



THE PARENT SLEEP CHECKLIST

What you're seeing · why the brain is doing it · what to do about it

A quick-reference companion to *Your Child's Sleeping Brain: A Parent's Guide to How Sleep Builds a Human* · Christopher W. Pierce, CMHC, NCC

Age	What you're seeing	Why — the biology	What to do
NEWBORN · 0–3 months · needs 14–17 hrs per 24 hours			
	No day/night pattern. Wakes every 2–3 hours around the clock.	The master clock (suprachiasmatic nucleus) is not mature until 3–4 months, and melatonin — the hormone signaling biological night — is not yet rhythmic. There is no biological night yet.	Stop scheduling; start setting the clock . Bright light and normal noise by day; night feeds dim, quiet, and boring. Contrast is the whole lesson.
	Wakes the instant you set them down.	Newborns enter sleep through active sleep (the REM ancestor), not deep sleep — the reverse of adults. They are not deeply asleep for ~20 minutes.	Wait for the limbs to go genuinely floppy before the transfer. Count 20 minutes.
	Twitching, grimacing, grunting, irregular breathing.	Active sleep is the motor system testing its own developing circuits — healthy neurological development, not distress.	Leave it alone. Call your pediatrician for pauses over ~20 seconds or any color change.
	<i>Parent note:</i> you are running on fragmented sleep.	Deep restorative N3 sleep is front-loaded into the first half of the night, so fragmented hours are not equal to the same total in one block.	Protect one early 4–5 hour block with a partner covering a feed. If low mood or hopelessness lasts 2+ weeks, call your provider. In the U.S., 988 is available 24/7.
INFANT · 4–11 months · needs 12–15 hrs per 24 hours			
	The "four-month regression" — a good sleeper suddenly wakes every 90 minutes.	Nothing regressed. Sleep architecture is reorganizing into adult stages , so your baby now surfaces to near-waking at the end of every cycle — several times a night, permanently.	Hold the routine steady; it passes. Pause 60 seconds before responding — some of that noise is a baby resettling alone.
	Only falls asleep nursing, rocking, or held — then wakes needing it again.	Sleep-onset association. Whatever is true at falling-asleep is what the brain looks for on surfacing at 1 a.m. Normal learning, not manipulation.	Put down drowsy but awake at bedtime , when sleep pressure is highest. Graduated check-ins or camping out both work — consistency matters more than method.
TODDLER · 1–2 years · needs 11–14 hrs per 24 hours			
	Screaming, standing, protesting at bedtime.	Object permanence has arrived — they now know you exist elsewhere in the house. New motor skills get rehearsed at every opportunity, including bedtime.	Keep the routine identical. Build in 10 fully present minutes — much bedtime resistance is a bid for connection.
	Bedtime fell apart after a nap change.	Naps release sleep pressure — adenosine, the chemical that builds drowsiness all day. A late nap deflates the drive bedtime depends on.	End naps by ~3:30 p.m. When a nap drops, move bedtime 30–45 minutes earlier for several weeks.

Age	What you're seeing	Why — the biology	What to do
PRESCHOOL · 3–5 years · needs 10–13 hrs per 24 hours			
	Screaming, sweating, eyes open, unreachable — 1–3 hours after bedtime.	Night terror , not a nightmare — erupting out of deep N3 sleep, which peaks at this age. The child is not awake and will not remember it.	Keep safe, speak little, do not try to wake them . Prevention is an <i>earlier</i> bedtime — overtiredness is the main trigger.
	Endless curtain calls: water, one more story, one more hug.	Limit-setting insomnia . Delaying worked before, so the brain filed it as a strategy that works. Not scheming — reinforcement.	Front-load every predictable request into the routine. Use a bedtime pass : one card, one request, then it is gone until morning.
	Monsters, the dark, fear of being alone.	Imagination has developed far enough to generate the fear, but not far enough to dismiss it. Evidence does not work on it.	Do not debate whether monsters exist. Give equipment and agency — their own flashlight, "monster spray," a guard-duty stuffed animal.
	Lies awake for an hour before falling asleep.	Bedtime is set ahead of their actual biological sleep onset, so the bed is becoming associated with frustration.	Bedtime fading : temporarily move bedtime to when they truly fall asleep, then walk it back 15 minutes every few nights.
SCHOOL AGE · 6–12 years · needs 9–12 hrs per 24 hours			
	Sleepwalking, sleep talking, or bedwetting past age 5–6.	Children run far more deep N3 sleep than adults, and the transitions out of it are not yet smooth. Linked to unusually deep sleep — not laziness.	Safety-proof the house — stair gate, locked doors. Guide back to bed without waking. No shame . Mention persistent bedwetting to your pediatrician.
	"I can't shut my brain off." Worries surface at lights-out.	Bedtime is the first quiet moment of the day. Worrying in bed conditions the bed itself into an arousal cue — the mechanism behind adult insomnia.	Move the processing earlier — 10 minutes after dinner, or a worry notebook. Keep the bed for sleep only .
	Fine at bedtime, but mornings are a war.	Total sleep is short — usually schedule creep from homework and activities, not a routine failure.	Do the math out loud with your child : "Up at 6:45, 10 hours back, lights out at 8:45." Anchor the wake time, weekends within an hour.
TEEN · 13–18 years · needs 8–10 hrs per 24 hours			
	Genuinely cannot fall asleep before 11 p.m. or midnight.	Circadian phase delay — at puberty the clock becomes more sensitive to evening light and less to morning light, shifting sleep timing 1.5–3 hours later. Biology, not attitude.	Say it out loud: "Your clock really did shift. How do we protect the sleep you can still get?" This turns a nightly fight into shared logistics.
	Impossible to wake. Furious and barely verbal at 6:15 a.m.	They are woken near their core body temperature minimum — the lowest alertness point of 24 hours — and pulled out of deep sleep into sleep inertia , which impairs mood and thinking for 15–30 minutes.	Light before voice — open the blinds, then speak. Sunrise alarm. Give a 5-minute runway. Connect 30 seconds before the first instruction.
	Sleeps until 1 p.m. Saturday, then Monday is brutal.	Social jet lag . The catch-up is repaying real debt, but it also pushes the clock later — making Monday the worst morning of the week.	Allow a slide of about one hour , not four. Prohibition is unrealistic; a four-hour swing guarantees a wrecked Monday.
	Phone in the bedroom.	Evening light suppresses melatonin and content drives arousal. In an already phase-delayed brain, this compounds the delay.	One household charging station outside all bedrooms — including the parents' phones . A rule for everyone is a norm; a rule for one is a punishment.



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The six rules that work at every age

- 1. Fix the wake time first.** It anchors the clock harder than bedtime does — hold it within an hour on weekends.
- 2. Light in the morning, dim at night.** Light is the strongest input to the body clock — stronger than any routine.
- 3. When they fight sleep, go earlier — not later.** Pushing past tired releases cortisol and adrenaline, both wake-promoting. Overtired means wired.
- 4. Same routine, same order, every night** — and screens out of bedrooms. Repetition itself becomes the sleep signal.
- 5. Connect before you correct,** at bedtime and at wake-up. A calm nervous system can cooperate; an alarmed one cannot.
- 6. Check the biology before the behavior.** Nap timing, bedtime timing, light, and room temperature (65–68°F) resolve about half of all standoffs on their own.

Call your pediatrician if you see —

Loud habitual snoring, gasping, or pauses in breathing. The most important item here. Childhood sleep apnea usually comes from enlarged tonsils and adenoids, and often shows up as hyperactivity and inattention rather than sleepiness — easily mistaken for ADHD.

Bedwetting that returns after a child had been reliably dry, or daytime sleepiness despite adequate hours by the clock.

Attention, hyperactivity, or learning problems — ask for sleep to be part of the workup.

Parasomnias with injury, leaving the house, or persisting into the teen years.

Uncomfortable leg sensations at night or an urge to move the legs — often linked to low iron, and treatable.

Sleep changes alongside mood or appetite changes in a teen, or problems not improving after several weeks of a consistent plan.