COSLEEPING

COMPETENCY- The resident should be able to define cosleeping and advise patients on the pros and cons of cosleeping. The resident should understand the facts regarding cosleeping so as not to relay mere "beliefs" but give evidence based information to families so they can make an informed decision for themselves.

CASE 1: (taken from ref#3)- Jaquette, a 4 month old AA infant, is brought to the pediatrician for a health supervision visit. She was born full term and after a healthy gestation, labor, and delivery. She nurses vigorously, developmental milestones are normal, and her physical exam reveals an emotionallly robust, active, and physically healthy child. When the pediatrician inquires about her sleep-wake pattern, the mother informs him that she nurses Jaquette frequently through the night in the bed that they share. Both parents state that they are comfortable with this arrangement.

CASE 2: (taken from ref#3): Paul, an 18 month old toddler, has always slept in the same bed with his mother. A single professional woman who read extensively concerning child rearing before Paul's birth, his mother was aware that most child health specialists recommend separate sleeping areas for children and parents. At previous visits to her pediatrician, she intentionally avoided the subject. Although she stated that she enjoyed nursing Paul on demand while sharing a bed, she was beginning to feel ambivalence. She wanted to wean him from the breast, but she was unclear how to initiate the process.

QUESTIONS-

1. What is the definition of cosleeping/bedsharing?
2. What are the potential dangers of cosleeping?
3. What are the potential benefits of cosleeping?
4. What is the evidence linking cosleeping to SIDS?
5. Given the dissenting opinions on this subject, how should we advise our patients in clinic?

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1. Carter, N. "Babies sleeping with parents and SIDS: Invoking SIDS in cosleeping may be misleading." *British Medical Journal*. Oct 21 2000; vol 321: 1019.
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QUESTIONS

1. What is the definition of cosleeping? Cosleeping or bedsharing is simply the practice of parents and children sleeping together.

2. What are the potential dangers of cosleeping? ?
Ref#6: The current Task Force on Infant Sleep Position and SIDS of the cautions that cosleeping may be hazardous under certain conditions such as parental smoking, prone positioning, soft sleeping surfaces or loose bedding, entrapment hazards such as between the bed and wall or the mattress and the bed frame, parental depressed consciousness (either through medications or though alcohol), overheating, and preterm or low birth weight infants. These conditions have been found to increase the risk of SIDS independently of cosleeping, but are found to be more hazardous when combined with cosleeping. Specifically, the risk of SIDS is increased when parental smokers cosleep. In addition, sleeping with an infant on a sofa increases the risk of suffocation and entrapment (ref#1).

As stated in ref#5, there is one study against cosleeping in which the Consumer Product Safety Commission (CPSC)'s databases were reviewed from 1990 to 1997. The death certificates of children under 2 years of age who were placed in an adult bed were reviewed, and 515 death

were reported. Of these deaths, 394 occurred due to entrapment and 121 were attributed to overlying. Although the authors did not investigate deaths of children placed in cribs, they did cite another SPSC study from 1989 to 1991 in which an average of 50 accidental deaths occurred per year of infants in cribs compared with 64 deaths per year of infants in adult beds. Unfortunately, these data represent a case series and are not denominator based, making calculation of the relative risk of death for infants who cosleep impossible. In addition, no notation is made as to whether the parents smoked, had depressed consciousness due to alcohol or drugs, or any other proven hazards to infants in the sleep environment.

Ref#7: Dr. James J. McKenna, PhD and director of the Mother-Infant Behavioral Sleep Laboratory at the University of Notre Dame (Indiana) challenged the validity of the data in the aforementioned study, calling the data anecdotal and compromised by the subjective nature of death certificates and systematic bias of coroners. Also in that study was lack of detail as to whether the parents' smoked or had taken care to minimize the known risk factors for SIDS (i.e. prone positioning, depressed parental consciousness, etc).

3. What are the potential benefits of cosleeping? (ref#3)

According to Dr. McKenna, Professor of Anthropology and Director for the Center for Behavioral Studies of Mother-Infant Sleep, "when practiced safely and by choice, mothers and infants sleeping side-by-side is potentially ideal for promoting breastfeeding and healthy social relationships among family members." He points out several benefits to the infant and mother when cosleeping is done with the previously mentioned safety practices:

Benefits to the infant:

- increased breastfeeding in frequency and total duration (compared with solitary sleeping breastfed infants, cosleeping infants feed more and for longer durations at night)
- increased total sleep time
- mothers nurturing through sensations (touch, smell, sound, movements)
- synchronized sleep arousal with mother

Benefits to the Mother:

- Sleep time and quality improved
- Ovulation decreased (due to increased frequency and duration of nocturnal breastfeeding)
- Number of sleep disturbances and disruptions decreased

As stated above, cosleeping is associated with an increase in the duration and frequency of breastfeeding. In addition, breastfeeding allows rapid response to infant hunger cues. Responsive and contigent caregiving promotes the development of trust and fosters security in young children.

Breastfeeding is a demanding activity in the first months of life, and the mother must feed as often as 8-12 times in a 24 hr period. Cosleeping allows the mother to feed without fully awakening, contributing to her total sleep. Some working mothers find that night feedings are the only realistic way to maintain milk production, and sleeping with the infant is the only way to combine breastfeeding, working, and sleep.

4. How does this affect infant independence?

Ref3: According to Dr. Calvin Colarusso, Clinical Professor of Psychiatry at the University of California, San Diego, the major task of parents is to assist young children in the process of separation-individuation. He asserts that this process of independence begins by solitary sleeping. According to Dr. Martin Stein, Professor of Pediatrics at the same institution, it is an oversimplification to state that a specific event is required for successful individuation. He feels that as long as the infant is independent in many other tasks, cosleeping can be thought of as "psychological refueling or rapprochement" that allows the child greater psychological energy to be directed to daytime functions that lead to separation and individuation. Dr. McKenna adds that no study has shown that the goals for separateness and independence are obtained in the individual by separate sleeping arrangments for parents and children.

Ref#8: The results of an eighteen year longitudinal study on cosleeping children do not indicate a strong negative or positive correlate of childhood bedsharing and adolescent outcomes.

5. Does cosleeping increase the risk of SIDS?

(ref #5); it also references 11-16:
Several studies have been done in an attempt to answer this question. According to the 3 most recent and comprehensive studies, there is no increase in risk of SIDS from cosleeping unless the mother smokes.

6. **Given the controversy surrounding this subject, how should we advise the patients in this scenario**?

It is clear from a review of the literature on cosleeping that one cannot categorically accept or reject the practice. All viewpoints on the issue agree that families should be advised of health hazards such as parental smoking, loose bedding, depressed parental consciousness, prone sleeping, etc that make cosleeping dangerous. In some cases, these health hazards also apply to the infants' crib as well. Based on the lack of evidence neither condemning or supporting cosleeping, families should be given the pros and cons and be allowed to make the decision for themselves. It is important to maintain the role as the "medical informant" and keep the lines of communication open so that families continue their alliance with the physican. This also encourages the physician to enquire into the motivation for cosleeping (e.g. breastfeeding) so that parents who are taking on the goal of breastfeeding for the first year of life will feel supported.

Regarding Case #1, the likely motivation for cosleeping is breastfeeding and the parents and clinician should discuss the structure of the sleeping environment to make sure that no hazards exist. They should be encouraged to continue breastfeeding. They should also be asked to consider how this may affect (or not) resumption of their own sexual relationship and at what point they may want to terminate cosleeping. In this case, both parents seem comfortable with the present arrangement.

Regarding Case#2, the mother should be commended for successfully breastfeeding her child and reassured that it is okay to feel ambivalence toward cosleeping and/or continued

breastfeeding. Dr. McKenna states that the weaning process of breastfeeding is not too different between a bedsharing toddler and a solitary sleeping one. One method of weaning could be breastfeeding the child before bedtime and outside of the bed itself. The mother should be less willing to meet the child's night-time requests for food and to go to another room to eat if a request is made. She can eventually lengthen the intervals between feedings which will also serve to decrease her supply.

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