Frequently Asked Questions and General Advice About Cosleeping

by James J. McKenna, Ph.D.
Director of the Mother/Baby Sleep Lab
University of Notre Dame, IN

Introduction

Every couple is different, but parenting is best done as a team with both parents fully committed to raising children in the same way. It is always best for parents or partners to discuss their goals, concerns, and philosophies and to strive toward a consensus, because whatever the challenges might be, they are easier solved if you both agree on what experiences all of you want to share.

If both partners agree, bedsharing or roomsharing can be a wonderful way for Dad to spend time with the baby, talking, stroking and (if bedsharing) enjoying skin-to-skin contact. Especially if Dad is separate from the baby many hours during the day, bedsharing can be an important way to keep fathers emotionally involved.

Most popular parenting books on infant sleeping arrangements seem to ignore mentioning the ways in which practices can vary in meaning and function from one family to another. I want you to be aware that **no experience is the same for any two families because all families are different.**

That said, many parents wonder how cosleeping will affect their own relationship. Because your baby and your family are unique, it is impossible to say with certainty how cosleeping will affect your relationship. But we can say the following: new parents are faced with numerous challenges and rewards as they adjust to their roles as mothers and fathers, and developing a sleeping pattern that works for your family is just one challenge among many.

There are several things to keep in mind as you develop your cosleeping patterns.

Cosleeping doesn't have to affect tenderness and closeness between spouses. With the baby in bed, you can still talk, touch, laugh, massage and otherwise enjoy the connection with your partner.

Intimacy will have to be less spontaneous. You may need to start scheduling time together when someone else can tend to the baby, find some other place to be intimate after the baby falls asleep, or move the baby into a crib or bassinet after he falls asleep.

Learn about child development. Kids go through lots of different transitions as they grow, and each stage is just a stage. Parenting with your partner will be easier—and less frustrating—if you understand what is going on developmentally with your baby. Whether it is teething, separation anxiety, nighttime fears, or something else, these are all stages— and they are all temporary.

Will cosleeping get in the way of my child's ability to be independent?

Ultimately, absolutely not, but it may delay your baby's willingness to be alone when she sleeps. Sometimes parents are under the mistaken impression that if they don't train their babies to sleep by them- selves, somehow some developmental or social skill later in life will be kept from them, or they worry that their babies will never exhibit good sleep patterns as adults. In reality, there has never been a scientific study anywhere that has shown any benefit whatsoever to sleeping through the night at young ages, or even sleeping through the night as adults.

Independence and autonomy have nothing to do with self-soothing or forcing babies to learn how to sleep by themselves. Studies have shown recently that children who routinely sleep with their parents actually become more independent socially and psychologically, and are able to be alone better. The idea that you shouldn't pick up a baby or touch a baby during the night, which is believed by many who promote solitary sleep, is completely antithetical to a hundred years of biological information on what constitutes good development: the development of empathy, the development of autonomy, the ability to be alone when you need to be alone, and the ability to interrelate and to become inter- dependent with others. As you begin to know your child better and identify your priorities as a parent, you will guide your child toward these goals. When compared to solitary sleeping children, children who have coslept tend to make friends easily, are more innovative, better able to control their tempers, and are better problem-solvers.61, [62, 63, 64]

Earlier we talked about parenting trade-offs, and this is an important and useful concept here. For example, should you choose to routinely cosleep all night every night with your child, you should be prepared for the possibility that, when you are ready to wean your child from your bed, they may not be on the same timetable as you. One study found that, compared with solitary sleepers from birth, infants who cosleep from birth either learn or accept sleeping alone about a year later than infants who have no choice but to sleep alone. So the trade off may be this: the emergence of independent solitary sleeping in children may be delayed with routine cosleeping, but eventually separate sleep will not be a problem for your child, and the good news is that as parents you derived great feelings and memories from cosleeping. Along with those experiences, your child may have developed a more permanent capacity for self-sufficiency, resilience, comfort with affection, and the ability to be alone when necessary.65

Will we be able to get a good night's rest if we bring our baby into our bed?

The answer to this question depends in part on exactly how parents define a "good night's sleep," and whether bedsharing is a choice made by the parents or a situation they feel was imposed on them by their child's inability to sleep alone. But remember that the reason that many families unexpectedly decide to bedshare is that it permits the family to get more sleep. It is more accurate to say that some parents, while still happy with their decision to bedshare for emotional reasons, are not able to get as much uninterrupted sleep.

For many families it remains worth it to bedshare with older children, even if on some nights Dad or Mom makes a hasty retreat to an empty bed somewhere else in the house for some extra rest they feel they need—a system I refer to as "musical beds." Sometimes one parent takes the call from a child sleeping in another room and enters the child's bed, stays for while, then slips back into their own bed. Moms and Dads often take turns—or maybe just Dad does the nighttime responding (as I did). For families that like this method, it can work very well. (Upon reflection, I can honestly say I think back with gratitude for those times when my son called me into his bed to snuggle upon waking and feeling a bit insecure.) Again, each family should work to find what arrangements work best for them.

Contrary to popular belief, and according to the mothers themselves, the choice to bedshare with infants tends to promote a longer, more restful night's sleep for both babies and parents alike, and this is especially true if the mother is breastfeeding. A baby sleeping in a separate room, in order to elicit a feeding from the mother, needs to cry. This generally makes the baby less calm and more excited, even before the breastfeeding begins. While bedsharing mothers may have many more arousals, they perceive that their sleep is better when they are sleeping with their babies. And, of course, if you do experience difficulty sleeping with your child in your bed, you can still experience many of the benefits of cosleeping by having your baby sleep on a separate surface in the same room.

Many pediatricians say I will create a "bad habit" that will be hard to break if I bedshare. Is this true?

This ubiquitous warning is based on subjective, perceived values, not science. One family's "bad habit" is another family's most treasured time together. And for most (though maybe not all), bedsharing feels pretty darn good, and for all the right reasons. Like adults, infants and children will be reluctant to give up something that feels right to them. That said, any human habit can be broken and the way new sleeping arrangements are introduced depends on who the parents and children are and the special characteristics of the family.

There is absolutely nothing wrong with deciding that you are ready to have your child sleep in his or her own room, but the trick is to trust your own knowledge of your child in deciding how best to do this. Methods tried by some parents include making bedtime full of stories and rituals unique to your child or offering a sleeping companion doll or favorite object, easing the child from the bed by having the child sleep on the floor or a mat next to the bed or on a cot or bed in the room but not in the bed, or merely stressing the excitement of a new room or having special privileges for an older child. Changing routines is a necessary part of growing up, and the transition away from cosleeping can be a positive experience for your child.

What about naptimes?

Most babies do not mind sleeping alone during naps during the day—it is the darkness of nighttime that is intimidating. But it is ideal to not isolate babies even for naps.

Try to let your baby nap in a bassinet or crib wherever there are people around, if this is possible. Don't worry about your baby not being able to fall asleep, because most babies can sleep in the middle of a rock concert when they are tired. The old idea of "Shhhh! ...the baby is sleeping," only conditions a baby to sleep lightly and to stir at each extraneous noise. Babies feel secure hearing the voices of their brothers or sisters and parents while sleeping. The level of normal noises in a household assures a level of arousal in your baby that's probably just about right for the safest possible sleep. **And remember to purchase an extra set of baby monitors and put the speaker next to your baby!**

If I have twins or multiples, should we cosleep?

As with any aspect of caring for twins, there are added challenges to bedsharing, especially without the proactive involvement of your partner or spouse. My general recommendation is to place at least one twin back in the crib or bassinet after feeding and sleeping with one twin or multiple at a time, to place both or all infants back in the same crib or bassinet to cobed with each other (see the next chapter), or to place two or more bassinets next to each other.

If you do not have the kind of spouse or partner that sees him or her- self as an active partner in the care of your twins, it is best not to fall asleep with the twins in the bed. Moreover, if regularly bedsharing with your twins, it is essential to have a king-size bed and a partner who is more than a passive participant, and who has agreed to work with you to take responsibility for knowing exactly where each twin is at all times.

If the second adult does not agree to take responsibility for at least one twin, but you want to continue to bedshare, then do not leave one twin between yourself and your partner, but rather have both twins in front of you so that you can curve your body around them and shield them from your bed-mate.

Keeping yourself and your twins at some distances from each other will be important too, only because it is easier for one twin to want to snuggle as close to you, and in the process, as close (perhaps too close) to his sibling as he can get. Use only the lightest of blankets to ensure free air passage for both twins. Being mindful of the fact that hungry infants are quite capable of mistaking a sibling's nose for a breast is worth preparing for, because as strange or as funny as it may seem, one twin sucking on the nose of the other can quickly dehydrate the other. Yes, it has happened.

I recommend that if there is a partner in the bed who has no interest in monitoring or taking responsibility for one or both twins, after each breastfeed (and if not breastfeeding at all), it is best to place the infants back in a bassinet or crib to cobed. (Karen Gromada has written a wonderful book on parenting multiples.).

What is cobedding? Does it serve the same purpose as bedsharing?

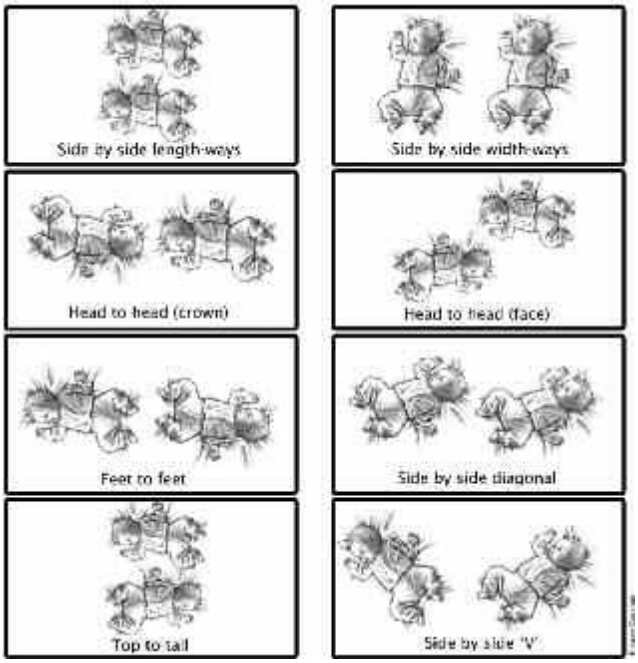
From a scientific point of view, this is an area that is little investigated. The term for cosleeping twins is "cobedding." Cobedding is another form of cosleeping, and is very different from what the majority of this book has been concerned with. Cobedding takes the form of two bodies of equal size and weight in the same crib. How cobedding functions, and its role in infant development and safety, is very different from other forms of cosleeping. Since twins and multiples in general (for reasons still unknown) are associated with a higher risk for SIDS, questions pertaining to what kind of sleep environment might best protect them or put them at increased risk is especially critical. Questions pertaining to cobedding emerge against the larger background of trying to understand why premature births occur, as many twins are born premature. Prematurity is the leading cause of hospitalization during the neonatal period, and is responsible for up to 75% of neonatal illness and deaths, so this is an area in need of much further exploration.67

The challenge of all newborns in making their way from the womb to the worldly environment is to re-establish some kind of "biorhythmic balance" by stabilizing the functions of sleep-wake cycles, eating pat- terns, blood chemistry levels, and respiratory and heart rates. Two teams of researchers have argued that the mutual sensory exchanges that are facilitated by cobedding may enhance the ability of any one twin to accomplish this task specifically by improving breathing, using energy more efficiently and, in general, reducing the twins' stress levels. It is known, for example, that the stress response which leads to increased cortisol production can negatively impact growth and development and generally alter thermal regulation, sleep duration, breathing and heart rate in potentially negative ways. These researchers found that, similar to what is observed to occur in the womb, cobedded twins move close together, touch and suck on each other, hold each other, and hug one another. Studies done by Dr. Helen Ball show that twins smile at each other and are often awake at the same time, supporting several anecdotal reports by parents of twins that their own infants prefer to be together, and that their babies settle better together and sleep more soundly when cobedded. Given the challenges of caring for two babies, as Dr. Ball points out from her studies, it is not surprising that parents will come to practice any behavioral care pattern which tends to maximize their own sleep and ease the burden of caring for and feeding two babies simultaneously.68, [69, 70]

Nowadays when you hear a recommendation against cobedding, it often illustrates cultural biases against cosleeping in general where medical authorities assume—without any data—that if some instances of bedsharing between an adult and a baby are dangerous, then certainly two infants of equal body size must likewise pose a mutual threat. When and where there is a gap in our knowledge, or little information is available, recommendations (whether medical or not) quickly rely on generalizations, stereotypes, and anecdotal information, which is then passed on as if proven scientifically to be true. In this case, studies of bedsharing involving adults and infants are being applied to the question of whether or not it is safe or beneficial for twins to share a crib. Some hospital nursery wards are already assuming that the AAP's recommendation against bedsharing applies to twins when, in fact, no twin studies were considered as the basis for those SIDS guidelines and no evidence-based considerations have, thus far, been used to justify hospital policies that argue against cobedding.

Cobedding Arrangements

As the following drawings from Dr. Ball's study of 60 parents of twins shows, there are many different ways that parents of twins arrange a cobedding sleep environment for their infants:



From Helen Ball (2006): "Caring for twin infants: sleeping arrangements and their implications." Evidence-Based Midwifery 4 (1) :10-16. Courtesy of: Evidence-Based Midwifery.

Is there anything different about cosleeping with an adopted baby?

Depending on their ages and experiences, adopted infants and children may have heightened needs for affection and contact, but, if older, they may not be used to intimacy. Watch care- fully how your child reacts to you and respond accordingly. It is also helpful, where possible, to know your child's history of experiences and assess what special needs or processes may be required to integrate the child into your family and to establish secure, safe and trustworthy new relationships.

If you have adopted an infant and not a child, of course, there is no difference. Regardless of cultural origin, place of birth, or ethnicity, all babies have the same needs. Since attachment between any of us can be greatly enhanced by contact, cosleeping behavior can greatly facilitate the developing bond between your adopted child and yourself. It may be the case that adoption agencies require infants or children to have their own rooms. But you will be joining millions of parents whose nighttime care and associations with their children are hardly defined nor limited by the number of bedrooms they have, or where a crib may be located.

What should a cosleeping family know about traveling together?

During the first few years of life, you will find your infant or child will feel especially reassured sleeping in your company when away from home. Many parents permit cosleeping while traveling who do not ordinarily practice it.

There does seem to be an elevated risk of SIDS for babies who experi- ence a previously unknown sleep environment. That is, babies between 2 and 4 months of age who are left to sleep alone while traveling and who ordinarily do not sleep alone have an increased risk (however slight) of dying from SIDS. And the reverse seems also to be true. A baby who does not ordinarily bedshare but who does while sleeping away from its home is at an increased risk of SIDS because she is in a new sleep environment. The bottom line: perhaps it is best while traveling to mimic as closely as possible what you ordinarily do at home. If you bedshare, bedshare; if you sleep apart, sleep apart.

Keep in mind that if you are bedsharing while traveling, you need to ensure that the bedsharing setup is safe for your baby (see Part II: How to Cosleep). **When you are traveling or on vacation, risk factors that may endanger your baby are still present. Risks may, in fact, be increased, so it will pay to be extra careful as to where and how your baby is sleeping while traveling.**

Will my child be different, in any negative sense, if I choose to cosleep or bedshare?

NO! Sleeping arrangements never, by themselves, create any specific kind of relationship that has not already been shaped by what occurs during the day. Sleeping arrangements only reflect the nature of the relationship a parent and child already share before they come to bed. In other words, sleeping arrangements generally reflect and sometimes strengthen, contribute to, or exaggerate the nature of the relationship that already exists, whether good or bad. Sleeping arrangements do not create a relationship: if the nature of a relationship is very, very good during the day, cosleeping simply makes whatever is already good just as good or even better at night.

In contrast, if a parent is depressed or is resentful of the infant during the day, these same dynamics will impact the child negatively during the night if the parents choose to cosleep. That said, cosleeping can be a wonderful way for content and affectionate parents to continue to deepen the bond with their child during the night.

How long should I cosleep with my child?

However long you want to! In fact, how long an infant or child sleeps in proximity to her parents has never been a concern throughout all of the evolution of our species. As long as cosleeping is enjoyed by everyone involved and the relationship it reflects is healthy during the day, cosleeping in some form or another never has to stop...but, of course, it will. There is no specific cut-off after which suddenly, or even gradually, the family cosleeping arrangement becomes harmful, unless some- one in the arrangement is no longer pleased or at some

point the situation has became socially, psychologically or physically unhealthy or undesired by a participating member of the family. Cosleeping (whether bedsharing or roomsharing) could never be best if all participants do not feel comfortable with the practice, and this is always the best time to stop. If anyone involved does not wish to cosleep, then cosleeping should never be forced.

I am reminded of the number of times my South American under- graduate students sheepishly come up to me after my lectures on cosleeping to whisper their stories that they could never tell to their peers for fear of ridicule. More often than not, they wish to tell me they STILL cosleep with their parents when they return home for the holidays! One of my young friends described how all of the kids jump into their parents' bed for conversation, storytelling, eating, watching TV, and for the simple enjoyment of sleeping together and being with each other in their parents' bed.

Should we cosleep if my partner is not the baby's father?

There is one study that has shown an increased risk of an infant dying when bedsharing with an unrelated adult male or other adult. However, the group that was studied for the most part had more than one risk factor present when these babies died.71 My guess is that if an unrelated sleeping partner is committed to an infant, assumes
responsibility for her, considers the bedsharing infant his or her responsibility in the same ways the mother doethen the bedsharing should be as safe as it would be if the biological father or an adoptive parent were bedsharing. But the point is worth repeating. Unrelated adults may not care to be responsible for the infant in the same way as a biological or adoptive parent might be, or may choose to disregard their own responsibility for the infant's safety. In any situation in which this is true, I would recommend against bed- sharing. Instead, place the baby next to the bed on a different surface.

What long-term effects will my baby experience if we cosleep?

It has never been proven, nor shown, nor is it even probable, that sleeping with your baby has any kind of negative long-term effects when the relationships between those involved are healthy. Instead, experts are finding that cosleeping can help develop positive qualities, such as more comfort with physical affection, more confidence in one's own sexual gender identity, a more positive and optimistic attitude about life, or more innovativeness as a toddler and an increased ability to be alone. One major epidemiological study showed cosleeping school-age children as being under-represented in psychiatric populations. And, while I do not know if you might regard this as a blessing or a curse, a survey of college-age subjects found that males who coslept with their parents between birth and five years of age had significantly higher self-esteem, experienced less guilt and anxiety, and even reported greater frequency of sex! Cosleeping is part of a loving, supportive environment that parents produce for their children, and this, in turn, will give them the confidence to grow into social, happy, loving adults.72

Is it possible to reduce night feedings in a cosleeping situation?

It is a difficult and unique process to wean a baby who has slept next to you from birth. The decision to wean is important, and should only be made if you feel it is necessary.

Some babies might have difficulty adjusting to less breastfeeding. One strategy for less night breastfeeding is to breastfeed your baby more during the day. Placing a barrier between your breast and the baby, or sleeping facing in opposite directions can sometimes reduce the infant's detection of milk nearby and eliminate some feeds, as can simply placing the baby in a crib in your room, or next to you in a bassinet.

If your baby is crying to be fed, Dad can walk with the baby to help her learn a new association. Dad's role in weaning a baby from night feedings can be very rewarding for fathers, leading to a new aspect of the attachment relationship with the baby.

Trusting and using your own judgment and experience with your baby is important—and every baby will give you different insights as to what might work best for them and only them. Like the decision to cosleep or bedshare, the decision to wean has to be made carefully and with full attention to the needs of each individual family.

Should I bedshare with my premature or underweight baby?

In almost all of the epidemiological studies of which I am aware, infants who are small for gestational age or premature are disproportionately represented as SIDS victims and as victims of sudden unexpected infant death in bedsharing situations. While the reasons for this are not yet known, and could possibly include in-utero developmental events or assaults to the fetal nervous system (some of which are induced by maternal smoking, which can cause intra-uterine growth retardation), it is probably safer not to bedshare with your underweight or premature infant. Routine bedsharing does not seem to be found to contribute to the survival of these more fragile infants, so it is best avoided. Place your premature or underweight baby right next to your bed on a different surface, but not in bed with you. Skin-to-skin contact while awake, however, is extremely protective, and sensory exchanges with an adult are known to be clinically beneficial to developmentally disadvantaged infants. The more holding, carrying and breastmilk made avail- able for these special babies, and the more physical interactions you have with them, the better.

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More Frequently Asked Questions

by James J. McKenna, Ph.D.
Director of the Mother/Baby Sleep Lab
University of Notre Dame, IN

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1. What is 'cosleeping' in the context of infant caregiving practices?

Co-sleeping in the context of infant care practices refers to any situation in which the infant sleeps close, within sensory range, of a committed caregiver permitting each (the infant and caregiver) to detect and respond to the sensory signals and cues of the other (smells, whisperings, movements, sounds, touches, heat (for details and explanation see (downloadable from this website) McKenna et al 1993; Mother-Infant Cosleeping: Toward a New Scientific Beginning, by James J. McKenna and Sarah Mosko. Ch. 16 in Sudden Infant Death Syndrome: Puzzles, Problems and Possibilities. R. Byard and H. Krous, eds. London: Arnold Publishers, 2001.or McKenna et al 2007).

Mother-infant cosleeping with breastfeeding is humankind's oldest and most successful sleeping arrangement. Cosleeping remains a cross-cultural human universal, a species-wide behavior, an expectable and physiologically normal sleeping arrangement likely designed by natural selection to maximize infant survival and well-being. Only in a relatively few select cultures (Western, industrialized societies) have infants ever slept outside the company and presence of their breastfeeding mothers. The adoption of the prone infant sleep position, bottle rather than breast feeding, and infants sleeping separate from their parents each proved to be independent risks for SIDS meaning…the dismantling of the human pattern of back sleep, with breastfeeding, with sleeping next to others caused the "SIDS" epidemic…unique to the Western world..and a loss of possibly as many as 600,000 babies. Lets never forget that.

By the way, keep in mind that infants do not have to be in the same bed in order to "cosleep", as a bassinet next to the bed, or a crib, where baby and mother or father are within range of detecting each others signals and cues is all that is necessary. Separate surface cosleeping of this variety is recommended by all.

As regards sleep products I recommend "ArmsReach Cosleeper (http://www.armsreach.com/) which is a bedside bassinet" which attaches to the parents bed but provides a separate sleep space for the infant. I don't usually recommend products but I sure recommend this product and have since I started researching the risks of SIDS and the importance of breastfeeding. The ArmsReach Cosleeper attaches tightly and firmly to the parental bed by way of a tight cord, pulling it to the bed, preventing gaps, or movement of the bassinet away from the bed, and has a small drop of about four inches to the mattress that permits infant separation but only slight, four inches down from the adult mattress as the baby sleeps in its own "nest". The bassinet has a rail facing the side of the adult bed (see photo on my homepage) preventing a parents body (or blankets or mother's limbs) from drooping over the infant, that could represent a potential risk.

The really good news is that over a million of these bassinets have been sold over the last fifteen to twenty years without one infant dying or being injured! There is no crib I can think of that has this safety record. The ArmsReach Cosleeper is, as it turns out, is about as safe as safe can be. And that's why I so enthusiastically and proudly recommend them.

Do recall that cosleeping with an infant on a couch, recliner, or sofa, though also forms of cosleeping are, however, dangerous and should be avoided as they increase the chances of suffocation, regardless of sobriety.

*Dr. Gettler and myself have a recent paper reviewing the whole concept of "cosleeping" from a biological and present, cultural, perspective. See Gettler LT, McKenna JJ. in press. Cosleeping. Barrett D, McNamara P, (eds) The Encyclopedia of Sleep and Dreaming. Santa Barbara, CA: ABC/CLIO Press.

2. Is Room sharing a form of cosleeping?

Yes, it is. Roomsharing, or dare we say, mother-sharing, where the infant is simply in the room of a supervising caregiver (mother or father) also can describe an ever safe, simple, form of cosleeping. This form of cosleeping is safe for all families and would be, in my mind, the preferred and default sleeping arrangement, especially for nonbreastfed infants.

My one problem with this arrangement, which is, of course, minor, is the name for it. I think it best to remember that the inert walls of the room are not, of course what is being shared here, or is what is protective. Rather, what is protective is what goes on in the room between the caregiver and the infant, both in a reactive sense, but mostly in terms of a proactive behavior. Here I am referring to the effects on the infant of ongoing sensory exchanges with a caregiver through the night and how it changes, and stimulates changes, in the infant's physiology including the infant's sleep architecture, arousals and sleep stage transitions, making it altogether a safer form of sleep i.e. more time in lighter (Stage 1-2) rather than deeper (Stage 3 or 4 sleep, see Mosko et al 1996). The latter stages of sleep i.e. deeper sleep, is known to be more difficult for infants to arouse from in order to terminate life- threatening apneas or breathing pauses.

Proximity, of course makes it much more likely and possible that more interaction will take place between the mother and infants during the night, including more breastfeeding and mothers are better able to detect or discover and respond to an infant in some kind of trouble. (This is what I mean when I say that roomsharing is really mother-sharing or father- sharing as it is an active and not a passive arrangement).

3. Aside from convenience especially if breastfeeding are their any health advantages to keeping baby close in the form of separate- surface cosleeping?

Absolutely. With only 25% of its brain developed at birth the human infant 'expects' and depends on proximity and contact with its caregiver's body, usually (but not always nor necessarily) the mother. Sleeping close to your infant is not simply a nice social idea but, for the infant, it represents a form of expected physiological regulation and support. Indeed, infants require this contact and proximity especially because of nutritional needs (breastfeeding) but also because of the immaturity of their thermo-regulatory, immune and cardio-respiratory systems, in addition to their dependence on touch, all systems closely tied together to promote efficient functioning of all of the infant's immature organs and the central nervous system in general.

Sleeping close to infants further enhances the abilities for both mothers and fathers and infants to socially and psychologically "attach", and infants to attach to them, which ultimately strengthens the infant's emerging psychological system and future resilience as proximity permits the mother-infant, father – infant relationship to engage in ways that contribute to the emergence of optimal (healthy) infant emotional development.

The short-term dependence on the proximity of a caregiver for physiological regulation, and protection is just finally being recognized scientifically as being extremely important and beneficial (see Barak et al. 2011 Should Neonates Sleep Alone, downloadable from this website) Mosko et al., 1998; McKenna et al 2007), and helps to explain why infants should avoid sleeping alone outside the sensory range by which a caregiver and infant detect each others sensory signals, cues, or stimuli, all of which facilitate and represent interactions that augment neurological connections and provide the foundation for the development of cognition and intellectual development, and the proliferation of neural networks that support these systems.

Remember that at birth the human infant's immune system is not yet fully functional, either, nor is it's digestive system. This is clear when Dr. Tiffany Field's work is considered. That is, she published research showing that massaging an infant 15 minutes everyday increases the infants intestinal elasticity, apparently, or releases more growth hormones, and/or reduces stress, (or some combination of these processes) leading to greater calorie absorption, therein, enhancing daily weight gain sometimes as much as by 47%. For infants touch is great medicine! (see McKenna and McDade, 2005, downloadable from website).

Moreover, at birth the infant's breathing i.e. respiratory system is also not yet fully developed, as regards complete control of both voluntary and involuntary breathing and the relationship between the two systems especially during sleep (see McKenna et al 2007 for explanation and McKenna 1986); nor is the infant's thermo-regulatory system developed as the infant is unable to shiver, for example, to keep its own body warm. Indeed, the human infant's physiology is not designed to function optimally outside the context by which usually the breastfeeding mother can compensate for the infants developmental (neurological) vulnerabilities. In a sense proximity to parents during the night acts as a buffer between the immature infant and the microenvironment within which it lives.

Perhaps all of the above examples i.e. how the parents sensory proximity changes the infant's physiology in a positive way explain why separate surface cosleeping is lifesaving. At least three epidemiological studies show that infants sleeping close to an active, caregiver, an potentially able to exchange sensory stimuli (combining periodic touch, vision, smells, vocalizations, movement cues, breathing sounds, CO_2 gas, as well as breastmilk) on close but separate surfaces cuts an infant's chances of dying from SIDS or from some other asphyxia event anywhere from a third to a half (see Carpenter et al. 2004; Mitchell and Thompson 1995; Blair et al. 1995).

4. My mom asks if my baby sleeps in my bedroom will she ever go into her own room?

Interestingly, "co-dependence" (if this is what your mom is getting at) is not a nasty word; indeed, co-dependence and interdependence in general is indispensable to maximize healthy human development and is especially critical for human infants, born so neurologically immature at birth. Interestingly, but not really surprising, when a human infants inherent need for contact and proximity (reassurance through touch, parent directed vocalizations, emotional support) are met by parents early in their lives rather than becoming "dependent" as is always suggested in the popular press the reverse is actually true: that is, early dependence leads to early independence and self sufficiency and, perhaps even, enhanced self – confidence. Some people confuse an infant's willingness to sooth itself back to sleep as a sign of "independence", autonomy and/or a life long sense of confidence. But life long self sufficiency and/or

confidence (and, trust, for that matter) has absolutely nothing to do with the age at which an infant puts its self back to sleep without its parent or loved one, i.e. to "self soothe". All children eventually learn how to put themselves back to sleep. What is really being pushed on parents here is the arbitrary social idea and/or judgment that the earlier the infant does not need intervention the better (in some way for the infant and eventual child and adult) and this concept is inappropriately used as a weapon often by false claims suggesting that if an infant or child cannot by some pre-determined age "self-soothe" it never will, or that something is either wrong with them, and is in need of repair, or that their parents are deficient (for not setting "boundaries"). Again, this is silly and offensive.

More accurately, these judgments are social in form and nature and have no scientific merit or meaning at all. No other people on the planet other than those from Western industrialized societies worry about such differences between children. Our culture has carefully constructed this as a concern. Unfortunately this implies that the pediatric sleep research community (in general) accepts uncritically the mistaken assumption that solitary, bottle-fed infants represent the "normal" and/or "optimal" human infant sleep and feeding arrangement, and the context from which measurements of "normal, infant sleep" can be derived. Again, this cannot be supported by worldwide data scientifically and rests on false scientific assumptions. Such a context for study is in reality, artificial, and one in which normative measurements of human infant sleep is not really possible, as it is not the environment within which infant sleep for our species develops. Moreover, that measuring solitary infant sleep, in the context of bottle feeding is appropriate is ethnocentric as solitary sleep is unique to a small corner of the world, the industrialized West. . It is a perspective, unfairly promoted often by medically trained professionals unaware that this is social ideology masquerading as species-wide science and represents a general view of children's' sleep development that mostly favors recent social values (or personal preferences) and not infant or parental biology. This model overlooks or dismisses the diverse ways we humans all develop healthfully but at different rates and in vastly different contexts. But some accord more with our biology than do others. Western infant sleep practices depart widely from normative biological experiences that has had deleterious consequences.

Psychologists Meret Keller and Wendy Goldberg from the University of California, Irvine found that the capacity for self- sufficiency as well as the capacity for full engagement with others, and "problem solving skills" which are enhanced by routine co-sleeping from birth. Keller and Goldberg (2004) conducted the first systematic studies of "independence" which began with a definition of what they meant by the term "independence", and they were the first to research team to actually provide a definition. They found that according to their mothers a toddler's ability to be alone and to solve problems (while alone) was based on their routine sleeping arrangements from birth. Routine solitary sleepers (not bedsharing toddlers) were the toddlers less able to be alone and less able to solve problems presented to them, while alone, quite the opposite of what is so frequently assumed.

(See, Keller and Goldberg 2004. Cosleeping: Help or hindrance for young children's independence? Infant and Child Development 13:369-368 DOI:101002/icd.365.

5. Does "sleeping arrangement" alone actually determine independence of dependence in children?

Probably not. Sleeping arrangements likely enhances such positive attributes already there, or clinically relevant or related ones involving psychological or social skills acquired from the relationships the child has with his or her parents, and other social experiences and relationships. Human development in general is likely much too complex for any one, single kind of experience or condition to be determinative of a person's psychological or social skills…including something called, independence (or it's opposite). Whether a child is more independent or not and how it is likely explained by multiple interacting, factors and the outcomes are likely specific to particular contexts or behavioral domains. Assuming that these concepts are operationally defined (independence or dependence) it is highly likely that childhood

independence, defined here as some measurement of a child's ability to act alone or to make a decision alone, or to solve a problem alone, or to comfort itself, is likely produced in any number of ways, and it may be an accurate description pertinent only to the domain within which it is being measured. For example is the independence being examined in a social, intellectual, or activity context? This is a long winded way of saying where a baby or child sleeps hardly acts alone to influence or determine over-arching, lifelong developmental abilities, characteristics or propensities, applicable to all aspects of that child's life. Rather such capacities are likely heavily influenced also by the nature of the total relationship that the child has with his or her parents over a 24- hour period, all day every day… and the nature of the relationship that is brought into the bed to share, if some form of cosleeping is practiced. The "content" and form of daily relationships matters a great deal and probably just as much as sleep location itself, when human development overall is being considered.

Surely when social relationships in the child's nexus is strong during the day and involves a lot of engagement and contact by reassuring parents, and this positive engagement is extended throughout the night, the child is getting more of that which is already good, therein further reinforcing such personality qualities as self comforting skills, confidence, self-worth, and social-cognitive engagement skills along with more positive emotional-empathic capacities altogether. In addition, the child's own genetic endowment is constantly acting in concert with the infants or child's overall environmental experiences, too. There is no simple relationship between these variables.

6. My sister's baby died of SIDS when he was just 3 months old. This has made me fearful as to what to do with my own new baby when she/he comes in January. What has your experience taught you in this regard? Does SIDS run in families?

Last question first: SIDS does not run in families.

I have studied SIDS risk factors since my own son was born some thirty-two years ago. In my mind the best ways to help prevent SIDS or accidental suffocations and to assure optimal infant and maternal health are:

Do not to smoke during your pregnancy or after, or let people smoke in the presence of your baby after it is born. Safe infant sleep therefore begins when your baby is sleeping and developing in your womb, especially as regards how much damage maternal smoke can do to the fetal brain.

Always place your baby on his or her back for sleep;

Breastfeed your infant exclusively for at least six months, and for a year in general, if at all possible;

Dress your baby lightly for sleep (especially if you are sleeping with them in your bed) and make sure regardless of where the baby is sleeping that there is no "stuff" around him or her, such as, excessive blankets, heavy duvets or spreads, or stuffed animals (wherever your baby sleeps);

If formula or bottlefeeding (with no breastfeeding) sleep close to the baby at least in the same room, within sensory range, on a separate surface and not in the same bed;

If routinely bedsharing it would be best to pull the bed off its frame with the box spring and mattress on the floor in the center of the room. Bed frames can have gaps between the mattress and the frame (head board or foot board) into which an infant might slip and suffocate.

Lowering the height of the bed reduces the chances of a baby rolling off a bed and getting hurt, although, breastfeeding babies barely if at all move around in beds as they are too interested in being next to their mothers breasts with all of those good smells being emitted.

Never let children sleep next to your baby; best not to have another child in the bed with baby at all.

Never push a mattress against a wall and assume it is safe there. Mattresses pushed against walls migrate quietly and without fanfare or notice by those in the room. Sometimes the mattress pulls away from the wall creating a gap or space just large enough to permit an infant to slip into it. It is not easy to remember to check each night to see if the mattress has slipped just enough away from a wall to pose a risk to an infant slipping between the wall and mattress and suffocating.

Likewise be careful with end tables, or lamp tables next to the adult bed. That space could pose a risk to the infant as well. Remove close tables that might create a gap into which an infant could roll and get stuck and suffocate.

Educate yourself (and your partner) to all the known adverse factors associated with using a crib safely and bedsharing, and if you are unable to remove all adverse factors associated with bedsharing keep your infant close, but on a separate surface. Again, I call this "separate surface cosleeping" and it works just fine and is better for families who do not breastfeed their infants, or if the mother smoked during her pregnancy, or if some other adult other than the father is in the bed, or if that adult sleep partner is indifferent to the presence of the infant, or if older children are likely to come into bed with the baby.

Of course drugs, alcohol, or desensitizing medications should never be taken if sleeping in a bed next to an infant.

If you or your partner are excessively tired it is best to have infant sleep along side the bed but not in it.

7. Why don't you think bedsharing can be done safely enough if a mother is bottlefeeding?

Breastfeeding changes where and how the baby is placed next to the mother, to begin with, and the infant's arousal patterns, how sensitive the baby and the mother are to each other's movements and sounds and proximities, as well as the infant's and the mother's sleep architecture (how much time each spends in various sleep stages and how and when they move out of one sleep stage into another) are very different between bottle feeding and breastfeeding mother-infant pairs. Not only is the physiology or sensitivity of the mother to the baby, and the baby to the mother completely enhanced if breastfeeding and if routinely bedsharing, i.e. each reacting to each others sounds and movements and touches compared to the bottle or formula fed, bedsharing mothers and infant, but breastfeeding mothers and infants arouse more frequently with respect to each others arousals, and breastfeeding mothers and infants compared with bottle feeding mother-infant pairs spend significantly more time in lighter rather than deeper stages of sleep. Lighter sleep makes it easier for a mother and infant to detect and respond to the presence of the other, making the bed sharing arrangement much safer.

Breastfeeding mothers typically place their infants under their triceps, mid chest level, and often sleep on their side curling up around the infant protectively with their knees often pulled up under the infant's feet. This position may be instinctive but it does not happen when a mother bottle feeds her baby. Indeed, bottle fed infants are typically placed much higher up on the bed and near pillows (and sometimes on top of pillows, very dangerous) that can obscure the infants air flow, and expose infants to potential gaps (head board to mattress) into within infants could slip.

Also, bottle feeding-bedsharing infants move in directions away from the mother, thus, increasing the risks of some kind of asphyxial event, compared with breastfeeding infants, according to the research by Dr. Helen Ball. (Please check out her website at the University of Durham). That is why Dr. Ball and myself agree that bottle fed infants are safer if they sleep alongside their mothers on a different surface but not in the same bed.

Never let an infant sleep alone in a room by itself, especially by itself on an adult bed or couch, and always be attentive to the infant, carrying or keeping an infant in your mind (as most parents do, anyway);

8. Why do a disproportionate number of babies die while bedsharing?

Because many parents either do not know what minimizes risks in the bedsharing environment, or what is dangerous, or they simply do not take the time to proactively make sure that their bed, and who is in it, is as safe as current research can tell us.

Bedsharing parents should remain knowledgeable of what specifically injures or kills infants in social (as well as solitary-crib) settings. Medical authorities and coroners are not usually forthcoming about the details associated with bedsharing deaths, like if the infant was sleeping prone in the bed, an independent risk factor for SIDS, for example, Indeed, one former President of First Candle once called parents who bedshared guilty of "uneducated parenting" and suggested that parents bedshare because they think it is "cool". She also chose not to make any distinction between parent's bedsharing in a breastfeeding context, and a situation in which a non-breastfeeding young mother drank eighteen cans of beer and overlaid her infant tragically. In other words this representative of First Candle saw no difference between a sober, breastfeeding mother bedsharing and a nonbreastfeeding, inebriated mother bedsharing. She implied that the risks incurred in each setting were the same.

But do know, regardless of this woman's low opinion of parents (especially her insulting statement that bedsharing mothers bedshare because they think it "cool", most of the deaths in bedsharing environments ARE preventable when all known adverse modifiable factors are removed and all known precautions including bedsharing only if breastfeeding are respected.

In sum, overwhelmingly, bedsharing deaths are associated with at least one independent risk factor associated with an infant dying. These include an infant being placed prone (on its stomach) and placed in an adult bed without supervision, or no breastfeeding, or other children in the bed, or infants being placed in an adult bed on top of a pillow, or who bedshare even though their mothers smoked during the pregnancy therein compromising potentially the infants ability to arouse (to terminate too little oxygen, or to terminate an apnea).
Drug use and alcohol have historically been associated with poor outcomes for bedsharing babies so if drugs and/or alcohol are present, please don't bedshare.

In sum, to understand the likely causes of most sleep-related deaths it is not enough to know simply where or with whom the infant was sleeping; but rather one must know how the infant was sleeping, and in this case, how the bedsharing was being practiced because especially bedsharing is not a simple, or singular behavior. Bedsharing is composed of many different behaviors. Most researchers that defend a parent's right to become informed and make this choice to bedshare for themselves acknowledge that bedsharing is a heterogenous activity and no one bedsharing environment is necessarily the same as another. The specific conditions within which this sleep "practice", takes place is critical for understanding outcomes whether good or bad (see McKenna and Mosko 2000, for details, also, McKenna et al 2007 for comprehensive review, both available on this website for downloads)

9. What are some of the common questions that are not asked but which are critical in understanding why some infants die while bedsharing?

One might be: did the death occur while an infant slept on a couch? This is not bedsharing but sometimes the two (couch sleeping and bedsharing) are used interchangeably. This is inappropriate. Couch sleeping is always dangerous. Another question sometimes skipped over is: was the infant sleeping prone, for example, or with other children, or with an inebriated adult or parent, or with a mother who smoked during her pregnancy all critical factors in why and infant may have lived or die. And, of course the question: was the mother breastfeeding her infant when the baby died because almost all bedsharing deaths involve non breastfeeding, but bottlefeeding babies. (see, Fox Investigative News Report on the situation in Milwaukee, Wisconsin, on who specifically dies while bedsharing , a video linked to this website).

10. Do you support a family's decision to bedshare? Do you think it is safe enough?

With certain caveats I do support safe bedsharing. (I would likely bedshare with my own baby after taking all the precautions.) But I would also have an armsreach cosleeper by our bed and the baby would likely sleep in bed and/or in the cosleeper for most of the night. I think it incumbent and appropriate, however, for parents to ask themselves before they bring their baby to bed with them to consider how they would evaluate (as much as might be possible) their choice if a tragedy were to occur and their baby died? Would you as parents assume that you must have overlaid their baby, as that will be what coroners and medical officials are likely to suggest and at very least, rather than the infant being said to have died from SIDS, the ideology against any and all forms of bedsharing is so popular now that the local coroner will likely call the death a SUID…sudden unexpected infant death suggesting that suffocation cannot be ruled out. It is important to consider how much confidence you would have in yourselves, in the precautions you have taken, how much agreement you and your partner share as regards the importance to each of you and your baby of bedsharing and appropriateness of bedsharing for your specific family.

11. What other infant care practices protect and contribute to an infant's health and well being, including nighttime safety?

The more you hold and respond and carry your baby, the better. Try not to over use plastic carriers or other hard -surface devices because carrying babies in contact with your body will contribute to the healthy development. This is especially true when considering the speed of the developmental trajectory of your baby's neck muscles which can be protective if a baby needs to move its head away from a surface that is obscuring it's ability to get oxygen. Body to body (skin-to-skin) carrying is excellent. Next best, in my opinion, are baby-carrying (baby wearing) wraps or snuggles made out of cloth which permits maximum exposure of the baby's face giving babies freedom to swivel its head and to look and track people and objects, to engage, is more optimal. Try to cut down on keeping babies in plastic holding or carrying containers as it is contributing to some babies developing flat heads. That is parents often don't realize how many hours per day their baby's head has been propped up against hard objects for many daytime hours contributing to the infant developing a flat head.

Platycephally (flattening) of the head is not necessarily if at all caused by infant sleeping on their backs but by how long babies lean their heads against hard objects or, what I call, "transformer baby furniture, or furniture that can change into many different pieces (like those transformer toys in the eighties and nineties) making it easy to keep babies heads against hard surfaces for an excessive amounts of time therein reshaping the infant's head.

12. In your publications you have argued that arousals are good for babies. Is nighttime infant arousal, rather than uninterrupted sleep, really good for babies? Doesn't this conflict with the world of pediatric sleep medicine who push for infants sleeping through the night alone, as early in life as is possible?

In a nutshell, yes to all those questions. In my writings and based on my scientific research and that of others I contradict popular notions including what many well intentioned pediatricians believe i.e. the notion that continuous, uninterrupted infant sleep is good or normal or healthy for human infants. I reject this proposition entirely. Indeed, I believe our obsession with infants "sleeping through the night" at young ages…and the whole icon associated with the "sleep like a baby" ideal, i.e. without stirring or arousing, is a product of wishful thinking but more importantly a negative image with faulty and dangerous assumptions that could only emerge in bottle or cows-milk and formula culture, where infant isolation was thought to benefit them.

Indeed I think this "sleep like a baby" mentality explains why so many of our infants supposedly have "sleep problems to solve". My contention is that most infants have no sleep problems to solve, but parents do because of an imposed cultural model of how infants should sleep, that never really had anything to do with how infants really sleep, at all. Moreover, I believe that the current models promoted by pediatric sleep researchers that ignore feeding method and the importance of breastfeeding and breastmilk-delivery and the nutrition ir provides are fundamentally flawed having emerged from recent cultural ideologies and not from studies of the biology of infancy or parenting.

I have argued in refereed (downloadable) papers that not only have these culturally imposed infant sleep goals and beliefs effected parents deleteriously but they lead to the adoption of biologically inappropriate standards and expectations as to how infants are supposed to sleep. I argue that these models inappropriately prioritize infant sleep consolidation at the expense of what is really important for infants in the first year of life and that is breastfeeding, which requires babies to wake up frequently. Frequent breastfeeding and the engagement with the mother that accompanies it is essential for optimal brain growth and the development of the infants immune system. I argue that our obsession scientifically with the solitary sleeping infant as normal and optimal, the alleged gold standard on infant sleep research methods, is fundamentally flawed and tells us nothing about how the human infant sleeps or develops sleep.

My first studies aimed to demonstrate that only by deriving infant sleep measurements in the mother infant cosleeping -breastfeeding context could we begin to understand more accurately what constitutes human-wide, species-wide, normal, healthy infant sleep. Indeed, I argue that the cultural dismantling of the three basic components of normal human infant sleep i.e. sleep position (on the back for breastfeeding which was changed to prone sleep), feeding method (from breastfeeding to formula or cows milk, bottle feeding) and infant sleep location (from next to the mother within sensory range to nighttime separation, a separate room) fostered and promoted the SIDS epidemic which is was limited to the industrialized, western world. Tragically, these culturally based practices led to the deaths of possibly as many as 600 thousand infants from SIDS, in part because our society promoted a kind of premature deep, uninterrupted sleep, in sensory-deprived (solitary) environments for which the naturally vulnerable and neurologically immature human infant was not and is not, biologically prepared.
I believe that the neurosciences, especially studies in psychobiology more strongly support the notion that short continuous arousals during the night for babies is not only normal but protective and is exactly what occurs (and should occur) when babies breastfeed through the night and sleep close to their mothers, as they detect and respond to maternal odors, sounds and movements, all of which induces such arousals as our NICHD funded research documents (see Mosko et al 1997). The lighter sleep, that all of these maternal-induced arousals promote, gives rise to what we consider to be "safer sleep" for infants especially for the level of neurological immaturity through which all human infants must pass.

In 1983 in a chapter found in the "Frontiers of Psychiatry" edited by Justin Call and Eleanor Galensen, infant psychiatrist Isabel Paret showed that the more infants are picked up and held and aroused during the day the more they arouse at night. What I would like to suggest is that a great deal of holding, carrying, responding to, and touching infants never hurt them, but surely too little of it does. Human infants are primates and primates can never get too much touching! Apparently, all of this arousing through touch enhanced by more holding by parents during the day might help protect infants sleeping at night. That is, by arousing more during the day infants arouse more at night, meaning that do not sleep quite as deeply as our research shows that the more infants arouse the less time they spend in deeper, stage 3-4, sleep. This could potentially help them avoid having to confront a more difficult challenge of arousing at night from a much deeper stage of sleep in order to terminate an apnea or breathing pause, which is especially difficult for arousal -deficient infants (see Mosko et al 1997 this website, and McKenna et al 2005 or McKenna et al 2007).

Again, some might think this a bad thing: I think it a good thing as it is protection from SIDS. The problem with the SIDS baby was not that they ever aroused too much, but that they aroused too little…Many SIDS infants had a hard time awakening (before they died) and were often overly sleepy and rather listless, as described by their parents before their deaths. It could be said, that's SIDS victims were not able to arouse enough, or had too little practice getting good at it. It's kind of sad and strange to think that babies never died because they kept their parents awake, but because they did not keep their parents awake enough, by virtue of their frequent arousals.

13. What else do nighttime infant arousals accomplish and what is the connection between arousals and an infant sleeping through the night?

As mentioned above, arousals lead to the baby breathing more stably over time, and to more variable heart rates and breathing. Variability in breathing patterns of infants is good and a sign of health, ordinarily, and such variability is often associated with more substantial inhalations of oxygen, leading to shorter apneas in deep stage of sleep from which awakenings can be difficult (see Richards et al 1998). Moreover, if practice makes perfect than the more arousals induced by various forms of co-sleeping the better the arousal skills that potentially can act protectively in response to a cardiac or pulmonary crisis.

Babies are not designed to sleep through the night in the first six months, at least, of life. They are designed to wake often to breastfeed. Breastmilk does not have dense calories i.e. caloric staying power that keeps a baby sleeping, in the way that cows milk does, for example as it is obviously designed for optimal cow brain growth and development.

Contrary to what many pediatric sleep researchers claim, or at least, lead parents to believe, the consolidation of human infant sleep is not what is important biologically for an infant especially in the first six months of life. Rather consuming breastmilk (the (product) and experiencing the breastfeeding process, the engagement with their mothers, socially, cognitively, emotionally, intellectually, and psychologically is what is important to them and thi sis intimately and functionally interdependent with the type of sleep that they experience. In fact what constitutes normal and healthy infant sleep cannot be understood independent of nighttime breastfeeding as the two co-evolved and was designed by natural selection to maximize infant health and well-being. Unfortunately when infant sleep research was begun in western countries neither breastfeeding nor infants sleeping in the presence of their cargivers was thought to be appropriate, healthy, or beneficial while solitary, bottle fed babies, and all the measurements derived from solitary sleeping, bottle fed babies was thought to be normal and healthy. And these data are STILL unfortunately thought to be what all parents and infants should aspire to replicate. But given that most of our babies breastfeed in 2011 and sleep close to their parents, obtaining these alleged clinically normal measurements is not only impossible but certainly not good for the baby.

Keep in mind that human infants sleeping alone and formula-or cows milk fed infants was one huge, untested cultural experiment. These practices never emerged from studies suggesting that they befioted infants. Indeed, they are unusual practices from a worldwide perspective, and represent unique, westner industrialized social ideologies that can be used to explain why, compared to other parents on the planet, why especially western parents have so much problems dealing with their infant's or child's sleep. It is as if parents in our society suffer from the disease of misguided expectations pertaining to their infant's sleep, that do nothing but lead to unhappiness, exhaustion, disappointment and familial misery.

Remember….personal preferences, influenced by recent western cultural values and social ideology, NOT studies of the natural biology and needs of the human infant have argued against babies arousing at night to feed a lot; and, indeed, the "sleep like a baby" or "shhhhh the baby is sleeping" model, while some kind of western ideal is NOT what babies are designed to do nor experience, and it is definitely not in their own biological or emotional or social best interest. The whole notion of sleeping through the night is scientifically bogus and a mis representation of what "sleep like a baby" really means, which is, waking up all night to breastfeed and receive the proper nutritional input that maximizes brain growth and cellular proliferation, and the kind of 'lighter sleep' for which babies are designed.

The first job assigned to an infant is to breastfeed frequently in order to feed its growing brain that will double in the first year of life. Not only will human breast milk stimulate and provide the basis of optimal general growth but the interactive delivery system will contribute to the right connections between different neural modalities including motor, emotional, cognitive, and social areas the govern emerging skills and relational talents. The phrase "sleep like a baby" should be eliminated from American lexicon. How about if we replace it with a new phrase: "arouse, breastfeed and then you sleep like a baby" despite what more adult centric sleep proponents proclaim. Sleeping through the night i.e. consolidating sleep could only be achieved in a bottlefeeding culture. But we are no longer a bottlefeeding culture so this concept is particularly obsolete.

14. My husband has been deployed to Iraq three times. We are expecting our first baby and I want the baby to relate to his/her father -- any ideas?

Nothing can substitute for the presence and physical proximity of the father but that said consistent voice contact or visual images (computer video conferencing?) or photos will help the infant prepare to attach. And your own excitement and enthusiasm speaking about (and of) your baby's father likewise will be noticed and positively affect the infant. And don't forget that fathers are better able to bond with their babies as well if exposed to their infants sensory (visual and auditory) stimuli (pictures, video, audio tapes) as much as is possible during his absence. So even if the baby will not be able to respond to seeing the Dad on tape, or to his voice in the early weeks or months, the exposure will become familiar to your baby and make a difference when the father is finally able to be with his baby. And, as well the father can most certainly bond with his baby, in many ways the more he is exposed to and involved with his child. Ultimately, this technologically-based contact will benefit their relationship, not to mention the fathers emotional well being.

15. I have always been a very light sleeper. The least little soundwakes me up and I can't go back to sleep. Am I wise to attempt co-sleeping when my baby comes?

It depends on how badly your sleep is affected and what your own sense of needs might be and your social relational priorities. Obviously, if you really cannot sleep at all and your health and well being and ability to enjoy your infant is negatively impacted then more extreme measures might have to be taken, such as having the Dad sleep in the same room with the baby while you sleep elsewhere. Some people are more sensitive than others. You DO need to respect your own needs or you will not be able to help

others and enjoy them. That said, don't forget, this sensitivity and ability to respond to your infant does, however, benefit your baby. The ability to hear your infant, to be in a position to respond to your baby or some internal mishap, a "stop-breathing episode" for example, makes parental sensitivity not just a nice idea but protective. You might be surprised, too, about how much more willing you might be to sacrifice consolidated or uninterrupted sleep where and when it improves your infants emotions or behavioral dispositions, and seeing your baby's contentment sometimes make the sacrifice of losing sleep all the more acceptable. But again, if you cannot adjust not feel good sand healthy about your presence sleeping close to the baby by all means it is best to accommodate your health here because ultimately this will benefit you and the relationship you have with your baby.

16. Money is tight these days. Is it true that breastfeeding is the economical way to go?

Breastfeeding saves at least 300 dollars a month that otherwise would be spent on bottles, formula or milk costs, leading to enormous yearly family savings. It makes good financial sense, aside from all the health benefits to both mother and infant alike.

17. Do you recommend cloth diapers or is it OK to go with disposables?

Whatever you and your infants prefer and /or what seems to work successfully, and avoids skin rashes and/or infant discomfort. But do think green!

18. I'm a working mother of a 2 year old and a new 3 month old baby. Is it our best advice that I try find a nanny or am I better off to locate a day care center for both of them?

If you possibly can afford it, find a nanny or a baby sitter to come to your home. This is a difficult issue and one that has led to bitter scientific feud much like the issue of bedsharing (see question below). Let me say, first of, that it is always better to keep especially young infants especially those less than six months of age in their own home with the babysitter or nanny rather them in daycare centers. Some babies die from SIDS because they were brought to daycare centers. According to Dr. Rachel Moon twenty percent of SIDS cases occur amongst infants being left in daycare centers with many dying on the first day or first week of being left there. Nobody knows why, or what it is in the home environment with mother being present, or father, that specifically protects the infants, but protection, it is. Sometimes parents have no choice and if this is the case then the best you can do is to make surer the daycare meets and/or exceeds governmental and/or country requirements for security, safety, number of caregivers per infant or child attending.

19. I heard that there is a serious difference of opinion between those that think that there are no serious consequences or developmental-emotional effects of babies being in daycare centers and those that think there are. What is the problem, here and what exactly is the debate about?

In a recent book by Dr. Peter Cook (Mothering Denied) describes better than most others the difficulties that Dr. Jay Belsky has had convincing his fellow scientists that social ideology is passing for, if not dictating, scientific interpretations of studies on this issue (as is true for the bedsharing debate), in favor of dismissing the serious concerns and negative developmental correlates of infants and children being placed for long hours, early in their lives, in daycare centers.

Keep in mind that human beings have always assisted each other in caring for each other's infants. Indeed, new work by Sarah Hrdy (2009) and Lee Gettler (2010) illustrate the important role that direct care and investment by others likely played throughout human evolution, causing scientists to consider that we are really "cooperative breeders" insofar as individuals other than the mother have significantly enhanced the human infant survival. The idea is that such alloparenting as such 'substitute care' is called

likely lessened maternal energetic costs associated with lactation and infant care in general, permitting mothers to ovulate sooner explaining why the great apes but not humans may be facing extinction, as great apes have a much longer birth interval such that they are not replacing themselves, demographically.

But this said infants throughout our evolution were never too far from their mothers and not at all were they certainly not for very long were they distant from them, especially when they were extremely young. Nor were babies with strangers for significant numbers of hours out of any day, it is thought, which can happen in today's industrialized societies where babies can spend all day in a day care center amongst changing caregivers none of whom may have the time to develop a spell attachment or social bond with the baby. A shocking 20% of all babies who die from SIDS, do so at Day Care centers and many do so in the first few weeks of separation. We don't know yet why these babies die but it could be related to the stress of such extreme separations from the primary caregiver, usually the mother.

In his book entitled Mothering Denied, Cook describes an editorial in The Wall Street Journal of July 16, 2003. The article focuses on Jay Belsky— one of the leading scholars in what is called the National Institutes of Child Health and Human Development (NICHD) Network. Belsky clearly argues that (as Cook described here) while an "unpopular finding" and not one that many of the investigators were happy with or wanted to hear, the effects of daycare on child development "confirmed that the more time children spent in daycare arrangements up to 54 months of age, the more aggression, disobedience and conflict with adults these children showed in kindergarten at that age." These patterns remained, Dr. Cook describes, "even after the study had controlled for many features of the children's families and the quality and type of daycare that the children had experienced." The study found that spending a lot of time in daycare predicted more truly aggressive and disobedient behavior, not just more assertive or independent behavior, as some had alleged" (Cook, who cites Belsky, 2003).

Cook reports Belsky saying…."Not that you'd know any of this from reading the NICHD's press release or listening to many of the commentators." He pointed out that the results were not politically popular, since "many (of the investigators) have made their careers representing good childcare as a sort of social cure-all.… Because child-care is here to stay", the argument goes, "only the improvement of its quality is important." Anyone highlighting disconcerting evidence is simply against children." He added, "One must wonder why, after the government invested tens of millions of dollars, so many are bending over backward to minimize the results. Belsky (cited in Cook) argues…. "Ultimately, it is the tendency of all too many social scientists (and the public) to deny, dismiss or minimize findings they do not like, while embracing, if not playing up, those they do like, that gives social science a bad name—as ideology masquerading as science. What those who deny, dismiss or minimize the latest findings continually fail to appreciate is that they hold no monopoly on wisdom or caring, nor even necessarily do they speak in the best interests of many American children and families. They spin developmental science in support of their political views, failing to realize the disservice they do to children and families alike, to say nothing of the scientific enterprise itself."

I might add here that this situation unfortunately describes the supposed bedsharing debate: those that support informed choice to bedshare and who, like myself, who deplore inaccurate, simplistic generalizations about the "dangers" of sleeping with baby (and mis-representations about the bedsharing issue, who differ from the governments position) are demonized, belittled at professional meetings sponsored by professional groups (like First Candle) and attempts to ostracize repeatedly take place. Good science, can be used, as it is here perhaps like a social weapon to intimidate parents into accepting an ideology allegedly backed by science that in these areas exist only to support a priori views.

In 2001, Belsky suggested that, "as more and more children were spending more and more time in non-maternal care arrangements, at younger and younger ages, even small effects, when experienced by many children, might have broad-scale implications for how classrooms, communities and even societies operate." From Mothering Denied. Peter S. Cook: 37.

20. I have followed your advice in many articles you've written. My baby has always slept in our room in the co-sleeping bassinet you recommended. When is it wise to start having the baby sleeping her own crib in her own room and how do I start this?

Let me answer this by first saying that the word, "infant", is derived from the Latin word, infan, meaning a human being before speech. Infants are not capable of the physical production of speech (and relatedly) full speech comprehension until at least 15 months and later with a great deal of infant- to- infant variability. In other words at least pre speech infants are still completing their gestation, so to speak, and so my own preference both as a father and scientist is to encourage parents to let the infant and toddler sleep as close to them as is safe for as long as they can, without specifying an artificial, arbitrary "cut off." These developmental "cut-offs" especially for sleeping arrangements have nothing to do with established empirical-based principles, or scientific findings about when infants must sleep alone or learn to "settle" themselves or risk suffering some permanent psychological or cognitive disorder or handicap. Malarkey. These cut-off recommendations are generally cultural or value-based, or simply, personal preferences or opinions of sleep researchers. Insofar as this is true, and insofar as a healthy social relationship exists between the child or infant and the adults sleeping with them, there are no necessary cut-offs, except for when someone in the arrangement is not happy, or if the parents perceive of some special need the child has, or if sleeping separately seems to be an appropriate remedy or strategy for some family problem or issue.

And always remember, outside-external authorities do NOT know your family's situation, as well as you do. This is a personal decision not a medical one. And it is yours to make. You are the expert here knowing as well as you do your infant's needs in relationship to your own and your overall circumstances; and while you will be bombarded by well intentioned professionals and friends or family parents all telling you why you "must get that child or baby out of your bed or room"! Do not be intimidated. Thank them for the advise but remind them that only you have the ultimate right and knowledge to make such a decision. As long as the nature of the relationships brought to the bed to share are healthy and appropriate during the day, as I have said many times, there is no reason to assume that those relationships turn sour at night, or become pathological at night, or that by sharing a sleep space with your children that something otherwise healthy is suddenly about to turn, unhealthy. Again, this issue is a great example of where social ideology and personal preferences (made by others) often passes as scientific truths and privileged information. It isn't. Parenting goals vary from family to family. And they matter. When both physiological and psychological-emotional factors are considered it seems a 'no brainer' to me to suggest that infants should sleep close to the parents, at least sleeping in the parent's room, and that how long children do so is up to those participating.

21. My son David was born very prematurely. The Arm's Reach Co-Sleeper Bassinet I bought was the best investment we ever made. There was enough room to hold his oxygen tank and other necessities for his care. Is there another device you would recommend that would add to his comfort and make life a bit less stressful for us?

Not really. I think for your premature infant you are exhibiting just about the best infant care practice possible. It is not safe to have a very small, fragile, premature baby sleeping next to a parent in a western bed, but very important to have them sleeping alongside the bed on a different surface. The infant-parent sensory exchanges and the monitoring by the parent, coupled with breastfeeding are about as good as it gets for your premature infant. When awake you and your partner should hold and be in contact with your baby as much as is possible. Contact isn't just "nice', it is a positive factor in the regulation of your baby's physiology.

22. What constitutes a "safe sleep environment" irrespective of where the infant sleeps?

In a way, preparation for safe sleep for an infant begins prenatally, when a healthy gestation occurs without the mother ingesting any cigarette smoke.

Stepping aside from dangerous social factors, such as adult inebriation or adult bedsharing while under the influence of drugs, or infants sleeping alongside disinterested strangers, and ignoring (for the moment) the physical-structural-furniture and bedding aspects of "safe infant sleep" always occurs in the context of, and under the supervision of, a committed, sober adult caregiver who is in a position to respond to infant nutritional needs, crises, and can exchange sensory stimuli all of which represents just what babies depend on for maximum health. Infants should sleep on their backs, on clean, firm surfaces in the absence of smoke, under light (comfortable) blanketing with their heads never covered. "Sleep suits" are ideal for infants. The bed/crib/bassinet should not have any stuffed animals or pillows around the infant, or other children in it (if an adult bed); and never should an infant be placed to sleep alone in a bed, or on top of, or around a pillow but rather, if bedsharing, infants are best positioned under the breastfeeding mother's arm, usually under her tricep, the universal position for a breastfeeding-cosleeping infant.

Sheepskins or other fluffy material and especially beanbag, or body-fitting sponge, mattresses should never be used. Waterbeds can be dangerous, too, and always, if bed furniture or frames are used the mattresses should tightly intersect the bed-frame and no spaces or gaps should exist around circumference of the bed either with a frame or night table.

To be sure, infants should never sleep on recliners, couches or sofas, with or without adults wherein they can slip down (face first) into the crevice or get wedged against the back of a couch, or fall between pillow seats.

23. What makes for the safest possible bedsharing environment?

What is safe always depends on the totality of the social, psychological, nutritional, emotional, and physical circumstances (furniture including bedding, mattress quality and stiffness) within which the "bedsharing" occurs. There is not one singular risk or benefit factor that alone determines safety. To begin with, whether or not bedsharing is safe begins with a consideration of the adults, usually the mother, who will be sleeping with the baby. How much does a mother "want" to sleep, ow much does it mean to her. How much effort will the mother or father assert to arrange the safest possible environment, assuming that they have the capacity and knowledge to do so. Those mothers or fathers for whom having their baby close and next to them means the most and those that can follow through with avoiding all of the adverse factors presently know, and who breastfeed, will construct and enjoy the safest possible bedsharing environment.

Non-smoking, sober breastfeeding mothers and partners who likewise accept and welcome and adopt safety precautions altogether make for the creation of the most safe bedsharing environment. As regards the mother she will exhibit more physiological and mental sensitivities to their babies movements, position and sounds, than do bottle feeding moms. Bedsharing breasfeeding mothers and infants spend more of their nighttime sleep in lighter rather than deeper stages of sleep. This makes easier for infants to awaken to terminate longer or potentially dangerous, breathing pauses or apnea and mothers are better able to detect and respond to their babies needs. So you might think about putting babies on a different surface, to sleep alongside you, rather than have the baby in the bed, if you bottlefeed. It is not that a deeply committed bottlefeeding mother can never bedshare safely but it remains true that the natural physiological mutual regulatory effects that change a breastfeeding mother-infant dyads behavior is unique when breastfeeding occurs.

But if breastfeeding, even if one uses a co-sleeper, the baby will often simply want to sleep next to you, to snuggle in physical contact, and all parents should therefore be prepared for this contingency. Knowledge makes your baby safer. If a decision is made to bed-share, ideally, both parents should agree and feel comfortable with the decision and "Dads" as well as moms should take responsibility for the safety, through the night, of his or her baby. In other words, reflect on that sticker stuck on car bumpers that say: "baby on board". This suggests that each adult bedsharer should agree that he or she is equally responsible for the infant and acknowledge that the infant is present. This means say to yourself before you sleep: "My baby is next to me. I must be sensitive and alert." My feeling is that both parents should think of themselves as primary caregivers. Moreover, infants a year or less should not sleep with other children siblings - but always with a person who can take responsibility for the infant being there.

Obviously, persons on sedatives, medications or drugs, or if intoxicated --or excessively unable to arouse should not cosleep on the same surface with the infant. To be extra safe long hair on the mother should be tied up to prevent infant entanglement around the infant's neck--(yes, it has really happened) and extremely obese persons, who may not feel where exactly or how close their infant is, may wish to have the infant sleep alongside but on a different surface.

It is important to realize that the physical and social conditions under which infant-parent cosleeping occurs, in all its diverse forms, can and will determine the risks or benefits. What goes on in bed is what matters, and the nature of the relationship brought to bed to share.

On a more sobering note, it may be important to consider or reflect on whether you would think that you suffocated your baby if, under the most unlikely scenario, your baby died from SIDS while in your bed. Just as babies can die from SIDS in a risk free solitary sleep environment, it remains possible for a baby to die in a risk-free cosleeping/bedsharing environment. Just make sure, as much as this is possible, that you would not assume that, if the baby died, that either you or your spouse would think that bed-sharing contributed to the death, or that one of your really suffocated (by accident) the infant. It is worth thinking about.

24. Is there only one "best" sleeping environment for me and my infant? What actually determines where a baby will sleep?

In a nutshell, no, of course not,. There is no one place that every given infant should sleep, except to say that infants should never sleep outside the supervision of a committed caregiver but that does not imply that the baby must be bedsharing, only that some sort of close proximity such as roomsharing is more optimal to an infant sleeping alone in a room by itself.

And the assumption by pediatric sleep researchers that there is one ideal sleeping arrangement for all, or that cosleeping is harmful and detrimental or that infants need to "consolidate their sleep as soon in life as is possible" is not only fallacious but harmful and it explains why western parents are the most exhausted, disappointed least satisfied, (yet, most educated and well read), I am convinced, than any other parents on the planet, as regards their infant's sleep.

There is no "one-size-must (or-can) fit-all" answer to the question of where any infant or child will most ideally and safely sleep. Some safety issues are known, so certainly they should be followed as I have outlined in answering many of these questions But what any infants sleep location socially or psychologically means to parents is very powerful and it affects the overall safety and satisfaction that different families have to the same sleeping arrangement and environment. Arranging the "best" place for an infant to sleep varies from family to family depending on their circumstances.

This is because where an infant sleeps is not just physical place but has special social meaning, too, and may reflect the parents philosophical parenting goals; or sometimes where an infant sleeps reflects how family members get the most sleep. Sometimes it reflects what is practical and economically possible. Some families, for example, are too poor to buy a crib so that have no choice but to cosleep in the form of bedsharing. Other parents have multiple bedrooms and several cribs but never place their babies in them but prefer instead that the baby spend sleep with them in their bed.

Often where infants and children sleep is relational in nature, and not medical at all. That is, where babies end up sleeping at, say, 3:23 am on Tuesday morning reflects, among other things, the special needs, temperaments, and desires and/or nutritional needs of infants and children, and, for parents, too. Infants have a lot to say as to where they will end up sleeping as their bodies are designed to settle when close to their parents. It makes them happy to cosleep which generally means it is biologically appropriate and the environment that maximizes the chances of protection and well -being.

Where an infant or child sleeps is usually not determined by only one factor anyway but by a variety of them involving biology, physiology, and economics. The parents social values including what it means to be a "good" parent and how parents want to express love and nurturing, or protect their privacy and how they are able to get the most sleep are all possible factors that determine where a baby can be found at night.

You could say also that where infants sleep reflects the parents emotional needs as well as possibly childrearing goals or philosophies. There is no one way to arrange your baby's sleep, before you retire for the night and how well one approach works is, as always, determined by factors pertinent to each family depending on what parents want, hope for, and see as reflecting the kind of relationship they want to share with each other and with their infants and other children.

Try to remember that you will come to know special things about your baby better than anyone. Become informed, but then make your own decision and trust your feelings and feel good about and not ashamed of your decision.

Try not to hide your decisions from others but educate them to the variety of decisions that parents make. How you and the other caregivers feel about privacy and separation, or being close to the baby even when the baby is sleeping but you are not, and the physical circumstances of your house, can make a difference as to what approach or practice might work best for you. For example, some parents who retire for bed

much later than the baby feel more comfortable if the baby is kept within proximity where, for example, the baby can be easily seen or heard, or "checked on". In these cases, the baby may not be officially "put to bed" in the sense of being placed in a room where all contact is broken. Rather in these instances the parents might place the baby in an open hall in a bassinet, or let the baby sleep in a bassinet in the living room, or in a carrier seat close enough to permit a kind of informal monitoring.

25. Do babies need silence to fall asleep?

Interestingly, infants can fall asleep in the middle of a rock concert if they need to. Indeed, infants can protect themselves from excessive stimulation but what they cannot protect themselves from is too little stimulation. Infants and older baby's as you might notice often fall asleep quickly in the context of family noise, rather than in silence, as is generally thought. This is because the baby probably feels more secure hearing that a caregiver - or perhaps that something-- is going on nearby. Human voices are reassuring to infants. It is always possible that a loud TV or an active herd of siblings could make it impossible for the baby to sleep - but generally it is hard to keep a baby awake if he or she is sleepy. But you can be the judge of how "intrusive" the noise level might be. Some parents may choose to put the infant in a separate room with the door closed, where sensory access between the baby and the parents (and other family members) is not possible or likely. My preference is never to close the door to a baby's room since babys' find sleep when they need it, and they were not designed biologically or psychologically to sleep in complete social isolation in a sensory deprived context.

Some parents find it comforting to put some kind of walkie-talkie in the room, which is fine, except that a more appropriate use of the walkie-talkie talkie would be to turn the amplifiers around. That is broadcasting family voices into the baby's room, if the baby must be in a room by itself, letting the baby hear the chatter of its parents and siblings, rather than the other way around can be very proactive and protective. Fifty years (at least) of human developmental research shows that baby's respond positively to physical and psychological sensory signals (sounds, voices, sights, smells, touches, movement) from others when they "feel" that they are not alone. We might presume that external social noise gives young children a sense of security -- or something akin to a baby thinking "it's nice to know someone is around, should I need them".

26. Will our baby sleep through the night sooner if he or she shares our bed?

There exists no longitudinal data that can answer this question. Infants and children are certainly more content sleeping with their parents or others, judging from their behavior. But a variety of scientific studies indicate that rather than it being completely controlled by the environment, the baby's own maturational rate as influenced by its unique internal needs to awaken, to feed, to find reassurance, or to oxygenate, are as much influencing factors in night waking and "sleeping through the night" as is sleep location, per se.

Moreover, it is interesting to note that where infants and parents routinely cosleep the infants are for the most part less likely to cry, when they do wake up, compared with solitary sleeping infants. Seemingly, the infants "feeling" the presence, of a parent permits it to return to sleep without fully awakening, or awkening the parents (unless the infant want to feed) so the question of "sleeping through the night" becomes less relevant.

27. Does bedsharing or solitary sleeping mothers get more sleep?

Generally, bedsharing mother-infant pairs have many more transient arousals (very brief) and the infant breastfeeds much more frequently; but the perception by these mothers of their own sleep in these cases can, nonetheless, be very positive. And in several research papers one by Ball et al (2004) and by McKenna and Volpe (2007) we determined that bedsharing was the solution to, and not the cause, of too little sleep. But this is different for different mothers and families. In our laboratory study of bedsharing compared to solitary sleeping mother-infant dyads bedsharing mothers received more sleep in minutes than did solitary sleeping mothers (Mosko et al 1997). And, interestingly, mothers underestimated how many times they woke to breastfeed by as much as 50%. And in one of our research papers having asked routinely bedsharing mothers and routine solitary sleeping mothers, after a night of sleeping as they usually do at home 84% of bedsharing mothers said that had "good" or "enough" sleep while only 64% of the solitary sleeping moms said that had "good" or "enough" sleep, following an evening in which they practiced their home routine sleeping arrangement.

I might add that pediatric sleep pioneer, Dr. Tom Anders, observed that many solitary sleeping babies awaken for short periods throughout the night without parental knowledge, even where they sleep in a crib, alone. Some babies will simply go back to sleep while others, presumably with different needs and sensitivities, will awaken and "signal" their need for contact with the parent. Should infants do so i.e. signal parents, it is not necessarily a sign of immaturity, stubbornness or an attempt to manipulate their parents as is sometimes suggested. Laboratory studies reveal that the average duration of infant and maternal awakenings in the cosleeping environment are shorter on average than the awakenings mothers and babies experience when baby awakens in another room, and requires intervention before going back to sleep (see Mosko et al 1997).

One bit of information might help here: from a biological perspective, it is appropriate for babies to awaken during the night during the first year of life. In fact, although infants can be conditioned to sleep long and hard alone, and without intervention and, hence, fulfill the cultural expectation that they should "sleep through the night" the fact remains that they were not designed to do so, and it may not be either in their best biological or psychological best interest.

28. Is infant night wakings always a problem or a sign of a clinical problem that needs professional treatment?

Quite simply, no, not at all. As always, parental goals and needs lead parents to interpret their infant's behavior, including night awakenings, very differently. For example, many parents do not worry about night awakenings because especially where the babies sleep next to them, the infants are content and less likely to awaken and remain distressed.

29. What are the advantages of having our baby sleep with us?

Advantages can only be assessed in view of how parents feel about their infant being close or -- next to them, and calculated in a positive way only if parents are knowledgeable about how to cosleep safely.

Some obvious advantages can include: the baby will know that you are there-and can respond emotionally and physiologically in potentially beneficial ways. Babies will breast feed more often with less disruption to mothers sleep - and the baby will receive more sleep as will the mother compared with solitary sleeping

breast feeding babies - as recent studies show (see our publications available for downloading). Babies arouse more frequently, but for shorter average durations than if the baby slept apart - and spend less time in deeper stages of sleep which may not be beneficial for babies with arousal deficiencies - as also shown in recently published refereed articles. Babies cry significantly less in the cosleeping environment which means that more energy (at least theoretically) can be put into growth, maintenance and protective immune responses.

More breast feeding which accompanies cosleeping also can be translated into less disease and morbidly, indeed, when breast feeding is enhanced. Proximity of the infant potentially permits the parents to respond to changes in the baby's status - such as if it were choking or struggling to breathe - and, of course, proximity makes it more likely that if a baby was fighting to rid itself of blankets over it's head, the parent might here the event and intercede.

Working mothers who feel guilty of not having enough time to be with their babies during the day often say how much better they feel by being able to nurture and protect their babies at night, when sleeping close and, hence, strengthening attachment, as can Dad. Given the right family culture, cosleeping can make mother, dad and baby feel very good, indeed.

30. What are the long term effects on my baby of sharing a bed?

While advocates of solitary infant sleeping arrangements have claimed any number of benefits of infant sleeping alone, the truth o the matter is, few, if any, of these supposed benefits have been shown to be true through scientific studies. The great irony is that, not only have benefits of solitary infant sleep NOT been demonstrated – and simply assumed to be true, but recent studies are beginning to show the opposite that is, it is not solitary sleeping arrangements that produce strong independence, social competence, feeling of high self esteem, strong sexual identities, good comportment by children in school, ability to handle stress, but it is social or cosleeping arrangement that contribute to the emergence of these characteristics. These references and a more detailed discussion of these issues are cited in our downloadable paper: McKenna James J and Lee T Gettler (2008) Cultural influences on infant sleep biology and the science that studies it: toward a more inclusive paradigm, part II. In Sleep and Breathing in Children: A Developmental Approach, vol.2. GLoughlin, JCarroll and CMarcus (eds) New York: Marcel Dekker. Pp. 183-221.

Consider, for example:
* Heron's (1) recent cross-sectional study of middle class English children shows that amongst the children who "never" slept in their parent's bed there was a trend to be harder to control, less happy, exhibit a greater number of tantrums. Moreover, he found that those children who never were permitted to bed-share were actually more fearful than children who always slept in their parent's bed, for all of the night (1).

* In a survey of adult college age subjects, Lewis and Janda (1988) report that males who coslept with their parents between birth and five years of age had significantly higher self-esteem, experienced less guilt and anxiety, and reported greater frequency of sex. Boys who coslept between 6 and 11 years of age also had higher self-esteem. For women, cosleeping during childhood was associated with less discomfort about physical contact and affection as adults. (While these traits may be confounded by parental attitudes, such findings are clearly inconsistent with the folk belief that cosleeping has detrimental long-term effects on psycho-social development.

* Crawford (1994) found that women who coslept as children had higher self esteem than those who did not. Indeed, cosleeping appears to promote confidence, self-esteem, and intimacy, possibly by reflecting an attitude of parental acceptance (Lewis and Janda 1988).

* A study of parents of 86 children in clinics of pediatrics and child psychiatry (ages 2-13 years) on military bases (offspring of military personnel) revealed that cosleeping children received higher evaluations of their comportment from their teachers than did solitary sleeping children, and they were underrepresented in psychiatric populations compared with children who did not cosleep. The authors state: "Contrary to expectations, those children who had not had previous professional attention for emotional or behavioral problems coslept more frequently than did children who were known to have had psychiatric intervention, and lower parental ratings of adaptive functioning. The same finding occurred in a sample of boys one might consider "Oedipal victors" (e.g. 3 year old and older boys who sleep with their mothers in the absence of their fathers)--a finding which directly opposes traditional analytic thought" (Forbes and King 1992).

* Again, in England Heron (1994) found that it was the solitary sleeping children who were harder to handle (as reported by their parents) and who dealt less well with stress, and who were rated as being more (not less) dependent on their parents than were the cosleepers!

* And in the largest and possible most systematic study to date, conducted on five different ethnic groups from both Chicago and New York involving over 1,400 subjects Mosenkis (2000) found far more positive adult outcomes for individuals who coslept as a child, among almost all ethnic groups i.e. African Americans and Puerto Ricans in New York, Puerto Ricans, Dominicans, and Mexicans in Chicago than there were negative findings. An especially robust finding which cut across all the ethnic groups included in the study was that cosleepers exhibited a feeling of satisfaction with life.

But Mosenkis's main finding went beyond trying to determine easy causal links between sleeping arrangements and adult characteristics or experiences. Perhaps his most important finding was that the interpretation of "outcome" of cosleeping had to be understood within the context specific to each cultural milieu, and within the context of the nature of social relationships the child has with its family members! For the most parts, therefore, it is probably true that neither social sleep (cosleeping) or solitary sleep as a child correlates with anything in any simple or direct way. Rather, sleeping arrangements can enhance or exacerbate the kind of relationships that characterize the child's daytime relationships and that, therefore, no one "function' can be associated with sleeping arrangements. Rather than assuming that sleeping arrangement produces a particular "type" person it is probably more accurate to think of sleeping arrangements as part of a larger system of affection and that it is altogether this larger system of attachment relationships, interacting with the child's own special characteristics that produces adult characteristics.

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31. Cosleeping and Overlaying/Suffocation: Is there a chance I'll roll over and crush my child?

To claim that there is NO chance of an adult overlaying a baby would be ridiculous, but so would it be irresponsible to claim that an infant could never be killed while traveling in an automobile, or while sleeping alone in a crib which has an overly soft mattress, or crib slats which do not prevent the infant's head from passing between them. In each case, the dangers are significantly reduced - and the potential benefits of car travel or infants sleeping alone (where this is what parents want) can be realized -- when the safety precautions unique to each choice of behavior are regarded. In the case of automobile travel, strapping infants correctly into a consumer safety approved car sits, and not driving while under the influence (of drugs or alcohol) makes car transportation worth the relatively small risk such travel imposes.

No infant sleep environment is risk free. My opinion is that the right to consider what known risks factors exist and how or if they apply, and to to weigh those risks in relationship to the circumstances within which bedsharing will occur belong with the parent, and not with external authorities making decisions for them. As regards cosleeping (in the form of bed-sharing) what we know to be true scientifically is that for nocturnal infant breast feeding and nurturing throughout the night both mothers and babies were designed biologically and psychologically to sleep next to one another. And while beds per se did not evolve mother-infant cosleeping most assuredly did. Infant-parent cosleeping with nocturnal breastfeeding takes many diverse forms, and it continues to be the preferred "normal" species-wide sleeping arrangement for human mother-baby pairs.

In the worldwide ethnographic record, mothers accidentally suffocating their babies during the night is relatively unheard of, except among western industrialized nations, but here there are in the overwhelming number of cases, explanations of the deaths that require reference to dangerous circumstances and not to the act itself. Please see our paper by Gettler and McKenna (2010), downloadable, entitled “Never Sleep With Baby? Or Keep Me Close But Keep me Safe”

Let me expand a bit on what we know to be true scientifically. Anthropological and developmental studies suggest that mothers and infants are designed to respond to the presence of the other, and no data have ever shown that among mother-baby pairs who cosleep for breast feeding in a safe cosleeping/bed-sharing environment that mothers are unable to sense the proximity of their babies in order to avoid smothering them. Our own laboratory sleep studies of cosleeping/bed-sharing mothers infant pairs (2 to 4 month olds) reveal that both breast feeding mothers and their infants are extremely sensitive throughout their night - across all sleep stages - to the movements and physical condition of the other. The healthy infant, that includes most infants, are able to detect instances, where for example, their air passages are blocked. They can respond very effectively to alert the mother to potential danger, and they have the physical skills to maneuver out of danger, under normal circumstances. That being said, modern societies and the objects on which we sleep and the social and physical conditions within which bed-sharing can and often does occur especially among the urban poor forces professionals to be very guarded when discussing bed-sharing and/or cosleeping. But, at the same time, health professionals have no right judging parents who bedshare as irresponsible, or to imply that they are, which is what can happen in popular discourse over these issues.

Like so many things in life the truth is a bit complex: there is no one outcome (good or bad) that can be associated with cosleeping in the form of "bed-sharing, but rather a range of outcomes (from potentially beneficial to dangerous and risky) depending on the overall circumstances within which the cosleeping takes place.

For example, the condition of the sleeping surface - the bed (in Western cultures) and the condition and frame of mind of the adult cosleeper (s), and the purposes for cosleeping --are very important in assessing the relative safety, dangers or potential benefits of sleeping with an infant or child. During my many years of studying infant-parent cosleeping/bed-sharing, I am unaware of even one instance in which, under and acknowledged safe social and physical conditions, a mother, aware that her infant was in bed with her, and breastfeeding in her own environment, ever suffocated her infant.

But important precautions need to be taken if families elect to bed-share. And bed-sharing should be avoided entirely if the mother smokes (either throughout her pregnancy or after) as maternal smoking combined with bed-sharing increases the chances of SIDS.

While there is evidence that accidental suffocation can and does occur in bed-sharing situations, in the overwhelming number of cases (sometimes in 100% of them) in which a real overlay by an adult occurs, extremely unsafe sleeping condition or conditions can be identified including situations where adults are not aware that the infant was in the bed, or an adult sleeping partners who are drunk or desensitized by drugs, or indifferent to the presence of the baby. In these cases often the suffocation occurs while the parent and infant sleep on a sofa or couch together.

In my own work I stress that a distinction must be made between the inherently protective and beneficial nature of the mother-infant cosleeping/breast feeding context, and the conditions (of the mother and the physical setting including equipment) within which it occurs - which can range from extremely safe to unsafe and risky.

While mother-infant cosleeping evolved biologically, it is wise to recall that beds did not; whether sleeping in a crib or in the adult (parental) bed, the mattress should be firm and it should fit tightly against the headboard so that an infant cannot during the night fall into a ledge face down and smother. Since contact with other bodies increases the infant's skin temperature, babies should be wrapped lightly in the cosleeping environment especially, and attention should be given to the room temperature. Obviously if the room temperature is already warm (say above 70 degrees F, the baby should not be covered with any heavy blankets, sheets or other materials A good test is to consider whether you are comfortable; if you are, then the baby probably is as well.

Avoid cosleeping with a baby on a couch as too many that I know of slipped face down into the cracks between the pillow seats and were compressed against the back wall of the couch, or fell face down into the back part of the couch and suffocated. Personally, I would also avoid cosleeping on waterbed, although there may be some instances they are firm enough and lack deep crevices (around the frame) that could be deemed safe.

Under no circumstances should the baby sleep on top of a pillow, or have it's head covered by a blanket. Moreover, if another adult is in the bed, the second adult should be aware (made aware of) the presence of the baby, and it should never be assumed that the other adult knows that the baby is present. Parents should discuss with each other whether they both feel comfortable with the baby being in the bed and with them. I always suggest that if parents elect to cosleep in the form of bed-sharing each parent (and not just one) should agree to be responsible for the baby. Such a decision, by both sleeping adults, maximizes attention to the presence of the infant.

Toddlers or other little children should not be permitted to sleep in the adult bed next to an infant as toddlers are unaware of the dangers of suffocation. Moreover, it is unsafe for a infant and a toddler to sleep alone together in the same bed.

Finally, it is not a pleasant thought to consider, but I always think that it is important to consider if, by chance, an infants died from SIDS while sleeping next to you, would you assume that you suffocated the infant, or would you know that you did not, that the infant died independently of your presence? If you are unable to believe that a SIDS could occur independent in the bed-sharing or bed-sharing/breast feeding context, just as it can under perfectly safe solitary sleeping conditions, then perhaps it might be best to have the your infant cosleep next to you on a separate surface, rather than actually in your bed. Regardless of what you decide, it is important to consider the possibility, no matter how remote and unlikely such a scenario may be. That SIDS can, indeed, occur, where safe bed-sharing, breast feeding and complete nurturing and care for the infant has occurred, makes this question worth discussing amongst you and your partner.

Let me end on a positive note: all else being safe, bed-sharing among nonsmoking mothers who sleep on firm mattresses specifically for purposes of breast feeding, may be the most ideal form of bed-sharing where both mother and baby can benefit by, among other things, the baby getting more of mother's precious milk and both mothers and babies getting more sleep - two findings which emerged from our own studies.

32. Why do babies wake up so often and so easily? Why do they seem to sleep longer/more profound when mommy is lying beside them?

If infants do wake up easily, and this is always a relative description, just as it is for adults, then it is likely biologically appropriate and dependent on method of feeding (bottle or breast or mixed) and general comfort level (condition of diaper and/or satiation-hunger status). Recall that breastfed infants wake up much more frequently and at shorter intervals than do bottle fed infants since cows milk is designed for cow brain growth (much less volume compared with human brains) and body growth rates while breast milk has just the right composition which means fast burning sugars and much less protein and fat...for that ever-growing human infant brain whichi triples in size in the first year. All human beings including infants have their own unique sleep personalities and no two human infants (adults or infants) are the same. Mostly infants wake up because it is in their best interest to do so as their neurobiology is not designed for sustained, deep and consolidated sleep at young ages, before six months of age. They appear not to wake up as much next to their mothers but actually in terms of small arousals and even larger ones they wake up more, but they do not necessarily alert the mother because they sense their own safety (or whatever emotion or physical sense that reduces stres or anxiety) which comes with smelling her milk and feeling her body, hearing her breadth and feeling her movements and rhythms.

33. Many parents are afraid of practicing co-sleeping, as they pediatrician tells them that it has been considered to increase the risk of SIDS. What is the truth about co-sleeping and SIDS?

First of all, the question must be first responded to by asking…what kind of cosleeping are you referring to? It is scientifically fallacious to say that co-sleeping increases the chances of SIDS especially in light of the fact that hundreds of different co-sleeping patterns exist, which vary in degrees of safety and/or benefits and outcomes associated with them. Room sharing is a form of cosleeping and it is known that roomsharing decreases an infants chances dying by a third of one half compared with babies sleeping alone. But perhaps more importantly, no human infant (meaning no present living human beings) would or could be alive today had our ancestral mothers not have slept next to their infants for physiological regulation, management, protection, and to breastfeed throughout the night. It is one thing to delineate which kinds of "cosleeping" in diverse settings are safer or less safe or not safe at all, therein

acknowledging the diverse types of co-sleeping and the need to educate parents to the known factors which increase suffocation risks or some types of SIDS (say, evoked by overheating or the covering an infant's heads or sleeping on a couch with an infant or letting other children sleep next to a baby; but it is an altogether different and immoral strategy to claim in an unqualified way that mothers bodies, no matter what, cannot safely sleep next to their infants, or that these bodies are inherent lethal weapons, no matter what. Most co-sleeping cultures either have never heard of SIDS or have the lowest infant mortality or SIDS rates in the world, These co-sleeping cultures are characterized by mothers who breastfeed and do not smoke suggesting that it is not co-sleeping that is the problem at all, but how it is practiced.

Saying without qualification that "cosleeping causes SIDS" is the equivalent of saying that the mothers body and capacities are inherently deficient, the very body against which everything an infant can or cannot do biologically, or needs to do, is explained including infant survival itself. This strategy and comment presently being used by medical institutions not only gets the science wrong, ignores contrary evidence, and dismisses any critiques of that science that claims to show that all bedsharing is dangerous, but they attempt to pass on to the public social judgments for science. They assume, and present their statements, as if they are backed up by systematic studies that prove that parents are not intelligent nor capable enough to take care of the sleep environment within which they "co-sleep" and that during sleep parents all become insensitive to their infants need, and are incapable of responding to their infants needs or conditions when scientific studies published in the best medical scientific journals contradict and refute their claims. A double standard in assessing the causes and solutions for solitary sleeping- crib sleeping, infant deaths, and any and all forms of co-sleeping infant deaths is typically practiced.

34. One thing parents fear about co-sleeping is that their child will never learn to sleep alone? What do you tell these parents?

All infants eventually learn to sleep alone and follow the patterns of their families. This is not a skill that requires teaching. It is an acquired an inevitable skill. Co-sleeping babies 'decide' to learn to sleep alone, later than do routinely solitary sleeping infants, this is true but they DO eventually learn to sleep alone, for sure, perhaps a year and a half later than do infants who were forced to sleep alone from birth. It's a matter of timing and not whether they ever learn how. In fact, I am not even sure it is something the co-sleeping children cannot do as early as solitary sleeping children. It may be that they just don't want to, and why should they when sleeping with mom and dad feels so safe and good. This is a cultural concept i.e. being afraid that children will never learn to sleep alone.

35. Why do babies wake up when they fell asleep in your arms and you try and "put them down"?

Because infants are biologically designed to sense that something dangerous has occurred, separation from the caregiver…and they feel, through their skin, that something is different such as a missing the softness of the mother's touch, the heat of mother's body, the smells of mother's milk, the gentleness of mother's moving –breathing chest and the feeling of being protected. Infants are alerted because insofaras their own body is concerned infants are about to be abandoned and it is therefore time to awaken to call the caregiver back the very caregiver on whose body the infant's survival depends.

36. Does Breastfeeding reduce the chances of SIDS?

Yes. Venneman et al 2009 were first to find unqualified proof of this long suspected fact having conducted a populations-based study of 333 infants who died of SIDS between 1998 and 2001 matched in age to 998 "control infants" born 4 to 6 weeks after the case infants.

According to their abstract…".The response rate was greater for case families vs control families (82.4% vs 58.7%).Interviews were conducted at the same age for case infants and control infants. Autopsy protocol for case infants was standardized.Most SIDS cases (59%) occurred between ages 2 and 5 months. Interviewers administered questionnaires regarding exclusive breast-feeding, partial breast-feeding, or no breast-feeding at ages 2 weeks, 1 month, and in the month before SIDS in case infants or in the last month before the interview in control infants.

Multivariate analysis controlled for maternal smoking in pregnancy, maternal family status, maternal age at delivery, socioeconomic status, previous live births, infant birth weight, bed sharing in last night, pillow in infant's bed, additional heating in last sleep, sleep position, and pacifier use. At age 1 month, 39.0% of case infants vs 71.9% of control infants were exclusively breast-fed (adjusted OR, 0.48; 95% confidence interval [CI], 0.28 - 0.82). At age 1 month, partial breast-feeding did not significantly reduce the risk for SIDS.In the month before death or in the last month before the interview, 9.3% of case infants vs 33.5% of control infants were exclusively breast-fed (adjusted OR, 0.27; 95% CI, 0.13 - 0.56).In the month before death or interview, 12.9% of case infants vs 27.9% of control infants were partially breast-fed (adjusted OR, 0.29; 95% CI, 0.16 - 0.53).

Survival curves showed that partial breast-feeding and exclusive breast-feeding were linked with a decreased risk for SIDS at all ages.

Breast-feeding decreased the risk for SIDS by approximately 50% at all ages. Limitations of the study included low response rate for control families, higher socioeconomic status in participants vs. nonparticipants, possible residual confounding despite multivariate analysis, and possible recall bias because of retrospective design.

From: Vennemann M, Bajanowski T, Jorch G, Mitchell E. Does breastfeeding reduce the risk of Sudden Infant Death Syndrome? Pediatrics 2009; 123: e406-10.

See Also: Fredrickson DD, Sorenson JF, Biddle AK. Relationship of sudden infant death syndrome to breast-feeding duration and intensity. Am J Dis Child 1993; 147: 460.

37. To avoid controversy and/or arguments is it ok just to lie about the fact you bedshare with your baby regularly. Does it do any harm?

It's not nice to lie, in general, but it is especially timely that all the bedsharing parents should come out of the bedsharing closet, so-to-speak, and proudly proclaim their sleeping arrangements and the legitimacy of their choice. By not being honest the science of bedsharing gets very skewed. FEW examples of families safely cosleeping provide public officials with a license to assume authority over this issue when in fact, its only parents that can and should. By not having indicated that you bedshared and your baby lived and thrived it artificially elevates the statistical calculations measuring the relative risks of bedsharing compared with crib sleeping. Lower estimations of how many people safely bedsharing in our population significantly makes crib sleeping look much, much safer than bedsharing because parents are not afraid to say that their babies sleep in cribs; but many who bedshare and their babies live, and are not therefore counted in relative risks of crib vs. bedsharing statistics.

Also, keep in mind that by lying about bedsharing one inadvertently supports the idea that something is wrong with it, under any and all conditions. Lying about it pathologizes safe bedsharing and makes it morally suspect. Hiding one's bedsharing behavior only accentuates then the problems other parents face, too, leaving them stranded and without support, or knowledge that at least half of other parents bedshare, too. That can be comforting and reassuring and provides opportunities to share experiences and to learn.

38. How many western babies have "sleep problems to solve"?

As regards how many infants have what is considered a "sleep problem" in western society that, too, is hard to ascertain exactly as it depends on how one defines an "infant sleep probIem" and who is doing the defining; but roughly speaking somewhere between 40-60% of western babies are 'said' to have sleep problems to solve. My contention is that there is nothing wrong with the babies at all but the sleep model that is being culturally imposed on them which is the cause of the "problem" and not the biology of the infant that suffers through that imposed cultural model and set of expectations it produces.

From a biological point of view, one question begs answering: why or how could 40-60% of otherwise healthy infants have sleep problems to solve and if this is percentage is anything near the truth then the cultural and or scientific models of normal healthy slep that underlie our cultural ideologies must reflec far more about adults than they do about babies. It also suggests that models of sleep, and our expectations and goals for parents, might actually prove to be the cause of the very sleep problems parents must try to solve!

39. How recommendable are "apnea monitors" like "Angel Care"?

It depends on what the apneas are thought to be useful for, who recommended them, and whether the problem they are attempting to eliminate has been shown by good science to be effectively improved or prevented by that particular monitor. My opinion is that their usefulness is highly limited. Apnea monitors are not recommended to prevent SIDS, though I understand why parents of potentially ill infants might feel more secure by using them. Many mothers that start out using apnea monitors give them up and rely on their own capacities to stabilize their infants. Mother's proximity and monitoring coupled with the infants capacity to sense mothers sensory stimuli including their breathing sounds and the sensations of their mother's breadth should prove extremely effective in most cases. At very least, mothers' exchange of sensory stimuli with her infant sleeping on a separate surface very close, will not hurt that infant.

40. What is your opinion on the American Academy of Pediatrics labeling all bedsharing as "hazardous" and recommending against it without qualifications even if the mother is breastfeeding and the context is absent of any maternal (or paternal) smoking, before or after pregnancy, or other known bedsharing riskfactors?

*Please see my video interview (on home page) in which I discuss this question in more detail than I will here. This video is on the opening page of my website

This is a complex question. A full answer covers many different areas from the scientific, as regards what constitutes the safest infant sleep from a biological point of view and the research that supports it, and how we as diverse professionals from different fields and disciplines teach it without asserting inappropriate civil or legal authority that is not ours or anyone's to assert. There is no accurate simple message, either, although some want it to be and it is this school-of-thought that wants a simple message about bedsharing that is: "never" do it." This website and the science that supports this website's information argues that such ha simple, singular message is misleading and scientifically false and inappropriate.

Here are some things to thing about. Beginning with the notion that In an open and free society such as ours, and a scientifically-based (literate) society it is morally appropriate (and legally justified) that our citizens be presented with unbiased information on personal health issues, information that has not been filtered or subject to a selective presentation, by those with power, as regards what THEY deem relevant to the debate (bedsharing) that is under discussion.

Unfortunately, concerning bedsharing, many health-county-regional-state- professionals apparently think all parents are equally unable to make reasonable judgments for themselves as regards whether they are able or not to bedshare safely, to weigh the relative risks and benefits, and that therefore, it must be done for them, and with as much legal authority and veiled threats as they can present.

In my opinion what has happened in this area is that a kind of social ideology is now embedded within the medical paradigm, to the extent that that social judgments are masquerading as scientific judgments making the science a pseudo science, as a relatively small number of people have been placed in a position wherein they can choose what relevant lines of evidence (and what counter arguments) are acceptable and which are not, as deemed by themselves. These people actively ignore, indeed, find offense with, any ideas, data, or alternative views that do not support their own a priori views. But "authorities" must be challenged publicly and privately and by research and arguments formulated against any monolithic viewpoint that endorses or supports fallacious underlying assumptions.

Having served as a consultant both for the American Academy of Pediatrics subcommittee on breastfeeding, and as an ad hoc consultant for the Infant Sleep Position and SIDS AAP committee in 2004-2005 which was studying the bedsharing issue and eventually recommended against bedsharing altogether, I was at one point very hopeful if not confident that a compromise would be forthcoming i.e.that the AAP sub-committee would support and educate breastfeeding mothers who chose to bedshare.Not only did they choose not to make distinctions between types of bedsharing preferring instead to label any and all bedsharing as "hazardous" these recommendations have been expanded in 2011 as a the seven person AAP committee even more strongly renewed its recommendation against any and all same-surface co-sleeping, especially bedsharing. The truth is that there has always been much more agreement than disagreement on bedsharing issues when and how to bedshare and when not to, but the present rhetoric being endorsed and promoted by the AAP and First Candle and many “Safe Infant Sleep Committees” around the country would suggest otherwise and, indeed, the public wars being led by governmental agencies and by medical groups against bedsharing are nothing less than disresepctful and vittriololic of parents who choose to bedshare safely.

Unfortunately, the rhetoric against bedsharing parents has turned very ugly and negatively judgmental and condemnatory. Indeed, the rhetoric is nothing less than threatening, of any and all bedsharing parents even when risks are minimized; and the zeal and imprecise language which is being used by many technicians involved in what is considered “safe infant sleep” campaigns is over simplified to the point that it is inaccurate, misleading, and inappropriate, and is itself dangerous on many different levels, both politically and scientifically (see Gettler and McKenna 2010 avilable on this website).

In Baltimore Maryland, for example, one community health poster promotes a “safe infant sleep” message called the A,B,C’s of safe infant sleep… The poster recommends: A for infant sleeping 'alone' (a dangerous practice); B for the infant sleeping on it’s back; and C, for the infant sleeping in a crib. No mention is made of breastfeeding or infants as protection against SIDS or SUDI, or sleeping on a different surface next to the parents, i.e. separate surface co-sleeping a practice that is recommended by the AAP.

Many anti-bedsharing posters reflect an authoritative tone as if those in power have the right to address the public as if they are children who have no choice, or rights to disagree, or rights to think for themselves about this issue. The poster goes on to say: “no exceptions” as if not to bedshare is a military order that must be obeyed, or else! Anti-bedsharing campaigns have become practically synonomous with the absence of the mother as many if not most of their posters involve a crib isolated from th eparents room with the baby sleeping in it, directly contrary to their own recommendations that no infant should sleep outside the room of a committed adult.

Certainly, there is a cadre of individuals working for local child protective services and infant mortality review boards and SIDS prevention subgroups that use inflammatory language and make condescending statements about bedsharing parents and maintain that “good parents” would never bedshare under any circumstances. Indeed, one leading spokesperson for First Candle once insinuated that parents bedshared to be "cool" and commented how bedsharing did not reflect "educated" parenting. This spokesperson seemed to think that the fact that a Texas infant was suffocated by her bedsharing mother who had drunk 18 cans of beer before retirng to bed with her doomed infant had anything to do with changing the risks of bedsharing in general..as if any bedsharing is equally as irresponsible.

Many individuals in the organization known a First Candle have taken on the role of suggesting that there is only ONE legitimate position on the issue of bedsharing and it is their right to decide WHAT that position must be, which is not to do it, ever. They imply forcefully that “good parents” MUST accept uncritically their own anti-bedsharing discourse. The situation in the United States is so bad that local prosecutors are sometimes warning parents that if their babies are injured or die in a bedsharing situation they will be prosecuted, regardless of circumstances.

Suggestions are being made, and local county policies are being formulated (see Gettler and McKenna 2010) that make the assumption that parents have no rights whatsoever to read infant death or mortality data differently, and to become informed over what and where the legitimate disagreements over the bedsharing issue are, so that they can make tup their own minds as to how known bedsharing risk factors apply to their own circumstances. One of the most dangerous consequences of the attitude that only certain people have the right to decide where a baby sleeps is that the parents' civil rights and liberties are being threatened if not denied as are the rights of their infants, to gain unhindered access to their mothers' bodies for nighttime nutrition (breastfeeding) and physiological regulation achieved through nighttime contact. It is as if the representatives of Safe Sleep Committees nationwide, who are generall supported by public monies, assume that it is their civil right and not the parents civilrights to make one of the most important decisions parents make: how they will choose to care for and express their love to, their infants. I encourage parents, therefore, to be conscious of the importance of publicly announcing their bedsharing practices to encourgae more openess for those parents who feel more inhibited or fearful about exposing the fact that they bedshare. By talking about bedsharing it becomes normalized and this is very important, especially in making it easier to get information to parents about how to maximize safety.