



Disruptive Behavior and Aggression

Disruptive Behavior or Aggression?
Suspect Oppositional Defiant Disorder or Conduct Disorder?

Safety check: Neglect/Abuse?
Drug abuse?
Specific plan to hurt someone?

If acute danger, have duty to protect or report risks. Consider consultation.

Think about comorbidity: ADHD
Major Depression (irritable mood type)
Bipolar disorder
Anxiety disorder

Diagnosis:
See DSM-5 criteria.
ODD: Pattern of angry/irritable, argumentative/defiant and vindictive behavior of > 6 months
CD: Pattern of behavior violating rights of others/societal norms > 1 year
Rating scale screen: Vanderbilt ADHD scale

Can problem be managed in primary care?

NO

Referral to Mental Health Specialist

YES

Child Focused Treatments

Parent Focused Treatments

Individual psychotherapy focused on problem solving skills, and helping identify and institute tangible rewards for desired behavior. (Avoid group therapy as may reinforce negative behaviors.)
Parent involvement/training is essential to get positive results.
Encourage "special time" interactions between parent and child.

Young Children: strongly recommend a therapist to teach behavior management skills. Many models for this like Parent Child Interaction Training (PCIT), the Barkley method and 1-2-3 Magic.
Adolescents: recommend parent/family therapy or training such as functional family therapy (FFT) or Multisystemic Therapy (MST).
Parent should create some regular positive time with their child (like "special time") as this helps other discipline to be more effective.
Encourage parent to utilize our bibliotherapy/video references on learning behavior management techniques.

If ADHD present, strongly consider use of stimulant medication.

Although not preferred, if very severe symptoms or if unable to make progress with child/parent counseling after a reasonable counseling effort over a few months, consider medication as symptom focused treatment trial. Note planned, purposeful aggression is not helped by medication.
If use a medicine, identify child specific treatment goals which can be monitored to measure treatment effects, like the frequency/severity of violent incidents. Stop any failed medication trials before beginning any new prescription (avoiding polypharmacy).
Non-specific medication options for maladaptive impulsive aggression include divalproex sodium, lithium, atypical antipsychotics, stimulants, and α -2 agonists. The α -2 agonists are usually preferred as a first trial due to overall lower side effect risks. Antipsychotics like risperidone have greater cumulative medical risks, but are more likely to yield a decrease in aggression.

Primary References:
AACAP (2007): Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. JAACAP 46(1):126-141
Pappadopulos E, Woolston S, Chait A, et al. (2006): Pharmacotherapy of aggression in children and adolescents: efficacy and effect size. J Canadian Acad Child Adolesc Psychiatry 15(1):27-39
Cheng K and Myers KM. Child and Adolescent Psychiatry The Essentials, LWW, Inc. 2011.

Non-Specific Medications for Disruptive Behavior and Aggression

- If used, choosing a single medication is strongly recommended over polypharmacy
- Establish a specific target to treat, and measure the response over time (such as anger explosion frequency, duration)
- Aggression is not a diagnosis—continue to look for and treat what may be the cause, usually prescribing psychotherapy and behavior management training as the treatments of choice

Drug Name	Dosage Form	Start Dose	Sedation	Weight Gain	Extra-pyramidal symptoms	(+) RCT evidence in kids?	Editorial Comments
Risperidone (Risperdal)	0.25, 0.5, 1, 2, 3, 4mg 1mg/ml	0.25mg QHS	+	+	+	Yes	Most child research support of the meds in this group
Aripiprazole (Abilify)	2, 5, 10, 15, 25, 30mg 1mg/ml	2mg QD	+	+	+/-	No	Long 1/2 life, takes weeks to build effect.
Quetiapine (Seroquel)	25, 50, 100, 200, 300, 400mg	25mg QHS	++	+	+/-	No	Pills larger, could be hard for kids to swallow.
Ziprasidone (Geodon)	20, 40, 60, 80mg	20mg QHS	+	+	+/-	No	Greater risk of QT lengthen, EKG check
Olanzapine (Zyprexa)	2.5, 5, 7.5, 10, 15, 20mg	2.5 mg QHS	++	++	+/-	No	Greatest risk of weight gain, increased cholesterol

Table + and - from Fedorowicz VJ, Fombonne E. (2005), Lublin, H; et al (2005), and Correll CU et al (2009)
*Pappadopulos E et al., J Cdn. Acad. Child Adol. Psych. (2006)

Monitoring for all atypical antipsychotics: AIMS exam at baseline and Q6months due to risk of tardive dyskinesia. Warn of dystonia & NMS risks. Weight checks, fasting glucose/lipid panel Q6months at minimum

Other Medication Options

Drug Name	Description	(+) RCT evidence in kids**	Monitoring	Editorial Comments
Lithium	A salt, is renally excreted	Yes	Baseline EKG, BUN/creat, TSH, CBC. Lithium level after 5 days. Q3month Li. Q6mo TSH,BUN/crt	Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal
Valproate	Anti-seizure	Yes	CBC, LFT at baseline, in 3 month, then Q6month. VPA level checks needed	Sedating, weight gain, rare severe toxicity of liver, ↓platelets
Carbamazepine	Anti-seizure	No	CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed	Aplasia and rash risk. Note a negative result trial with kids and oxcarbazepine & bipolar disorder
Clonidine, Guanfacine	α-2 agonists	Yes	Pulse, BP	Orthostasis, sedation sign of excess dose, avoid high doses, rebound hypertension if quick stop

**Pappadopulos E et al. (2006) and lit. review

None of the medications on this page are FDA approved for aggression treatment, with the exception of risperidone and aripiprazole which are approved for irritability/aggression treatment in autism.

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

CODE 0 = NONE 1 = MINIMAL, MAY BE EXTREME NORMAL

MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

2 = MILD 3 = MODERATE 4 = SEVERE

EXAMINATION PROCEDURE

EITHER BEFORE OR AFTER COMPLETING THE EXAMINATION PROCEDURE OBSERVE THE PATIENT UNOBTUSIVELY AT REST (E.G., IN WAITING ROOM). THE CHAIR TO BE USED IN THIS EXAMINATION SHOULD BE A HARD, FIRM ONE WITHOUT ARMS.

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT. 2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW? 3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE, HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES. 4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION) 5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.) 6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE. | <ol style="list-style-type: none"> 7. ASK PATIENT TO PROTRUDE TONGUE. OBSERVE ABNORMALITIES OF TONGUE MOVEMENT.) DO THIS TWICE. *8. ASK PATIENT TO TAP THUMB, WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.) 9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.) 10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.) *11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS, AND MOUTH.) *12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE. <p>** ACTIVATED MOVEMENTS</p> |
|---|---|

FACIAL AND ORAL MOVEMENTS:	1. MUSCLES OF FACIAL EXPRESSION E.G., MOVEMENTS OF FOREHEAD, EYEBROWS, PERIORBITAL AREA, CHEEKS; INCLUDE FROWNING, BLINKING, SMILING, GRIMACING	0	1	2	3	4
	2. LIPS AND PERIORAL AREA E.G.. PUCKERING POUTING, SMACKING	0	1	2	3	4
	3. JAW E.G., BITING CLENCHING, CHEWING, MOUTH OPENING, LATERAL MOVEMENT	0	1	2	3	4
	4. TONGUE RATE ONLY INCREASE IN MOVEMENT BOTH IN AND OUT OF MOUTH. NOT INABILITY TO SUSTAIN MOVEMENT	0	1	2	3	4
EXTREMITY MOVEMENTS:	5. UPPER (ARMS, WRISTS HANDS FINGERS INCLUDE CHOREIC MOVEMENTS (I.E., RAPID, OBJECTIVELY PURPOSELESS, IRREGULAR SPONTANEOUS) ATHETOID MOVEMENTS (I.E., SLOW IRREGULAR, COMPLEX SERPENTINE). DO NOT INCLUDE TREMOR (I.E., REPETITIVE, REGULAR, RHYTHMIC)	0	1	2	3	4
	6. LOWER (LEGS, KNEES, ANKLES, TOES) E.G., LATERAL KNEE MOVEMENT, FOOT TAPPING, HEEL DROPPING, FOOT SQUIRMING, INVERSION AND EVERSION OF FOOT	0	1	2	3	4
TRUNK MOVEMENTS:	7. NECK, SHOULDERS, HIPS E.G., ROCKING, TWISTING, SQUIRMING PELVIC GYRATIONS	0	1	2	3	4
GLOBAL JUDGMENTS:	8. SEVERITY OF ABNORMAL ACTION	0	1	2	3	4
	9. INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0	1	2	3	4
	10. PATIENT'S AWARENESS OF ABNORMAL MOVEMENTS	0	1	2	3	4
DENTAL STATUS:	11. CURRENT PROBLEMS	0	1	2	3	4
	12. DOES PATIENT USUALLY WEAR DENTURES?	0	1	2	3	4

NOT APPLICABLE: PATIENT HAS NO HISTORY OF TREATMENT WITH NEUROLEPTICS FOR ONE MONTH OR MORE.

EXAMINATION COMPLETED

PHYSICIAN'S SIGNATURE DATE OF EXAMINATION.....

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Monitoring for all atypical antipsychotics: AIMS exam at baseline and ~Q6months due to risk of tardive dyskinesia. Warn of dystonia risk. Weight checks, fasting glucose/lipid panel ~Q6months at minimum.

Time Out

“Time out” means taking a specific time away from attention, interesting activities, rewards or other reinforcement. It usually means placing the child in a dull, boring place immediately following an undesired behavior, and having them remain there for a specific amount of time. Time out can also involve a temporary loss of parental attention or interaction in situations where the physical space is limited (like no talking for 5 minutes while riding in a car).

It is often said that the length of time out should be one minute for each year of age, but adjustments need to be made based on developmental level — for instance a developmentally delayed child should have their time out times significantly reduced.

Time outs are simple in concept, but can be hard to implement. Here are some tips for greater success:

- **Set limits that are consistent** — if a given child behavior requires a time out one day it should always get that response. Inconsistency leads to more testing of the limits.
- **Focus on changing only one or two types of misbehavior at a time.** For instance if hitting a sibling is the main concern, focus your efforts on consistent time outs for that behavior and try to let other things slide for a while until you have results.
- **When you announce the time out, do not continue to engage verbally with your child.** This is very important — children that continue to verbally engage with you, bargain, plead, and yell back and forth with you will not receive the benefit from a time out because they are in essence receiving MORE attention from you during a time out rather than less. You can't control what their mouth does, but you can control your own. Remain calm, and refuse to take the bait.
- **Time outs should occur *immediately after misbehavior.*** A time out many minutes later sends a confused message. Delaying a time out by lecturing the child before the time out also hurts the process. The action of being quietly brought to a time out location and having no verbal interaction from you speaks far more loudly than any words can.
- **If giving a warning before use of time out, make it count.** For instance saying “do it one more time and you will get a time out” needs to be followed up by actually initiating the time out if they do “it” one more time.
- **Remember that kids enjoy making a splash.** Like throwing rocks in the water, triggering a parent to lose their cool can be entertaining or satisfying for a child. Keeping your cool when setting limits avoids inadvertently reinforcing their behavior to occur again.
- **You determine when the time out is over, not the child.** Setting a timer can make this seem less arbitrary to the child. Don't be punitive with your child immediately after time out (e.g., lecturing, forcing a child's apology). Simply “resume business as usual” or congratulate them on regaining personal control. *Then actively look for the next positive behavior to praise.*

Robert Hilt, MD

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Special Time

Also known as “Child Directed Play”

A strength based approach to overall child behavior problems.

Goal of this is to establish regular times when parent and child have a positive experience in each other’s presence, supporting family self confidence, pleasure and hope. Regular special time together is like money in the bank that lessens times of crisis and re-establishes motivation for positive behaviors. Without regular positive parent/child interactions, corrective discipline is far less effective. For instance, families often find that time-outs work better after initiating special time.

How to do special time:

- Important to be done regularly, every day is optimal, but two or three times a week consistently is OK. Siblings should receive equal opportunity.
- Parent picks time of day.
- Label it “special time.”
- Pick a time short enough that it can be done reliably as scheduled, usually 15-30 minutes.
- Do it no matter how good or bad the day was.
- One on one without interruption.
- Child picks the together activity, which needs to be something the parent does not actively dislike doing and which does not involve spending money or completing any task or chore.
 - Examples might include playing together with child’s toys, or drawing pictures together.
- End on time: may use a timer to help. Remind child when the next special time will be. You may choose to play with the child more after taking a break from each other.
- If the child refuses at first, tell the child that you will just sit with him/her for that time, and/or that you will continue to invite the child to participate when next special time is scheduled.
- Parents also need to have some special time for him/herself. Parents who feel nurtured themselves find this is easier to do with their child.

Robert Hilt, MD

Treating Disruptive Behavior and Aggression Using Functional Analysis

Identify the behavior

Character	(what they do)
Timing	(especially noting provoking and reinforcing factors)
Frequency	(times per day or per week)
Duration	(i.e. 30 minute behaviors are different than 30 second behaviors)

Analyze and make hypotheses about the function of the behavior

- **Communication.** This is the primary etiology to investigate for young children or if a child lacks communication skills. Maladaptive behavior may communicate physical discomfort like pain, GI distress or illness. It may also communicate *emotional discomfort* like boredom, anxiety, anger, frustration, sadness, or over-excitement.
- **Achieving a goal.** How does performing the behavior benefit the child, what does he/she gain? This might include escaping an undesired situation, avoiding a transition, acquiring attention, or getting access to desired things like toys or food.
- **No function.** If there is no function identifiable for the behavior, this suggests causes like seizures, medication side effects, sleep deprivation, and other medical or psychiatric disorders.

Modify the environment by changing provoking and reinforcing factors.

- Enhance communication — could try naming the thoughts or feelings that you believe the child may be having, like “I see that you want to eat right now.”
- Use simple, concrete sentences and questions with child.
- Remain calm since your emotional reaction may reinforce an undesired behavior.
- Increase structure — provide schedule of day’s events, use routines, anticipate transitions. Describe an upcoming routine to prepare for new situations. Teach child how to ask for help and how to tell adults when they need a break.

- Modify demands — match the task to their developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

Consult with a behavioral specialist to facilitate process and support family.

- Behavior modification specialists can make tailored suggestions for the family’s situation.
- If behavior is at school, consult with the school psychologist for a behavioral intervention.

If strategies are insufficient or behavior is severe, or places child or others at risk of harm, consider augmentation with medications.

- See Care Guide section, “Non-Specific Medications for Disruptive Behavior and Aggression”.

A. A. Golombek, MD and Robert Hilt, MD

Bullying: Advice for the Primary Care Clinician

Bullying is aggressive behavior intended to hurt another person, often to gain power. It can be physical, verbal, social, in-person or in cyberspace. Strategies to address this common problem include:

Screening for bullying, especially when there is any acute change in mood, behavior, sleep, or somatic symptoms, or any change in social or academic functioning.

- 1) With **patients**, screening questions include, “Sometimes I hear about kids getting picked on... Have you been bullied or bullied others? How often? Have you seen bullying? How did you respond? Have you sent or received things electronically that may be bullying?”
- 2) With **parents**, screening questions include, “Sometimes bullying can really affect kids’ health and functioning... Have you seen your child being bullied by other kids? Have you heard about any bullying involving your child? Has your child talked about witnessing bullying at school?”

Educating child and family that bullying is not okay and should be addressed. Create a plan:

With a bullying **victim**, immediate action steps to recommend include:

- Walking away and telling a trusted adult who can be accessed quickly.
- Consider confronting a bully (elevate posture, eye contact, “bullying is not okay”).
- Changing the topic. Using humor.
- Accessing peers for support and ideas.

For a bullying **bystander**, action steps to recommend include:

- Asking adults to help during or even after the event.
- Stepping in to change the situation, label the bullying, using humor, suggesting a compromise.

Working directly with the bully:

- 1) Inquire about the motivation for bullying. Why is the bully trying to be in control? Talk about both how to lead and how to respond to feeling left out.
- 2) Bullies may be experiencing trauma in their own lives. Screen for abuse.
- 3) Discuss what makes a good friend and attempt to build empathy for the victim. Try to engender positive feelings towards making others feel good.
- 4) Review the potential negative consequences of bullying (friends avoiding, bigger peers may challenge, school policies).

Engage parents, school and other care providers about the bullying:

Parents and school staff should review the use of non-physical and non-shaming behavior management techniques, and set clear expectations for empathic behaviors. Children can be taught by counselors and teachers to use problem solving, emotion regulation, and anger management coping skills and how to make plans for alternative actions. Adults should model treating others with kindness and respect. Adults should monitor their child’s social media use. Parents can encourage participation in pro-social activities to build peer networks, enhance social skills, and gain confidence.

Parents and school officials can **learn more** about how to stop bullying at www.stopbullying.gov

Rebecca Barclay, MD and Robert Hilt, MD

Reference: Buxton, Potter, and Bostic. Coping Strategies for Child Bully-Victims. *Psychiatric Annals*. 2013;3:101-105; stopbullying.gov (4/30/14).

Disruptive Behavior and Aggression Resources

Information for Families

Books parents may find helpful:

Your Defiant Child: Eight Steps to Better Behavior (2013), by Russell Barkley, PhD

The Explosive Child (2001), by Ross Greene, PhD

The Difficult Child (2000), by Stanley Turecki, MD and Leslie Tonner

1-2-3 Magic: Effective Discipline for Children 2-12 (2004), by Thomas Phelan, PhD

Raising an Emotionally Intelligent Child (1998), by John Gottman, PhD

SOS Help for Parents (2006), by Lynn Clark, PhD

Parenting Your Out-of-Control Teenager: 7 Steps to Reestablish Authority and Reclaim Love (2001), by Scott P. Sells, PhD

Your Defiant Teen: Ten Steps to Resolve Conflict and Rebuild Your Relationship (2013), by Russell Barkley, PhD

Videos parents may find helpful:

1-2-3 Magic: Managing Difficult Behaviors, by Thomas Phelan, PhD

Managing the Defiant Child, by Russell Barkley, PhD

The Kazdin Method for Parenting the Defiant Child (book with DVD), by Alan Kazdin and Carlo Rotella

Raising an Emotionally Intelligent Child, by John Gottman, PhD

Websites families may find helpful:

American Academy of Child Psychiatry Oppositional Defiant Disorder resource center

www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx

Oppositional Defiant Disorder information from Mayo Clinic

<http://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/basics/definition/con-20024559>

The Incredible Years training programs

www.incredibleyears.com

Lives in the Balance

www.livesinthebalance.org



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Child and Adolescent Psychiatric Consultation
In Collaboration with the Wyoming Department of Health



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Sleep Hygiene for Young Children

- Keep consistent bedtimes and wake times every day of the week. Late nights can cause fatigue that throws off a sleep schedule for days.
- Avoid letting the child spend lots of non-sleep time in bed, which keeps the brain from associating the bed with sleep time.
- Child's bedroom should be cool, quiet and comfortable. There should not be any "screens" (phone, tablets, video console, televisions, computers) in the bedroom.
- Bedtime should follow a predictable sequence of events, such as bath time, brushing teeth and reading a story.
- Avoid high stimulation activities just before bed, such as watching television, playing videogames, or rowdy play or exercise. If there are nighttime awakenings, these same activities should be avoided.
- Physical exercise as a part of the day often helps with sleep time many hours later.
- Relaxation techniques such as performing deep, slow abdominal breaths or imagining positive scenes like being on a beach can help a child relax.
- Avoid caffeine (soda, chocolate) in the afternoons and evenings. Some children's sleep can be impacted by any caffeine at all at any time of day. Even if caffeine does not prevent falling asleep, it can still lead to shallow sleep or frequent awakenings.
- Worry time should not be at bedtime. Children with this problem can try having a "worry time" scheduled earlier when they are encouraged to discuss their worries with a parent and then put them aside.
- Children should be put to bed drowsy, but still awake. Letting a child fall asleep in other places or with a parent present in the room forms habits that are difficult to break.
- A comforting object at bedtime is often helpful for children who need to feel safe and secure when the parent is not present. Try to include a doll, toy or blanket when you cuddle or comfort your child, which may help them adopt the object.
- If you need to check in on your child at night, checks should be brief and boring. The purpose is to reassure the child you are present and that they are okay.
- If your child is never drowsy at the planned bedtime, you can try a temporary delay of bedtime by 15-30 minutes until the child appears sleepy, so that the child experiences falling asleep more quickly once they get into the bed. The bedtime should then be gradually advanced earlier until the desired bed time is reached.
- Keep a sleep diary with naps, sleep and wake times and activities to help you find patterns and problem areas to target. This can be very helpful when discussing sleep challenges with your care team.

Robert Hilt, MD

Primary Reference: A Clinical Guide to Pediatric Sleep, by Jodi Mindell and Judith Owens

Sleep Hygiene for Teens

- Keep consistent bedtimes and wake times every day of the week. Late nights or sleeping-in on weekends can throw off a sleep schedule for days.
- The bedroom should be cool, quiet and comfortable. Teens who stare at the clock should have the clock turned away.
 - Restrict use of any “screens” (phone, tablet, video console, television, computer, etc) while in the bedroom. These can all function as sleep prevention devices.
- Bedtime should follow a predictable and non-stressful sequence of events, such as picking out tomorrow’s outfit, brushing teeth, and then reading relaxing non-screen material or listening to music.
- Avoid high stimulation activities in the hour before bed, such as watching television, playing videogames, texting with friends, or exercise. Avoid the same during any nighttime awakenings.
- Avoid going to bed hungry or overly full.
- Physical exercise as a part of the day often helps with sleep time many hours later. Getting outside every day, particularly in the morning, may also be helpful.
- Relaxation techniques such as performing deep, slow abdominal breaths or imagining positive scenes like being on a beach can help encourage relaxation.
- Avoid caffeine (soda, chocolate, tea, coffee, energy drinks) in the afternoons/evenings. Some teen’s sleep can be impacted by any caffeine at all at any time of day. Even if caffeine doesn’t prevent falling asleep it can still lead to shallow sleep or frequent awakenings. Alcohol, tobacco, or sleep aids also can interfere with the natural sleep cycle.
- If the teen awakens in bed tossing and turning, it is better for him or her to get out of bed to do a low stimulation activity, (i.e. non-screen reading) before returning to bed when feeling tired. If sleep still will not come, the teen should spend more time relaxing out of bed before lying down again. This keeps the bed from becoming associated with sleeplessness.
- Worry time should not be at bedtime. A teen may find it helpful to have a “worry time” scheduled when he or she is encouraged to journal about worries or discuss them with a parent or other support, and then put them aside.
- Teens should go to bed drowsy, but still awake. Falling asleep on the couch or in non-bed locations may form sleep associations or habits that are difficult to break.
- If the teen is never drowsy at the planned bedtime, temporarily delay bedtime by 15-30 minutes until the teen is sleepy, so that the teen experiences falling asleep more quickly once in bed. The bedtime should then be gradually advanced earlier until the desired bed time is reached.
- Keep a sleep diary with naps, sleep and wake times and activities to help find patterns and problem areas to target. This can be very helpful when discussing sleep challenges with the care team. There are also apps available that can help with tracking sleep habits.

Robert Hilt, MD

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