

Guidelines to Sleeping Safe with Infants

Maximizing the chances of Safe Infant Sleep in the Solitary & Co-sleeping (Specifically, Bed-sharing) Contexts

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Below I have summarized and highlight some of the issues to be concerned with as you make your own decisions about where and how your infant should sleep.

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

a) Infants should sleep on firm surfaces, clean surfaces, in the absence of smoke, under light (comfortable) blanketing and their heads should never be covered. The bed should not have any stuffed animals or pillows around the infant and never should an infant be placed to sleep on top of a pillow. Sheepskins or other fluffy material and especially bean bag mattresses should never be used. Water beds can be dangerous, too, and always the mattresses should tightly intersect the bed-frame Infants should never sleep on 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.

Bed-sharing: It is important to be aware that adult beds were not designed to assure infants safety!

b) if bed-sharing, ideally, both parents should agree and feel comfortable with the decision. Each bed-sharer should agree that he or she is equally responsible for the infant and acknowledge that the infant is present . My feeling is that both parents should think of themselves as primary caregivers.

c) 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;

d) persons on sedatives, medications or drugs, or is intoxicated --or excessively unable to arouse should not cosleep on the same surface with

the infant.

e) excessively long hair on the mother should be tied up to prevent infant entanglement around the infant's neck--(yes, it has really happened!)

f) 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.

g) it is important to realize that the physical and social conditions under which infant-parent cosleeping occur, in all its diverse forms, can and will determine the risks or benefits of this behavior. What goes on in bed is what matters.

h) 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/bed sharing 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 you really suffocated (by accident) the infant. It is worth thinking about.

I do not recommend to any parents any particular type of sleeping arrangement since I do not know the circumstances within which particular parents live. What I do recommend is to consider all of the possible choices and to become as informed as is possible matching what you learn with what you think can work the best for you and your family.

What is the "proper" sleeping arrangement for me and my baby?

There is no one way to arrange your baby's sleep, before you retire for sleep, and how well one approach works is, as always, determined by factors pertinent to each family and baby (temperament, sensitivity etc.) which are not known to an "advise giver" or the "expert". Try to remember that you know your baby better than anyone. Become informed, but make your own decision and feel good about it.

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 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.

Interestingly, infants and older baby's fall asleep more easily 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 care giver - or perhaps that something-- is going on nearby. 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 baby's find sleep when they need it, and they were not designed biologically or psychologically to sleep in complete social isolation. 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 pump family noise into the baby's room, letting the baby monitor the parents and siblings, rather than the other way around. Fifty years (at least) of human developmental research shows that baby's respond positively to physical and psychological sensory signals (sounds,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".

[Co-sleeping 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 irresponsible, 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. 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- and not maximize infant and maternal health and infant survival! Infant-parent cosleeping with nocturnal breast feeding 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 virtually 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.

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, which 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. The truth is that 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 your infant or child. During my many years of

studying infant-parent cosleeping/bed-sharing, I am unaware of even one instance in which, under safe social and physical conditions, a mother, aware that her infant was in bed with her, ever suffocated her infant. But just as is true for other aspects of infancy or childhood important precautions need to be taken if families elect to bed-share. For example, 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.

I would 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 safer not to permit an 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 infant 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

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. 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 morbidity, indeed, 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 its 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 - can feel better about nurturing and, hence, being in interaction with their baby during the night - and hence, further augmenting and cementing their relationships, as can Dad. Given the right family culture, cosleeping can make mother, dad and baby feel very good, indeed.

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 of the matter is, none 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 be demonstrated - simply assumed to be true, but recent studies are beginning to show the opposite that is, it is not, for example, solitary sleeping arrangements that produce strong independence, social competence, feeling of high self esteem, good comportment by children in school, ability to handle stress, strong gender or sex identities - but it is social or cosleeping patterns that might, indeed, contribute to the emergence of these characteristics. 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 parents 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 parents bed, for all of the night (1).

* In a survey of adult college age subjects, Lewis and Janda (2) 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 (3) 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" (4).

* Again, in England Heron (1) 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 possibly most systematic study to date, conducted on five different ethnic groups from both Chicago and New York involving over 1,400 subjects Mosenkis (5) found far more positive adult outcomes for individuals who coslept as a child, among almost all ethnic groups (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 part,s, 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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[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. 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. Moreover, it is interesting to note that where infants and parents cosleep the infants are for the most part undetected by the apparent, and the infant upon "feeling" the infant's presence, returns to sleep without awakening the apparent so the question of "sleeping through the night" becomes less relevant.

Of course, years ago Dr. Tom Anders observed that 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 attempts to manipulate. Interestingly, 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. 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 interest. 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.