Sleeping with Your Baby

James J. McKenna, PhD
Indiana, USA

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Cosleeping refers to many different ways babies sleep in close emotional and physical contact with their parents, usually within arm's reach. It is very important to acknowledge that cosleeping does not simply refer to bedsharing, for example, but it refers also to roomsharing, or any situation in which parents and infants are within arm's reach but not necessarily sleeping on the same surface.

There is no right way to cosleep, nor does cosleeping occur in one correct configuration. While some ways of cosleeping are safer than other ways, some are not safe at all. One thing is for sure -- regardless of whether or not you sleep on the same or different surface, or in the same or different room, remember that no one knows your baby better than you, and no one can anticipate and respond to the immediate needs of your baby as well as you.

It is true that we need to be very conscious of how we cosleep. If bedsharing, how we arrange bedding, other children, pets, and furniture must be done with care. In order to protect and promote the well-being of your baby, you will need to be aware of safe cosleeping strategies, particularly if you choose to bedshare. Mothers' bodies certainly evolved to sleep next to their infants, but one potential problem is that the recent diverse and complex furniture on which Western mothers and families sleep did not. Other dangerous conditions include when mothers smoke and bedshare, and when any adult in the bed takes drugs or alcohol.

How and where your family chooses to cosleep can be adapted, though, or modified, to what you and your baby need in order to sleep as comfortably and safely as possible.

Sleeping With Your Baby Is Normal

For most of human history (and before written records were kept) covering hundreds of thousands of years, mothers have effectively combined cosleeping and breastfeeding to provide for their babies' immediate social, psychological, and physical needs. Whether born in Indiana, USA or Papua New Guinea, human infants are especially vulnerable, slow developing, and must rely on their parents' touch, carrying, and feeding for survival. Most mammals are born with 60 to 90 percent of adult brain size. Humans are born with just 25 percent of adult brain size. Compared with other mammals, human infants take the longest time to grow up, and they remain in a biologically dependent state for the longest period of time. In this immature state, human babies are, for the first few months of life at least, unable to efficiently regulate their body temperature without mother being in proximity, and they are unable to make effective antibodies found in mothers' milk to protect themselves from bacteria and viruses. Human infants cannot control their bowels, speak, make tools, digest large molecules, or walk. In the words of anthropologist Ashley Montague, human infants are "extra-gestators" (1), meaning they complete their gestation after birth, and someone's got to be there to help with it.

Due to this extreme human developmental immaturity, babies require parental (especially maternal) smell, touch, sounds, and movement in order to feel secure and to have their physical needs met at an optimal level. All primate infants, including humans, biologically expect to be in close contact and proximity with their caregivers. In fact, human infants are at birth not adapted to the outside physical environment, but only to what mother's body offers the infant. There is no such thing as giving a human infant too much contact or affection -- they thrive on touch, and grow more the more they get of it (2). When deprived of these sensations, a baby will use her primary survival response -- crying -- and will produce cortisol, a stress hormone, as she attempts to attract the attention of her parents.

Cosleeping, traditionally an extension of our human need for infant-parent closeness, is significant to our evolutionary endurance. Anthropological studies that examined the sleeping customs of families in tropical, non-industrialized cultures have discovered that all of these hunter-gatherer and tribal-level societies share sleep with their babies (3). Researchers consider these societies to be more similar ecologically and adaptively to prehistoric cultures, whose members coslept in order to ensure their infants' survival and well being. Thus, cosleeping is a very, very old practice among human beings.

It is only in recent history that mothers in a relatively small area of the world have the dubious luxury to ask two basic questions: "How will my baby be fed?" and "Where will my baby sleep?" The advent of these questions stems from the discovery and production of baby formulas, and from society's emphasis on the alleged benefits of bottle-feeding. Bottle-feeding enables mothers to spend more time apart from their babies, and with rising affluence in the middle class and an increased value on individualism, separate bedrooms for parents and children became more common and culturally fashionable. By the mid-1900s, it became very common, for the first time in human history, for babies to be bottle-fed and then placed to sleep on their stomachs (to promote uninterrupted sleep) in a room far from the sensory range and supervision of their parents. It did not work out very well for babies. Culture changed, but the infant's need for mother's milk and contact with the mother's body did not.
Along with this trend came another alarming development -- babies in increasing numbers were not waking up. Sudden Infant Death Syndrome (SIDS), for which we scientists still have no explanation, grew. We still do not know the exact causes of SIDS, also known as cot or crib death, only that there may well be many causes that interact with a range of possible environmental stressors, which include maternal smoking, not breastfeeding, and the prone (stomach) infant sleep position. SIDS is diagnosed only following a full toxicological report and post-mortem analysis, when all other causes of death have been ruled out. SIDS remains, then, a “diagnosis by exclusion.” When SIDS was first defined as a medical entity in 1963, the death rate from this tragic syndrome was between two to three babies per 1,000 live births in most Western nations. SIDS emerged in Western societies alongside never before tried infant care innovations: artificial milk or cow’s milk, prone infant sleep, and infants sleeping alone in rooms by themselves. Coupled with increasingly more mothers smoking before and after their pregnancies, a real SIDS epidemic was in the making.

In many Asian cultures, where cosleeping and breastfeeding (as well as low maternal smoking rates) are the norms, SIDS is either considered rare or is simply unheard of. A baby put to sleep alone in his own room is an image seen only in the last hundred years or so and only in industrialized Western societies. Our culture’s emphasis on independence, individualism, and self-reliance has helped drive the ideology that babies should sleep alone. Without any developmental evidence supporting such conclusions, it was merely assumed that forced solitary sleeping for infants and children led automatically to secure, independent adults without any sleeping problems. These assumptions have hurt us, but it is not too late to return to doing what cultures across the world consider the norm: cosleeping.

Cosleeping Is Good for Babies

A baby who sleeps in proximity to her parents is reassured by the continual reminders of the caregivers’ presence -- touch, smell, movement, warmth, and, by virtue of increased breastfeeding, taste. These sensations provide emotional security for the baby, and, if the newborn is breastfeeding, a steady supply of signals and cues (such as fragrances from mother’s milk) that promote more breastfeeding and increased nourishment. If your baby’s well-being is threatened -- for example, if he is choking or struggling to move a blanket away from his face -- you will (if attentive) be able to help right away. In such a protected and nurturing environment, your baby will benefit from an almost immediate response to his or her needs.

When babies, especially before they can verbalize their needs, do not have their needs met, they cry. Crying evolved as an alarm signal reserved for critical circumstances involving pain, hunger, or fear, and it is used to elicit mothers’ retrieval behavior. Years ago it was learned that prolonged crying decreases oxygenation and increases heart rate, which in turn then augments cortisol, a stress hormone.

Some studies have suggested that elevated levels of cortisol in infancy can cause physical changes in the brain, promoting a greater vulnerability to social attachment disorders. At the very least, the energy lost in crying could be better put into growth or maintenance (4). Babies who cosleep are much less likely to cry themselves to sleep, or even to cry at all, and so avoid releasing an excess of this hormone. However, many parents are now encouraged to use “controlled crying techniques” to manage infants and young children who do not settle alone, who wake at night, or who settle only if held or permitted to sleep in proximity or contact with parents. So concerned is the Australian Association of Infant Mental Health about the use of such techniques that the organization issued the following statement: “Controlled crying is not consistent with what infants need for their optimal emotional and psychological health, and may have unintended negative consequences” (5).

Babies are warmer when they sleep next to their moms, reducing the need for heavy or numerous blankets. Throughout the night mothers and infants are exchanging sensory experiences, such as body heat, that serve to regulate the baby’s state. When a newly born infant is removed from his mother’s uterus, for example, the baby can experience a loss of up to one degree Fahrenheit of body temperature, generally explained yet again by the production of stress hormones. This drop in temperature can reduce immunity, making a baby more susceptible to infectious diseases, and takes energy away from growth and development in an attempt to regulate the baby’s temperature. One study found that among 11- to 16-week-old infants, babies who slept alone had a lower average axillary (underarm) skin temperature than babies who breastfed and slept alongside their mothers (6).

Babies who sleep with their mothers and breastfeed spend less time in the deepest stages of sleep (stage three and stage four), from which arousal is more difficult should the baby need to awaken quickly to terminate a dangerous apnea (episodes in which one stops breathing). Instead, cosleeping babies spend more time in lighter stages of sleep (stage one and stage two). Light stage sleep is thought to be physiologically more appropriate for young infants, and more natural and conducive to safe sleep for babies, because it is easier to awaken to terminate apneas than it is when babies are in deeper stages of sleep. The shorter durations of deeper stage sleep promoted by cosleeping can potentially protect those infants born with arousal deficiencies (suspected to be involved in SIDS). Moreover, cosleeping significantly increases the total number of infant arousals as the baby gets a lot of practice in arousing to mother’s external sounds, movements, and touches. This increase in arousals may improve her ability to develop awakening skills that can prove handy should the infant’s oxygen supply decrease following a breathing pause. The baby not only stirs in relationship to mother’s movements, but the smells of her nearby also contributes to the infant’s tendency to remain in light sleep for a longer period of time (7).

Both pre-term and full-term infants can benefit significantly from the physical presence of their parents, although I do not recommend that premature infants actually sleep in the bed with their mothers due to their increased vulnerability and small size. Nonetheless, aside from the ability of infants to learn at a faster rate due to the greater number of social interactions and frequent communicative patterns that come with increased contact and proximity, scientific studies show that when babies rest on their mothers’ or fathers’ chests, enjoying skin-to-skin contact, they breathe more regularly, use energy more efficiently, grow faster, and experience less stress (8). In several recent reviews, Dr. Sari Goldenstein, Dr. Makhuaul, and Dr. Helen Ball point out that skin-to-skin contact, sometimes referred to as kangaroo care, leads to earlier discharge of premature infants, fewer apneas, and fewer bradycardia incidents (periods of slow heart rates) (9). Maternal contact is known to act as a pain killer for newborns and
increased touching and holding help infants to recover rapidly from birth-related fatigue (10). Spontaneous breastfeeding is also facilitated by contact as well as serving to encourage the mother to continue to breastfeed for longer periods of time per breastfeeding session (11). Sleep duration increased among infants who experienced skin-to-skin care, and they seemed less agitated in general while enjoying more stable heart rates and breathing patterns leading to greater overall oxygenation (12).

There are also benefits for mothers. Skin-to-skin contact is associated with a significant increase in maternal oxytocin levels (a hormone released during breastfeeding) in two Swedish studies (13), which suggests that uterine contraction would be enhanced and milk ejection improved, to the benefit of both mother and infant. Finally, there is a report that skin-to-skin contact is also associated with lowered maternal anxiety and more efficient participation of mothers in caring for their newborn infants (14).

Letting a baby cry herself to sleep is advice given to parents with the goal of raising a child that is self-reliant, able to comfort herself, and comfortable with aloneness. Researchers are now finding that in extreme cases leaving children to cry without offering any comfort can cause lasting damage to their brains. Persistent distress as a child is being linked with higher rates of depression and emotional problems later in life. Many child psychologists now believe that babies know best, and parents should follow the instinct that directs them to try to soothe a crying baby.

As a developmental extension of the skin-to-skin experience, parent-infant bedsharing, when practiced safely, can be a warm and snuggly experience that many parents enjoy. However, it is much more than that – it is a biologically driven process whereby the baby’s body temperature is regulated and steady breathing is promoted in part by the sounds of mother’s breathing and by the infant feeling the mother’s rhythmic chest movements. In many biological studies these cues are shown to act as “hidden” stimuli by which the young of other mammals time their next breath (15, 16)!

Even the mother’s expelled carbon dioxide (CO2) is not wasted in a cosleeping situation; the amount of CO2 the mother expels in her breath acts to stimulate infant breathing (17). Expelled CO2 appears to act as a potential back-up should the baby’s own internal drive to breathe falter or slow, since the baby’s nasal regions can both detect and respond to the presence of this gas by breathing faster.

And there are still more advantages to parent-infant contact. During skin-to-skin contact, the infant body stimulates just the right brain cells to be nurtured and connected to each other. In a sense, nighttime cosleeping can be said to extend the needed micro-environment that during the day also fosters a variety of social, communicative, and emotional skills because baby is being monitored and protected. A mother is certainly more than a service provider; she is the entity around which the human infant was designed not just to be awake, but to sleep. The English psychologist Donald Winnicott spoke of the baby’s profound dependence on others for life-sustaining support when he said, “There is no such thing as a baby, there is a baby and someone.” When considering what infants need or trying to explain what infants can or cannot do, nothing makes sense except in relation to the mother’s body.

References

**Safe Sleeping Tips**

**Do:**
- Make sure baby is sleeping on a clean, firm, non-quilted surface.
- Provide a smoke-free environment.
- Place baby on her back to sleep. If you breastfeed in bed, make sure baby is on her back at the end of the feed.

**Avoid:**
- Bedsharing if any person in the bed has consumed alcohol, taken drugs (illegal or legal) that could make him/her extra sleepy, or is too exhausted to be aware of baby.
- Bedsharing if any person in the bed is a smoker. Exposure to cigarette smoke increases baby's risk of SIDS.
- Bedsharing if any person in the bed has an illness or condition that affects his/her awareness of baby.
- Bedsharing if the parent sleeping next to the baby is markedly obese, unless the mother is breastfeeding and has considered how to compensate in some way for the greater weight differential.
- Bedsharing if older siblings who do not understand the risks of suffocation are sleeping in the same bed with infants less than one year old.
- Bedsharing if any pets will be sharing the bed with baby.
- Sleeping with baby on a waterbed, recliner, couch, or armchair.
- Placing babies in an adult bed alone and unsupervised. Never leave an infant alone on an adult bed.
- Thick bedding; sheets and blankets should be porous, preferably cotton. In cold weather, use layers of thin bedding rather than one heavier blanket.
- Dressing baby too warmly -- if you are comfortable, baby probably is, too. Remember that close bodily contact increases body temperature.
- Strings and ties in hair or nightclothes -- these pose a strangulation risk for the baby.

**Cosleeping Q&A**

Some pediatricians say that bedsharing creates a “bad habit” that’s hard to break. 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 (thought 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.

**How long should I cosleep with my child?**
However long you want to! In fact, how long an infant 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.

**What long-term effects will my baby experience if we cosleep?**
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. 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.
Benefits of Cosleeping for the Breastfed Baby (when known adverse factors are absent)

Greater milk supply: As babies breastfeed throughout the night, their sucking stimulates their mothers to produce more of the milk needed for proper nourishment.

More frequent breastfeeding: Studies tell us that more frequent infant feeds reduce crying duration, thereby contributing to babies' energy conservation and calm wakefulness.

Longer breastfeeding sessions: Longer feeds ensure that your baby receives enough daily calories to provide adequate nutrition and weight gain.

Longer breastfeeding period: By continually breastfeeding over time, babies receive the immunological and nutritional benefits they need for optimal growth and development.

Increased safety: Breastfeeding babies are being constantly monitored throughout the night, and tend to be placed on their backs, in the recommended supine position, with their noses and mouths unobstructed.

Increased infant sleep duration: Babies who sleep alone must cry loudly enough to wake their parents who are sleeping several rooms away. By sleeping together, babies achieve a longer and better rest period.

Lower stress levels: When babies do not have to cry to have their needs met, thus becoming agitated, they are able to stay calmer and more content.

Temperature regulation: Babies are warmer when they sleep next to their moms, and mothers can sense their baby's temperature and respond by adding a blanket if her infant seems chilled or by removing covers if her infant is overheated.

Increased sensitivity to mother's communication: Moms and babies who routinely sleep together have a heightened and enhanced sensitivity to each other's smells, movements, and touches.

Benefits of Cosleeping for the Breastfeeding Mother (when known adverse factors are absent)

Greater milk supply: Breastfeeding on demand throughout the night helps mothers establish and maintain their supply.

Increased protection from breast and other reproductive cancers: Bedsharing increases both breastfeeding frequency and duration in months, increasing the cancer-protective effects of long-term breastfeeding.

More rapid excess weight loss after pregnancy.

Enhanced attachment and parental fulfillment: Especially for working mothers, increased time with baby during the night enhances attachment and helps the mother to feel fulfilled as a parent.

Reassurance that baby is safe: Most breastfeeding mothers who routinely bedshare with their babies tend to place their babies on their backs, and sleep in a position that keeps the baby from burrowing under pillows or quilts.

Increased sleep duration for mother: Studies have demonstrated that mothers who sleep with their babies tend to have more and evaluate their sleep more positively than do mothers who sleep apart from their infants.

Lower stress levels: The increased nipple contact that occurs during nocturnal breastfeeding works to increase the mother's production of oxytocin, a hormone that contributes to a sense of calm and well-being.

Increased sensitivity to baby's communication: Mothers are able to respond quickly if an infant wants to feed, thus lowering anxiety that the baby's needs are not being met.

Co-sleeping with your baby does not necessarily mean sharing the same bed as them. You can position a bassinet right next to you or have a crib in the same room. This is the safest possible way to co-sleep with your child without having to share the same surface. If you do decide to place your baby on the bed with you, make sure there aren't any pillows, loose blankets or thick comforters. These materials can cause suffocation, smothering, and overheating. Always place your baby on their back. This will reduce the risk of SIDS. #3 What to Avoid When Co-Sleeping. Avoid consuming drugs or substances Co-sleeping with your baby. Co-sleeping is a very personal decision. Sleep Consultant, Katie Bartley, shares some important tips to consider before bringing baby to your bed. As a sleep consultant and parent to three small children, I am often asked about co-sleeping. It is certainly a personal decision but one that I encourage parents to discuss and agree on together. Let's first begin with what co-sleeping actually entails. Some believe it is having your children in the same room or in a bassinet attached to your bed. However, for the sake of this conversation I am referring to co-sleeping a...