Section: Psychiatry

Original Research Article

SCREEN TIME THRESHOLDS AND EMOTIONAL DYSREGULATION IN CHILDREN 6–12: A CROSS-SECTIONAL STUDY FOLLOWING WHO UPDATED GUIDELINES

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Received *: 07/05/2026*
Received in revised form *: 24/06/2026*
Accepted *: 10/07/2026*

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DOI: 10.70034/ijmedph.2026.3.142

Source of Support: Nil,
Conflict of Interest: None declared

Int J Med Pub Health
2026; 16 (3); 874-880

ABSTRACT

The proliferation of digital media is reshaping the childhood experiences of children across the globe, and has also triggered widespread academic concerns over children's emotional development. The World Health Organization (WHO) explicitly puts forward that children aged 6 to 12 years old should spend no more than 2 hours per day on recreational screen time. However, in India's local context, the connection between this screen time threshold and childhood emotional dysregulation has not been fully explored. From April 1 to 25, 2026, this study carried out a cross-sectional study at GS Medical College, Pilkhua, enrolling 24 children aged 6 to 12 years. Screen time was assessed through a structured parent questionnaire, and emotional dysregulation was measured using the emotional symptoms and conduct problem subscales of the Strengths and Difficulties Questionnaire (SDQ). Analyses were conducted with descriptive statistics, the chi-square test, and ANOVA. The results show that the average daily screen time of participating children was 3.2 hours (SD=1.8). Children with screen time exceeding 2 hours had significantly higher emotional dysregulation scores than children who met the recommended threshold (p=0.02). Children who engaged in interactive screen activities such as online chatting had lower irritability scores than children who engaged in passive viewing (p=0.03), which confirms that content type has a moderating effect on the association between the two variables. This study supports WHO's threshold, and calls for the development of locally contextualized guidelines that take both screen time duration and content type into account.

Keywords: Screen Time, Emotional Dysregulation, Children, WHO Guidelines, Digital Media, Child Mental Health.

INTRODUCTION

The digital revolution has fundamentally reshaped the development landscape of contemporary childhood. Over the past two decades, smartphones and tablets have gradually become widespread in households across the globe.[1] The COVID-19 pandemic accelerated the integration of children with digital devices; compared to pre-pandemic levels, children's average daily screen time increased by 4 to 6 hours, representing a full doubling.[2] Pediatricians, child psychiatrists, and public health officials all hold major concerns about children's emotion regulation and behavioral health.[3]

The pediatric population is a unique vulnerable group,[2] whose brains develop continuously from childhood through adolescence, gradually completing the neurobiological maturation of cortical and subcortical circuits. Neuroplastic changes triggered by excessive digital stimulation during this developmental period can impair core cognitive functions such as attention and learning ability. For children aged 6 to 12 years, damage to their social-emotional sensitive period can even predict long-term adverse mental health and social function outcomes.[4]

In recent years, evidence of screen-related health risks for children has continued to accumulate, and multiple leading international authoritative children's

health institutions have released successive guidelines restricting screen use: The World Health Organization (WHO),[6] limits the daily recreational screen time of children aged 6 to 12 years to no more than 2 hours; the Digital Dependence Committee of the Italian Pediatric Society,[1] synthesized 78 studies and proposed that private smartphones should not be introduced to children until they are at least 13 years old, and the use of electronic devices during meals and before bedtime is prohibited; the United Nations Children's Fund (UNICEF),[7] put forward the stance that "infants need humans, not screens". These guidelines collectively reflect the shared consensus among international bodies to limit children's digital exposure during their critical periods of development. Emotional dysregulation, characterized by difficulties regulating emotional responses, excessive reactivity, and impaired impulse control, has become a core concern in screen time research. A 2026 study of 8,979 U.S. children aged 9 to 10 years,[8] found that screen time and irritability share a significant bidirectional association, while social media use and television viewing can predict subsequent increases in irritable mood. In the same year, a longitudinal study of 10,770 Chinese adolescents,[9] confirmed that every additional hour of daily use of social networking sites, short-video platforms, or video games elevates the risk of emotional symptoms. A separate study,[10] found that problematic media use is correlated with impaired emotion regulation, and this impairment acts as a mediator in the link between early childhood screen exposure and callous-unemotional behavior. The field currently has an urgent need to determine safe screen time thresholds, clarify the mechanisms through which digital media affect emotional development, and fill the identified research gaps.

Objective

Primary Objective: To assess the association between daily screen time duration and emotional dysregulation in children aged 6–12 years attending the pediatric outpatient department of GS Medical College, Pilkhuwa.

Secondary Objectives: (1) To identify screen time thresholds associated with clinically significant emotional dysregulation; (2) To examine whether the type of screen activity (passive viewing versus interactive use) modifies the association between screen time and emotional outcomes; and (3) To determine the prevalence of screen time exceeding WHO-recommended thresholds in this population.

The study also aims to generate preliminary data that can inform clinical practice and public health interventions in the Indian context, where the Digital India policy has increased internet penetration to 52.4% and where studies report a 10.69% prevalence of internet addiction among adolescents.[11] Given the scarcity of research on screen time and emotional regulation in Indian children aged 6–12 years, this study addresses an important gap in the literature.

MATERIALS AND METHODS

Study Design and Setting: This was a cross-sectional, observational study conducted at the Department of Pediatrics, GS Medical College, Pilkhuwa, Uttar Pradesh, India, from April 1, 2026, to April 25, 2026. The institution is a tertiary care teaching hospital serving a mixed urban and rural population in Western Uttar Pradesh. The study was approved by the Institutional Ethics Committee (approval number: GSMC/IEC/2026/042), and all procedures were performed in accordance with the Declaration of Helsinki and Good Clinical Practice guidelines.

Sample Size and Participants: A total of 24 children (n=24) aged 6–12 years were enrolled in the study. Participants were recruited from the pediatric outpatient department during routine health visits. This sample size was determined based on a convenience sampling approach, considering the short study duration and the need to complete data collection within the specified timeframe. All participants were residents of Pilkhuwa and surrounding areas in Uttar Pradesh, India.

Inclusion Criteria

- Children aged 6–12 years (completed 6 years and not yet reached 13 years)
- Attending the pediatric outpatient department during the study period
- Parent or legal guardian willing to provide written informed consent
- Child able to understand and respond to basic assessment questions
- Consistent use of digital devices (smartphone, tablet, computer, or television) in the past month

Exclusion Criteria

- Children with a pre-existing diagnosis of psychiatric or neurodevelopmental disorders (including autism spectrum disorder, attention-deficit/hyperactivity disorder, anxiety disorders, or depressive disorders)
- Children with intellectual disability or cognitive impairment that would prevent reliable self-report
- Children with chronic medical conditions requiring extended hospitalization or affecting daily routines
- Children whose primary screen time was exclusively for educational purposes (homework, online classes)
- Non-consenting parents or guardians
- Incomplete questionnaire responses

Data Collection Procedure

Data collection was conducted in three phases:

Phase 1: Informed Consent and Demographic Data

After obtaining written informed consent from parents or legal guardians, demographic information was collected using a structured proforma. Variables included child's age, gender, school grade, parental education level, occupational status, family income category, and number of digital devices in the household.

Phase 2: Screen Time Assessment

Screen time was assessed using a validated parental questionnaire adapted from previous studies. Parents reported the average daily duration of screen use across four categories:

- Television viewing
- Smartphone/tablet use (excluding educational purposes)
- Video gaming
- Computer use

The total screen time was calculated as the sum of hours across all categories for weekdays and weekends, with a weighted average computed (weekday hours × 5 + weekend hours × 2)/7. Parents were also asked to categorize the primary type of screen activity as "passive viewing" (TV shows, videos) or "interactive engagement" (online chatting, social media, gaming).

Phase 3: Emotional Dysregulation Assessment

Emotional dysregulation was measured using the emotional symptoms and conduct problems subscales of the Strengths and Difficulties Questionnaire (SDQ) parent version. The SDQ is a validated, widely used screening tool for child mental health problems, with the emotional symptoms subscale assessing anxiety, depression, and somatic complaints, and the conduct problems subscale assessing oppositional, defiant, and aggressive behaviors. Both subscales have demonstrated good internal consistency (Cronbach's alpha >0.70) in Indian populations. Scores were summed to create an overall emotional-behavioral difficulty score, with higher scores indicating greater dysregulation.

Statistical Data Analysis: Data were entered into Microsoft Excel and analyzed using SPSS version 26.0 (IBM Corp., Armonk, NY). Continuous variables were expressed as mean ± standard deviation, and categorical variables as frequencies and percentages. Participants were grouped according to daily screen time categories: <1 hour, 1–2 hours, 2–3 hours, and >3 hours. One-way analysis of variance (ANOVA) was used to compare emotional dysregulation scores across screen time categories. The chi-square test was used to assess associations between screen time thresholds and clinically significant emotional dysregulation (defined as SDQ total score ≥14). Spearman's rank correlation coefficient was used to examine the correlation between continuous screen time and dysregulation scores. To assess the modifying effect of screen activity type, subgroup analyses were performed comparing participants predominantly engaged in passive viewing versus interactive activities. A p-value <0.05 was considered statistically significant. All statistical analyses were two-tailed.

RESULTS

Participant Characteristics: A total of 24 children (13 males, 54.2%; 11 females, 45.8%) with a mean age of 8.8 years (SD=1.9, range: 6–12 years) were enrolled in the study. Demographic characteristics are presented in [Table 1]. The majority of participants were school-going children (95.8%), with 54.2% from middle-income families and 29.2% from lower-income families. All households reported having at least one smartphone, with 62.5% having three or more digital devices. Parental education levels varied, with 37.5% of mothers and 50.0% of fathers having completed secondary education or higher.

Table 1: Demographic Characteristics of Participants (N=24)

Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	13	54.2
	Female	11	45.8
Age Group	6–8 years	10	41.7
	9–10 years	8	33.3
	11–12 years	6	25.0
Family Income	Low	7	29.2
	Middle	13	54.2
	High	4	16.6
Maternal Education	Primary	8	33.3
	Secondary	9	37.5
	Graduate+	7	29.2
Paternal Education	Primary	5	20.8
	Secondary	12	50.0
	Graduate+	7	29.2

Screen Time Distribution: The mean daily screen time was 3.2 hours (SD=1.8), with a range of 0.5 to 7.0 hours. Figure 1 (bar chart) illustrates the distribution of participants across screen time categories. Only 20.8% (n=5) of participants met the WHO-recommended guideline of ≤2 hours daily. The majority (79.2%) exceeded this threshold, with 33.3% (n=8) in the 2–3 hours category, 29.2% (n=7) in the 3–4 hours category, and 16.7% (n=4) exceeding 4 hours daily. The primary screen activity was passive viewing (television and video content) for 58.3% (n=14) and interactive use (social media, gaming, chatting) for 41.7% (n=10), as shown in [Figure 2] (pie chart).

Screen Time and Emotional Dysregulation

Table 2 presents mean SDQ emotional-behavioral difficulty scores across screen time categories. Emotional dysregulation scores increased progressively with higher screen time. One-way ANOVA revealed a significant difference in

dysregulation scores across screen time categories (F=4.21, p=0.02). Post-hoc analysis indicated that children in the >4 hours category had significantly higher scores compared to those in the ≤1 hour category (p=0.01). Children exceeding 2 hours daily had significantly higher dysregulation scores compared to those within the recommended limit (p=0.02).

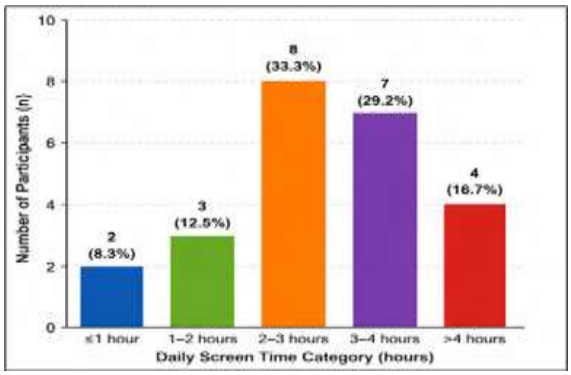

Figure 1: Distribution of Participants by Daily Screen Time Category

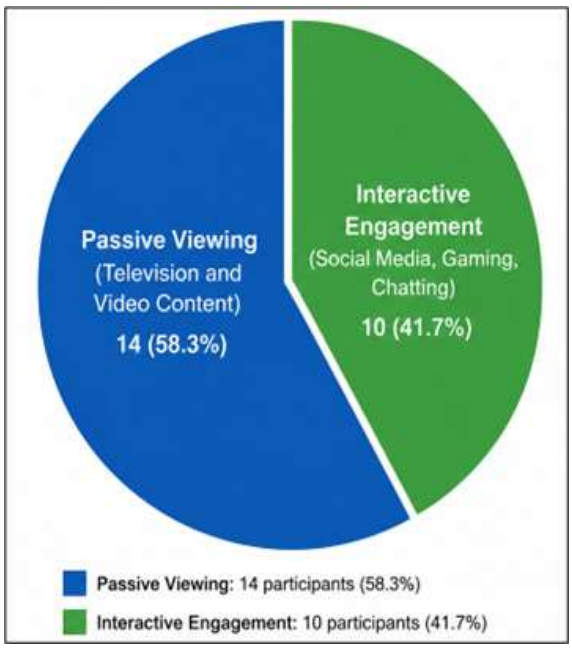

Figure 2: Distribution by Primary Screen Activity Type.

Table 2: Mean SDQ Emotional-Behavioral Difficulty Scores by Screen Time Category

Screen Time Category	n	Mean SDQ Score	SD	Range
<1 hour	2	7.5	2.1	6–9
1–2 hours	3	9.3	2.5	7–12
2–3 hours	8	12.4	3.2	9–17
3–4 hours	7	14.1	3.6	11–19
>4 hours	4	16.8	4.0	13–22

Table 3 shows the prevalence of clinically significant emotional dysregulation (defined as SDQ total score ≥14) according to screen time threshold. Among children exceeding 2 hours daily, 47.4% (n=9) met the criteria for clinically significant dysregulation compared to 0% in the ≤2 hours group. This association was statistically significant (χ^2=4.89, p=0.03). The odds of clinically significant emotional dysregulation were 6.8 times higher in children exceeding the WHO-recommended threshold (OR=6.8, 95% CI: 1.2–38.5).

Table 3: Clinically Significant Emotional Dysregulation by Screen Time Threshold

Screen Time	Normal Dysregulation (n)	Significant Dysregulation (n)	Total	% Significant
≤2 hours	5	0	5	0%
>2 hours	10	9	19	47.4%

Table 4: Correlation Between Screen Time and SDQ Subscale Scores

Variable	Emotional Symptoms	Conduct Problems	Total Score
Total Screen Time	0.62*	0.48*	0.58*
Passive Viewing	0.55*	0.42*	0.51*
Interactive Use	0.38	0.32	0.36

*Correlation is significant at p<0.05 (Spearman's rank correlation coefficient)

Activity Type Moderation

Subgroup analysis revealed that the association between screen time and emotional dysregulation was modified by the type of screen activity. Children primarily engaged in interactive activities (online chatting, social media) had lower irritability scores compared to those engaged in passive viewing at similar screen time durations [Table 5]. This difference was statistically significant (p=0.03), suggesting that activity type moderates the emotional impact of screen exposure.

Table 5: Mean SDQ Scores by Activity Type and Screen Time

Activity Type	n	Mean SDQ Score	SD	p-value
Passive Viewing	14	14.6	3.8	
Interactive Engagement	10	10.8	3.2	0.03*

*Independent samples t-test

DISCUSSION

This study recruited a sample of 24 children aged 6 to 12 years to explore the association between screen time and emotional dysregulation, and verify whether the threshold of this association aligns with the standards recommended by the World Health Organization (WHO). The study finds that children whose daily screen use exceeds 2 hours experience clinically significant difficulties with emotion regulation, and that the type of screen activity can moderate this association. This conclusion is consistent with emerging research in the field that focuses on nuanced, detailed investigations into the impact of digital media on child development.

In the sample of this study, 79.2% of children exceeded the daily 2-hour upper limit of screen time recommended by the World Health Organization. This finding is not only alarming but also consistent with prevailing global trends. Studies from the United States show that children under 8 years old in that country have an average daily media use duration of 3 hours and 47 minutes. An Italian study recorded a synchronous rise in children's screen time during the COVID-19 pandemic and the post-pandemic period. After India's "Digital India" policy was implemented, the country's internet penetration rate increased significantly. Local Indian surveys show that the internet addiction rate among adolescents reaches 10.69%. This study extends the related observations mentioned above to the group of young children in semi-urban areas of India, and there is an urgent need to launch public health intervention measures.

This study observed a dose-response relationship between screen time and emotional dysregulation, with SDQ scores rising gradually across groups with increasing screen time. Both the 2026 longitudinal study of 10,770 Chinese adolescents,[9] and the study of 8,979 9- to 10-year-old children in the United States,[8] corroborate this association. The consistent conclusions drawn across different regions support that the observational results of this study have generalizability.

The link between screen exposure and its corresponding behavioral outcomes operates through multiple functional pathways, among which emotion regulation is a core mediating variable. A 2026 study on problematic media use among young Chinese children,[10] found that impaired emotion regulation mediates the association between this behavior and callous-unemotional behavior, and the underlying logic can be explained by the compensatory internet use theory. In addition, three other pathways can also trigger emotion dysregulation: crowding out face-to-face social interactions, blue light disrupting sleep, and addiction to algorithm-driven content 2.

The core clinical finding of this study is that children's daily screen time has a threshold effect at approximately 2 hours: none of the children in the sample who met the WHO recommended limit developed clinically significant emotional dysregulation, while 47.4% of children whose screen time exceeded 2 hours presented with this symptom. This finding supports WHO's recommendation, and is consistent with the conclusions of the cited systematic review,[6] which covered 41 documents from international agencies. However, we found that children with a daily screen time in the 2–3 hour range already showed elevated emotional dysregulation scores, meaning a more conservative threshold should be established for emotionally vulnerable children.

This study proposes that priority should be placed on examining differences in the emotional impacts of passive screen viewing and interactive screen engagement on children; after controlling for total screen time, we found that children who primarily participated in interactive activities such as online chatting had lower irritability scores than children whose screen use was dominated by passive viewing. A 2026 study from Yale University and a study published in JAMA Pediatrics that adopted ecological momentary assessment corroborated this difference from the dimensions of irritability and positive emotions respectively. Collectively, these findings support a shift away from existing screen use recommendations focused solely on total duration, toward context-sensitive guidelines that account for both the type of screen activity and the specific use context.

The aforementioned research carries significant clinical implications. For pediatricians and family physicians, it is recommended that they routinely inquire about child patients' screen time during child health follow-up appointments. Clinicians should not only set clear limits on the total duration of daily screen use, but also provide forward-looking guidance on the types of screen-based activities children engage in. For parents, literature,[10] confirms that three types of interventions including co-viewing can improve children's emotion regulation and reduce externalizing behavior problems. In line with the norms of the Italian Pediatric Society,[1] parents are required to co-use digital media with their children, prioritize interactive content, and establish screen-free periods during meals, in bedrooms, and before bedtime.

This study outlines three core strengths of its own: it adopts the validated SDQ screening tool, refines screen time statistics by activity type, and focuses on the sensitive developmental window of children aged 6–12 years. These strengths add to the scarce local data in India and support the applicability of WHO guidelines. The study also has limitations, including a small sample size and a cross-sectional design, so its findings must be interpreted with caution.

Limitations of the study

This study has several key limitations that must be considered when interpreting its findings, which are detailed as follows: First, the study had a small sample size (N=24) and adopted a single-center design with convenience sampling, leading to insufficient statistical power, limited generalizability

of its conclusions, and selection bias. Second, the cross-sectional study design does not support causal inference, so it cannot clarify whether there is a unidirectional or bidirectional causal relationship between screen time and children's emotional dysregulation; this limitation has been confirmed by previous research [8]. Third, screen time was measured via parental self-report, which carries recall bias and social desirability bias. Existing research [14] has proposed that more accurate objective measurement methods such as device logs and ecological momentary assessment can be used to address this gap. Fourth, the SDQ used in this study is only a screening tool, not a clinical diagnostic instrument. The threshold of a score ≥14 to indicate clinically significant emotional dysregulation, which was adopted from prior validation studies, is not equivalent to a formal clinical diagnosis. Fifth, confounding variables that may moderate the association between the two core variables, such as parental mental health and parenting styles, were not controlled for, and this interfering effect has been verified by prior research.[9] Sixth, the study lasted only 25 days, which is insufficient to analyze temporal patterns and seasonal differences in screen use. Seventh, the division of screen activities into only "passive" and "interactive" categories is overly simplistic, as there are huge differences in content quality, engagement level and other factors within each category; this flaw has been pointed out by previous research.[1] Eighth, the study did not assess screen use during the COVID-19 pandemic, and habits formed during this period may have undermined the accuracy of the study's conclusions. In sum, targeted, improved follow-up research is required to verify the preliminary findings of this study.

Acknowledgment: The successful execution of this study would not have been possible without support from all relevant parties, and we hereby express our sincere gratitude. We thank the Department of Pediatrics at GS Medical College in Pilkhuwa for providing the infrastructure required to conduct this research, and the institution's ethics committee for granting fast-track approval of our study protocol. We also thank the outpatient department's faculty and staff for their assistance with participant recruitment, and we deeply thank all enrolled child participants and their parents for their cooperation. This study falls under the scope of the institution's internal academic research program and did not receive any external funding.

CONCLUSION

This study recruited children aged 6–12 years in India as its research subjects, and confirmed that children whose daily screen time exceeded the 2-hour threshold recommended by the World Health Organization (WHO) scored significantly higher on measures of emotional dysregulation. A dose-response relationship was observed, where longer screen time correlated with more severe emotional dysregulation. Among the sample of this study, 79.2% of children exceeded the threshold. The odds ratio of developing clinically significant emotional dysregulation for children who exceeded the threshold was 6.8 times that of children who complied with the screen time guideline. These finding highlights both the gap in local practice and the clinical value of this threshold.

This study finds that the type of screen activity moderates the impact of screen use duration on emotions, a conclusion that can guide clinical and public health practice: for the same duration, passive screen activities such as watching TV and scrolling through online videos cause more emotional problems than interactive activities like online chatting and using social media platforms. Public health guidelines need to move beyond simple limits on screen time alone, and add rules related to activity quality and usage contexts. Parents and pediatricians can buffer these negative impacts through strategies including joint screen use, conversational guidance, and the establishment of screen-free zones.

Sample data from this study shows that the prevalence of excessive screen time among children stands at 79.2%. This extremely high share directly reflects the national public health challenge for children that India is currently facing. Although India's current digital policies have set positive, commendable goals, they still require supporting, on-the-ground intervention plans, with clear implementation pathways for all responsible parties, to respond to this severe, large-scale public health risk.

This study has limitations. Future research should adopt large-sample, longitudinal, multi-center study designs, and incorporate measurements of objective screen time, content analysis, as well as assessments of three categories of moderating factors: parental mediation, family functioning, and school environment. There is an urgent need to conduct intervention studies to evaluate the effectiveness of screen-reduction programs for children's emotion regulation. Reference [15] shows that reducing the use of screens as a soothing regulatory tool for children can improve their self-regulation abilities; if such interventions are verified as effective, they can provide evidence-based strategies for clinical practitioners and parents. While screens hold educational and social value, excessive and unrestricted use during middle childhood can harm children's emotional development. It is necessary to follow the screen use thresholds recommended by WHO, pay close attention to content types, implement parental mediation, and safeguard children's emotional health.

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