example, parents may hear stories about children who virtually train themselves and think of this as normal. Such stories can lead parents to forestall training until their children initiate it themselves and/or terminate it prematurely if their children exhibit any resistance at all. Although some children may successfully self-initiate and complete training, they are few and very far between. For most children, toilet training requires good timing, proper planning, and concentrated child and parental efforts. This chapter provides some general information about how to proceed.

WHEN SHOULD TRAINING BEGIN?

First and foremost, parents need to feel ready. Has the crisis at work passed? Does the household seem relatively stable now, and likely to continue without unusual disruptions in routine for a few weeks? Having other parts of life running smoothly eases the chore of toilet training. The child also needs to feel ready for training, and several clues can help you identify your child's readiness. For example, prior to starting potty training, your child should:

- Have reached the age of at least 20 months; preferably 2 years old or older
- Have the ability to pick up objects, lower and raise pants or clothing, and walk from room to room easily
- Have the ability to stay dry for several hours at a time, urinating about five to six times a day, and completely emptying the bladder
- Understand household toileting words, words like "wet," "dry," "pants," "bathroom"
- Understand simple instructions, such as "Come here, please" and "Sit down"
- Follow reasonable instructions without raising a big fuss
- Show some awareness of the need to urinate or defecate

HOW DO I BEGIN?

Parents should announce the beginning of training in a way that makes the event seem important and fun for their child. In terms of equipment, a potty chair should suffice. You will need to allow plenty of time. Ideally, set aside at least two full days to start training. Starting on a weekend free of any of out-of-home obligations provides an ideal situation. You should also prepare to set aside personal modesty, because parent modeling plays an important role in effective toilet training.

HOW DO I TEACH MY CHILD TO USE THE TOILET?

Once you have determined that your child is ready, you may begin the toilet training process. Follow these steps:

1. Warm the house. A cold bathroom can feel very unwelcoming. Also, dressing and undressing, an important part of training, feels more comfortable in a warm environment.
2. Remove your child's disposable training pants or other absorptive undergarments.
3. Have your child bare to the waist. This way you can tell from watching your child's belly whether elimination seems imminent. If household standards allow for complete undress, having your child free of clothing can prove even more helpful. Some sensibility about toileting privacy emerges early, and most children prefer to eliminate in their diaper or clothes and become reluctant to do so when fully unclothed.

4. Allow your child to drink as much as possible. Increased fluid intake means increased urine output and thus increased learning opportunities for your child.
5. Schedule regular toilet or potty chair sits. If a weekend has been set aside, toilet sits should occur at least every 2 hours. Additionally, if your child exhibits any indication of toileting urgency, call for an immediate toilet sit.
6. Take your child to the bathroom; do not ask, "do you need to go?" Most children would prefer not to go the bathroom and thus asking them may not yield useful answers.
7. Ensure that your child's feet rest upon a firm surface. This may require a stool. Stability optimizes comfort and performance, especially with bowel movements.
8. Read to your child during extended toilet sits; doing so makes the sit more tolerable and possibly even fun.
9. Point out, but do not criticize or punish accidents. Say, for example, "Honey you've had an accident, let's get you cleaned up."
10. Praise all successes. In the early stages, it may be helpful to supply small rewards for success (e.g., sticker, a small toy, a piece of candy).

Try to make the entire affair unhurried, relaxed, and fun. Children love games, and toilet training can be structured like one. Try keeping score: hits go in the toilet and deposits everywhere else count as misses. Parents should do everything they can to have their child "win." If your child does not win immediately, it is okay to express disappointment, but not in your child, merely in the outcome. Say, for example, "Oh, too bad, maybe you can get it in the toilet next time."

WHAT DO I DO IF MY CHILD INITIALLY FAILS?

Avoid using the word "failure" in a toilet training program. Delays can happen, however. If 2 or 3 weeks of trying produce no consistent progress, and you and your child are beginning to feel frustrated, it is best to declare a full moratorium on toilet training for a month. During that time, allow your child to resume using disposable training pants. Let your child know that he/she may use the toilet, but only if he/she specifically asks to. At the end of the month, the program can begin anew.

SUMMARY

Unfortunately, parents cannot escape this task. Full toilet training remains one of the primary criteria for civilized, independent, socially engaged living. It has increasingly become a criterion for entry into preschool and even into some daycare settings. Fortunately, although the task can require a lot of time, it does not involve a lot of complexity, and it can provide a fun parent–child learning opportunity and sense of accomplishment.

WHERE TO FIND OUT MORE

Books

Fifteen favorite potty training books:
http://www.parents.com/toddlers-preschoolers/potty-training/gear/15-favorite-potty-training-books/

Websites

American Academy of Family Physicians
Toilet training
http://familydoctor.org/online/famdocen/home/children/parents/toilet/179.html
Parenting.org
Starting Toilet Training: The 7 P Plan
http://www.parenting.org/precious-beginnings/life-lessons/starting-toilet-training-7-p-plan
Intensive Toilet Training
http://www.parenting.org/precious-beginnings/life-lessons/intensive-toilet-training

CHAPTER 2

Bed Wetting

Patrick C. Friman

Tom, an 8-year-old otherwise completely healthy boy, woke up this morning in urine- soaked pajamas and bedclothes, just as he has nearly every day since he stopped wearing diapers. Fortunately for Tom, his parents consulted their pediatrician when they realized that the success of his early toilet training did not extend to nighttime. He told them that Tom did not wet the bed because of laziness, stubbornness, or emotional disturbance, but because he suffered from a condition called enuresis.

Enuresis is the technical term used for chronic urinary accidents that occur after the age of 5 years. Historically, professionals as well as parents tended to treat afflicted children harshly. Today, however, the situation for these children has improved considerably. Professional and parental science-based knowledge of enuresis has expanded steadily over the past 40 years, and afflicted children have benefitted tremendously. Where professionals formerly interpreted enuresis as a sign of serious psychiatric disturbance, they now recognize it as a largely inherited condition, much more likely caused by an overly sensitive bladder or very deep sleep than a disturbed psyche. They also know it has a time-limited course and usually proves highly responsive to appropriate treatment. However, although most cases do not give parents reason for serious worry, some medical conditions can also cause wetting accidents, most notably diabetes and urinary tract infections. Therefore, the first professional a parent should consult is a medical doctor, preferably the child's primary care provider.

WHAT CAUSES BED WETTING?

There are two types of enuresis—*nocturnal* (accidents occur only during night time sleep) and *diurnal* (accidents occur only during waking hours). The best-known and best-documented cause of both types of enuresis involves family history; the probability of

enuresis increases with the number and closeness of blood relatives who have a history of wetting. Children with enuresis also often have bladders that are overly sensitive to filling. This causes them to urinate more frequently throughout the day and night than do children who do not suffer from the condition. Afflicted children are often slow to mature physiologically, especially in the areas of bone growth, secondary sexual characteristics, and height, each of which catches up to normal levels over time. Scientific evidence indicates that bedwetting children often prove more difficult to awaken than their nonbedwetting peers. Some evidence, mostly but not entirely anecdotal, suggests that increased stressors (e.g., birth of a sibling, family disruption) can cause continent children to become temporarily incontinent.

IS ENURESIS A MENTAL HEALTH PROBLEM?

Scientific studies do not support the view that chronic bed wetting is a psychological problem. Children with enuresis do exhibit a slight increase in psychological problems, but the increase seldom signals something serious. More likely, the enuresis itself, as well as the reaction of others, causes the increase in emotional problems.

HOW IS ENURESIS TREATED?

The need for treatment of enuresis predates modern civilization, and the variety of techniques used in antiquity appear to have been limited only by the imagination of the ancient therapists and their tolerance for inflicting unpleasantness on young children in order to eliminate urinary accidents. Some of the noxious treatments reported in a review of ancient approaches to enuresis included binding the penis, burning the buttock and lower back, and forcing children to wear urine-soaked pajamas. In fairness to the ancient therapists, the health consequences of prolonged enuresis during their era became quite serious, due to the limited means for cleaning bedding and ineffective methods for managing infections.

The evolution of treatment for enuresis that began in earnest early in the 20th century abandoned the physically harsh treatments in favor of far more humane and highly effective approaches. The initial breakthrough involved use of an alarm that parents could place on the bed. The alarm, attached to a sensor pad, would emit a loud buzzing sound almost instantly after urine moistened the pad. The child would then awaken (independently or in concert with a parent), clean up the accident, use the toilet appropriately, and return to bed. Published reports of successful alarm treatment for bedwetting appeared in the early 1930s and have steadily continued since then. Alarm-based treatment for bedwetting provides one of the best scientifically supported treatments for child behavior problems of any kind. Between the time of those early reports and now, scientific investigators have modified alarm treatment and supplied a variety of supplemental strategies that increase the odds of success by using multipart treatment packages. For example:

- *The pajama alarm.* Most therapists now use an alarm that attaches to the pajamas instead of the bed. These employ smaller, easier-to-use sensors, and work just as effectively. When attached to clothing during the day, they also help treat daytime accidents.

- *The silent vibrating pajama alarm.* An alarm that vibrates after accidents is available, and it too works as effectively as the bed-based alarms. Parents find it particularly useful for situations in which more than one child sleeps in the same room and for treatment of daytime accidents.
- *Retention control training.* This frequently used supplemental treatment involves teaching children to keep themselves from urinating when they get the urge to go. This allows children to learn to expand the time between trips to the bathroom and produce greater volumes of urine during at each toilet stop.
- *Over-learning.* During the early stages of treatment, some therapists encourage children to drink large amounts of fluid before bed in order to increase the number of accidents and thus the number of times the child can learn from reacting to the alarm.
- *Scheduled toilet visits.* All bedtime programs should include at least one and preferably two scheduled toilet visits: one before the child's bedtime and again before the parent's bedtime. If your child has already wet before your bedtime, begin waking him or her a bit earlier. For daytime wetting, multiple bathroom visits are needed, and should be scheduled when the probability of urination is high or instructed whenever a child's physical movements indicate urination is imminent (e.g., grabbing pants, shifting weight from foot to foot).
- *Kegel exercises.* These involve starting and stopping urine flow three or four times during the course of a urination (wet practice) or exercising the muscles used to do so (dry practice). These exercises work for a broad range of wetting in children and adults, including postpartum and geriatric patients.
- *Self-monitoring.* Requiring children to record any behavior they are trying to reduce typically results in at least a small reduction in that behavior. Asking the child to chart his or her progress during treatment for enuresis is a strategic part of many programs.
- *Incentive systems.* Enuresis treatment requires effort on a child's part, sometimes a lot of it, and incentives for small amounts of progress can sustain the child's motivation to continue. At a minimum, offer your child praise for an accident-free day or night. You may even reward your child with a small gift such as a coloring book, some stickers, or a small toy. In particularly stubborn cases, a decrease in the size of the accident (i.e., urine spot) might provide a reason for an incentive.

The preceding strategies and treatments can be used to help you manage and ultimately eliminate your child's wetting problems. It is important to note that there is one particular strategy that many parents use, but that is not at all effective. Do not limit or prohibit your child from drinking before bed. Many parents try this strategy before they seek professional help. It does not work and, in fact, can take an already unpleasant situation and make it worse for the child. Enuretic children should be allowed to drink a reasonable amount of fluid before bed if they feel thirsty.

WHAT ABOUT MEDICATION?

An additional option for both nocturnal and diurnal enuresis involves medication. Unfortunately, the only two medications that have been shown to effectively reduce

urinary accidents, imipramine (brand name: Tofranil) and desmopressin (brand name: DDAVP), can have some serious side effects such as nervousness, sleep disorders, stomach and intestinal problems, and tiredness. These drugs should be used with caution. Additionally, neither drug cures enuresis. Typically, accidents resume when the use of the medication stops. Thus, medicines make the most sense in situations where an accident-free night is truly needed, such as a sleep-over or at camp, rather than as a primary treatment.

SUMMARY

Enuresis or bed wetting is a common childhood problem that has a long history of misunderstanding and of ineffective approaches to, and mistreatment of, afflicted children. Scientific research, however, has led to much more accurate and benign understanding of the problem, as well as highly effective forms of treatment. In fact, the breakthroughs in treatment over the past several decades represent one of the most significant achievements in clinical child and pediatric psychology.

WHERE TO FIND OUT MORE

Books

Mills, J.C. & Crowley, R. (2005). *Sammy the Elephant and Mr. Camel: A story to help children overcome bedwetting*, 2nd ed. Washington, DC: Magination Press.

Websites

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/cs/root/facts_for_families/bedwetting
American Academy of Family Physicians
http://familydoctor.org/online/famdocen/home/children/parents/toilet/366.html

CHAPTER 3

Fecal Soiling

Patrick C. Friman

Poor Tim—at 6 years old, he has few friends, often seems distracted or unhappy, and occasionally exudes an odor not unlike a soiled diaper. In fact, he frequently soils his underwear and often hides it, only to have it discovered as the odor intensifies. His increasingly frustrated parents view Tim as stubborn or lazy, as well as sneaky. They scold him frequently for the accidents and punish him for the hidden underwear. Tim's parents feel somewhat embarrassed and have not consulted a doctor for this problem.

Tim isn't stubborn or lazy; he has a condition called *encopresis*. Encopresis is the medical term for fecal soiling by a child who has already been toilet trained. Unfortunately, such problems are common, often underreported, undertreated, and overinterpreted. Because of underreporting, this condition can actually go untreated for extended periods of time (as in Tim's case), which can result in frustrating, serious, and potentially life-threatening medical problems. It can also cause problems with the child's social relationships and emotional development. Early detection and treatment is also important because the primary causes of encopresis can include physical diseases. For example:

- *Hirschsprung's disease,* in which a person's colon lacks certain nerve cells, leading to constipation
- Diseases of the spine that affect healthy colon function
- Some forms of developmental disability

Social problems can result from encopresis because soiling evokes more revulsion from peers, parents, and important others than almost any other child behavior problem. Fecal accidents are a major contributor to child abuse, and children who soil themselves still frequently suffer shame, blame, and punishment for a condition almost totally beyond their control. When children hide their underwear, as Tim does, it usually happens because some form of punishment has occurred, either verbal or physical or both.

WHAT CAUSES ENCOPRESIS?

There are two types of encopresis: *retentive* and *nonretentive*. Retentive encopresis is the most common. Approximately 85%–90% of children with encopresis have the retentive type, the most fundamental cause of which is constipation. For children, a combination of factors can trigger the process including: family history (i.e., genetics), dietary factors (e.g., insufficient roughage or bulk in the diet, irregular eating habits), difficulties with toilet training (e.g., punitive or unstructured approaches), and toileting avoidance by the child. Any of these factors, alone or in combination, puts the child at risk for slowed movement of fecal matter through the colon and the uncomfortable and often painful bowel movements that result. Uncomfortable or painful bowel movements, in turn, motivate afflicted children to retain feces, and this leads to a range of problems including fecal accidents. When severe retention occurs and the problems become chronic, the child may develop *fecal impaction*, a large blockage caused by the collection of hard dry stool. When this occurs, liquid feces will seep around the hard mass, producing what some call *paradoxical diarrhea*. Although the child actually has serious constipation, he or she appears to have diarrhea. Some parents try to "treat" this condition with the over-the-counter antidiarrheal agents, which only makes the problem worse.

IS ENCOPRESIS A MENTAL HEALTH PROBLEM?

In short, retentive encopresis is not a psychological disorder. A small number of studies have detected an increase in psychological problems among children with encopresis, but the increase is seldom clinically significant. It is more likely that the encopresis, and social reactions to it, cause the mental health issues than it is that mental health issues cause the encopresis.

An important exception regarding mental health problems as a cause of soiling does exist. As mentioned, a small percentage of children with encopresis (5%–20%) have the nonretentive type. These cases involve children who have regular, well-formed, soft bowel movements somewhere other than the toilet, usually but not always in the clothing. We do not have a good understanding of the causes of these cases; we do know that they are routinely difficult to treat. And, it does seem very likely that mental health problems play a significant role in nonretentive encopresis.

HOW IS ENCOPRESIS TREATED?

Treatment for the two subtypes of encopresis (retentive and nonretentive) differs. Treating the retentive type involves a combination of psychological, behavioral, and biological components typically referred to as the *biobehavioral approach*. This treatment has proven successful in a number of scientific studies and involves the following steps:

1. Seek a medical evaluation to rule out specific illnesses and any secondary medical concerns.
2. Eliminate all sources of punishment for bowel accidents.

3. Undertake a "cleaning out" of the colon (initiated by medical personnel and transferred to parents on an as needed basis).
4. Use stool softeners as prescribed by your family physician or treatment provider. The most frequently used softener is oral polyethylene glycol 3350 (MiraLax), an over-the-counter, tasteless white powder that softens stools through fluid retention.
5. Establish a consistent toileting schedule, one that requires one or two toilet sits a day that should last at least 5 minutes but no longer than 10 and that are timed to correspond with times when your child typically has a bowel movement.
6. Make sure your child's feet are supported by a firm surface (this may require a step or stool) whenever he or she sits for a bowel movement. The support makes it easier for your child to exert the push necessary for a bowel movement.
7. Establish dietary changes as prescribed by your family physician or other health-care professional.
8. Ensure that your child drinks enough fluids (e.g., six to eight 8-oz glasses of fluid a day).
9. Reward your child for successful bowel movements—at a minimum, give your child praise.

In contrast to treatment for retentive encopresis, no treatment has become widely accepted or even well defined for the nonretentive type. In very general terms, treatment for nonretentive encopresis appears to involve a combination of problem solving, toilet scheduling, psychotherapy, and elements of the biobehavioral approach based on a sound diagnostic process. If you think your child may be suffering from nonretentive encopresis, you should seek professional advice.

SUMMARY

Fecal soiling is a common childhood problem that has been misunderstood for centuries, and the result has been a long history of ineffective approaches to, and mistreatment of, afflicted children. Scientific research, however, has led to a biobehavioral approach to assessment and treatment, and it has consistently proven effective. Nonretentive encopresis will prove more difficult to treat because its causes differ. But the breakthroughs over the past 30 years have proven significant, and professional psychotherapeutic intervention can help in such cases.

WHERE TO FIND OUT MORE

Books

Bennett, H. J. (2007). *It hurts when I poop!: A story for children who are scared to use the potty.* Washington, DC: Magination Press.

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CHAPTER 4

Sleep Problems

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Four-year-old Becky's mother wakes up to see her daughter at her bedside and hears, "Mommy, I'm lonely. I want to sleep in your bed." This has been happening quite frequently and Becky's mother always pulls her daughter into bed with her. She wonders however, if this is the right thing to do.

Nine-year-old Fred has recently had nightmares that wake him up. He dreams about ninjas stalking him. After awakening, he has trouble getting back to sleep without checking under his bed and in the closet. He wants to keep a flashlight and baseball bat near his bed, just in case he needs them for self-defense.

Childhood sleep problems are common. Approximately 25%–40% of children experience problems such as taking a long time to fall asleep, refusing to settle to sleep, sleepwalking, nightmares, or waking during the night. Although parents may expect that young children will demonstrate some difficulties with sleep, it may not feel like a problem until the sleep difficulties become frequent, prolonged, and require a substantial amount of parent time during the night. One common misperception holds that children will grow out of sleep problems. Some children will spontaneously improve their abilities to settle to sleep as they age; however, sleep problems often extend past early childhood and many children have sleep problems at different developmental stages. Problems related to falling asleep or maintaining sleep during the night also come up in middle-childhood and adolescence. However, parents may or may not recognize problems during these developmental stages as children become more independent in their sleep patterns. In older children, feeling excessively sleepy during the day often may offer the only visible clue that the child has a sleep problem.

COMMON SLEEP PROBLEMS FROM INFANCY TO ADOLESCENCE

Infants and Young Children

In infancy, the most common problems with sleep involve settling to sleep and waking during the night. Many infants seem unable to settle to sleep on their own and may require parents to help out by rocking, feeding, or holding them. Quite often, the same behaviors used to settle the infant to sleep at bedtime bear repeating during the night when the baby awakens. Studies of normal sleep show that people experience multiple arousals during the night as they make transitions between light and deep sleep states. Most individuals won't remember waking during the night because routine behaviors, such as turning over or repositioning one's pillow, typically allow them to return to sleep almost immediately. However, when infants or young children have this normal transition between sleep states they may become alert, and cry out for the parent. We call this a problem of *sleep onset associations*. This refers to the comforting experience that the baby or young child had at bedtime (e.g., being rocked or fed) and their wanting to recreate this experience during the night.

It is not always easy to tell whether your child is waking up for a "good reason." Parents often try to discern a specific problem that may be keeping their child awake, such as hunger, teething, illness, or feeling uncomfortable. Often, problems go on for many months before parents consider other explanations. While sleep onset association problems occur more commonly in infants, they may also come up in older children. An older child may require that his parent lie with him at bedtime and later seek out his parent in the middle of the night after a normal arousal. Typically, the parent needs to lie with the child again for the child to return to sleep.

There are other types of problematic sleep behaviors that children may exhibit. Children may demonstrate repetitive body movements during the night or may get out of bed in a confused state. Sleepwalking occurs fairly commonly in childhood. This problem worsens with sleep deprivation, so it can often intensify when children sleep in other settings, such as at a friend's house or while on vacation. During sleepwalking episodes, some children may rock back and forth, bang their heads, or engage in repeated leg movements. This can be alarming, so it is helpful to take certain safety precautions. Keeping your front door locked so that your child doesn't sleepwalk out of the house and removing dangerous objects so that your child doesn't hurt himself can provide some sense of security.

Parents often ask about the difference between nighttime fears, nightmares, and night terrors. *Nighttime fears* are typically normal and harmless. Such fears peak at ages 5–6 years and again at ages 9–11 years. Some very common fears include fear of killers or intruders, being left alone, hearing noises, thinking there is someone else in the room, and monsters. These fears typically come up at bedtime or in the middle of the night and make it hard for children to settle to sleep. *Nightmares*, on the other hand, are frightening dreams that usually awaken a child. Many children feel afraid to return to sleep and go to their parents seeking comfort. Nightmares usually occur during the latter half of the night and differ from night terrors because the child remembers the event, does not seem confused or disoriented, and will typically feel soothed by his parent's presence and reassurance. Sleep or *night terrors* typically occur in the first third of the night and involve sudden arousals, often with a piercing cry or scream. The child looks extremely fearful and usually