

2014

Where should baby sleep?: an examination of discourse regarding bed sharing in the United States

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Where Should Baby Sleep?
An Examination of Discourse Regarding Bed Sharing in the United States

A Thesis
Presented to
Eastern Washington University
Cheney, Washington

In Partial Fulfillment of the Requirements
for the Degree
Master of Arts Interdisciplinary History and Anthropology

By
Kari McClure Mentzer
Winter 2014

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Acknowledgements

First I offer my gratitude to my advisor and committee chair, Dr. Julia Smith, for her support and encouragement. She helped me find structure while still giving me room to explore. She offered her thoughts, listened to my ideas, read and re-read, corrected, and then read again. Her guidance and her confidence in me kept me going.

I must also acknowledge Dr. Jerry R. Galm, for his years of support and advising, for asking hard questions, and for all the discussions over coffee. His assistance through all the unexpected turns of my academic career has been critical to my success. He has pushed my understanding of anthropology to new levels, and cultivated a love for other cultures in my heart. I cannot thank him enough for the opportunities he has placed in front of me. I appreciate his thoughts and his edits which helped bring polish to this work.

I would like to thank the members of my committee, Dr. Laura Hodgman and Paul Victor, for taking the time to examine my research and offer comments and questions. Through the years, each has provided me with tools and advice that I will take with me into the future.

I would also like to say a quick thank you to the staff at Archaeological and Historical Services: Karen Arndt, Timothy Smith, Ryan Ives, Stephen Emerson, Dana Komen, Pamela McKenney, Sara Walker, Fred Crisson, and especially Stan Gough and Rebecca Stevens. Their unyielding support and encouragement, along with a place to work, and their great company have been a tremendous help. I have been very lucky to have you as my coworkers.

Finally, I have to thank my family for supporting me through this, Cheri, Erin, Jared Alyssa, Taegan, and Noble. You each played a part in inspiration and dedication. L. Elizabeth Magee, you have given me strength in many ways, and are greatly responsible for my future studies.

My deepest heartfelt gratitude goes to my husband Damon for listening to articles, for reading sections, for providing feedback, and being my thesaurus—all while taking care of everything so I could do this, thank you. None of this would be possible without all that you do, everyday.

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CHAPTER 1

Introduction

Introduction

Throughout recorded history, mothers and their babies have slept next to each other as a function of breastfeeding and ease of caring for an infant. While this practice is still the norm in many cultures, in the United States the normative pattern has become solitary sleep for infants. Other sleeping patterns are judged inferior and even dangerous. Nonetheless, American parents continue to share their bed with their infants in large numbers. This thesis explores how infant sleep is experienced by modern American parents and how our current cultural norms came to pass. It examines the discourse available to parents regarding infant sleep, including both popular and official sources as well as reviewing other scholarship about the emergence of that discourse in the late 19th and early 20th century. Finally, this paper analyzes how parents use these sources in online discussions about infant sleep and how parents internalize and challenge official accounts of the reasons to practice or avoid bed sharing.

In the following chapters, popular literature regarding infant sleep will be examined and common themes and elements explored. To better understand those themes and elements, a history of children's sleep and sleep rhetoric will be provided along with an examination of current official recommendations. An introduction to each of these elements is mentioned below along with a review of the practice of bed sharing in the United States and other cultures.

Stearns et al. (1996) argue that in America, the solitary infant sleep paradigm arose rather quickly around the turn of the 20th century and was solidified by the 1930s. Fueled by a changing society at the end of the Industrial Revolution, and the rise of the field of pediatrics, the development of this solitary sleep paradigm is well documented in the discourse of advice magazines, medical recommendations, and

popular literature. Once in place, this paradigm has had lasting persistence. The reasons given for putting babies to sleep alone in the early 1900s are remarkably similar to the reasons given by modern proponents. These reasons focus on maintaining the routine of the pre-baby family, requiring the baby to adapt quickly so schedules, marital relations, and nighttime sleep are not interrupted. They are often justified in terms of child health and safety.

A review of today's authors offering advice on infant sleep reveals the above themes are still the basis for the solitary sleep argument. Appropriate development and integration of children into society through sleep training is repeated persistently. A commonly expressed goal of these authors is to aid the parent in getting their child to sleep through the night. However, this goal may not be normative behavior for children until well into toddlerhood, as many experts note, but it still remains as a hallmark of "good parenting" (McKenna and Gettler 2007, NSF 2004, Pantley 2002).

Dr. James McKenna (McKenna and McDade 2005) offers an explanation of how this standard was maintained, and a detailed examination of his ideas will be provided later. He argues the study of infant sleep, only established once babies were sleeping alone, has generated a whole body of research based on the premise that solitary sleep for infants, as well as sleeping "through the night," is appropriate and desirable. In a circular pattern, this research has led to the broader cultural acceptance of babies sleeping alone. More importantly, this circle of research has influenced the opinion of the medical community in regards to infant sleep. In a multi-faceted process, this research continues to normalize solitary sleep, along with the increased medicalization of infant sleep, pushed infant sleep to one of top concerns for pediatricians. The concerns of pediatricians regarding infant sleep initiated an investigation by the American Academy of Pediatrics, which would lead to the most significant shift in discourse regarding where infants should sleep to date.

The American Academy of Pediatrics (AAP) launched their first investigation into infant sleep practices in the early 1990s. However, the AAP did not offer a strong opinion on bed sharing until 2005, when the group declared bed sharing unsafe citing research associating bed sharing with an increased risk of Sudden Infant Death Syndrome (SIDS) and possible accidental asphyxiation and injury (AAP 2005). The assertion that a correlation exists between bed sharing and possible infant death could arguably be the most important argument made in the bed sharing debate. It assured the interest in bed sharing is not just about parental preference, but instead is a matter of life and death. However, an examination of the research concerning bed sharing shows a more complex situation. In spite of all the recommendations, research appropriately studying the actual risks of bed sharing, when safely done between parents and an infant, is remarkably hard to find.

In spite of all of the recommendations and reports condemning bed sharing, there is ample scholarly evidence that not only can bed sharing be done safely, but also that many parents choose to bed share, and those numbers are increasing. A cultural comparison shows that in a great number of cultures, including those in industrialized countries, bed sharing is part of the normal infant sleep strategy. Western cultures are not an exception, as some might expect. Dr. Helen Ball, a researcher in the U.K. found that there nearly 70% of parents co-sleep at least some of the time; however, she also found those numbers can be masked by improperly conducted surveys (Ball et al. 1999).

This evidence for widespread (and perhaps increased) bed sharing may suggest that the popular discourse regarding infant sleep practices should be more affirming toward bed sharing than that of the authoritative entities mentioned above. But research reveals otherwise, indicating that bed sharing is still not accepted practice, even with increased practice. Dr. Ball's research of bed sharing practices revealed that, in spite of the very high rate of bed sharing in her research group, none of the first time parents she studied indicated they would bed share when asked. Very few of the experienced parents

expressed the likelihood they would practice bed sharing, even when they had used bed sharing for their previous children. Even though a majority of these parents used bed sharing, they were either reluctant to admit they would choose bed sharing or they were expressing their desire to achieve the cultural norm of solitary sleep for their infant.

This suggests a dilemma for many American parents: they are torn between choosing to sleep with their infant, and negotiating the authoritative rhetoric promoted by the AAP and popular culture. One way to look at this struggle and how it is experienced by parents is in the comment threads of parenting message boards regarding infant sleep practices. By analyzing these comment threads it may be possible to address several questions regarding the discourse surrounding infant sleep practices in the United States.

1. What kinds of rhetoric and data available on bed sharing do parents use (and presumably assimilate) in their discussions? Which sources do parents choose to use? How do these sources inform parental discourse?
2. What themes emerge for parents struggling with this diametrically opposed rhetoric (e.g. do parents that choose bed sharing tend to feel the need to justify their decision and do parents that don't tend to judge the parenting of those that do, or do both groups feel the need to justify decisions)? What rhetoric do they employ when defending their decision?
3. What rhetorical and practical strategies are evidenced by parents who are opposed to bed sharing on theoretical/informational grounds, but for practical reasons find themselves to be bed sharers? What response do these parents get from other parents?

By exploring these questions it may be possible to gain a better understanding of landscape of parenting in 21st century America, and examine our own ideals and ideologies surrounding the care of our children. However before analyzing online parental discourse, there a few other considerations that should be taken into account.

Cross cultural comparisons are sometimes mentioned in popular books, and there is a paragraph in the AAP's technical report regarding other cultures that practice bed sharing. The AAP report asserts that there are cultures where SIDS rates are low among bed sharers, but also cultures where the rate is very high. However, there is not one single citation to support these assertions. However, because these cultural references exist, it is helpful to look at other cultures and their understanding and practices regarding bed sharing.

In addition, it is also helpful to understand what Americans are doing in regards to bed sharing before examining what they say they do. The data in this area are often contradictory, so it helps to reference a study done in the United Kingdom that may explain some discrepancies. Analyzing current trends in breast feeding might also explain some bed sharing choices. Covering these final topics before presenting discourse analysis regarding infant sleep and bed sharing will allow a more complete understanding of what parents say and do.

Cross Cultural Comparisons

Margaret Mead began the anthropological investigation into infant sleep with her study in Samoa in the 1920s, where she found babies slept with their mother for as long as they breastfed, which could be three years (Mead 1949). Since then, there have been a multitude of studies conducted regarding infant sleep practices, both cross cultural comparisons as well as specific cultural descriptions.

In 1971, Barry and Paxson coded and quantified the sleeping arrangements of 127 different culture groups. This "report has often been cited as defining the normative pattern of infant sleeping arrangements worldwide" (McKenna et al. 2007, p 136). For the cultures examined, Barry and Paxson found that 79% chose to keep their infants in the same room as the parents, and 44% chose to bed share (sharing the same sleeping

surface). Nelson et al. (2000), conducting a much more recent study, used the HRAF probability sample and found that 47% of cultures examined described some sleep contact with infants, and also noted that infants sleeping in separate rooms was unusual, but gave no details. Whether it was similar to the 21% of cultures Barry and Paxson (1971) identified as having separate sleeping spaces or not is therefore unclear. Studies involving specific cultures and their infant sleeping practices have been undertaken in numerous societies. In Asia, high rates of co-sleeping are found in China, Thailand, Korean, and Japan. In China, bed sharing was reported for 18.2%-55.8% of parents for children up to 7 years old (Caudill and Plath 1966), while parents of children in Hong Kong specifically have a bed sharing rate of 32% (Nelson and Chan 1996). Thai children shared a bed with their parents 60.0% of the time (Anuntaseree et al. 2008). Korean families have the highest occurrence of co-sleeping at 98%. Exact bed sharing numbers are not available, but the distance between the mother and baby was recorded to be 50 cm for 98% of the co-sleeping infants (Lee 1992). In Japan, bed sharing is seen as one of the methods to help amalgamate a new baby into the family, and as such bed sharing is common, 60% of Japanese parents indicate that they share a sleeping surface with their infant (McKenna 2007).

In indigenous Central and South America, the data are very similar. In Mayan families all of the children studied by Morelli (1992) slept with their mothers until they were toddlers. This study, which had an American component showing that none of the parents of American babies reported bed sharing when the child was under 3 months, and only 11% did after 6 months, also revealed that Mayan mothers felt shock, disbelief, and pity when they heard American babies slept alone. All of Brazilian Terena children also sleep with a family member according to a study conducted by Reimao and others (1998).

Abel et al. (2001) researched the practice of infant sleep for several cultures in and around New Zealand including the Maori, Tongan, Samoan, Cook Island, Niuean,

and Pakeha (European). They found that the Pakeha often put their babies to sleep alone, but the Pacific groups chose sleep contact between mother and child. The authors cite a cultural difference in the goals of the parents when choosing a sleep practice. The Pacific Islander group expressed a desire to foster connectedness with the family and society in general while the Europeans expressed a desire to foster independence and autonomy for their infants. This is a common theme when choosing a sleeping arrangement for an infant and is generally the explanation given for discrepancies found between ethnic groups within Western culture as well.

Why it might seem that all Westerners would share the sleep alone practice for their infants, many researchers have discovered that there are cultural pockets of differentiation within the Western mainstream. In the Appalachians, families choose to keep their infants with them while sleeping to strengthen the familial bond (Abott, 1992). The same is found in Japanese-American families, presumably from a carrying over of Japanese tradition that also is focused on strengthening the family (Caudill and Weinstein 1969, Latz et al. 1999). However, it should be noted that the rates of Japanese-American families choosing to bed share is far lower than those of Japanese families in Japan (Caudill and Weinstein 1969). Black American families have been shown to have rates of bed sharing up to 70% (in comparison to 35% of whites), and black children frequently are all night bed sharers (Lozoff et al. 1984). Similarly, Hispanic families in the United States have also been found to have much higher rates of bed sharing than their white counterparts, 21% and 6.7% respectively (Schacter et al. 1989). In neighboring Canada, bed sharing is far more common for whites as well: 98% of Canadian mothers studied with single children aged 6-12 months report using bed sharing at some point within their child's first year. At the time they were questioned, 70% were using bed sharing and 74% of the women who did so indicated that they were bed sharing intentionally (Messmer et al. 2012).

In Europe, there is a wide variation in infant sleep practices as well. In Italy, parents generally keep babies in their room, if not in their bed. Like the Mayan families, they also find the American tradition of a separate room to be unkind to the baby (Wolf et al. 1996). In Sweden, Lindgren et al. (1998) found that 23% of 3 month olds slept with their parents in 1998. Ball et al. (1999) found that in England 70% of new parents and 59% of experienced parents practiced bed sharing at least some of the time with their infants, even though none of the new parents thought they would before the birth of their baby, and only 35% of experienced parents thought they would. Switzerland reports a bed sharing rate of 5.9% for 3 month olds and 6.6% for 9 month olds, much lower rates than other countries with bed sharing studies completed (Jenni and O'Connor 2005).

While not very common, and certainly not in the detail above, some cross cultural information is presented to parents through various media. Statistics on Japan's bed sharing rate, which is very high, in relationship to its rate of SIDS, which is very low, is cited by McKenna (2007). The AAP (2011b) and Ferber (2006) mention cultures where the bed sharing rate is high, and so is the SIDS rate, but neither the AAP or Ferber cite any source to confirm their assertions, nor do they state exactly what they consider to be a high rate of SIDS. Ferber (2006) suggests that in these cultures a wide series of factors are likely at play including extreme poverty and a lack of pre-natal and post-natal care, which are both risk factors for SIDS. However, without references or mention of specific countries and rates for SIDS, it is difficult to analyze these statements. At best they offer a possible counterargument against the protective nature of bed sharing against SIDS, albeit a very weak one. At worst, they are assertions not based in fact, and create a bias against bed sharing that can't be substantiated with any evidence.

Current Infant Sleep Practices in United States

It is clear from a large volume of research that bed sharing is a common infant sleep practice in the United States (Crowell et al. 1987, Elias et al. 1986, Hanks and Rebelsky 1977, Lozoff et al. 1984, Madansky and Edelbrock 1990, Rosenfeld et al. 1982, Schacter et al. 1989). But actual numbers are somewhat difficult to discern. Data on this topic can be somewhat problematic as many parents are reluctant to admit that they bed share, likely because of the stigma against bed sharing in Western culture (Blair and Ball 2004, Ball 2003, Hooker 2001). Studies that reference co-sleeping prior to the early 2000s do not delineate between co sleeping and bed sharing as that distinction was not defined until the turn of the 21st century. Co-sleeping is now considered to be the practice of placing the infant in the parents' room for sleep, while bed sharing is specifically defined to be sharing a sleeping surface. It is important to note that bed sharing does not necessarily mean sharing a bed, sleeping on a couch or armchair is technically considered bed sharing under this definition. This terminology is still often confused amongst parents and popular authors alike and they often use the term co-sleeping to mean sharing a bed with an infant.

According to the National Center for Health Statistics survey 1991-1999, 25% of Americans always (or nearly always) bed shared with their infants. Another study conducted in 2000 discovered that 47.3% of American families practiced bed sharing at least some of the time (Willinger et al. 2003). This study presents evidence that bed sharing is on the rise in the United States, increasing from 5.5% in 1993-1994 to 12.8% in 1999-2000 (Willinger et al. 2003). However, the data found by different studies are sufficiently variable that it's hard to make clear comparisons of changes over time. A survey of 100 mothers in 2007 assessed marital quality in relationship to four pre-assigned categories of sleeping arrangements: 1) infants as solitary sleepers, in their own bed by 12 months of age, 2) infants as early bed sharers who slept in the parental bed for all or part of the night prior to 12 months of age, 3) infants as early co-sleepers who

shared a room with a parent for all or part of the night, and, 4) infants as reactive co-sleepers who began co-sleeping after the first year, or were early co-sleepers or bed sharers who, after an extended amount of time as a solitary sleeper, returned to the parental bed. This study found that 45% of respondents were early bed sharers, 31% slept alone, 12% were early co-sleepers, and 12% were reactive co-sleepers (Germo et al. 2007). However, it should be noted that Germo only asked at 6, 12, 24, and 36 months of age where the child usually slept, and it is unclear how a child who was co-sleeping at 6 months and then in his own room at 12 months would have been classified.

Ball et al. (1999) offer an explanation as to why the data regarding infant sleep practices can seem so contradictory. According to their research, when asked where an infant slept, a large number of respondents answered where the baby was first placed for nighttime sleep, whether or not the baby was moved during the night. When asked specifically if the baby was moved during the night, parental responses changed dramatically. Changing how the question about infant sleep practices was asked changed their results dramatically. When asked only where the baby slept, 9% of new parents and 12% of experienced parents indicated a bed sharing practice. When asked if the baby was moved at some time during the night, the data changed to 70% and 59% reporting bed sharing respectively. Without knowing exactly how parents were questioned about their infant sleep strategies, or knowing if parents were asked about moving an infant during the night, it is difficult to determine comparable actual bed sharing numbers. Still, it may be possible to derive some basic understanding of bed sharing trends in the United States using this contradictory data.

There is a strong link between breastfeeding and bed sharing. The two actions reinforce each other so that breastfeeding increases bed sharing and bed sharing increases breastfeeding. Bed sharing has shown to increase the duration of each feed, the number of feeds a night, and the number of months an infant breastfeeds (McKenna et al. 1999, Ball 2003). A woman who breastfeeds is more likely to co-sleep and a co-sleeping

mother who is breastfeeding has more breastfeeding sessions that last longer (Ball 2003, Blair et al. 1999, McKenna et al. 1999, Mitchell et al. 1997). The US has had a steady climb in breastfeeding rates since the 1970s when breastfeeding was at an all-time low. In 1994, 60% of babies had been breastfed at least at some point, and approximately 29% of those children were still receiving breast milk at 6 months of age (McDowell et al. 2008). The rates of breastfeeding mothers increased every year for the decade of 2000-2010; in 2010 77% of new mothers breastfed in the early postpartum period, 49% breastfed at 6 months, and 27% were still breastfeeding at one year.

McKenna and McDade describe bed sharing and breast feeding as a mutually reinforcing system where, “the choice to breast feed leads in many cases to increased bed sharing behavior, which, in turn, increases the number of breast feeds per night, while facilitating decisions by mothers to breast feed for a greater number of months” (2005, p145). Within this framework, it is not difficult to deduce that with an increasing number of mothers choosing to breastfeed their infants from birth, there will be an increase in mothers choosing to bed share as well.

In light of all of this data, it seems likely that a large percentage of American mothers are choosing to bed share at least part of the time. The relationship between bed sharing and breastfeeding and the increased numbers of breast feeding mothers suggest bed sharing may be higher than past studies have reported. Further, studies have shown that bed sharing can be underreported by parents unless careful questioning is utilized to overcome the cultural fear of admitting to the practice. This also suggests that the numbers of bed sharing parents in the United States are likely higher than many studies report. This could have interesting consequences for the parental discourse, as many mothers are caught between what is presented as mainstream and acceptable “best practices” of infant sleep strategies (solitary sleep) and what they actually do (bed share).

CHAPTER 2

Popular Advice Literature

Introduction

Infant sleep is the top concerns for new parents, according to pediatrician Dr. William Sears and Dr. Laura Jana (Sears 2014, Jana and Shu 2011); as such, there is no shortage of advice in popular media for new parents. One of the most readily available sources of discourse on infant sleep is popular advice literature aimed at parents. In addition to countless websites dedicated to advice on infant sleep, there are numerous parenting magazines and books available that discuss infant sleep practices at length. There is not room here to address the editorial content on the seemingly infinite number of websites and magazines (there is a large area of overlap here as many magazines also have websites). The large amount of data in those contexts would justify an entirely separate investigation.

Instead, this study focuses on the most popular advice books available to new parents. To do this, I chose the top fifteen books from Amazon's best seller list of early childhood advice books and analyzed those which addressed the issue of infant sleep in particular. This resulted in a total of eleven books. In the top selling book, *Baby 411* (Brown and Fields 2012), the author provided a list of six popular books on infant sleep. I decided to include the four books in that list that were not already in my list. I also included Harvey Karp's newest (2012) book because it often comes up when searching for his bestselling 2002 advice book (already on this list of books to be analyzed) and he has a major reversal of opinion between these two books. The resulting list is sixteen books in total. The list of books discussed and some information about their contents can be found on Table 1.1.

Title and Author	Focus of Book	Stance on Bed Sharing	Major Sleep Component	Authors Degree
Brown, A. and Fields, D. <i>Baby 411</i>	General infant care	Neutral	Sleep Training	M.D.
Ezzo, G. and Bucknam, R. <i>On Becoming Baby Wise</i>	Infant Sleep and Care	Against	Sleep Training through feeding	M.D.
Ferber, R. <i>Solve Your Child's Sleep Problems</i>	Infant Sleep	Neutral	Solving sleep issues through a variety of methods	M.D.
Giordano, S. and Abidin, L. <i>Twelve Hours Sleep by Twelve Weeks Old</i>	Infant Sleep	Against	Sleep Training through feeding	n/a
Hogg, T. and Blau, M. <i>The Baby Whisperer Solves All Your Problems</i>	General infant care	Neutral	Sleep Training though pick-up/put down	RNMH
Jana, L. and Shu, J. <i>Heading Home with Your Newborn</i>	General infant care	Neutral	General information on infant sleep	M.D.
Karp, H. <i>The Happiest Baby on the Block</i>	General infant care	Recommended	Babies don't sleep, do what works to get rest	M.D.
Karp, H. <i>The Happiest Baby Guide to Great Sleep</i>	General infant care	Against	Sleep training might be necessary	M.D.
Kurcinka, M. <i>Raising Your Spirited Child</i>	Spirited child care	Neutral	Spirited children need extra help	Ed.D.
Mindell, J. <i>Sleeping Through the Night</i>	Infant and child sleep	Neutral	Sleep Training	PhD
Morell, S. and Cowan, T. <i>The Nourishing Traditions Book of Baby & Child Care</i>	Alternative Infant and Child Care	Neutral	General information on infant sleep	M.D.
Murkoff, H. and Mazel S. <i>What to Expect the First Year</i>	General infant care	Neutral	General information on infant sleep	n/a
Pantley, E. <i>The No Cry Sleep Solution</i>	Infant Sleep	Recommended	No crying sleep training	n/a
Sears et al. <i>The Baby Book</i>	General infant care	Recommended	Attachment Parenting	M.D.
Simkin et al. <i>Pregnancy Childbirth and the Newborn: The Complete Guide</i>	General infant care	Neutral	General information on infant sleep	PT, RN
Weissbluth, M. <i>Healthy Sleep Habits, Happy Child</i>	Infant Sleep	Neutral	Variety of programs to help with sleep	M.D.

Table 1.1 *Popular Authors*

Seven of the sixteen books listed discuss infant sleep primarily; the others are general books regarding infant or child care and either offer a chapter or a section dedicated to the topic of infant sleep. There are three books that are overtly against bed sharing and three that recommend it. There are a number of books that are listed as neutral, as they do technically state the choice to bed share is the parents'. Also included in the table is the level of education of one or more of the authors. This is important information to which informs the argument made later in the chapter regarding the medicalization of infant sleep.

Everyone Needs More Sleep

The overarching theme for the popular advice books was getting more sleep. No matter what side of the bed sharing debate the authors supported, or even if they were completely neutral, every author put forth advice meant to increase sleep for both the parents and, when possible, for the infant. Several who offer an opinion on the subject agree that parents with babies who sleep in their own rooms have the longest stretch of uninterrupted sleep (Murkoff and Mazel 2010, Brown and Fields 2012, Karp 2012, Ferber 2006, Mindell 1977). However, those who advocate for bed sharing, argue that for breastfeeding mothers, wakings are not full wakings and overall bed sharing parents feel more rested (Pantley 2002, Sears et al. 2013). Other authors note that while there may be a greater number of wakings, breastfeeding bed sharers get at least the same amount of sleep as those who don't bed share, and some studies show they get more (Weissbluth 2003, Karp 2002, 2012).

Most authors agreed that infants and children need more sleep than adults for a variety of reasons. While the reasons given by the popular advice authors are not as far reaching as they were in the previous century (nobody worried that a lack of sleep required children to have less homework), Morell and Cowan (2013) state that "sleep is

as important as food for a growing baby!” (p 157). Several authors mention that human growth hormone is released during sleep; this is obviously of great importance to a developing child (Ezzo and Bucknam 2012, Brown and Fields 2012). Others just noted that proper sleep is necessary for proper development and babies who get more sleep are happier, content, and can focus better on all the things babies need to learn (Murkoff and Mazel 2010, Ezzo and Bucknam 2012, Pantley 2002, Ferber 2006, Mindell 1997, Weissbluth 2003). A baby that doesn’t sleep well is described as stressed, insecure, exhausted, lazy, impulsive and hyperactive (Ezzo and Bucknam 2012). For some authors, learning to sleep well as a child translates into healthy sleep habits as an adult (Jana and Shu 2011).

A child requiring more sleep often dovetails with discussions of parents needing more sleep. Mindell (1997) offers an entire segment of her book dedicated to the topic of coping with lack of sleep, the importance of sleep to adults, and how to reduce tension and relax as an adult. The consequences of sleep deprivation are felt especially by mothers. New mothers can be described as lacking confidence, exhausted, weary, or too tired for family (Murkoff and Mazel 2010, Ezzo and Bucknam 2012). The effects can extend into her mental wellbeing as well. Kurcinka (2006) describes living in a haze with no energy to “experience any joy” (p 342). A baby that is having sleep problems may be a cause for depression in mothers (Weissbluth 2003). The effects of sleep deprivation on the mother can have far reaching effect into her family. “It impacts the welfares of everyone in the household, making the difference between being a joyful, alert parent or a fatigued one” (Ezzo and Bucknam 2012, p 49). Stress can leak over into relationships, negatively affecting marriages as mothers and fathers struggle with the need for more sleep. “More than one marriage has been saved with the onset of a sleeping baby” (Mindell 1997, p 9).

The goal for both parents and infants is sleeping through the night or at least creating an arrangement where if the infant wakes, the parents are not disturbed. Every

author acknowledges biologically, babies will wake up during the night. Sleeping through the night is defined differently depending on the author. The smallest length is defined as 5 hours a night (Pantley 2002, Brown and Fields 2012) and the longest as 12 hours (Giordano and Abidin 2006). Authors also vary in their advice about the age at which a baby should sleep through the night, but on average those who advocate sleep training state that babies can sleep through the night somewhere from 2-6 months (through the night meaning whatever the author previously defined).

The manner in which to achieve the feat of making a baby sleep through the night was the area in which the majority of the themes developed. Where a baby sleeps, the safety of the sleeping space, how the baby falls asleep, and how parents should respond to the infant are all intrinsically linked in these authors' advice to getting the baby to sleep through the night.

Sleeping Better Alone

One major carry-over from the development of modern child sleep practices of the early 20th century is the idea that a baby will sleep better in its own room. In the previous century Stearns et al. (1996) suggest this may have been to isolate the baby from the noise of cleaning a house or having guests over; however, modern authors offer a variety of reasons for establishing a separate nursery.

Authors advocate for a separate sleeping space on the premise of better sleep for both parents and babies. For babies, they argue that a parent's mere presence can be enough to encourage a child to wake more often and demand attention at those times. A child who cannot see or smell their parents will presumably go back to sleep. Parents also sleep less, waking to every noise and tending to every cry (Murkoff and Mazel 2010, Ferber 2006, Mindell 1997). This is seen clearly in one author's statement, "One of the

major disadvantages of having your baby as a roommate is that it results in less sleep for everyone” (Mindell 1997, p 75).

However, Karp in his 2012 book argues against a separate room for the baby, asserting that it is not as convenient or safe, as co-sleeping can protect against SIDS. Jana and Shu (2011) also recommend room sharing per AAP recommendations which state room sharing can reduce the risk of SIDS. Other authors mention this recommendation and suggest a newborn should sleep in the same room, but suggest moving the baby after a few weeks (definitely before six months) to prevent sleep problems for the baby (Murkoff and Mazel 2010, Morell and Cowan 2013).

Creating a Space for Baby

Establishing a nursery is a prevalent theme found in the 20th and 21st centuries. Mothers are encouraged to decorate a space and make it special for baby. This often includes mention of the crib, and if not the crib, then the crib bedding. “...Many expectant parents plan on creating a separate nursery filled with adorable decorations and a lovely crib” (Simkin et al. 2010, p 382). In some cases, discussion of the nursery revolves around safety. Murkoff and Mazel (2010) dedicate five pages of their book to each item in a typical nursery and how to choose the safest version of each. The idea that a separate room for each child was an indicator of status in the early 20th century has developed in the 21st century to include an association of bed sharing and room sharing with poor and ethnic groups. The way this is manifested in popular literature is interesting. Often, it isn’t overtly stated as only the poor bed share, but is only slightly more nuanced. The most overt example, Brown and Fields (2012) state, “...some folks may not admit to sleeping in a family bed...the percentage of family bed sleepers are higher in some ethnic and lower-income groups” (p 219). Other authors don’t include

demographic information, but simply refer to cost as preventative to a separate space for baby (Murkoff and Mazel 2010, Ferber 2006).

The discussions around the purchase of a crib reveal an assumed level of affluence amongst the audience. The discourse is centered on purchasing a crib that is not older than 10 years because of safety concerns (Murkoff and Mazel 2010, Jana and Shu 2011, Pantley 2002, Morell and Cowan 2013). The large recall of drop-side cribs in 2009 and subsequent discontinuation of their production (Jana and Shu 2011) pushes that age down to 5 years old or newer. Parents, of course, can buy an older crib, but they would have to trade affordability for safety. Often the crib is referred to as the “big ticket item” (Jana and Shu 2011, p 104) and “one of the more important pieces of furniture” parents will buy (Murkoff and Mazel 2010, p 49). One author argues that you will have to buy a crib even if you choose to co-sleep because they are so necessary (Morell and Cowan 2013). The focus on the importance of the crib implies that those parents who do not buy one, or buy an older one, do not care enough about their infant’s safety or well-being.

The large amount of discourse surrounding the purchase of this expensive piece of furniture, with very little discourse on alternatives for those who cannot afford such a large purchase, creates a standard that should be followed “unless housing and financial limitations dictate otherwise” (Ferber 2006, p 48). Acquiring an older crib, even if the parents cannot afford a new crib, means that they are sacrificing the safety of their child. In Brown and Fields (2012) this standard has a slightly more overt tone of discrimination. It first asserts bed sharing is something people would not want to admit to, and then, in the very next sentence adds that some “ethnic and lower-income groups” (p 219) practice bed sharing more than average, makes it seem that these groups are more likely to practice something that is generally shameful. .

The cultural pressure to create a separate sleeping space for the baby (nursery) along with concerns of socioeconomic status may influence people’s choice when it

comes to where a baby sleeps. The subtle suggestions that include what is appropriate, needed, and safe, definitely suggest that a crib is a must-have piece of furniture.

Therefore, bed sharing is definitely not on the list of acceptable behaviors. In addition, it may be harder for a family that has spent a large amount of money on a crib and even more by creating a nursery to not utilize it. This might be apparent in parent discourse and will be examined later.

Safety

The safety of the infant is understandably a ubiquitous theme. Nearly every author includes a section on how to make a sleeping space safe for baby (Karp 2002, 2012, Pantley 2002, Murkoff and Mazel 2010, Jana and Shu 2011, Sears et al. 2013, Morell and Cowan 2013, Ferber 2006, Mindell 1997, Simkin et al. 2010, Ezzo and Bucknam 2012, Weissbluth 2003, Brown and Fields 2012). Many authors describe a safe space for baby if he is placed in an adult bed, repeating many of the same recommendations found for crib sleeping: firm mattresses, light blankets, no pillows, and light clothing (Simkin et al. 2010, Murkoff and Mazel 2010, Jana and Shu 2011, Ferber 2006). While in the last centuries the concern regarding sleep sharing was the risk of overlaying a child, now that risk includes not only overlaying, but also entrapment, strangulation, and SIDS.

It should be noted that when safety issues are raised, it is never incidentally. Every section on safety in these books is fairly long, often consisting of several pages. The major concerns are SIDS and accidental suffocation from bedding either in the crib or on the adult bed. The AAP concerns and recommendations are repeated throughout: place a baby on his back for sleep, no soft bedding, and a firm sleeping surface whether the author advocates for a crib or an adult bed.

This focus on safety is important in bed sharing discourse, because by putting so much emphasis on safety it makes it highly likely that safety will also be the focus in bed sharing discourse. This even more likely given the discourse provided by the AAP and CPSC (discussed in the next chapter) that bed sharing is never safe. The result is with few exceptions (Sears et al. 2013, Pantley 2002, McKenna 2007) bed sharing is considered dangerous by every authored source studied here. This places parents who practice bed sharing in a situation where, by practicing a sleep strategy that they believe is beneficial to their baby (and themselves) they are considered by mainstream culture to be placing their baby in dangerous situations.

Intimacy Concerns

Parental needs are still a theme for many modern authors. Stearns et al. (1996) suggested that the rising interest in recreational sex between couples may have been a motivating force for a separate room for baby and that is still a concern. Whether it is healthy for a baby to witness sexual acts is not a concern raised by modern authors. Instead the concern is with a baby in the parental bed there will be no time or space for intimacy between the couple. This conversation has definite gendered tones and focuses on marital relationships. Often the concern raised is that the father will move out of the bedroom so that he can get some sleep. “*Dad often ends up on the couch to get some sleep*” (emphasis authors’) (Brown and Fields 2012, p 220). Morell and Cowan (2013) also insinuate that a father may not be happy with bed sharing (to the detriment of the marriage) “Mom proudly announces at the one year checkup that she is still bed-sharing and at the two-year checkup, confesses that she is divorced” (p 158). Karp (2012) also cites the statistic that 25% of fathers move out the family bed when discussing his reasons for not supporting bed sharing.

Mindell (1997) doesn't identify father or mother in her section of book that otherwise has much the same tone. She raises concerns that one parent may be using the baby, and bed sharing, as a means of avoiding sex. She closes with a theme many authors raise in regards to bed sharing "...be sure co-sleeping is not a way to avoid facing other issues and that it is not being done to fulfill needs of yours that should be met by other means" (p 77). Murkoff and Mazel (2010) admonish that if you share the bed with your baby to "make sure you're both on board," and "consider your feelings and your spouse's," and mention the difficulties of "making love" with a baby in the room (p 264). Ferber (2006) argues that if parents choose bed sharing they should only do so if both parents agree. If one parent is opposed, or even both are (the child demands bed sharing), then the possibility of resenting the child could cause marital conflict.

Another aspect of this theme is simply the availability of sex. "Many women lack the energy and interest in sexual relations after the baby is born. Don't use the baby in your bed as an out" (Brown and Fields 2012, p 220). Some authors address the issue of sex directly, such as Mindell (1997) who states "It is difficult to have an adult or private conversation when a child is sleeping in the same bed. And it is deadly to your sex life" (p 76). Others are more discreet, calling for a separate room for baby so the infant is "less intrusive on their 'adult' time" (Jana and Shu 2011, p103), or suggests making other "arrangements for intimacy" (Murkoff and Mazel 2010, p 265-266). "The greatest danger of prolonged bed-sharing is lack of time for intimacy between mom and dad" (Morell and Cowan 2013, p 158). Sears et al. (2013) explain that in regards to sex, "It's up to the mother to not let the 'baby's coming between us' scene occur" (p 348). There is a general reluctance on the part of some authors (Ferber 2006, Mindell 1997, Morell and Cowan 2013) to suggest having sex outside of the parental bedroom, although Murkoff and Mazel (2010) suggest pulling out the sofa, and Sears et al. (2013) note any room in the house can be used for lovemaking. Our culture associates the parental bedroom with

sex when other cultures do not (Mead 2001), which helps explain why other cultures have higher rates of bed sharing and where sex is not a concern in bed sharing discourse.

The focus on the father in these excerpts is interesting. Conversations presume the father is excluded from nighttime care and convey a sense that a woman may be forced to choose between getting some sleep and keeping her marriage. Brown and Fields (2012) discussion on this topic is particularly focused on this gendered idea. They argue that a woman should not bring a baby to bed and “sacrifice [her] marital relationship” (p 220). They assert that babies are very active sleepers and their movement and noises could wake even a heavy sleeper. The father might be forced to move out of the bed to get some sleep. No mention is made here of the mother getting any sleep. This is perhaps because it is well documented that many mothers end up bringing a baby to bed because that is only way they get any sleep (Weissbluth 2003, Sears et al. 2013, Germon 2007).

Karp (2012) offers a similar discussion, letting women know “Men work hard all day—so helping out at home makes them feel like they’re being expected to give 110 percent” (p 110). He continues by saying a new dad might get less sleep than she does. He suggests a new mother should encourage the father (especially if she is not interested in sex) with “touching and cuddling. And as a special gift...maybe even give a little sexy massage” (p 111). In fairness, he does ask men to be patient with their sexual frustration as their partner may be uninterested for good reasons. But in his notes to dads he includes, “She went through enormous and difficult body changes. She now has to go through all the effort to get back in shape.” and “Don’t bug her about cleaning and cooking. Suck it up and help out (even though *you’re* tired and stressed, too). Buy her flowers every Friday for two months” (p 110).

These kinds of discussions don’t seem to take into account the division of labor that still exists in America today. Medina (2010) notes, 70 percent of the domestic chores fall to the woman, and a new baby increases her household workload three times

more than it increases the workload for her husband. Karp (2012) assumes completely that the wife is not working after childbirth and is on maternity leave. He does not offer any evidence of consideration of alternative scenarios, even though Hogg and Blau (2005) note that 20% of fathers are the primary caretakers of new infants. Having this discourse in a book that the woman is more likely to read (as 89% of nighttime care falls to the mother) (Karp, 2012), delivers a message to her that is very clear. This discourse makes women responsible for managing the balance between getting sleep and keeping her marriage intact, while also maintaining the sexual nature of her relationship.

Very little of this burden is placed on fathers in these books. Several authors do include a mention of having dad take over nighttime time care for a time, especially if the baby is overly attached to mom, or offering bottles (Hogg and Blau 2005, Pantley 2002, Ezzo and Bucknam 2012, Karp 2012), but only two authors call outright for the father's involvement. Weissbluth (2003) says, "After all, no matter how stressful his job might be, the father at work always gets some breaks. A mother with a baby might not get any breaks during the day" (p 66).

Sears et al. add, "Fathers are more than a supporting role in baby tending." "...[F]athers are indispensable...It's the father's job to nurture the mother so that she can nurture the baby" (p 10). They include a section to fathers only in nearly every section of his book with advice for how to bond with baby, baby care, and relationship advice (2013). But this is the only regular inclusion of this kind of advice for fathers; other books simply remain silent on the subject.

The discourse around intimacy focuses generally on the mother and her responsibilities to her husband. There is some inclusion of fathers and their responsibilities, but this is a small consolation for the mother who is told she needs to do it all so that her partner can get some sleep and not feel overworked. It might be important to parental discussions of bed sharing that the most consistent involvement of

fathers comes from the biggest supporter of bed sharing; however, even that author (Sears et al. 2013) puts the responsibility of maintaining the sexual relationship on the mother.

The Schedule

The previous themes have helped establish the need for solitary sleep, mainly the necessity of getting enough sleep, but also maintaining family relationships. Following themes center on strategies to achieve this goal. Scheduling is one such strategy. Doing the same things with the baby at the same time every day is considered just as important in this century as the last. Scheduling is mentioned by nearly every author. The schedule, which is also tightly tied with a bed-time routine or ritual, allows the baby to know when he is expected to sleep and helps him achieve sleep without assistance (Murkoff and Mazel 2010, Ferber 2006, Ezzo and Bucknam 2012, Pantley 2002, Mindell 1997, Kurcinka 2006, Hogg and Blau 2005, Weissbluth 2003, Karp 2012). Much like the earlier discourse around learning to fall asleep by himself, some authors discuss the need for the baby to have a schedule so that he can learn self-discipline later in life (Murkoff and Mazel 2010). Kurcinka, (2006) who addresses spirited children, argues that routine and scheduling help these children negotiate their intense emotions. The parents are also then free to plan according to their own needs (Murkoff and Mazel 2010).

The relationship between feeding and sleep seems to be a relatively new theme discussed by many authors as a method of securing a schedule on which to base sleeping intervals. Timing feedings, and spacing them at appropriate levels (not too close together), some authors argue, assures the baby will find his natural sleeping rhythm and assist the parent in achieving the full night's sleep with little difficulty (Ferber 2006, Karp 2012, Ezzo and Bucknam 2012). Morell and Cowan (2013) offer a similar theory, arguing that if a baby doesn't sleep through the night it is probably because of mom's diet. If her diet is appropriate, then the baby will have regular feedings and develop a

natural schedule. Following a strict feeding schedule is not recommended by most when the baby is still very young as infants cannot go more than a few hours without eating and still grow appropriately, so instead they suggest beginning this around the second or third month. In Brown and Fields's (2012) book they mention that when Ezzo and Bucknam first published their book in the 1990s, the AAP issued a warning about it because the feeding schedule was so strict it had the potential to endanger infants. Ezzo and Bucknam have since relaxed their position on this point and allows for more feedings in the early weeks (2012). Many authors suggest using some method of timed feedings to stretch the time between nighttime wakings (for babies sleeping in a separate room) until they can be eliminated (Murkoff and Mazel 2010, Karp 2012).

Learning to Fall Asleep

The most commonly held theme of the popular advice authors is the need for the baby to learn to fall asleep without assistance (Jana and Shu 2011, Murkoff and Mazel 2010, Ferber 2006, Ezzo and Bucknam 2012, Pantley 2002, Brown and Fields 2012, Giordano and Abidin 2006, Mindell 1997, Weissbluth 2003). The concern for many popular authors is that this is a skill that a child must learn or a parent must train into the child. Often the term used is self-soothing, and it is related to a more secure, independent, happy, and better behaved child. Ezzo and Bucknam (2012) cite a study that shows at one year, children who are allowed to cry are better problem solvers, while children "whose parents routinely suppressed their cries could not overcome the simplest obstacles separating them from their parents" (p 142-143). They also cite the AAP when they state that many children need to cry to let off steam and settle down. There is a concern from earlier centuries that proper adult sleep habits must begin in childhood. Jana and Shu (2011) putting a newborn down awake is "promoting healthy

lifelong habits—and that most certainly includes the very important life skill of falling asleep without assistance” (p 101).

To train the child to fall asleep by himself, many authors suggest the method commonly known as “cry-it-out.” This method has two commonly held forms, the rapid extinction method, where the baby is just left to cry without any interference from its parents until morning, and the progressive waiting method, in which the parent offers reassurance and comforting (generally without picking up) at ever increasing intervals throughout the night (Brown and Fields 2012, Ferber 2006, Mindell 1997, Ezzo and Bucknam 2012, Giordano and Abidin 2006, Weissbluth 2003). This method, or at least the naming of it as “cry-it-out,” seems to have originated with the publication of Ferber’s book (1985). His method is described by several authors as a means to teach a baby to fall asleep without assistance, although not always with approval (Murkoff and Mazel 2010, Ferber 2006, Brown and Fields 2012, Morell and Cowan 2013, Pantley 2002, Hogg and Blau 2005, Weissbluth 2003, Karp 2012). But it must be noted that in the most recent publication of his book, Ferber attacks the blanket use of this method saying, “Many people thought I recommended a single method to treat all sleep problems...even worse, the particular method they refer to...has sometimes been incorrectly described as the same ‘cry it out’ method that my suggested techniques were meant to counter” (p xviii). Understandably perhaps, Ferber does not wish to be known as the father of cry-it-out, but since that term is ubiquitous, it will be used here. This is not a new theme to parent sleep strategies, as previously mentioned Dr. Spock thought this was an expected part of nighttime parenting. Dr. Spock suggested using a towel under the door of the nursery if the crying of the child was bothersome (Spock 1946). Proponents of the cry-it-out method assert that most babies will only cry for 3-5 nights while learning to fall asleep on their own (Giordano and Abidin 2006, Brown and Fields 2012, Ezzo and Bucknam 2012, Ferber 2006, Mindell 1997, Weissbluth 2003).

In opposition to this method, Sears et al. (2013) and to a smaller extent Pantley (2002) argue that crying-it-out is not a natural solution to nighttime wakings and might be psychologically harmful (at least in the short term) to the child. Hogg and Blau (2005) see no reason to let a child cry alone, and assert that it could damage the bond of trust between a parent and baby. They suggest a method of picking up the baby until he is calm and then putting him down. If he cries, that's fine, pick him back up until he goes to sleep and stays asleep. According to these authors, this can take weeks. Karp (2002, 2012) thinks the AAP advice of letting a baby cry to "blow off steam" is not good advice, especially for young infants, and argues that babies cry because they need help from parents. He suggests using a pick-up/put down method much like Hogg and Blau (2005). Sears et al. (2013) and Pantley (2002) argue that a parent should address a child's needs during nighttime wakings and when the child is ready, they will sleep through the night on their own, which can take up to two years (Sears et al. 2013, Pantley 2002). Kurcinka (2006) encourages parents to find what is right for them and their child, and not listen to the "shoulds" our culture tells them.

Another theme, a sub-set of learning to fall asleep without assistance, is the use of what is commonly referred to as "props" by popular authors. While this is not a new concept, as Watson also warned about a baby becoming too attached to any one object to instigate sleep in the 19th century (Stearns et al. 1996), popular authors also include swings, vibrating seats, pacifiers and breasts (Ezzo and Bucknam 2012, Brown and Fields 2012, Murkoff and Mazel 2010, Ferber 2006, Mindell 1997, Hogg and Blau 2005, Karp 2012). Many authors warn against using either a pacifier or a mother's breasts as comfort items, as they could lead to night wakings and the inability to fall asleep if the item is not near (Ezzo and Bucknam 2012, Brown and Fields 2012, Murkoff and Mazel 2010, Ferber 2006, Pantley 2002, Giordano and Abidin 2006, Mindell 1997, Karp 2002, 2012, Sears et al. 2013). Further, some authors regard sharing a sleep surface with an infant as a prop as well (Ezzo and Bucknam 2012, Hogg and Blau 2005, Karp 2012). Pantley (2002)

describes letting a baby sleep in your arms as a mistake, and earnestly asks parents to set their babies in a bed once asleep. However, in the very next paragraph, she rethinks this statement and tells parents that if they want to hold their children while they sleep, to go ahead, but “those beautiful, bonding, peaceful habits are very hard to break, so choose them carefully” (p 72-73).

On the other side of this argument, several authors recommend using a pacifier, usually once breastfeeding is established if the parent has chosen to breastfeed. This often stems from the recommendation of the AAP to use pacifiers to reduce the risk of SIDS (Simkin et al. 2010, Jana and Shu 2011, Karp 2002). Weissbluth (2003), Karp (2002), and Sears et al. (2013) recommend nursing to comfort a baby. Weissbluth (2003) argues that any attempt to keep a baby from nursing to sleep or sucking to sleep is unnatural and asserts it won’t cause any problems with sleep association as the child grows.

Attachment

One of the only themes strictly new to the 21st century is parent-infant attachment. Parental confidence and attachment are topics tackled by many authors, especially in regard to the cry-it-out method. Those who condone the cry-it-out method go to great lengths to reassure parents that this will not affect the bond they share with their parent, “Rest assured, sleeping in a room alone will not turn your child into an axe murderer” (Morell and Cowan 2013, p 159). Mindell (1997) address these questions individually in regards to sleep training: “Am I a bad parent?” “Will this cause my child harm?” “Will my child be scarred for life?” “Will my child still love me in the morning?” (p 138-139). The tone of these questions reveals the guilt and conflict this method creates for many parents.

Some authors suggest the cry-it-out method will enhance the parent-child bond, “when parents are instructed not to attend to their children's crying (the technique called “extinction”), over time measurements of infant security significantly improved and all the mothers become less anxious” (Weissbluth 2003, p 275). Weissbluth also offers excerpts from a number of studies that show that controlled crying while sleep training has no long term negative effects on children.

Some authors go so far as to argue that responding to every nighttime cry can be harmful. For example, Ezzo and Bucknam (2012) state in their book, “healthy protection turns to unhealthy overprotection to the long term detriment of the child...Attachment Parenting...too often produce the opposite: an emotionally-stressed, high-need, insecure baby and one tired mom” (p 41). They and others argue that setting limits for the baby which allow for controlled crying not only results in a happier baby in the long run, but will help the mother feel more confident in her parenting abilities (Ezzo and Bucknam 2012, Giordano and Abidin 2006).

However, others feel this type of training does affect attachment negatively and assert that bed sharing forms a better parent-child bond. Dr. William Sears has coined the term “attachment parenting” (note that this is the approach Ezzo and Bucknam criticize above). He describes this method of parenting as “commonsense parenting we all would do if left to our own healthy resources” (Sears et al. 2013, p 3). A major part of attachment parenting is to respond to every cry a baby makes. He argues that a child who is parented in the attachment method will cry less and have better development and intelligence. Murkoff and Mazel (2010) similarly say that babies who are tended to immediately when they cry are more likely to develop a secure attachment to the responder and will be more independent and cry less. However, neither side presents clear evidence to support their claims. They also say that a mother who is free to care for her child in the manner that feels most natural to her is more confident (Sears et al. 2013, Pantley 2002).

It stands to reason that discussions regarding bed sharing will follow a similar pattern. Those that advocate bed sharing will assert they have the better parent-infant attachment, while those who argue for solitary sleep will argue that attachment is not affected by sleep training.

Discussions of Bed Sharing in Particular

Every author addresses bed sharing specifically, offering a variety of opinions. Most authors choose a middle-of-the-road stance, arguing that where a baby sleeps is the choice of the parents and what will work for them. These authors include information on how to bed share safely, the pros and cons of both bed sharing and solitary sleep, and do not offer much discourse for or against either choice (Simkin et al. 2010, Jana and Shu 2011, Murkoff and Mazel 2010, Ferber 2006, Mindell 1997, Weissbluth 2003). However, some authors are decidedly pro-bed sharing or pro-solitary sleep. Their discussions of their preferred method and the opposing opinion are charged with the highest stakes: the life, development, and happiness of the child and parents.

Giordano and Abidin offer the shortest, but very plain argument against bed sharing:

Babies should sleep in their crib, in the nursery. While some experts think it is fine for babies to sleep in their parents' room, either in a crib or the parents' bed for the first six weeks, I disagree. The parents' bedroom is an adult safe haven. It also sets up a bad habit that the parents have a tough time breaking after the six weeks have passed. The baby learns to depend constantly on the parents to fall and stay asleep. This is the antithesis of what my plan is about (2006, p 42-43).

While their statement does not include bed sharing specifically, it decries even co-sleeping and says that babies should not sleep in the parents' bed. This is a strong statement against bed sharing, a subset of co-sleeping. Note that in their statement,

Giordano and Abidin touch on themes of the importance of babies sleeping in a crib, sleeping alone in a nursery, parents' presence as a prop for sleep, and adult intimacy concerns. These themes are all common arguments against bed sharing.

Ezzo and Bucknam (2012) offer probably the strongest argument against bed sharing. They invoke studies from the AAP and the Consumer Product Safety Commission CPSC to state that bed sharing is a dangerous fad. They state that over 500 deaths in the CPSC study were from parents overlaying their infants, and argue that even this number is too small. They quote the AAP reports calling bed sharing a risk for SIDS, controversial, and hazardous. They close their arguments with, "This is why co-sleeping with infants may be the ultimate risk decision of our day. Infant deaths related to unsafe sleeping practices have reached 'epidemic' proportions; and every one of those deaths was preventable...safe and sensible sleeping arrangements start with baby out of mom and dad's bed" (p 59-60). A closer examination of this particular statement will be provided later in this chapter as it provides an interesting look into the medicalization of infant sleep.

Ezzo and Bucknam's (2012) major argument (or expressed concern) regarding bed sharing is centered on safety, as discussed above. However, throughout their book they relate attachment parenting and nursing a baby to sleep (both large components of many bed sharing methods) with a host of unwanted effects: exhaustion, insecurity, stressed marriage, and increased stress for parents. They are particularly damning of attachment parenting. Ezzo and Bucknam assert that attachment parenting is based on birth-trauma theory from the 1940s, for which there is no scientific evidence. He uses terms to describe attachment parenting as: inventing a boogeyman, false vulnerabilities, and apophenia (creating a connection where none exists). This could be a probable source of discourse for parents who take a particularly strong anti-bed sharing stance online.

In two cases, the authors have had a change of stance in regards to bed sharing over time. Ferber (1985) went from not addressing bed sharing at all to acknowledging that bed sharing is a working strategy for some parents (2006). He even provides advice for those parents and does not simply advise moving the child out of their bed. He notes in his latest publication that in his earlier work he only addressed bed sharing in “a regrettably brief reference that only repeated the conventional attitude of the day” (Ferber 2006, p xix). In his newest work, he addresses bed sharing specifically, arguing that it is no better or worse than solitary sleep if done for the appropriate philosophical or practical reasons. If it is done in reaction to a sleep problem, then he believes there is no reason to work toward the child sleeping alone. Throughout his 2006 publication, he addresses issues for bed sharing parents and provides strategies so they might be able to keep the child in their bed, but still get a full night’s sleep.

Harvey Karp, on the other hand, had a reversal of opinion in the other direction. He first advocated for bed sharing saying, “Sleeping with your baby is a natural continuation of the womb experience” (Karp 2002, p 224). He discusses other cultures and their use of bed sharing. He even cites Dr. James McKenna’s research proposing a possible protection against SIDS for the co-sleeping infant (this research will be described in chapter 4). Further, Karp criticizes the study done by the CPSC as “off target” (p 225) and not constructive. Instead, he offers a list of how to bed share safely in that early book.

However, in his newer book, Karp (2012) argues heartily against bed sharing. He uses a wide variety of studies to support his position: studies that show bed sharing babies may have their faces covered by bedding for up to an hour each night, studies that show bed sharing babies often sleep on their sides (and not their backs like the AAP recommends), and studies that suggest a link between bed sharing and an increased risk of SIDS for young babies and those babies of parents who smoke. He names the studies by location and provides citations for some of them in an appendix. Karp, perhaps in the

spirit of full disclosure, also cites several studies that show bed sharing is not an increased risk factor for SIDS for “parents who are sober, attentive, and nonsmoking” (p 50). However, he notes that both the AAP and the Canadian Pediatric Society do not support bed sharing. After expressing this disapproval, he still includes methods of making bed sharing safer for those parents who still chose to the family bed. He also notes he is very supportive of bed sharing after the first 4-6 months.

It is interesting to note that with his change of opinion on bed sharing, Dr. Karp also slightly changes his stance on a number of other related topics. In his first book he was against any scheduling and against any cry-it-out method as a means of sleep training. He expressed no concerns about bed sharing and the effect it might have on a marriage. But in his second book, he is in favor of flexible scheduling infant feeding and sleep times, and advises that a cry-it-out sleep method might be appropriate for some people. He raises concerns that the family bed will isolate fathers and put pressure on marriages. These differences could stem in part from the fact that his second book is strictly about sleeping and includes children of ages up to 5. His first book only dealt with young infants and sleep was merely a chapter with some sections regarding questions of infant sleep. It is also possible that the difference in discourse regarding bed sharing is tightly associated with a set of cultural ideals in infant sleep.

In this selection of authors, there are three that support bed sharing as a nighttime sleep strategy. Pantley (2002) is included amongst those authors that actively support co-sleeping. While like the other authors, she also includes information for solitary sleepers, she relies heavily on the works of Sears and tells the reader that she co-slept with all four of her children. She states that she believes that a child should be tended to at night, especially if they are hungry, but that many nighttime waking habits can be curtailed over the matter of a few weeks. Included in her literature are excerpts from other doctors and authors which all explain that the cry-it-out method lacks compassion, is stressful, feels terrible, and traumatic. In addition to these statements Pantley also includes the

experiences from parents who tried some cry-it-out method, and did not have the desired results. They often describe the training in stressful terms. Finally, Pantley includes a narrative which explores one way the crying child might perceive the event. The narrative is full of language like terror, pain, screams, sobs, ache, and “Nothing helps. It is unbearable. He begins to cry again, but it is too much for his strained throat; he soon stops” (p 10). While Pantley isn’t at all against solitary sleep, she is solidly not for sleep training methods that involve allowing infants to cry. And many parents, when they find that cry-it-out solutions (or any other method) will not work, often take their baby to their bed (Germon 2007, Sears et al. 2013, Weissbluth 2003).

Dr. William Sears is also pro-bed sharing and offers the strongest argument for its practice (Sears et al. 2013). Sears et al. offer a wide variety of reasons that bed sharing is better for parents and babies: babies go to sleep easier, babies stay asleep better, more sleep for babies, more sleep for mothers, ease of breastfeeding, time with baby for parents working during the day, a chance to bond for those babies who stayed in the hospital for various reasons, and babies thrive. Contrary to what Ezzo and Bucknam (2012) assert, there is no mention of birth- trauma theory in attachment parenting in *The Baby Book* (Sears et al. 2013), though it is possible it is referenced in another work.

Sears et al. (2013) then spends a chapter addressing the common criticism of bed sharing. Sears et al.’s argument against the idea that bed sharing babies will become dependent on their parents to fall asleep comes in two parts. They first argue that the parents are creating good and content memories for the baby. This isn’t really an answer to the “bad habit” question. However, in the second part of the argument, where they address falling back to sleep without assistance, the authors argue that it is unnatural for babies to soothe themselves before a year old; they simply cannot do this. They believe asking babies to soothe themselves before this age is “creeping into the ‘Let’s have babies conveniently’ mindset” (p 346). Sears et al. continue by suggesting that a need not met at this age will not go away but will return as a “disease of detachment” such as

anger, withdrawal, and aggression. Thus, parents have an obligation to soothe their baby.

Sears et al. (2013) attack some other common criticisms of bed sharing. They note that several cultures practice bed sharing and bed sharing isn't an unusual custom. While acknowledging the idea that the bed sharing infant will never want to be in their own bed, they argue that the parent's job isn't to make their child's nighttime independent, but rather to make the child's nighttime secure so that independence might develop naturally. They argue that intimacy for the parents is still possible, and offers several possibilities for parents to continue a healthy sex life. They also note that a parent who has decided that bed sharing is not for them is not a bad or neglectful parent. Instead, they have made an appropriate appraisal of their own situation and that these parents should not feel pressured to practice a nighttime ritual they don't believe in or that doesn't meet their needs.

One major argument Sears et al. make in favor of bed sharing is that bed sharing reduces the risk of SIDS. Dr. William Sears first proposed the possibility that sleeping mothers affected the arousability of infants at the International Congress of Pediatrics in 1986, and consequent research has supported this (McKenna 1986, 1994). Dr. Sears summarizes some parts of James McKenna's work in bed sharing biology in his book. In doing so, Sears et al. point to a number of protective factors for infants: synchronized sleep cycles between mother and child, mutual awakenings, less time in deep sleep, more arousals, more breastfeeding, less prone sleeping, and a lot of touching and interaction. Sears et al. close this segment by suggesting that while bed sharing cannot prevent every case of SIDS, that parents who bed share, should they lose a child in this manner, could "feel in their hearts that they did everything they could to prevent this tragedy" (Sears et al. 2013, p 123).

Medicalization of Infant Sleep

One major theme included in every one of these books is the medicalization of infant sleep. Each book includes a form of medical endorsement. In some cases the author or co-author is a doctor. Most include references to various scientific studies that support their particular assertions around infant sleep. It might be assumed that the authors that include the most medical authority will carry the greatest weight with their readers and those arguments might be the most readily discernable in parental discourse.

While it began in the 19th and 20th centuries, the involvement in discussions of infant sleep by experts in general and pediatricians in particular has reached a new level in this century. Out of sixteen books, nine of them are authored or co-authored by medical doctors (Karp 2002, 2012, Sears et al. 2013, Weissbluth 2003, Ferber 2006, Jana and Shu 2011, Brown and Fields 2012, Ezzo and Bucknam 2012, Morell and Cowan 2013). One author has a doctorate in psychology (Mindell 1997); another is a registered nurse (Hogg and Blau 2005). Kurcinka (2006) has an MA in Childhood Education, which is appropriate as her book is devoted to raising the spirited child and only has one segment dedicated to infant sleep. Three authors do not have similar credentials of their own, but do have a forward written by an MD (Murkoff and Mazel 2010, Giordano and Abidin 2006, Pantley 2002). Pantley also has praise from a PhD specializing in the study of infant care, James McKenna, printed on the first page of her book. Clearly, some sort of medical endorsement is necessary to be considered legitimate in the realm of infant sleep.

To solidify the idea that doctors are the proper source for advice for infant sleep, one has to only look at the contents of this selection of books. In addition to advice on infant sleep, all but one book (Giordano and Abidin 2006) includes mention of at least one study and often they mention several. All but two authors (Giordano and Abidin 2006, Mindell 1997) explicitly reference the AAP and one of those two (Mindell 1997)

quotes the AAP standards of safe infant sleep even though she doesn't cite them explicitly as an authority. Seven authors cite the CPSC (Murkoff and Mazel 2010, Brown and Fields 2012, Pantley 2002, Sears et al. 2013, Karp 2012, Ezzo and Bucknam 2012, Jana and Shu 2011). Additionally, several cite James McKenna's work in infant sleep (Sears et al. 2013, Pantley 2002, Simkin et al. 2010, Kurcinka 2006). Although they don't cite him explicitly, Murkoff and Mazel (2010) mention his study that shows that mother and infant sleep cycles become synchronized while sleeping. With all of these official citations of information, it is easy to see the proliferation of the medical, and to a lesser extent the scholarly, community into infant sleep practices.

It isn't any huge surprise that parents might believe they need medical help in this area. The discourse surrounding infant sleep often suggests that infant sleep is problematic, and when everyone offering advice to fix it is a doctor, seeking medical advice makes sense. But do Americans view infant sleep as problematic? According to a study done by the National Sleep Foundation in 2004, 6% of parents of infants believe their child has a sleep problem, while 11% of parents of toddlers (aged 12-35 months) believed their child had a sleep problem. Even more, 76% of all parents surveyed said they would change something about the way their child sleeps. This study shows that many Americans believe some of their child's nighttime behavior is undesirable, but they don't necessarily consider it problematic. Only a relatively small number think their child's sleep is problematic.

So, from where is the idea that infant and toddler sleep is problematic originate? The 2004 study also reveals that only 11% of parents of infants and only 10% of parents of toddlers had asked their doctor about a sleep problem, which is very similar to the number of parents who reported a sleep problem. So, perhaps the source of the "problem" side of infant sleep is the medical community. Some evidence can be found in the same study completed by the National Sleep Foundation which found that 55% of doctors asked parents about infant sleep, and 60% asked about toddler sleep. More

evidence is found in the language of the books themselves. When a baby doesn't sleep through the night, this is often considered "problematic" (Murkoff and Mazel 2010, Ferber 2006, Mindell 1997, Ezzo and Bucknam 2012). The title to Richard Ferber's book (*Solve your Child's Sleep Problems*) focuses a great deal on a child's not being able to fall asleep by oneself or not sleeping through the night, and a fair amount to the medical reasons a child might have problems with this. Weissbluth (2003) also includes a chapter devoted to actual sleep disorders, in addition to common behavioral issues with infant sleep. Mindell (1997) does the same. Brown and Fields (2012) state that if your baby won't sleep through the night at six months old, "you need help" (p 213). There is a great deal of discussion about the problem of infants and toddlers not sleeping through the night, and yet 46% of children from 12-35 months still wake at least once a night and require some type of parental intervention (NSF 2004). Pantley (2002) asks the question that if half of toddlers are still waking at night, is it really a disorder, or just what is normal? But the assertion that there is, in fact, a problem comes from a group of authors, nine of whom are medical doctors, one is a doctor of psychology, one is a registered nurse, and one is a childhood education expert, it becomes easy to understand that parents may believe the help they need with their problem is medical help for a medical problem. These authors tell them so both with their words and their credentials.

The medicalization of infant sleep in America leads to the final, and perhaps the most influential, theme to come out of the 19th and 20th centuries: sharing a sleeping surface with your infant is medically dangerous. In addition to the discussions of the dangers of overlay, entrapment, strangulation, and asphyxiation, the discussions of the 21st century include the dangers of SIDS. Due to the ubiquitous nature of this argument and its basis in the assertions of official entities like the AAP and CPSC, it will be addressed in the next chapter.

Summary

Popular authors on infant sleep cover a wide range of topics, such as the baby sleeping alone, safety, the importance of infant sleep to health for the infant and to adult sleep, concerns about parental intimacy, scheduling, and the importance of a child learning to fall asleep without assistance, sharing a sleep surface with an infant, and the medicalization of infant sleep. Other themes are very new to infant sleep, such as feeding children in a manner to extend nighttime sleeping, and parent-infant attachment.

Many authors choose an in-between stance in regards to bed sharing, offering the pros and cons, and ultimately stating it is the choice of the parents. Many of these authors suggest, however, that a baby be moved out of the parent's bed before 6 months of age, as after that time, transitioning may be difficult. There are some similarities between those that favor bed sharing and those who favor solitary sleep. Many bed sharing advocates do not condone cry-it-out methods and do support nursing a baby for comfort, while the opposite is true for supporters of solitary sleep. But these are not completely consistent divisions. Weissbluth (2003) supports nursing a baby to sleep, without supporting bed sharing overmuch. And Sears et al. (2013), the largest bed sharing advocate, admits that there are times where sleep training will be appropriate.

While the opinions are clear, the information these authors provide to support them is often contradictory and not always complete. It may be very hard for parents to be certain who to trust and believe. For example, Brown and Fields (2012) assert that there are no studies to prove there are benefits to bed sharing, as does Ezzo and Bucknam (2012) but each share a number of studies that show sleep training has no ill effects on youngsters. On the other hand, Sears et al. (2013) state that there are numerous studies that show the benefits of bed sharing and studies that show harm is done by sleep training. Ezzo and Bucknam, and Sears et al. each cite studies that exactly contradict each other on multiple occasions. No one seems to have made an attempt to make sense

out of this contradictory information. They simply cite the studies that support their opinions.

Sometimes authors offer contradictory evidence within their own books. Simkin et al. (2010) notes both sides of the co-sleep debate. They state the AAP regards the practice as not safe and notes McKenna asserts the practice as safe. Karp's second book (2012) simply notes that there are contradictory studies and he chooses to err on the side of caution in suggesting parents avoid bed sharing. Some authors cite studies that suggest SIDS is higher when bed sharing (Brown and Fields 2012, Ezzo and Bucknam 2012), while others cite studies that say co-sleeping is protective against SIDS (Mindell 1997, Karp 2002). Murkoff and Mazel (2010) say there is no data to determine the answer either way. A major problem in this area is confusing the terms co-sleeping and bed sharing. Mindell (1997) for example says that co-sleeping has been found to lower rates of SIDS (which it has according to many studies), but she includes this statement not under "sharing *a room* with your baby" but under "sharing *your bed* with your baby."

There are some issues with Ezzo and Bucknam's (2012) statements in particular. They misquoted the CPSC study in saying that it found that 500 infants died from parents overlaying them. In that study, the total number of accidental deaths in the study was 513, which included entrapment, suffocation, overlay, and asphyxiation. Most of these deaths occurred while children were sleeping alone. The total number of deaths from overlay was 121 (from parent *or* sibling) in seven years, which suggests that fewer than 17 babies each year die from overlay by a parent (A discussion in regards to possible significance of this statement will be offered later in this chapter while a discussion regarding the CPSC study can be found in chapter 3). There is no indication that unsafe sleeping arrangements have reached epidemic proportions. In 2010, the CDC reported that of all children, 2,063 deaths were reported as SIDS, 918 as cause unknown, and 629 as accidental suffocation and strangulation in bed (CDC 2014). This is approximately 90.25 deaths per 100,000 children (Murphy et al. 2013), including the SIDS deaths. Even

if every unknown death was caused from sleeping in a parent's bed, that is less than 4 children in 10,000. This is hardly "epidemic" proportions. However, that will not change the dialogue that bed sharing is causing an "epidemic" of preventable infant deaths.

Given the contradictory nature of the information provided, the number of scientific studies presented, and the somewhat contentious manner in which bed sharing is addressed in these books, it seems very likely that parental discourse will reflect some confusion. It might be expected, that like these authors, parents will reference studies and authors that support their side of the argument, but not those that contradict it. It might also be expected that, like these authors, the individual parents will contradict themselves in their bed sharing discourse.

CHAPTER 3

Origins of the Discourse Surrounding Infant Sleep

Introduction

The previous chapter explained the bulk of modern discourse regarding infant sleep. This chapter is dedicated to exploring the origins of the discourse presented by popular authors. To have the most complete understanding of the discourse surrounding infant sleep it is necessary to examine where the standards of infant sleep began, and under what circumstances. The exploration of children's sleep history provides the historical backdrop to understand how infant sleep practices have changed and why the focus has gone from how a baby sleeps, to where a baby sleeps, to the medical safety of infant sleep. Children's sleep history shows that the medicalization of infant sleep began in the early 20th century, and examining our current official recommendations reveals how extensive this discourse has become. The official recommendations regarding infant sleep radically changed how we view infant sleep, especially with the advancement of the AAP into the relationship between infant sleep and SIDS. The result has tremendous effects on the discourse of infant sleep practices in United States.

Children's Sleep History

The best understanding of current rhetoric surrounding infant sleep practices begins with knowledge of when it arose and under what conditions. Some may find it surprising that concerns over infant sleep aren't found in the historical record until the mid-19th century. Prior to this time, it is generally assumed that infants slept with their parents or caregivers, or perhaps a sibling at night, and during the day were in proximity to their primary care givers, either by being held or worn, or through the use of a cradle that could move room to room with a parent. But the turn of the 20th century marked many cultural changes, several of which had effects on infant sleep practices. The second

Industrial Revolution changed the way in which people used their days (and nights). This in turn affected the way people related to each other and their children. The role of the middle class woman changed dramatically, and the rise of advice columns and ladies magazines increased the pressure on these women to do household tasks and infant care “right.” Finally, the emergence of pediatrics as a field at the same time as concerns about infant sleep first arose created a false need for a medical solution to the non-medical problem of infant sleep.

Peter N. Stearns, et al. (1996) offers a comprehensive look at children’s sleep history incorporating magazines, medical studies, education reports, and popular advice. In this historical review the authors describe the change in sleep culture from the 19th to the 20th centuries, and how this affected the way in which children were treated in regards to sleep practices. A comprehensive review of this material can be found in Appendix 1. This chapter examines the common themes in discourse that developed in the 19th and early 20th century regarding infant sleep. In review it becomes clear that the issue of where a baby sleeps is tightly intertwined with the issue of how a baby sleeps. In every case, the motivation for solitary sleep was to facilitate either the baby sleeping better and longer, or learning the skill of falling asleep. As such, discussions here focus on themes of how a baby should sleep, not just sleep location.

Perhaps the most prominent theme developed at this time is the idea of “strength and self-sufficiency through new sleep habits” (Stearns et al. 1996). The concept of sleep training came from psychologist John Perhops in the early 1900s. He proposed that beginning from birth babies should be kept on a strict schedule and be put in their beds without excessive holding or rocking as a means for them to learn independence and the ability to adapt to society as they grew. The best place for this to happen was in the baby’s own space, separate from his parents, so he would not become dependent on them to fall asleep. This particular aspect of infant sleep advice, perhaps tied to the rise of American Individualism, asserts that children should conform to the pre-baby household

schedule. Too much assistance falling asleep results in an overly dependent, insecure child. This specific assertion has been picked up by a number of prominent modern doctors and other popular writers whose works were discussed in the previous chapter and may be the most important argument in infant sleep today.

The ability to fall asleep on one's own was believed to enable children to get enough sleep to avoid major health issues caused by over-tiredness. A concern that children were not getting enough sleep became common in the early 20th century. One doctor even compared over-tiredness to malnutrition as far as lasting damage. A major movement to avoid tiring children that included no homework assignments swept the nation (Stearns et al. 1996). Stearns et al. argue that this concern seems to stem from a concern regarding related adult sleep issues. The thought was that if a child could be trained early to sleep well, as an adult they would have enough sleep to be able to function at work. This lack of sleep among adults was at that time thought to be a problem. This concern that children's health and even adult health centered on training the child to sleep properly through strict schedules and sleep training is another theme that developed in the last century and is still found today, with some adaptations.

A major selling point of the strict schedule was the ability of the middle-class mother to complete her daily housework. Stearns et al. point out changes in society increasingly meant that middle-class mothers had less help in the house than they may have had before. Knowing exactly when a baby would be eating and sleeping allowed her to schedule her daily work. While not included in the Stearns et al. history, no doubt the emergence of infant formula, first making its appearance in the late 1800s and becoming ubiquitous by 1950, had some influence here. As formula became the preferred food for infants (including cow's milk as well), time between feedings undoubtedly expanded as formula and cow's milk are digested more slowly than breast milk (Ball 2003). This slower digestion time and the elimination of the physical need to feed a baby associated with breastfeeding allowed the mother to schedule feedings

according to her schedule instead of her baby's hunger. This led to a drastic change in how the scheduling of feedings should occur: no longer were they centered on the infant's immediate needs, instead they could be planned around the mother's needs and desires. It should be noted that these concerns mainly affected middle-class mothers, but the ideology has become a dominant one, and so it is important to understand its origins.

The ability to maintain a strict schedule with feedings scheduled further apart combined with concerns over quality of sleep, along with other factors (see Appendix 1), resulted in the idea that babies simply will sleep better if they sleep alone in their own room. Issues of noise, distractions, siblings, and sex were all topics of concern. It was thought that babies separated from others for sleeping purposes wouldn't be disturbed by the new noise of the industrial age or the distractions of parents entertaining into the night. Siblings were increasingly situated in separate rooms as a mark of economic status, and concerns over homosexuality. The concern over infants witnessing sex, especially with the rise of recreational sex between married couples, also led to infants having their own rooms. This led to another development: the invention of the crib. Since babies were no longer moved from room to room with the mother in a cradle, they needed a safe place to sleep. The creation of a separate space for the baby, involving buying a crib and decorating a room in which to place it permanently, may have started as a marketing strategy in the 20th century (Stearns et al. 1996), but it has become a cultural reality for many modern parents.

Infant safety became an important concern in the late 19th and 20th century as life conditions improved to a point where infant mortality was significantly lower (Stearns et al. 1996). For the first time, great emphasis was placed on not losing children to unsafe practices. A review of sources show that the concerns of overlaying (Flandrin 1979, Kellum 1974, Stone 1977) suggests protecting the child's life was a further motive for removing a baby from his parents' bed. Stearns et al. (1996) also contributes to the legitimacy of this concern. In their work they cite several times where the use of opium

for both parents and children was repudiated. It isn't hard to imagine there were a number of children who were accidentally overlain when a parent under the influence of opium rolled on them in their sleep.

A final and enormous consideration in the growth of the solitary sleep paradigm was the emergence of pediatrics as a specific field of medicine and with it the medicalization of infant sleep. The rise of pediatrics as a field and numerous studies done on infant sleep by these newly qualified doctors resulted in the establishment of a concept of "problematic" sleep. Where the sleep patterns of children had not been a concern before, they were beginning in early 20th century. The popular rhetoric of the time proclaimed the new medical experts had the answers to newfound infant sleep concerns (Stearns et al. 1996). The medicalization of infant sleep has had profound effects on modern discourse of infant sleep as was demonstrated in the previous chapter and will be discussed further below.

With these major themes in mind, it is clear that by the early 20th century, mothers in particular were under a tremendous amount of pressure to be certain they were serving their children's needs well by following all the guidelines of infant sleep. A new mother was increasingly on her own in the household as hired help was diminishing and in-laws increasingly living in separate homes. Add to that the diminishing role of the father in nighttime routines due to his late arrivals from work and the curtailment of family time after dinner (refer to Appendix 1) and the mother became the linchpin to her children establishing proper sleep habits. The stakes were high; if she didn't succeed her children could become ill, fail to learn the proper sleep habits necessary to be a successful adult, perhaps even die. Keeping in mind the cultural changes surrounding women at this time: the rise of feminism, the fight for suffrage, and entering the workforce in large numbers (beginning in World War I), it becomes apparent the guidelines for appropriate children's sleep are particularly gendered.

With the bulk of the responsibility for her children's sleep on her shoulders, these new guidelines worked to keep a new mother in her "sphere." There was housework to be done with little or no hired help, a sleeping baby was now a stationary person since he needed to sleep in a crib (not in a cradle or other mobile apparatus), and enforcing strict sleeping schedules. These factors all worked to keep mothers bound to the inside of their homes, isolated, facilitating proper infant sleep. While there is little if any literature on the subject, it must be considered that part of the rise of the paradigm of solitary scheduled sleep for infants may have been based on the threat of changing gender roles. Promoted by a male dominated medical community, the idea that successful infant sleep was critical in creating an adult who could sleep well enough to work created a new burden for women. That new burden may have its roots in combating new female roles.

The themes of managing household work and infant sleep are still pertinent to today's mothers. Modern women still do 70 percent of the domestic chores. A new baby increases her household workload three times more than it increases the workload for her husband (Medina 2010). Furthermore, the number of women who have an infant and are working outside of the home has risen steadily since 1975. In 1975 the number of working women who had an infant at home was 30%; that number jumped to 58% in 1998. In 2005, a study indicated 73% of women with infants worked full time (Shepherd-Banigan and Bell 2014). These considerations highlight the plight of many new mothers. Achieving a good night's sleep for herself and regular sleep schedule from her infant is undoubtedly not only desirable, but functionally necessary. While bottle feeding by fathers certainly eases some of the burden of nighttime care for infants, more mothers in the United States are choosing to breastfeed than ever before.

A large public health movement in recent years has boosted breastfeeding from an all-time low. Touting the "breast is best" campaign has convinced more women than ever that breast milk is superior to formula in nearly every way. Nearly 77 percent of new mothers breastfeed and nearly half of mothers are still breastfeeding at six months

(CDC 2014c). While this is good news for babies, it presents some very real problems for nursing mothers in the realm of infant sleep. Reviewing the information above, the importance of getting some nighttime sleep is paramount to many working women, but a nursing baby has been shown to wake more often than his formula fed counterpart, resulting in many more night wakings for the mother (Ball, 2003). Ball (2003) has shown that one often utilized strategy for compensating for this lack of sleep is bed sharing. She also found that for women who don't chose to bed share, they often choose to either give up breast feeding or utilize some method of sleep training. These women are in a difficult place rhetorically, they have to balance doing what is "best" (breast feeding) with what many popular authors (and official sources) argue is a dangerous practice (bed sharing). It is little wonder that these women might see frequent night wakings as a "problem" that needs to be fixed.

Stearns et al. argue that the creation of infant sleep problems can be traced to a set of factors: the rise of pediatrics and other children sleep experts, lower infant mortality, less household help for mothers, adult anxieties over their own sleep, and the new practice of infants sleeping alone. Working in concert, these factors contributed to the belief that infants had sleep issues that must be addressed. They postulate the circular nature of identifying infant sleep disturbances as problems and the decision to have infants sleep alone. "Surely [infants] cried more often, out of insecurity and loneliness, which is why so much advice was now needed about how to deal with such issues...sleep was a new issue because families and children were getting accustomed to very novel, and in terms of historical traditions, counterintuitive, arrangements" (Stearns et al. 1996). In other words, sleeping alone created a crying baby. A crying baby was considered to have a sleep issue for which the prescription was no assistance from mom to fall asleep, strict schedules, and solitary sleep. That solitary sleep, in turn, *maintained* a crying baby.

The goal ultimately, at the turn of the 20th century, was to have an infant who could fall asleep without assistance (e.g. nursing or rocking) and could stay asleep all night. That is still the goal, as the examination of modern popular literature in the previous chapter made clear.

Official Recommendations

The “official recommendations” regarding bed sharing, having been so described due to the authority of the recommending agency, involve only two major entities in the United States. The first is the CPSC and the second is the AAP. The AAP is mentioned in nearly every popular book discussed in the last chapter, and the CPSC is mentioned in several popular books (Jana and Shu 2011, Murkoff and Mazel 2010, Sears et al. 2013) as well as referenced multiple times in the AAP reports on infant sleep. Each group’s recommendations are available online, in the media, and through pediatricians and other government agencies; therefore, every parent is exposed to them. Examining the discourse they put forth and its possible effects on parental discourse is key to understanding both public and parent discourse. As the AAP has positioned themselves as the medical experts, and since infant sleep has been treated as a medicalized problem for over a century, their recommendations about infant sleep will be prominent. Thus, the discourse discussed here should be some of the most repeated in parental discourse as parents internalize or reject (or both internalize and reject) these recommendations. The perceived importance of the AAP recommendations for infant sleep is certainly reflected in the popular books discussed in the previous chapter.

Consumer Product Safety Commission

The CPSC was founded in 1972 by Congress to “protect the public against unreasonable risks of injuries and deaths associated with consumer products” (CPSC

2014). The CPSC has published several reports that involve the safety of infant sleep products including cribs, bassinets, swings, and infant sling carriers. However, one report important to this study was a general assessment of the risk of children sleeping in adult beds. This report is often cited in bed sharing discussions, as discussed above (Jana and Shu 2011, Murkoff and Mazel 2010, Weissbluth 2003, Karp 2012).

In October of 1999, the CPSC published an article in the *Archives of Pediatrics and Adolescent Medicine* regarding the dangers of placing infants and young children to sleep in adult beds, waterbeds, and daybeds. In this report the researchers looked at deaths reported to various agencies and departments of children under 2 years of age in adult beds from the years 1990-1997. Their investigation revealed a total of 515 deaths. Of these, 121 deaths were reportedly death from overlay (when a parent or older sibling lies on top of a child and the infant suffocates), and 394 were reported deaths from entrapment in the bed structure (where the child becomes trapped in a manner that leads to asphyxiation). The greatest number of deaths came from infants sleeping on an adult bed who became trapped between the wall and the bed, or who were caught between the headboard or footboard and the mattress. A few more were caught in the railing of the headboard or footboard, and a small number became trapped between the bed and another piece of furniture (Nakamura et al. 1999).

Citing nearly 64 infant deaths a year, the CPSC stated they believed people were unaware of the “danger posed by placing an infant to sleep in an adult bed” and suggested informing parents of these dangers via “health care providers in the context of a health educational program” (Nakamura et al. 1999). At their press conference to announce their findings, the chairwoman of the commission noted that their findings would be controversial, but to not report it would be “criminal” (Grossman 2000).

Undoubtedly, as parents are exposed to this message, it will influence their discourse concerning the ability to bed share safely. As the AAP and many popular authors have cited this report, more than a few parents will have this information in mind

when discussing infant sleep choices. However, far fewer parents have access or exposure to a response article from Elmer R. Grossman published in the following year. Organizations like the AAP and popular books using their work seem unaware of this work or unwilling to discuss it.

In his article, Dr. Grossman points out many flaws with the CPSC report and calls for better research. He begins by citing the many professionals, advocates, and experts that “all raised objections” to the proposed report and criticized the CPSC for the “untold numbers of parents who sleep with their babies [who] became anxious and agitated” (Grossman 2000). Dr. Grossman then examines the data and methods of the CPSC. What he found is the CPSC did not have good data to begin with. They relied on medical information provided from possibly unqualified persons, and then offered a recommendation with no basis of relative risk. In other words, they did not try to balance the deaths potentially caused by bed sharing with the deaths potentially prevented by it.

The CPSC acknowledged that for their investigations into crib deaths, nearly half of the cases had been originally misclassified (Grossman 2000). Still they made no additional investigation into adult bed fatalities. Instead, the CPSC used one-line descriptions on coroner reports and death certificates to classify manner of death when it is well known that infant deaths are difficult to classify even for experts and many medical examiners are “morticians with no training in medicine” (Grossman 2000, p 278). Grossman cites work done by O’Hara et al. (2000) that showed in some parts of the country, *any* infant death that occurs in an adult bed, that is not identifiable as entrapment, will be classified as overlaying. That suggests that the attribution of cause for infant deaths with no physical manifestations is based at least in part on the mortician's beliefs about the dangers of practices like bed sharing. As the CPSC gave no numbers in regards to the total number of infants that spend time in adult beds, relative risk is impossible to calculate (Grossman 2000). Given the argument by McKenna et al. (2007)

which asserts breast feeding prevents nearly 750 infant deaths each year, the CPSC report is revealed to be particularly one sided.

Having the knowledge regarding the quality of data the CPSC used, or the number of infants saved by breast feeding, would inform any discussion in popular literature involving the CPSC study, but the Grossman article, and the several letters to the editor to *Pediatrics* (O'Hara et al. 2000, McKenna and Gartner 2000, Drago 2000, Servan-Schreiber 2000) in response to the study are not cited either by the AAP or *any* of the popular advice authors in the last chapter. It is possible that some dedicated parents, willing to do a great deal of research, may find these articles, but these critical responses to the CPSC data is not expected to have much representation in the online discourse.

The American Academy of Pediatrics and Bed Sharing

Without question the AAP is the largest academic entity that argues against bed sharing in the United States. While the AAP claims their recommendations should not serve as a standard of care, their authority is such that it informs discourse in several other authoritative entities, in the media and in popular literature. Thus, it has come to serve as a *de facto* standard of care.

Formed in 1930, the AAP has grown into a multifaceted organization with departments dedicated to advocacy, research, community-based initiatives, member education, public education, and publication. The most noted of the AAP's publications is *Pediatrics*, the official peer reviewed journal of the AAP, in print since 1948. It is the venue where the AAP publishes all of its official recommendations. *Pediatrics* is the top cited journal in the field of pediatrics and in the top 100 cited journals in all of science and medicine (AAP 2014). The prominence of *Pediatrics* coupled with the 60,000 pediatric primary care givers that are members of the AAP ensures that the recommendations of the AAP are far reaching in the realm of infant care. Beyond their

eminence in the field of pediatrics, the AAP's task force on infant sleep generates reports that are supported and used by a wide variety of government agencies including the CDC, the FDA, the HHS, the NICHD, the MCHB, and the FDA (CDC 2014b). The AAP also works closely with the CPSC. To complete their ubiquitous representation, the AAP publishes a number of books on infant care including *Heading Home with Your Newborn*, one of the bestselling books of early childhood advice, which is mentioned in the previous chapter (Jana and Shu 2011). With influence in so many different outlets, it's hard to imagine how the recommendations of the AAP could possibly not serve as the standard of care for infants and children.

In an attempt to curtail the rate of SIDS in the United States, the AAP first issued a recommendation regarding infant sleep practices in 1992. According to the CDC, SIDS is defined as an infant death from ages 1 month to 12 months that can't be explained after a thorough examination of the death scene, an autopsy, or through clinical history (CDC 2014a). The AAP provides a history of their investigations into infant sleep in their 2005 report. In 1992, after reviewing research from Australia and Europe, the AAP issued a recommendation that all babies should be placed in a non-prone position. The "back to sleep campaign" began in 1994, with incredible results. In the decade following the new recommendations, the rate of SIDS dropped as more and more parents did not place their babies on the stomachs for sleeping, ultimately resulting a 53% decrease in SIDS. In 1992, the rate of SIDS was 1.2 for every 1,000 live births, and by 2001 the rate had dropped to 0.56 deaths for every 1,000. The rate of around 0.5 deaths per 1,000 live births seems to be the level at which SIDS deaths has stabilized as it has not changed significantly since 2001 (AAP 2005).

There was no mention of co-sleeping or bed sharing in the 1992 report (AAP 1992) or the follow up report of 1996 (AAP 1996). The first mention of bed sharing by the AAP was in a one page response to "lay media" speculation that research that showed maternal/infant synchronization of sleep patterns (in reference to James McKenna's

research discussed below) may have a protective effect against SIDS. The AAP's response (AAP 1997) to the speculation was to say that there was no evidence that bed sharing had a protective effect against SIDS. They went on to say that if a mother chose to bed share she should not smoke or be under the influence of drugs or alcohol, not use soft sleep surfaces, and not place any soft bedding under the infant. There was absolutely no mention of increased risk from bed sharing in this report (AAP 1997). This information was repeated in the official sleep recommendations issued in 2000, where bed sharing was afforded an entire paragraph. Other issues discussed in the 2000 report included the hazards of couch sleeping and other family members bed sharing (i.e. other than the parents), but still no official recommendation was made against bed sharing (AAP 2000).

The major shift in the AAP's official recommendations regarding bed sharing occurred in their 2005 report on infant sleep. The previous warnings regarding alcohol and smoking, and cautions against sleeping on a couch or armchair remained. Warnings about bed sharing with other family members, and soft bedding were added (AAP 2005). However, in this report the AAP cited several studies that showed an increased risk to infants for accidental death and SIDS when bed sharing. They presented evidence that infants younger than two months were at the greatest risk for accidental death and SIDS. More concerning, this warning included infants of nonsmoking mothers, who previously had not been considered at risk. The AAP stated in this report that there was no link to an increased risk to infants who were returned to their crib after night wakings and feedings. Several studies were presented that showed room sharing without bed sharing offered protection against SIDS. Based on this evidence, the AAP included in their 14 point recommendation that, because no epidemiological study had shown that bed sharing was a protective factor against SIDS, bed sharing while the infant or parent is sleeping should never be practiced. Instead, an infant should be placed on its own sleep surface (one approved by the CPSC) in the parents' room until the child is six months old. Even

including all this new information in their report, the AAP did not discuss bed sharing any more, or less, than the other topics included in their recommendations.

The tone changed somewhat in the *Expansion of Recommendations* technical report issued in 2011 (AAP 2011b). This report, which now included expanded recommendations in an effort to address other sleep-related infant deaths, devoted two full pages to the issue of bed sharing. For the first time, bed sharing received more attention than any other single risk topic. Citing a rise in sleep-related infant deaths, the AAP expanded their official recommendations to address modifiable and non-modifiable risk factors for “suffocation, asphyxia, entrapment, and other ill-defined or unspecified causes of death,” published in their 2011 policy statement, a general statement of recommended policy which supplements the technical report. In addition to the previous recommendations, the AAP included in their policy statement a censure of co-sleeping devices. The AAP also expanded upon their previous “recommend[ation] that infants not bed share during sleep,” (2005) to the “AAP does not recommend any specific bed-sharing situation as safe” (2011a). To further this point, they include a substantial list of bed-sharing situations that should avoided at all times. This list is similar to the earlier recommendations: warning against smoking, alcohol, soft bedding, and sleeping with multiple family members, but now each of these circumstances is simply described explicitly with specific examples. For example, the warning against bed sharing with other children in 2005 became a multi-part warning against bed sharing with multiple persons, bed sharing with anyone who isn’t a parent, including other children; and warnings against placing twins and other multiples in the same bed were included (2011a).

Previous reports did not recommend bed sharing, but this report states that there is not “*any specific bed sharing situation*” in which bed sharing could be considered safe (including bed sharing with a parent), and then provides a list of “situations to be avoided at all times” in case the previous statement wasn’t clear enough. This list of

situations includes bed sharing for infants younger than three months, and bed sharing with someone who is excessively tired. These situations, most likely, would include a wide sample of parents who would be most likely to bed share. New parents, unaccustomed to the many nighttime feedings of a newborn and struggling with sleep deprivation, often state they use bed sharing as a strategy to get more sleep (Ball 2003). But where previous AAP recommendations may have left a little room for a parent to feel bed sharing was still a choice (even if not a recommended one), this report is very clear: bed sharing is never safe. The effect is fairly severe. Stating that no specific bed sharing strategy is safe, and including a specific list for all the possible situations of bed sharing that should *always* be avoided, marks a distinct change in tone for the AAP's stance on bed sharing.

In all of these reports the main concern for babies is an increased risk of SIDS, with a secondary risk of accidental death by suffocation. However, the link between bed sharing and SIDS, accidental suffocation, and other unexplained death is a highly debated subject. A number of studies claim there is an association (Fleming et al. 1996, McIntosh et al. 2009, Arnestad et al. 2001, Scragg et al. 1993). The AAP has stated that bed sharing, a Level A recommendation, which means there have been enough studies completed to show enough of a risk that further studies are not likely to change their recommendations (2011a). However, a number of studies seem to show there is little to no risk when bed sharing is practiced without other risk factors (soft bedding, tobacco or alcohol use, entrapment risks eliminated) (Carpenter et al. 2004, McGarvey et al. 2006, Klonoff-Cohen and Edelstein 1995, Blair et al. 1999, Blair et al. 2009).

The effect is parental confusion. It seems unlikely that if the “experts” are incapable of identifying the risk of SIDS when bed sharing, that the average parent will be able to do so. The fact is, whether the link between SIDS, accidental suffocation, and other unexplained death can be linked to bed sharing or not, does not matter. Unless parents have an advanced degree in medicine, infant behavior, and statistics, they must

decide how much they believe the assertions of the AAP and the CPSC. But by linking possible infant death to bed sharing, these official statements have ensured the discourse around bed sharing for parents includes the highest possible stakes: the life or death of their child. The underlying official message seems to be that, if you chose to bed share, you are putting your child at risk for death. The logical conclusion is, if your child were to die in your bed, it would most certainly be your fault. Given the authority that the AAP has, and the implications they have placed on bed sharing, it is expected that this will be an argument highly visible in the online discourse of parents. It should be, if the data the AAP was considering was irrefutable. However, as the next chapter will show, scholarship on this issue is mixed.

CHAPTER 4

James J. McKenna: A Different View

Introduction

Dr. James J. McKenna is a professor of anthropology at the University of Notre Dame and is the director of the Mother-Baby Behavioral Sleep Laboratory there. A Fellow of the American Association for the Advancement of Science, Dr. McKenna is considered the world's leading authority on mother-infant co-sleeping, in relationship to breastfeeding and SIDS (MBSL 2014). In addition to the prominence he has because of his work, he often works with organizations that promote breast feeding and has given hundreds of lectures on breastfeeding, co-sleeping, SIDS, and the evolution of infant sleep (MBSL 2014). Several of the popular authors in Chapter 2 included mention of Dr. McKenna, or cite his work (Simkin et al. 2010, Murkoff and Mazel 2010, Sears et al. 2013, Kurcinka 2006). For the parent looking for information on co-sleeping or bed sharing, they are very likely to come across his research, and a major segment of his published work is available at the Mother-Baby Behavioral Sleep Laboratory website, cited above. Because of this, it is important to investigate what he and other researchers say about co-sleeping in general and bed sharing in particular as they may be one of scientific sources that supports bed sharing that is also easily accessible to parents.

The Science of Solitary Sleep

James McKenna offers insight into how the 19th and 20th century history of children's sleep helps to contribute to the notion that the healthiest choice for a baby was to sleep alone undisturbed. Due to the historical circumstances mentioned in Chapter 2, most infants were sleeping alone in cribs in their own room, undisturbed, and were formula fed at the time when the science to study their sleep patterns, electrophysiology, emerged (McKenna and McDade 2005, McKenna et al. 2007). Ball (2003) notes that the

widespread use of formula and cow's milk as the primary infant food changed the manner in which infants slept. Because it takes longer for a baby to digest a meal of formula, a breastfed baby will not sleep as long as a bottle-fed baby and will have sleep/wake patterns that vary greatly from its bottle-fed counterpart. A breastfed baby is also more likely to sleep next to its mother, which further changes the baby's sleep/wake patterns.

McKenna and McDade, (2005) argue that when the standards for infant sleep were created, no consideration was given to world-wide practices or the history of infant sleep before the Industrial Revolution. Because co-sleeping and bed sharing were at all-time lows, the first investigators of infant sleep, "operating within their own contemporary cultural context, used solitary-sleeping formula fed babies as their model for measuring and quantifying 'normal' and 'healthy' infant sleep" (McKenna et al. 2007). According to McKenna and McDade (2005) the results of these tests became the parameters disseminated through pediatrics and through parenting advice manuals. The hallmark of healthy infant development was the age at which he began to sleep through the night:

It is in this historical context that the social myths about the importance and normalcy of solitary infant amongst bottle-fed infant achieved 'scientific' validation. Under these guidelines, children who did not fit the bottle-fed, solitary sleeping model were considered to be outside the norm, and requiring a "cure" (McKenna et al. 2007).

Since babies who are breastfed follow a different sleep/wake pattern, babies who are breastfed often fall outside of the parameters of this definition for healthy infant sleep, waking and signaling (crying) more often.

The standard for healthy infant sleep developed using the bottle-fed solitary sleeper would remain until the 1980s when anthropologists began to question the normalcy and healthiness of infants sleeping alone (Ball 2003, McKenna et al. 2007). McKenna argues that the scientific validation of solitary sleep through

mechanisms like these sleep studies has skewed the discourse regarding bed-sharing. The result is that biologically protective sleep and mother-infant sleep contact is considered “inherently lethal while solitary crib sleeping is assumed to be healthy, beneficial, and always safer” (McKenna et al. 2007).

Evolution of Infant Sleep

In an effort to examine the proposed safety of solitary sleep, James McKenna began his research into SIDS during the 1980s when he hypothesized that evolutionary factors may have selected for infants co-sleeping with their parents and bed sharing may help a baby remember to breathe through parental breathing cues (1986). McKenna et al. (2007) question whether, with so much energy invested in procreation, evolution might have selected for a particular type of infant care. Further they question whether current culturally accepted “(and in some cases ‘recommended’) care-giving patterns expose today’s human infants to environments that are so far removed from those within which infant development evolved that maternal and infant health are compromised as a consequence” (p 134).

McKenna et al. (2007) examined research that explores the effects of mother-infant separation in primates. Citing several authors (Reite and Field 1995, Harlow 1958, 1959, Blum 2002, Coe and Levine 1981, Laudenslager et al. 1982, Coe et al. 1985) McKenna notes that even short term separations between a primate baby and its mother can result in negative physical reactions for the baby such as adrenal-cortisol elevations, abnormal breathing, negative changes to the immune system, heart arrhythmia, and depression.. A number of these kinds of responses have been recorded in human infants, but they are usually considered the result of long term mal-treatment and non-responsive parents (Ahnert et al. 2004, Kaufman and Charney 2001, Teicher et al. 2003). One study that focused only on nighttime separation of human infants, specifically during sleep

training, found that those infants who were left to cry had elevated levels of cortisol in their system, which is considered a sign of stress in infants of other primate species. The study, however, didn't note if those levels decreased once sleep training was completed (Middlemiss et al. 2011).

McKenna et al. (2007) notes only one study examines non-human primate co-sleeping (Fite et al. 2003). He argues this may be because non-human primates *always* sleep with their young and so research time and funding is spent on aspects of primate sleep that have variation. However, he argues that the idea that every non-human primate practices co-sleeping is worthy of consideration:

Thus, the absurdity of the notion of a nonhuman primate mother putting her vulnerable infant to rest alone, away from the safety of their proximity and care, throws into sharp relief the fact that this same notion is perceived as healthy, practical, and logical for human infants in many western societies (McKenna et. al. 2007, p 140).

To explore the idea of the biological need of human infants to sleep next to their mothers, McKenna proceeds to examine work done by Carol Worthman and Melby (2002) who examined the evolution of human sleep patterns. Worthman explores the idea that two evolutionary factors for humans – the loss of hair and the adoption of bipedalism – would have resulted in humans switching from arboreal sleeping to ground sleeping. The loss of hair would have had two results: infants would have a more difficult time clinging to mothers, making sleeping off the ground dangerous, and it would have meant less warmth for the human, necessitating some method of staying warm during sleeping hours, arguably sleeping in groups and close together (Worthman 2008, McKenna and Mack 1992). Ground sleeping would have resulted in increased danger from predators. Thus, human sleep architecture may have evolved to protect the sleeping humans from nearby predators. She argues that the human sleep cycle favors light sleep over deep sleep, possibly the result of evolutionary selection of a sleeping

pattern that allowed for easy wakings and awareness to compensate for the danger of predation. McKenna and Mosko (1990) notes this is the exact sleeping pattern of breastfeeding and co-sleeping mothers and babies, with many wakings through the night.

In addition to the theory that ground sleeping may have instigated evolutionary process that led to our current sleep cycles, McKenna with other authors also argue that the relative immaturity of the human infant may also have played a role in co-sleeping as the preferred nighttime strategy of human ancestors (McKenna and McDade 2005, McKenna and Gettler 2007). Human babies are the least neurologically developed primate at the time of birth, due in part to the relationship between the size of the human infant's head and the mother's pelvis. If pregnancy continued until the baby was more neurologically developed, the head would be too large to pass through the pelvis. In turn, the pelvis cannot become larger without compromising women's ability to walk. Part of being neurologically immature includes certain behavior in regards to breathing. In their chapter of the *Textbook of Human Lactation*, McKenna and Gettler (2007) present evidence that the "practice breathing" that an infant does in utero is stimulated by sound of the mother's blood rushing blood and patterns itself after her heartbeat. They argue this same kind of stimulation exists outside of the uterus when a mother sleeps near her child and the infant can hear her breathing and heartbeat. Further, they argue that when the co-sleeping mother exhales, it creates levels of CO₂ near the baby which may stimulate the baby to breathe more regularly (see also McKenna et al. 2007).

With these considerations in mind, McKenna (McKenna and Mosko 1994, 1993, 1990, McKenna et al. 2007, McKenna and McDade 2005) argues that the evolution of humans has selected for nighttime sleep that favors light sleep over deep sleep to protect against predators, and co-sleeping for warmth, protection, and as a function of assisting a neurologically immature infant in breathing. But McKenna also argues that these selections also benefit mothers (McKenna et al. 2007, McKenna and McDade 2005).

There are several studies which show for a mother who co-sleeps and breastfeeds she will breastfeed more often and for longer periods than a mother who breastfeeds but whose infant sleeps separately (Gettler and McKenna 2011, Mosko et al. 1996, Ball 2003, Baddock et al. 2007, Young 1999). This extra time nursing her child provides benefits for the mother (many of which will be discussed below) and, interestingly, may actually improve the evolutionary fitness of these mothers. McKenna postulates that the extra time nursing is more likely to cause amenorrhea in these women, which may protect them from certain cancers (cervical, breast, and ovarian), as well as protect them from other “reproductive impairments” (McKenna et al. 2007, Gettler and McKenna 2005). It also ensures that they will not have two young children at the same time, which would place both of them at risk.

McKenna (McKenna and Mosko 1994, 1993, 1990, McKenna et al. 2007, McKenna and McDade 2005) argues that these selected features of infant sleep and infant sleep care suggest that human infants are programmed biologically for the need to sleep with their mothers for their health and safety. He further postulates that co-sleeping might also provide protection from SIDS, which is sometimes related to neurological immaturity and infant apnea (pausing in breathing).

The Bed Sharing Dyad and Sudden Infant Death Syndrome

In the early 1990s, Mosko and McKenna ran two small studies at the University of California Irvine (UCI) Sleep Disorders Laboratory. Their goal was to use “an anthropologically informed approach that recognized the human species-wide pattern of mother-infant social sleep and its importance for nighttime feeding and infant regulation and support” (McKenna et al. 2007, McKenna et al. 1990, McKenna et al. 1993, Mosko et al. 1993). These first studies only involved a total of eight women, but the results were impressive. The team found that bed sharing mothers and their infants tend to have

synchronized sleep cycles, waking simultaneously with simultaneous changes in brain waves. It was also found babies who were co-sleeping had more shifts between the different stages of sleep than solitary sleeping infants, as did the mothers. They also spent less time in the third and fourth stages of sleep, which are the lightest.

These results led to a third, and larger study conducted at UIC, where the team studied infant sleep architecture, maternal sleep architecture, infant arousals, breastfeeding, sleep position, and CO₂ exposure. The infants participating in the study were both regularly bed-sharing and regularly solitary sleeping, each placed in bed-sharing and solitary sleep conditions (Mosko et al. 1997a,b,c). The results showed that, once again, both mothers and babies who bed share had less time in the deep stages of sleep, experienced more synchronized and overlapping arousals, and breastfed more often and for longer intervals. Infants were most frequently placed on their backs and sides for sleep, facing the mother, and the mother nearly always lay on her side facing the infant. When babies were placed on their backs, they most often would turn their head to face their mother (80% of the time for supine infants). Finally, levels of CO₂ were found to be elevated, especially if a blanket was used that could create a space for CO₂ to accumulate. These levels were within the range to stimulate infant breathing, but not high enough to be dangerous (Mosko et al. 1997a, McKenna et al. 2007).

These researchers are quick to note that these studies do not prove outright that bed sharing offers any protection against SIDS. However, they note that bed sharing does provide multiple benefits that are thought to reduce the risk of SIDS. Increased breastfeeding and non-prone sleeping positions are known to reduce risk. Some researchers believe immature neurological responses might be responsible for at risk infants “forgetting to breathe” or failing to arouse from a life threatening obstructive apnea. Bed sharing has been shown to stimulate breathing through lighter sleep, more arousals, more touching, and also possibly from the carbon dioxide breathed out from the mother. While McKenna says he doesn’t expect these factors will be a major

contributing factor for all infants, they might be a contributing factor for the at risk infant, and perhaps might prevent an unexpected infant death (McKenna et al. 2007, McKenna and Gettler 2007, McKenna and McDade 2005, McKenna et al. 1999, Mosko et al. 1997a, b, c).

Bed sharing and Breastfeeding

While Dr. McKenna's work in the physiological effects of bed sharing are well known and are among the most recognized arguments for bed sharing as a possible strategy to reduce the risk of SIDS in infants, his research has also contributed to the discourse surrounding bed sharing and breastfeeding. As noted above, one of the results of the sleep studies conducted in the early 1990s was that bed sharing mothers and infants breastfeed more often throughout the night and for longer periods. McKenna argues the relationship between bed sharing and breastfeeding is circular, each contributing to the other. Dr. Helen Ball has added research that suggests that conversations regarding breastfeeding should almost always include conversations about bed sharing (Ball 2003).

A quick glance at James McKenna's publications and presentations show a number of articles and presentations for La Leche League International, the *Textbook of Human Lactation*, breastfeeding consortiums, and breastfeeding associations. He has completed a wide variety of research not only into breastfeeding practices of bed sharing and solitary sleeping infants, but has also accumulated information regarding human breast milk and associated this with his theory of evolutionarily supported bed sharing (McKenna and Gettler 2005, Gettler and McKenna 2011, McKenna and McDade 2005).

In the 2005 article, McKenna and Gettler present information regarding human breast milk in comparison with milk of other mammals. They demonstrate that human breast milk is low in protein, low in fat, and high in carbohydrates. This is consistent with other mammals that tend to carry their young with them and remain in constant

contact (including co-sleeping at night) with their infants. This is because the quality of milk is such that it is digested very quickly and the infant requires multiple feedings throughout the day and night to meet its caloric intake needs. In comparison, animals that tend to leave their young for long stretches of time have milk that is high in fat, high in protein, and low in carbohydrates. This milk takes longer to digest and does not require multiple feedings throughout the day and night. Gettler and McKenna argue that the composition of human breast milk is evidence that the human infant has evolved to be close to its mother. In 2011, Gettler and McKenna completed a study in regards to the differences between mothers and babies that routinely bed shared and mothers and babies that routinely slept separately. As expected, the bed sharing group had more feedings during the night, for longer times, and the time between those feedings was shorter (but not significantly so). As a result, the authors argue that the child that routinely sleeps separately may not be getting enough milk to meet his daily caloric needs or get the most immunological protection from his mother's milk. The child is certainly getting fewer calories overnight. This could be even more significant in situations where the mother is unavailable for additional feedings during the day.

This is an important link in the debate surrounding bed sharing as it has been shown that bed sharing and breastfeeding often coexist, and those mothers that breastfeed longest, also tend to bed share. Dr. Helen Ball from the University of Durham offers a complete look at this phenomenon. In a 2003 article, she discusses the mechanism that may result in a number of mothers giving up on breastfeeding. Ball argues that the cultural expectations for the baby to sleep through the night from the start leaves mothers unprepared for the number of night wakings and the time it takes to tend to a baby that isn't in the bed. Thus, many mothers find they cannot cope with the lack of sleep required to breastfeed a baby sleeping alone. Ball notes they often take one of three actions: they switch to formula (or formula and cereal) to reduce night waking, they subject their infant to a method of sleep training to lengthen sleeping times, or they bring the baby to bed

with them and feed on demand. In her study, Ball also found that “almost all mothers who continued to breastfeed for more than 8 weeks incorporated bed-sharing into their nocturnal feeding and sleeping routine early on” (Ball 2003, p 186).

This relationship between breastfeeding and bed sharing is described by McKenna as “an integrated adaptive system” (McKenna and McDade 2005). It is particularly pertinent when considering that more women in the United States are breastfeeding their newborns and are continuing to breastfeed past 8 weeks, but are aware of the official recommendation is there is no safe bed sharing. These women may find themselves in a difficult position of choosing to breastfeed, but not wanting to bed share because of cultural discourse, and ultimately “failing” at breastfeeding because they can’t sustain months of waking every few hours to feed a hungry infant. McKenna asserts that in regards to breastfeeding and the choice to bed share:

It is necessary to publicly acknowledge the social and legal legitimacy of mothers or fathers making a proactive choice to ‘co-sleep’ when done safely. Not to do so will seriously limit the degree of mutual access health professionals and co-sleeping parents have to each other, therein reducing opportunities to discuss what it means to sleep safe with baby (McKenna and McDade 2005, p146).

Regarding Discourse

McKenna has one article that he has dedicated to the subject of discourse of parents regarding bed sharing (McKenna and Volpe 2007) and another dedicated to the discourse of the media and official groups like the AAP and CPSC (Gettler and McKenna 2010). In the article directed at the media and official sources, McKenna and Gettler argue that the blanket message of no bed sharing situation is safe, is not useful and in fact, is misinformed. They argue that blanket statements against bed sharing do not consider the many reasons parents choose to bed share, nor do they consider the many ways in which parents may choose to sleep with their infants. The present arguments that

the epidemiological studies are not conclusive, citing problems such as lumping bed sharing and couch sharing into the same groups, or not eliminating known risk factors such as smoking. Finally, Gettler and McKenna argue that the best public policy discourse will include topics of history, parental value systems, the need for sleep, method feeding, and family belief systems.

McKenna offers research covering the above topics in an article where he and Volpe (2007) examine what co-sleeping and bed sharing parents say in regards to the practice. McKenna found that often these parents are very defensive of their decision, even more so than he expected they would be. He argues that for there to be real change in the discourse surrounding bed sharing and for there to be better communication and public policy, these narratives need to be respected and understood. McKenna and Volpe argue that bed sharing and breast feeding are not independent child care actions, and should not be regarded as distinct processes but rather, “breastfeeding and forms of co-sleeping are biologically, socially, and psychologically (emotionally) interdependent,” (p 373) as might be expected when the evolution of breast feeding and co-sleeping is taken under consideration.

Guide to Safe Co-Sleeping

In order to provide parents with a manual of how to achieve safe co-sleeping McKenna has included safe bed sharing segments in a number of his articles. The entirety of his argument can be found in his 2007 book, *Sleeping with Your Baby: A Parent's Guide to Cosleeping*. In his book McKenna addresses a number of issues already discussed here. He defines co-sleeping as sharing a room with your infant, and bed sharing as sharing a sleeping surface with your infant. He asserts there are many ways to co-sleep and no one right way. McKenna includes cultural comparisons, species comparisons, and a list of all the good things co-sleeping does for babies, including less

crying, better temperature regulation, more breastfeeding, light sleeping, increased nightly arousals, more regular breathing, better growth, less apneas, and better heart rhythms. He also includes the benefits of increased breastfeeding: better immunological protection, protection for the mother against cancer, faster weight loss for the mother, lower stress for both mother and baby, and more sleep. McKenna acknowledges the parents that choose to bottle feed and offers them co-sleeping solutions, but notes that bed sharing while bottle feeding has been shown to be associated with increased risk, perhaps due to deeper sleep and the tendency of mothers who co-sleep with bottle-fed babies to place them on a pillow near their face.

McKenna dedicates a chapter in his book to explain why co-sleeping has been described as dangerous. He notes the history of infant sleep emphasized solitary sleep, and a lack of comforting as a means to “creating good moral character (defined as being a self-sufficient adult)” (p 54). He also explains how the media plays a role in making co-sleeping appear to be wildly dangerous. Often, when the media reports about a baby that has died while sleeping with their parents, they neglect to reveal (or they simply do not have) the context in which this death occurred. Issues such as drugs and alcohol consumption by the parent or sleeping on a problematic surface like a couch are seldom reported. Dr. McKenna notes the reason for this is because the medical community has decided that in the case of bed sharing the only message people need is “one simple negative message—never do it” (Nakamura 1999, in McKenna 2007, p 56). However, this message doesn’t take into account the fact that there are scientific studies that show bed sharing is not only safe, but beneficial. It also fails to acknowledge parents as capable of making their child safe as they make decision which “belongs only to parents and not to ‘outside authorities’” (p 56).

McKenna then gives parents the information he believes they need to make a sleeping space safe for their child. He begins with a list of instances when bed sharing shouldn’t be done, and when co-sleeping with the baby on a separate surface would be

preferable: if exclusive breastfeeding is not the plan; if either of the parents are obese; if either parent currently smokes; if the mother smoked during pregnancy; if the parents are sleeping on anything other than a large firm mattress (including couches, waterbeds, sheepskins or folding mattresses); if they use heavy blankets or many pillows; if they use drugs or alcohol; if there are other children that are in or are likely to climb into the bed; if there are pets that will be in the bed; or if there are any stuffed animals on the bed. He notes that the bed should be pulled away from the walls, and set on the floor if possible, making sure there is nowhere for a baby to become wedged between a bed and wall, bed and another piece of furniture, or any way for the baby to become entrapped in the headboard or footboard. He highly recommends dismantling the bed if possible. Finally McKenna suggests using a light blanket, keep the temperature in the room a little lower (heat from mom will keep baby warmer), and to keep long hair pulled back. He provides a sketch of what the preferred bed sharing room would look like: bed in the middle of the floor, on the floor; light blankets; mom between dad and baby, her hair pulled back; and baby dressed lightly.

Dr. McKenna closes his book by addressing common questions regarding bed sharing and co-sleeping. He assures parents that they can still have an intimate and tender relationship with your spouse and that co-sleeping may give fathers a chance to be emotionally involved. He argues that bed sharing will not prevent a child from becoming independent. Self-soothing is not at the root of autonomy, and every child can learn to sleep on their own. However he is careful to inform the parent that children who bed share often take longer to sleep on their own, and the possibility does exist that the child will not want to do so at the same time the parents wish it. For parents worried about getting a good night sleep, McKenna assures them that many may sleep better when bed sharing because they don't have to fully wake to check on a baby, or even to feed an infant that is right there. This is especially true for breastfeeding mothers. Also, McKenna admits that in the case of the alleged "bad habit," that many bed-sharing

children do not wish to leave the parental bed for what he describes as all the right reasons. But, he argues that any habit can be changed and new routines are part of childhood. So these things can be accomplished with consideration of each particular child and what works best for them and the family.

Dr. McKenna offers the bulk of the argument supporting bed sharing, and it is very likely that if bed sharing parents are incorporating discourse into their own statements and beliefs, they will originate with James McKenna. Perhaps one passage from McKenna's (2007) book sums up the theme behind much of his work:

I worry more and more about our society's willingness to overlook parental rights, acquired wisdom, and parental judgments in favor an increasingly impersonal and inappropriate one-size-fit-all "medical parenting science." Aside from *getting it wrong* on a scale with which we are already too tragically familiar (recommendations to place infants on their stomachs to sleep, place infants in separate rooms, and to bottle feed), such a world view, if left unchallenged, further undermines parents' enjoyment of their infants and, worse, leads them to doubt their own abilities to assess what their own infants really need and why, preventing them from making their infants happy, safe, and healthy (p 29).

CHAPTER 5

Discourse and Analysis

Introduction

This chapter is discusses the analysis of parental discourse regarding bed sharing in online settings. Reported rates of bed sharing, common themes in the discourse, and how that discourse connects with the official and public discourse described in previous chapters will all be explored. The goal is to better understand what kinds of discourse parents incorporate into their own discussion and how discourse affects the way they feel about bed sharing in general and parental choices (theirs and the choices of others) in regards to infant sleep practices. It will be interesting to see if any discourse seems to originate from the parents themselves, as this is a distinct possibility.

Methods

These samples are taken from two websites that are popular to mothers, have a wide viewership, and offer a forum for asking and answering questions. The first, BabyCenter L.L.C., reaches 36 million moms worldwide and according to their statistics has been used by 7 of 10 mothers of newborns in the United States. The second, Circle of Moms, is a question and answer forum for mothers that currently has more than 10.6 million members. On each site, the question, “Where should baby sleep?” was input into the search tool. Each site generated at least one question with comment threads that included at least 100 responses. For each site, the most recent question with 100 or more responses was chosen. This resulted in one thread of 182 responses (Circle of Moms) and another of 101 (BabyCenter). This allowed the analysis of a variety of relatively recent opinions.

Each response was given a unique number within its thread and any response that was duplicated exactly (exact answer from exact respondent) was noted and not recorded,

however they were assigned a number for tracking purposes. This changed the final number of responses for each thread to 178 and 98, respectively. It was decided that even though one thread was now below the 100 level goal, it would be kept as there was not another thread approaching this number of responses from the BabyCenter site. Each response was coded for common themes and sleep location. That information was input into a database so that it could be sorted by theme or sleep location and the results are interpreted below. All quotes from respondents are presented below exactly as they appear online, without correction to spelling, grammar, or punctuation.

The Questions

It is important to note what questions were asked in each thread, as this undoubtedly will affect the responses given. For the first thread (Circle of Moms) the question was:

Where did you baby sleep as a new born? My husband thinks it is safer for a new baby to be in a bassinet but I disagree and I would rather just use a crib from day one. He seems to think SIDS is only a risk if a baby in sleeping in a crib.

As such the majority of responses in this thread centered on the safety of either crib sleep or bassinet sleep. It may have been expected that co-sleeping responses may be limited to room sharing (and its likely protection against SIDS), but many respondents included their thoughts on bed sharing in particular. As expected there was a large amount of discussion centered on SIDS in general.

For the second thread (BabyCenter) the question simply states: “sleeping with baby.” It became clear after beginning to code this thread that the question originally had some other portion, but at the time this information was retrieved from the internet, the

question details had been removed. It might be inferred from responses¹ that the parent had a question regarding his or her son, who apparently did not like his bassinet, and s/he likely was using bed sharing as a sleep strategy and may have been concerned about the safety of that choice. The responses in this thread center around bed sharing and the safety of this choice.

The differences in the themes of these threads compliments each other nicely and what people were willing to say in a discussion about cribs/bassinets about bed sharing, and what people were willing to say to a person likely practicing bed sharing is very enlightening and will be discussed at length in a later segment of this chapter.

The Number of Bed Sharers

One of the first questions I wished to address is how many parents state they had used bed sharing as a strategy for infant sleep? Parents were counted as having used bed sharing if they said they shared a sleeping surface with their baby at any time. This included people who stated that bed sharing was their regular strategy, people who used it only sometimes, and people who admitted they slept in an armchair or couch with their child on a regular basis. People who did not specify where they slept with their child were excluded. In the first thread, 11 people did not specify where their child slept, and four did not specify clearly enough for determination (e.g. the respondent indicated they co-slept but did not specify bed sharing specifically). This left 167 respondents in that thread who specified where they placed their child for sleep. Of this 167, 67 indicated that they used bed sharing specifically as an infant sleep strategy. In the second thread, 14 people did not specify a specific strategy and 1 had confusing language and was therefore excluded. This left a total of 84 respondents who specified a nighttime sleeping

¹ Some quotes that help infer the question asked: "My daughter doesn't sleep well in her bassinet either.", "Our newborn wouldn't sleep more than an hour in her bassinet, either.", "Please be careful if you choose to share your bed with your baby." and "I'd recommend you read Dr Sears' *The Baby Book*. You will feel even better about co sleeping and he gives great advice on doing it SAFELY."

arrangement, and of these 68 indicated they used bed sharing. These results are displayed in Table 5.1.

	Total Number of Respondents	No strategy stated	Specific strategy stated	Strategy unclear	Bed Sharing	% of respondents using bed sharing
Circle of Moms	178	11	167	4	67	40.12
BabyCenter	98	14	84	1	68	80.95
Total	276	25	250	5	135	54.00

Table 5.1 *Percentage of bed sharers per thread.*

It is interesting to note that the percentage of bed shares is rather high. This might be expected for the BabyCenter thread as it was focused on bed sharing in particular, but it might have also been expected that the Circle of Moms thread would have had a relatively smaller number of bed sharing respondents as the questions specifically centered on cribs and bassinets. The supposed trend may still hold true. According to Willinger et al. (2003), 47.3% of American families practice bed sharing and Ball et al. (1999) found that 70% of parents were at least part time bed sharers. The numbers here are less (40%) and more (80%), which fits with the expected trend for each thread. This highlights the difficulty many researchers have deriving a solid number of bed sharers across a wide population of parents.

Respondents without a Strategy

One interesting outcome immediately noted in the above groups was the discourse trend for people who did not state a sleep strategy. Of the 25 people above who did not specify a sleeping arrangement, 19 remarked on an issue of safety or bed sharing (of the remaining seven, two are comments on the parent's choice in nighttime strategy and 5 are

concerning the clutter created by baby things; two of those were from the person who originally posted the question). Thirteen responses were regarding bed sharing, and eight discuss SIDS, with three commenting on both. Ten responses were on the dangers of bed sharing (three of these mention SIDS) and three claiming bed sharing is safe.

The three commentators who spoke in favor of bed sharing have very different kinds of comments from the others, and so they should be looked at separately. Two are very ambiguous. One states that Dr. Sears can provide information on how to bed share safely, the other notes that as long as the parents aren't overmedicated or drinking there is no danger of overlaying your child. The third comment is more strongly worded, as this woman is responding to one particularly aggressively anti-bed sharing post (which will be discussed later). She argues that bed sharers are not "nuts" and calls for an end to the personal attacks on bed sharers. She states that studies are not conclusive in either the case of co-sleeping or for letting infants "cry it out." This person argues "a well-rested parent is a better parent. And taking your little one to bed with you assures more rest for both parent and child. It is not nuts or crazy." This respondent says she thinks letting a child "scream continuously without a response...is nuts," and states that she feels this makes her no different (in name calling) than the other poster. However, it should be noted that this respondent is attacking the practice of cry it out as nuts, not necessarily the person. Although this is a fine line to draw, it is still there. As will be discussed later, not many bed sharing parents, or supporters of bed sharing are aggressive toward parents who are solitary sleepers. This is one of the few exceptions.

Of the ten that warned against the dangers of bed sharing, one offered just a general statement about the danger of bed sharing, one called it selfish, three noted the danger of overlay, three shared stories of people they knew who lost a baby because of bed sharing (one woman claimed her own son had died), and three mentioned the dangers of SIDS while bed sharing (including the woman who lost her son).

It is important to note that the mother who lost her son never says how he died. She does not specify if he died in his bed or her bed, or indeed from SIDS. She simply states that her son died and then gives her opinion on bed sharing. One of the stories regarding the death of a baby asserted the baby died from suffocation in the parents' bed, but then stated the cause of suffocation was unknown. The third story regarding the death of an infant here was involving a mother who nursed her son to sleep and he then became trapped between "her upper arm and breast." Like many stories offered about infant death in a parental bed, there is no information as to the state of the mother. Was she sitting in bed? Was she under the influence of any substance? How did the infant become trapped in such a difficult place on the body without the mother being aware? It is tragic and the effect is definitely severe, but the facts surrounding these deaths are not present and raise interesting questions. However, it appears that these stories weigh heavily against bed sharing due to the possibility of a parent overlaying their child.

Of the people who mention overlay in the above segment, one stands out as particularly aggressive toward the people who bed share. While many responses opposing bed sharing are strongly worded, it is not often that the people who choose bed sharing are themselves attacked. This is the post to which the earlier bed sharing supporter was responding. In this post the author attacks bed sharing parents, calling them "nuts" several times and "weird." The author also tells bed sharing moms to "set aside their own separation anxiety issues and start doing what is best for their marriages and babies."

Looking at these posts in particular might be useful as the respondents did not identify themselves with any sleep strategy, and therefore the information they are providing is information they feel is necessary for each questioning mother to have. Of course, their rhetoric often makes it clear which practice they consider appropriate. It may be these responses represent more of how these people feel about infant sleep and less to do with their own experiences. This may explain why it is in this group some of

the more verbally aggressive posts are found that are directed to a specific group of people rather than at the practice.

Discussions of Bed Sharing

There were a few trends discovered in the discussion of bed sharing in particular. These often grouped around whether the person practiced bed sharing or not, but some results were unexpected. Bed sharers often describe their own experiences in a positive light, but they are also the most likely to refer to bed sharing in general terms such as, “bad,” “a no-no,” “a bad idea,” or “not safe.” However, as expected the strongest words against bed sharing comes from those who do not practice it.

Parents Who Bed Share

Discussions of bed sharing from bed sharing mothers have several common themes. Many mothers discuss similar reasons for bed sharing, similar experiences, and similar concerns.

Not all mothers gave a reason for why they chose bed sharing, but nearly a quarter of all bed-sharing moms recorded indicated that their reason was related to sleep. Either the mom needed more sleep or the baby refused to sleep anywhere else. The next most common reason given was for the ease of breast feeding, while other less common but noted themes included needing to check on the infant in the night, worry about the infant’s breathing, and recovering from cesarean sections. Many mothers discussed how they felt about bed sharing. Terms such as, “wonderful,” “bonding,” “love it,” and “beautiful” occur fairly often. A few mothers note that they did not plan to bed share, but have enjoyed it.

Of the discussions where bed sharing is mentioned as either not safe, or is discussed in negative terms, bed sharing mothers were the most likely to be posting. Bed

sharing is specifically mentioned in a negative connotation 44 times throughout the forums. Of those 44 times, 24 of them are from mothers who are currently practicing bed sharing. Ten are from parents who have chosen a different sleep strategy and the other ten were discussed above from posters who did not describe a strategy.

Interestingly, more than half of the negative comments about bed sharing come from bed sharing mothers. Not all of these are overtly negative. In fact, the majority of them have a similar pattern of discourse. In 12 of these 24 conversations the mother mentions that she knows bed sharing is wrong, dangerous, or not appropriate but then qualifies her situation. “I know they say that’s not a good thing to do...but that way I can touch him through the night,” “i know its not as safe as cribs are...but he had colic really bad and would only sleep if he was being held,” “I know I’ve heard that’s a no-no, but sometimes you do what you feel most comfortable with,” are some examples of how these phrases are formed. Often these women also include a statement indicating that they feel judged for their decision: “I was really bad if you ask any healthcare provider,” “I will probably catch hell,” “I feel judged by other parents.”

This particular group of responses demonstrates that a number of women realize they are, according to mainstream culture, not supposed to be sleeping on the same surface as their child. However, they have found a way to excuse the behavior in their mind and make it acceptable, or they wish to appear as if they have a reason for those who might read it, for their behavior. It seems likely this is a very common occurrence for many bed sharing parents, even for those who don’t specifically state they are aware bed sharing is considered “wrong.” Nearly always when a respondent replies that they bed share, it is followed quickly with a reason they needed to do it. A lack of sleep, screaming baby, cesarean sections, and breastfeeding are all reasons given immediately following a declaration of bed sharing.

Another theme that emerges for bed-sharing parents who speak negatively about bed sharing includes regret; this theme is often tied with discourse surrounding

independence (of either the child or the parent). Six of the 24 parents indicated that they have some regret over bed sharing, usually because the baby is too dependent on the parents for falling asleep. These parents make statements such as “i should have listened to everyone and made him sleep by himself! “but if i had to do it over i would have stuck with the crib that way he wouldn’t have gotten use to sleeping with mommy and daddy!” It might be interesting to note that for the parents in this section that cited dependence issues and who also cited an age for their child the ages are 2.5 months, 4 months, 4 months, and 2 years. This seems to suggest that parents are particularly sensitive to the age at which a child should be able to fall asleep on their own, and that age is fairly young. It must be observed that this is only a few respondents and more answers in this area would make a stronger argument.

There were other less prominent themes that should still be explored. Four respondents note that either their husbands were sleeping in another room or on the floor. One woman said she didn’t like bed sharing, but her husband did. These responses support authors who suggest that bed sharing can be stressful on a marriage, but none of these women mentioned any long term difficulties with their husbands on account of bed sharing. Two of these parents discuss sleep training, and self-soothing, one of the two mentions sleep training was working for them at the moment (they had been doing it for four nights). The other said it was “bad enough to have to train then to self-soothe you don’t want then freaking out because they aren’t sleeping with you anymore!” Another two mothers indicated that they had difficulty sleeping with a bed sharing child, but did not discuss the issue any further.

Parents Who Don’t Bed Share

There were ten parents who spoke negatively about bed sharing and who didn’t bed share themselves, but six of them did mention that they shared a room with their

baby. Safety was the number one reason given for not allowing a child into the parental bed. This concern was cited by half of these respondents. Of those, three mentioned suffocation or smothering specifically. Two of those shared anecdotal stories of people they knew or heard of who had lost a child from overlying. One person mentioned that death is a result of bed sharing, but she did not mention suffocation or smothering in particular. As before, the stories involving the death of a child do not include details that would be helpful in determining the exact cause, and in these two statements it wasn't even made clear if the parent was in bed or on another sleep surface. However, it seems that the threat of overlying a child is still the number one concern: one person mentioned harm from falling, and no one mentioned entrapment or an increased risk of SIDS (the most cited concern from the AAP and CPSC). As with the respondents who did not specify a sleep strategy, it appears that a great deal of weight is given to anecdotal stories of parents accidentally smothering their child. This is interesting because epidemiological studies show the greater risk comes from entrapment, while overlaying is considered quite rare (Grossman 2000).

Three of these parents argue that a baby should just be placed in his own bed to learn to sleep or "to get used to it." One other parent simply argued her children were fantastic sleepers and she wouldn't do it any other way, while yet another parent argued that she would not bed share because she would never be able to get the children out of her bed. One parent in this group described bed sharing as selfish stating, "babies don't know where they are anyway. so justifying your own selfish behavior by saying a baby likes it is ridiculous." She continued to note that her place is with her husband and it was not for children to come between them. This again might support the idea that bed sharing causes marital problems. In this case it is clear the wife would never practice bed sharing, so the potential for marital issues from bed sharing is zero. This sort of response in addition to remarks where husbands are in different rooms might be the kind of statement that leads others to believe that marital problems arise from bed sharing.

The comments in this section of respondents have a different tone than those of the bed sharing parents. They are more stern and more dire. Unlike the bed sharing group, whose statements were most often self-reflective and justifying, these statements are directed out toward bed sharers and threaten aggressive consequences. The result is bed sharing parents face two, maybe three sets of condemning and critical voices including those opposing bed sharing, those practicing bed sharing, and perhaps even their own. One mother may have summed up the effect of all this judgment in her post. She, a bed sharing mother: “im a very sad mom because there are times that i accidentally fall asleep while feeding her at night i try very hard not to...is that okay??...im afraid that makes me a bad mom 2 sleep with her at least the half of the night.”

The Risk of SIDS

The risk of SIDS had interesting effects on the responses in these forums. The number of these responses may be inflated as one of the questions directly addressed SIDS as a concern, but the manner in which people respond still reveals a great deal about how they are processing SIDS information. It is most likely that the information they are getting in this regard is coming from the AAP, directly or indirectly.

SIDS was mentioned in some capacity by 65 respondents. While discussion about the risk of SIDS associated with bed sharing was almost non-existent (three commentators mentioned it as discussed above), eight stated overtly that co-sleeping could help lower the risk of SIDS. Two of these stated they were bed sharers, one did not state a strategy, and the other five are presumably room sharers. This may suggest that at least some people are hearing the AAP’s recommendation that room sharing reduces the risk of SIDS, but it also suggests that some (bed sharers) are choosing to use this information as they see fit, and not how it was intended by the AAP. While the overall

number of people who make this connection is relatively low, co-sleeping as a method of reducing the risk of SIDS is the most commonly mentioned preventative strategy.

Similarly, 11 people stated SIDS was the reason they chose their sleeping arrangements, but did not state they believed those arrangements to be necessarily protective. Many mothers stated they were “afraid,” and “worried” about SIDS, and chose methods of sleeping that they felt allowed them to keep a closer watch on their child. Four parents reported they used room sharing to this end, three used bed sharing, and two used a combination of the two. One parent stated that her child slept “everywhere,” while another remarked that she slept on the couch with her child because of a fear of SIDS. When remarking on their fears, two co-sleepers (one bed sharer and one non-descript co-sleeper) were among those who stated they believed co-sleeping reduced SIDS. One person confessed that she thought nothing would prevent SIDS, but being close made her feel better anyway, and one person stated that all SIDS deaths she had heard of happened in cribs, and therefore, wouldn’t use a crib. Two mothers mentioned they lost brothers to SIDS. Both used bed sharing. One put her child in her bed while the other shared a couch.

There were 29 people who offered preventative suggestions for SIDS. When discussing preventative measures that could be taken besides co-sleeping to reduce the risk of SIDS, a large number of strategies emerged. One person each mentioned using a wedge, a pacifier, a sleep sack, a firm mattress, a monitor, and breastfeeding. Likewise, one person each argued against crib bumpers, waterbeds, side sleeping, and overheating. One individual suggested that SIDS cannot be prevented. Interestingly, she stated a number of risk factors that existed in her child’s bed including toys, blankets, and propping him up. Seven people each mentioned back to sleep and no pillows, making these the second most mentioned preventatives (co-sleeping as a preventative against SIDS was the most mentioned preventative). No blankets had six mentions, and no toys or loose/extraneous things in the crib each had five.

The nature of the first question undoubtedly had an effect when discussing the risk factors for SIDS. While 34 provided what they believed were risk factor, nearly a third of those who mentioned SIDS stated that location had no effect on SIDS, saying some version of “SIDS can happen anywhere.” Blankets were mentioned three times; stuffed animals, overheating, pillows, and prone sleeping each had two respondents. Finally, one respondent each stated that the age of the infant, side sleeping, obesity, smoking, drugs/alcohol, and poor air flow was a risk.

The discourse surrounding SIDS in these forums is interesting because it may illuminate a little about what messages the AAP is successfully disseminating. Nearly every one of the AAP’s Level A recommendations (AAP 2011a) is covered here, though each factor may only get mentioned once. The only two Level A recommendations that weren’t mentioned were prenatal care and not using a cardiorespiratory monitor. There is some confusion on the Level B recommendations. Two of the three Level B recommendations (immunizations, tummy time to prevent plagiocephaly) were never mentioned. The suggestion that commercial devices aimed at reducing SIDS (e.g. positioning wedges) was mentioned as a preventative measure. Perhaps the most interesting outcome of the SIDS discussion is the discussion of co-sleeping and the reduction of SIDS. Co-sleeping was the most mentioned preventative measure in these forums, but not by room sharing parents only. Bed sharing parents are also accepting this as validation that they are also protecting their children from SIDS. This may be a symptom of the justification behavior noted earlier. There is apparently a large number of parents bed sharing with their children and these parents are struggling to justify their behavior in the face of a culture that is very critical of this choice. By accepting the AAP’s recommendation that co-sleeping may reduce SIDS, they may be adapting the language of the AAP to validate their own choices.

This seems an appropriate place to mention that the language of bed sharing, room sharing, and co-sleeping is still very much convoluted in a majority of these posts.

Very seldom are bed sharing and room sharing used as terms to describe sleeping strategies. Almost always the term co-sleeping is used and then further defined by the parent. For example, the parent might say they have been co-sleeping since day one when they brought their baby into their hospital bed with them. This confusion of language might also be a factor in the above discussion regarding the adoption of bed sharing parents of the AAP language concerning co-sleeping. It is a very distinct possibility that some parents are confused as to the difference in terms, and perhaps do not realize that co-sleeping and bed sharing are not necessarily the same practice.

Unsafe Practices

The final topic of discussion in the area of parental discourse is concerning unsafe practices admitted to by parents in the comment threads. Many of these practices have been unsafe by a number of authors, the AAP, and James McKenna, so it is interesting that these parents seem to have no knowledge of their increased risk exposure. There are 35 references to unsafe, and likely unsafe, practices reported by parents who are often explaining their preferred method of getting their child to sleep. The most reported strategy also happens to probably be the most dangerous. Seven parents remarked that the routinely used either the couch or an armchair as their shared sleeping surface with their infant, some parents reported using this sleep strategy for a number of months. As stated in other chapters, there isn't any source that considers this safe at any time. The CPSC, the AAP, James McKenna, and a number of popular authors address this issue specifically as inherently dangerous for infants.

Another reported strategy involved using a pillow in the baby's sleeping area, on which to either lay the baby, or prop the baby in a reclining position, reported by five people. The most commonly given reason for this practice was to make the baby more comfortable so that he would sleep for longer stretches. This reason was actually given

by a number of parents for other hazardous practices including prone sleeping, and devices used to keep babies on their sides. Longer sleep periods was also the reasoning behind a relatively large number of parents practicing borderline unsafe practices. Fourteen parents admitted to placing their child in either a swing or “bouncy chair” for extended periods of time, or even overnight in the hopes of attaining more sleep. While not necessarily as risky as, say, sharing a sleep surface with an infant on a couch, many experts do not condone letting a child sleep for long periods, or unattended, in chairs, swings, or car seats as young infants can slump, or get caught in the straps and asphyxiate.

One may consider in these cases, especially where the parent admits to a dangerous behavior in order to achieve longer sleep periods if some of their distress is caused by a culture that pushes the idea that even young infants are capable of “sleeping through the night.” While parenting a young infant is exhausting for certain, that exhaustion may be made to feel more oppressive if a parent were to believe that their child was not sleeping the “recommended amount” for their age. If parents were better prepared mentally to accept regular nighttime wakings as part of their child’s natural biology, they might be less likely to resort to hazardous practices to achieve the “sleeping through the night” milestone. It is beyond the scope of this manuscript to address this question, but it would be an interesting point of further research.

Summary

This analysis shows that there are a large percentage of parents who are choosing to share a sleeping surface with their infant. These respondents have justified their bed sharing as a response to some other problem like colic or lack of sleep. There is discussion relating to bed sharing in negative terms. The majority of this discourse comes from bed sharing mothers. Often these mothers do not necessarily seem unhappy

with their choice, but they do offer proof they understand that they are operating outside the mainstream culture. Other bed sharing mothers do express regret in their bed sharing choice, most often because of issues of dependence. They either regret their own lack of independence from their child, or dislike their child's dependence on them to instigate sleep.

The discussion against bed sharing from those who do not bed share most often asserts the dangers of overlaying a child. Several parents shared anecdotal evidence of children they "knew" who had died because of overlay or suffocation. Other issues with bed sharing were issues of dependence, marital issues, and anxieties of the mother. The concern that SIDS was increased because of bed sharing was only shared a couple of times, and was not found to be major concern.

The greatest concern expressed by a number of parents is SIDS. Many mothers stated that their sleeping arrangement was a response to the fear of SIDS, most of these mothers co-slept with the baby in their room, a few were bed sharers. Co-sleeping was the most described SIDS preventative followed closely by laying babies on their backs for sleep and not using pillows. There were a number of parents that were engaged in sleep practices commonly held to be unsafe: using pillows in the infants sleep area and sharing a couch or recliner as a sleeping surface were the most common.

There is still a great deal of confusion in regards to the terms bed sharing and co-sleeping. It seems very likely that many parents referring to co-sleeping actually mean bed sharing, but it is impossible to tell if they are perhaps using this as a way to share their experience without admitting to bed sharing.

CHAPTER 6

Final Thoughts and Future Examinations

The topic of bed sharing in the United States remains a controversial and hotly debated subject. Not only do popular authors disagree on the appropriateness of parents' sharing a sleeping surface with an infant, but also scholarship concerning the subject is also contradictory. This contradictory scholarship concerning the safety of bed sharing is rarely acknowledged by partisans in the fight. Instead, they focus on studies supporting their side. This is not surprising as the disagreement over bed sharing has deep historical roots in the United States and is grounded in late 19th and early 20th century ideology about how parents and children should behave.

The 19th and early 20th century marked the most significant shift in infant sleep and thinking about infant sleep perhaps ever seen in Western culture. "It is only in recent history that mothers in a relatively small area of the world have the dubious luxury to ask 'where will my baby sleep?'" (McKenna 2007, p 31). Cultural changes brought about by the Industrial Revolution changed the way people interacted with each other, and with their babies, in ways that had significant effects on sleep. The techniques developed at this time have had lasting effects, and are still incorporated by modern authors concerned with infant sleep. Adults were getting less sleep, and concerns about infants and children getting enough sleep gave rise to the concept of infant sleep problems. It became increasingly desirable that a baby get better sleep. Everyone from advice columnists to medical doctors offered solutions to get an infant to go to sleep quickly and to stay asleep all night (Stearns et al. 1996). Early advice advocated for infants to learn to sleep in their own room, to fall asleep with as little assistance as possible, not to be picked up when crying, and to only be fed once during the night (Stearns et al. 1996, Ezzo and Bucknam 2012). The burden of infant care fell to mothers, as fathers were expected to play a

distant role in parenting, acting only as the disciplinarian. Scheduling sleeping and feeding times was recommended to mothers, who perhaps were eager to organize their time as middle class women had less hired help in the early 20th century. This need was also fed by the expanding middle class, which often meant new mothers were in their own homes and didn't have in-laws living in the home to assist with the newborn. The advent of formula assisted new mothers in this project, allowing for longer sleep times and ease of scheduling (Stearns et al. 1996, Ezzo and Bucknam 2012, McKenna and McDade 2005).

Infant sleep and sleep strategies changed from a question of parental choice and biological need to a medical issue with prescribed solutions. McKenna and McDade (2005) argue that in the middle of the 20th century, when solitary sleep and formula feeding were the norms, we developed the skills and capacities to conduct the first scientific studies of infant sleep. Thus, the bottle-fed solitary sleeping infant became the standard to which all other infants were compared. The result was that breast fed babies with their frequent nighttime wakings were considered abnormal and in need of medical intervention. Modern popular authors, many of whom are medical doctors, often still hold to this paradigm. They express concern over adult sleep on a regular basis and assert that the solution to the sleeplessness that accompanies parenthood is training an infant to sleep in its own room, to fall asleep with little or no assistance, and to stay asleep throughout the night. Again the burden falls to mothers to accomplish this feat. Modern mothers are faced with a difficult dichotomy. No longer is formula considered superior. "Breast is best" discourse puts tremendous pressure on women to breastfeed. Without consideration of the reinforcing nature of breastfeeding and bed sharing, bed sharing is usually condemned. Mothers (who work outside of the home more than ever) are expected to nurse a baby in another room multiple times a night. In addition to this, they are still required to complete the majority of the household chores as well as maintain their marital relationships, often while working.

With few exceptions modern advice authors attack bed sharing in particular as a cause of infant sleep problems. Insecurity, dependence, and frequent crying are often blamed on bed sharing. Bed sharing is considered a bad habit, practiced by women who are not strong enough in character to do what is considered best for her child and her marriage. A mother who truly cared about her infant, family, and husband, would teach her child to fall asleep on his own with no assistance so that he could learn independence and self-sufficiency as an adult. Many authors offer a variety of studies to substantiate their claims. However, often no information is provided beyond the statement of an existing study. Specific studies and their details are almost never referenced, and many that are referenced actually show that there are no long term differences found in children who slept alone and those who shared a bed with their parents. The most common studies mentioned are those associated with the AAP's recommendations against bed sharing, and none of those studies are in regards to the issue of infant sleep itself. Modern authors lean most heavily on "personal experience" and their own testing groups to substantiate their claims that children who sleep alone and undergo some sort of sleep training cry less and sleep longer. And this is often true; but it is far from the whole story. There is at least one study that suggests that infants left alone to cry will, in fact, cry less over time (Middlemiss 2012). But research has shown these infants to be just as stressed as when they were crying, suggesting that they haven't learned to "self-soothe." Instead, they have learned that crying is an ineffective means to address their problem, so they stop using it. These babies still wake in the night, they just don't cry for their parents. There are further studies that show that long term effects of ignored crying can be detrimental, as levels of stress chemicals build up (Kaufman and Charney 2001, Ahnert 2004). Modern authors who address this issue assert that a few nights, or even a few weeks, of crying while learning to self-soothe is not the kind of crying to cause damage. However, it has not been rigorously studied, as very few scientists are willing seek permission or funding to let infants cry for long periods, even though thousands of

infants are doing exactly that every night in the United States (McKenna 2007). Instead, it appears that modern authors are simply repeating the rhetoric of the 19th and 20th centuries, providing opinions based more on accepted cultural norms than biological needs or scientific studies.

Even the one group claiming to systematically examine regular scientific studies is seemingly caught in old arguments. The AAP, who provides a substantial amount of evidence against bed sharing, doesn't present the whole picture. The AAP argues that bed sharing may increase the risk of SIDS and exposes the baby to inherent dangers such as suffocation, asphyxiation, and entrapment. However, Gettler and McKenna (2010) argue that the studies presented by the AAP do not eliminate confounding factors and studies that examine bed sharing under safe conditions have found bed sharing to have no increased risk of SIDS. They argue that any sleeping surface may be dangerous to infants; many infants die in cribs every year. Instead of educating parents on how to co-sleep safely, the AAP has chosen to issue a stern statement against bed sharing that has been picked up by the media and made into an absolute position against bed sharing. Aggressive ads against bed sharing have appeared across the country, making no effort to delineate between safe bed sharing and unsafe bed sharing. In some areas of the country, if a baby is found dead in its parents' bed, SIDS is not even considered as a cause. In those regions, the baby died from sleeping in its parents' bed.

The effect this has on parents is substantial, and it is reflected in the discourse surrounding bed sharing. Unlike comment threads regarding breastfeeding vs. bottle-feeding, where proponents of one side often attack the other side with mutual ferocity (Callaghan and Lazard 2011), bed sharing threads have a different tone. Those who bed share very seldom attack members of the solitary sleeping community, although the opposite is not necessarily true. Parents against bed sharing often make statements that directly state, or at least allude to the idea that parents who bed share are going to kill their child. It's not the threat of SIDS, or even entrapment (which the CPSC has argued

is the greatest danger) that these parents most often invoke. It's the threat of overlay, which studies have shown is incredibly rare. Parents who do confess to bed sharing almost always offer a justification for their choice, a reason that they have temporarily decided to share their bed with their infant, as it is true many parents practicing bed sharing also assert that they will stop in the near future. Bed sharing parents have internalized the message that bed sharing is wrong, and unsafe, as many of them who admit to bed sharing also state they know that is wrong. This undoubtedly causes these mothers stress and guilt, as they work to reconcile themselves to their practices versus their understanding of bed sharing.

The revelations of bed sharing discourse show that we as a culture still base our understanding of bed sharing on rhetoric developed a century ago, rhetoric that was based on ideals of production and gendered divisions of labor. Despite evidence that shows bed sharing can be done safely, does not affect childhood independence, and allows moms to breastfeeding longer and more often while getting more sleep, our culture does not accept it. However, a greater number of mothers are breastfeeding in the United States in the last 60 years, and the evidence is strong that many of these mothers are sometimes bringing their baby to bed with them.

This highlights a theme central to parents in the 21st century: trying to reconcile reality with proposed best practices. Much like the bottle-fed versus breast fed debate where mothers are urged to breastfeed with little regard to working schedules and the impossibilities of maintaining a milk supply when away from a baby, the bed sharing debate does not take into account the reality that exhausted mothers bring their babies to bed with them. Not only does bed sharing give the tired mom a chance to sleep, it also gives many mothers a chance to feel connected to their babies. As more mothers join the workforce, this little bit of extra bit of time to bond at night may be important to many mothers. None of the respondents in this study appeared to be fathers and it would be

interesting to see how they conceive of bed sharing and the effects of cultural discourse on their perceptions of their nighttime sleep strategies.

Harvey Karp (2002), in regard to the blanket statement against bed sharing put out by the CPSC, states “Unfortunately their recommendation was as off-target as someone suggesting we try to prevent the fifty thousand car accidents each year *by not driving*” (p 225). Gettler and McKenna (2010) call for an end to inappropriate rhetoric surrounding infant sleep so that discussions about how to safely share a sleep surface can occur. In their articles, these authors argue that better public health campaigns and medical advice will include more than just studies. Instead, they will accept the biological needs of babies and parents, as well as the realities of bed sharing practices. While this undoubtedly would help, it seems a majority of parents in this study were not overly concerned with what the AAP or CPSC have to say. Their major concerns come from the themes that developed over the last 100 years surrounding infant sleep and it seems unlikely until ideals of infant sleep are separated from the rhetoric of the hard working, independent American producer, that bed sharing will find much outward acceptance in the United States.

A principle contribution of this study is to thinking about this issue in more parent-focused ways. Previous scholarship has thoroughly investigated bed sharing from an empirical point of view, generating a tremendous amount of data on the numbers of bed sharing parents, the safety and practice of bed sharing, and possible outcomes. James McKenna has engaged discourse on the official level, arguing that the medical community needs to address the way it discusses bed sharing. Some work has been done to describe the reasons parents might utilize bed sharing, but I am not aware of any analysis of parental rhetoric and its origins. McKenna argues that to change the discourse of bed sharing, and to implement effective public health policies respect must be given to the “experiential knowledge acquired and used by parents” (McKenna and Volpe 2007, p 372). They argue that breast feeding and the choice to bed share may be “biologically,

socially, and psychologically (emotionally) interdependent” (p 373). I argue that in addition to this, the rhetoric employed by parents, its sources and effects must be thoroughly investigated and understood. The rhetoric employed, in addition to experience, is an integral part of how parents arrive at their decisions regarding the nighttime care of their infants. Rhetoric involved with the decision or assertions against bed sharing are of particular interest as these arguments may be convincing mothers to work against their own biological, social, and psychological tendencies.

This kind of research could have many practical applications as many of today’s parenting choices are strongly delineated in the same manner as the bed sharing debate. Rhetorical analysis in breast versus bottle feeding arguments, as well as arguments for and against immunizations could offer insight on how to improve communication between physicians and patients, as well as suggest better and more effective public health policies and messages. This thesis offers the beginning of such an investigation of our modern discourse, and hopefully provides a foundation on which further research can be based.

APPENDIX 1

A Comprehensive Review of Stearns et al. *History of Children's Sleep*

Stearns et al. begin their examination in the mid-19th century when discussions of sleep emerge in historical texts. A quick summary of children's sleep issues (with the occasional mention of a restless baby) covers mostly sleeping arrangements. Sleep position, bedding type, and length of sleep were the topics covered, and not with concern as much as in the vein of advice. "It was widely assumed that children slept easily and would properly regulate the amount of sleep they obtained" (p 346).

Change began in the late 1880s to early 1890s. Although still sparse, commentary at this time displays an important shift in the dialogue of infant sleep practices. For the first time, parents are urged to put their children to bed without holding or rocking (including cradles) so that the child might learn independence. Articles began pressing for children to sleep alone and the idea of "strength and self-sufficiency through new sleep habits," was born (p 348). This particular idea regarding infant sleep proved to be quite potent, first mentioned by several commentators, it was strictly defined first by psychologist John Watson in the early 1900s. His method urged parents to train the baby (even in the hospital) to adhere to the parent's time table. He believed that any coddling, rocking, or hugging would result in an unhappy child who could not conform to society (p 352-353). While Stearns et al. mention that Watson was "unique" in his views and shouldn't be afforded too much significance in regards to his influence on infant sleep practices (p 353), his While the late 19th century marked the beginning of change in infant sleep advice, the beginning of the 20th century laid the foundation for the present solitary sleep paradigm.

Stearns et al. point to several cultural shifts that occurred around the turn of the century that had a dramatic effect on children's sleep. One such shift was in regards to

adult sleep. In the first part of the 20th century the adults of the industrialized world were struggling with their own sleep issues. Fueled in part by the small amount of sleep that people were told to seek in the previous century (6 hours maximum)(p 347), sleep disorders of the 20th century had roots in the new loud noises and bright lights of the industrial age night (p 361). In addition to these external changes of the industrial age, there were new social changes as well. People were more interested in staying up late, having company, or being involved in social gatherings outside of the home (p 357); staying up late became a bragging right (p 362). Sleep, in general, was harder to come by, and at the same time, medical science was delving into a new science of studying the insomniac (p 361). Getting enough sleep was suddenly a medical issue, with new experts running innovative studies and disseminating new options for better sleep on a regular basis.

This focus on getting more and better sleep led to a widely held belief regarding infant sleep: for adults to be successful sleepers, they must have been trained into good sleep habits as children (p 361). The preoccupation with adult insomnia, linked with the idea that good sleep was a habit that must be learned, created a near obsession with children not becoming overtired. Stearns et al. note that Ladies Home Journal began affording more and more space to doctors explaining the importance of sleep in children's health (p 348). One doctor, Dr. William R.P. Emerson made a statement in 1919 comparing over fatigue with malnutrition as far as causing permanent damage (p 349). These ideas led to experts on children's sleep to promote sleep training. A vigorous schedule was to be set and rigorously held. There was a little room for the child to determine its own bed-times according to some behaviorists, but all agreed that no matter what the schedule, it should never waiver (p 353). Part of this sleep training was allowing the baby to learn how to fall asleep without the aid of any outside help. Bedtime was to be a time of "serious atmosphere and no toys or games" (p 352). Cuddling was indulgent, as was rocking. Some experts argued that bed toys should

be switched out at regular intervals to avoid the child becoming too dependent on one toy with which to fall asleep (p 355). A child who fussed in the night should never be picked up, as this would only encourage more fussing (p 354). It was believed that a child that was sufficiently trained would not only have enough sleep to avoid over fatigue, which could cause as much “ill health as the worst slums,” (p 350) but would also ensure the child would be well prepared for adult life and urban employment with strict schedules that required long periods of wakefulness (p 361).

The rigid sleep schedule had another and more important attribute, a new sleeping arrangement: sleeping alone. New mothers, encouraged to keep their babies on tight, undisturbed sleep schedules, were also encouraged to put their baby to sleep in a separate room. This was attractive to new parents for several reasons. A new mother was expected to enforce a rigorous sleep schedule for her children, which would allow her to tend to her household chores without interruption. A major concern of many middle class mothers who increasingly didn't have hired help (p 352, 359). However, many of the new devices used for cleaning were quite noisy, so it seemed logical to move the baby away from the noise and into its own room for these daytime sleep sessions (p 359).

Solitary sleep became desirable at night as well, influenced by a number of factors. Keeping the child isolated from busy nighttime activities was considered important (p 349). The commonly held belief that children needed quiet time before going to sleep, a strict ritual emerged, and it was generally considered better to put the child to bed earlier in the night, especially for young children (p 351). Young children should be put in bed before their fathers came home, as the stimulation from the interaction could lead to over fatigue of the child (p 349). The best way to provide this quiet time was to isolate the child in his own room. Solitary sleep at night was convenient for new parents who were often up later entertaining, something Stearns et al. argues led to less family time after dinner and the end of practices like father reading to the children before bed (p 359-360). Parents were also now looking to enjoy a sexual

relationship with their spouse for recreational purposes, something that was increasingly important at the turn of the century (Stearns et al. 1996, p 359-360, Stone 1977). And even though it has been shown to have no deleterious effect (Okami et al. 1998), Freud suggested that infants that witnessed sexual acts between parents were at risk for psychological harm (1908).

Concerns about sex and noise were not the only impetuses to solitary sleep. Many experts believed a child would simply sleep better alone. This included not sleeping with an older sibling. Prior to this new, solitary sleeping revolution, children were often moved from their parents' bed to a cradle in the same room as their parents, and finally to the same bed as older sibling of the same sex. But beginning in the 1890s, sibling bed sharing was slowly abandoned. Many families were having fewer children (thanks to better birth control) and the likelihood of having a same sex sibling with whom to share a bed dwindled. Being able to provide each child with their own bed in their own room became a matter of social standing, as only the poor would not be able to at least provide a separate bed for each child. Concerns grew that sibling bed sharing would undermine the independence of each child, or at least not respect each child's individuality. Finally, Stearns also argues that growing concerns regarding homosexuality at this time also could have played a role in parents separating their children's sleeping spaces (p 360).

Providing a safe sleeping space for infants and small children became a new concern as children were no longer sleeping under the direct supervision of an adult. As a direct result, the cradle (with its dependence fostering rocking motion) was replaced by the crib beginning in the 1890s. Some early versions of the crib attached to the side of the parental bed, but quickly were replaced by free-standing units. A free-standing crib, unlike the cradle, was not a mobile piece of furniture and would stay in the child's room. By the 1920s and 30s the crib had all but replaced the cradle with options for extending its use into toddlerhood, and its firm mattress was advertised, "In such a bed

any healthy baby should sleep not only soundly but correctly without a peep out of him...Restful sleep, with body relaxed and well supported, is vital to health” (p 358). Cribs were marketed in many styles, complete with a variety of bedding options to allow the mother to coordinate the crib with her vision for nursery décor.

Changes in infant health also played a role in the shifting culture of infant sleep. The turn of the century brought new lows to infant mortality rates, and a new awareness of infant’s and children’s health emerged, “Now that families might avoid the deaths of any children born, it became increasingly essential to achieve that result. If a child suffered, someone-most probably the parents-must be at fault” (p 356). Infant mortality was an important factor in the solitary sleep revolution according to several researchers. These authors cite several instances where mothers confessed to their priests that they had deliberately overlain their infants because they could not afford to feed them. The Catholic Church threatened excommunication, fines, and imprisonment for these mothers and this led to children being banned from the parental bed (Flandrin 1979, Kellum 1974, Stone 1977). Fears and concerns of overlay may also underpin the repeated concerns of opiate use in the early 20th century. Stearns et al. mention several time the admonishments of using opiates to help children sleep (p 346, 348, 361), but they also mention the regulation and cultural backlash against opium use in adults (p 361). It is possible that overlay in the 19th century also had its roots in opium use of the parents.

The last part of the 19th century had been very concerned with children’s fears of the dark, thanks to research done at the time on night terrors. Experts were concerned that parents should take care to comfort their children through these fears to help them sleep (p 356-357). But early in the 20th century, the new experts argued that this advice, while well meaning, was wrong and was contributing to issues regarding infant sleep. Stearns et al. note that this is not an uncommon tactic, for one group of experts to attack the advice of the experts that came before, and explains this same pattern can be

seen again when Dr. Spock would emerge and advocate for a gentler parenting than those in the early 20th. This helps create a mindset in the parent that everything they have been told before is not only wrong, but could be harmful to their child's health, and promotes heavily the idea that they seek out the correct way to proceed (p 356). Boasting new scientific data to support their theories, it is no wonder that the new medical field of Pediatrics suddenly became the authority on children's sleep issues. Stearns et al. also note that one hallmark of medicalization is for the new authoritative entities to exert their power over new areas (p 356), and the problem of children's sleep was decidedly new. Stearns et al. described the level of expert opinion regarding children's sleep as a "bombardment." It might be argued that parent's may have just as easily ignored the medical community, given its new foothold in their lives, and stuck with more traditional means of caring for their infants (especially when the new recommendations may have gone against their parental instincts) but medical authority was helped along by popular literature. More than a dozen articles a year in publications like *Parents' Magazine* were dedicated to "hazards of children's sleep" (p 356). The authors note that "Women's and family magazines carried standard essays on children's sleep from the 1920s onward, often unusually long and detailed pieces for this particular genre" (p 354).

The cultural focus on the consequences of poor sleep habits no doubt moved many parents to be certain they were doing their best to get it right. The changing concern of the late 19th and early 20th century forever altered the manner in which infant sleep was perceived. By 1920 "Specific advice not only mushroomed in volume and urgency, but also increased the amount of sleep held to be essential and the explicit scheduling required" (p 355). Stearns et al. summarize the reasons as: the impact of new expertise (p 355), changes in health and help (p 356), sleeping alone (p 357), and adult anxieties (p 360). Stearns et al. note that the discourse surrounding infant sleep in the 1920s and 30s was "particularly striking" and the themes developed there of strict

routines and the “problematic qualities” of children’s sleep remained through the following decades (p 354).

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