

Inner-City Caregivers' Perspectives on Bed Sharing With Their Infants

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Objective.—To understand parents' motivations for bed sharing with their infants aged 1–6 months, their beliefs about safety concerns, and their attitudes about bed-sharing advice.

Methods.—We conducted 4 focus groups with primary caregivers of infants ages 1–6 months who regularly shared beds with their infants. We recruited participants from an inner-city primary care center in Pittsburgh, serving primarily African American families who received medical assistance. Discussions were audiotaped and transcribed. Two investigators coded the transcripts and identified themes in an iterative process to achieve agreement between coders.

Results.—A total of 28 caregivers aged 17–50 participated. The majority were African American (86%), female (93%), single (50%), and high school graduates (71%). Eleven percent of participants breast-fed their infants. We identified 5 themes, common to all groups, to explain parents' motivations for bed sharing: 1)

better caregiver and infant sleep, 2) convenience, 3) tradition, 4) child safety, and 5) parent and child emotional needs. Parents expressed divergent views about the safety of bed sharing: 1) ambivalence regarding balancing risks of overlaying and suffocation with benefits of bed sharing, or 2) assertion that bed sharing poses no risks for their child. Common to all groups was the finding that clinicians' advice against bed sharing did not influence parents' decision, but advice to increase safety when bed sharing would be appreciated.

Conclusions.—Parents' motivation to bed share outweighed the concerns and the warnings of others. An understanding of parents' perspectives on bed sharing should inform counseling to promote safe sleeping practices.

KEY WORDS: bed sharing; cosleeping; focus groups; SIDS

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The safety of infant bed sharing with an adult remains controversial. Proponents point out historic and cultural contexts, claiming it facilitates breast-feeding and parent-infant bonding.^{1,2} A systematic review of the literature showed associations between bed sharing and breast-feeding but found no comparative studies examining parent-infant bonding.³ Several epidemiologic studies suggest an increased risk of death in infants who bed share, particularly with parents who smoke.^{3–7} The American Academy of Pediatrics (AAP) initially recommended against bed sharing only when certain risk factors were present.⁸ However, as a result of an accumulating body of evidence about the increased risk of sudden infant death syndrome (SIDS) with bed sharing, the AAP's 2005 policy statement recommended against bed sharing.⁹

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Despite the medical community's concerns about bed sharing, it is widely practiced in the United States. A nationally representative telephone survey conducted between 1993 and 2000 among caregivers of infants 0–7 months old found that 45% of caregivers spend some time at night sleeping with their infants.¹⁰ In the United States, ethnicity and socioeconomic status appear to influence rates of bed sharing, with higher rates among blacks, Latinos, and Asians and among families of lower socioeconomic status.^{11–13}

Studies exploring parents' beliefs and perspectives on their decision to bed share are limited. In one study, parents selected from a list of possible reasons for bed sharing and chose family tradition, a child's illness, limited space, and breast-feeding.¹² Qualitative studies of Pacific Island ethnic groups in New Zealand found that caretakers identified practical, psychological, and spiritual benefits to bed sharing. Additionally, many parents perceive bed sharing as protective of SIDS.^{14,15} A study conducted in Great Britain found breast-feeding and infant irritability or illness as primary reasons for bed sharing.¹⁶ Obtaining similar understanding of bed-sharing beliefs among parent populations in the United States would improve primary care providers' ability to engage parents in decision making to increase the safety of their infant sleeping practices.

Decisions regarding behavior choices are often guided by personal attitudes and beliefs. The theory of reasoned action asserts that people's behavior is determined by their beliefs about that behavior.¹⁷ Beliefs are in turn influenced

by attitudes about the behavior and the subjective norms of influential people and groups. Based on the concept that parents' beliefs about benefits and risks of bed sharing determine their decision to bed share, our objective was to explore parents' perception of those benefits and risks. We also examined parents' perceptions of advice about bed sharing from their child's primary care provider.

METHODS

Study Design

Qualitative research is used to elucidate social, emotional, and interpersonal dynamics associated with personal experiences, behavior, and decision making.¹⁸ Qualitative methodology provides a deeper understanding of participants' perspectives than traditional quantitative methods and allows more immediate elucidation of individuals' reasoning and beliefs.^{19,20} We conducted 4 focus groups in April and May 2005 with primary caregivers of infants aged 1–6 months who shared beds with their infants regularly. The Institutional Review Board at the Children's Hospital of Pittsburgh approved the study.

Subjects and Recruitment

We recruited from the patient population at the Primary Care Center (PCC) at the Children's Hospital of Pittsburgh. The patient population served by the PCC tends to be primarily African American, and most are insured by Medicaid. We used 2 methods to recruit parents: first, we posted signs with a phone number for self-referral in the PCC waiting room, and second, we asked PCC primary care physicians to identify and refer eligible and interested parents. Ideally, thematic saturation, a process by which researchers collect and analyze data until they are not learning anything new, is the main principle that guides sample size in qualitative studies.^{19–21} Our sample size was predetermined as a result of funding and time limitations and allowed us to conduct 4 focus groups, each comprising 6–10 participants. We were fortunate to achieve thematic saturation by our fourth focus group. During recruitment, interested parents were read a script detailing the purpose and logistics of the study. Parents were informed that they would receive \$50 as compensation for their time. Verbal consent was obtained from each participant at the time of the focus groups.

Inclusion/Exclusion Criteria

Interested parents were screened for the following characteristics: 1) bed-sharing parent or primary caregiver, 2) parent age >18 years, and 3) regular part-night or regular all-night bed sharing. Bed sharing was defined as parents and children sleeping in body contact with each other for all or part of the night. Parents bed sharing 3 or more times a week for part of the night met criteria for regular part-night bed sharing. Parents bed sharing 3 or more times a week for all of the night met criteria for regular all-night bed sharing.¹¹

Focus Groups

An experienced focus group facilitator moderated all 4 sessions by using a structured discussion guide. The guiding questions used in the focus groups were developed during meetings with all authors and in consultation with qualitative research experts. We designed the questions to explore 3 areas regarding bed sharing: 1) parental motivations, 2) parental issues and concerns, and 3) parental response to advice.

At the outset of each session, we presented the study purpose and ground rules for participation. We asked an initial ice-breaking question for parents to describe their best experience sleeping with their child. Our primary questions (Table 1) were followed by probing questions to clarify participants' responses. At the end of each session, we elicited participants' summarizing comments on bed sharing.

Study participants also completed brief, anonymous questionnaires, reporting their age, race, ethnicity, gender, education level, number of caretakers involved in parenting, breast-feeding practices, and location and frequency of bed sharing. Questionnaire responses were not linked to responses from the group discussions.

Data Management and Analysis

Each focus group session was audiotaped and transcribed by an independent professional transcription service. Unfortunately, as a result of equipment failure, the audiotaped recording of one session was unusable. For this focus group, written notes from the session served as the primary source of information. Because the session notes from the other 3 sessions indicated good correlation with the content and character of audiotaped discussions, we thought that the session notes from this focus group constituted an accurate representation of that discussion.

We used a grounded theory approach, assigning interpretive codes in an iterative fashion rather than relying on a preestablished codebook.^{22,23} Two authors read the transcripts and session notes, individually coded each session, and compared codes. Through an iterative process, we developed a final code list that was then reapplied to all sessions. No discrepancies in interpretations were noted. These codes were then organized into categories, and the authors examined codes and categories for emerging patterns and themes.²¹ We used ATLAS.ti version 5.0 software to organize and track the data analysis.

Table 1. Guiding Questions for Focus Group Discussions

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- Tell me about your best experience sleeping with your baby.
 - Tell me about your decision to sleep with your baby.
 - What do you see happening with your baby's sleeping over time?
 - If you were speaking with other parents about sleeping with your baby, what advice might you give them?
 - What kinds of concerns, if any, do you have about sleeping with your baby?
 - What kinds of advice have you been given about sleeping with your baby?
 - What do you see as the primary care provider's role in helping you with concerns you have about sleeping with your baby?
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The final step of our analysis was the process of corroboration or “triangulation,” a method used in qualitative analysis to ensure consistency and guard against bias.^{19,24} Several forms of corroboration were used. One method was investigator corroboration, having 2 investigators independently code the transcripts, and then compare their codes. Additional steps to ensure consistency included review of study findings among authors; and peer review with other investigative primary care providers in a formal work in progress and invited presentations. Reviewers endorsed good corroboration of our themes.

We used descriptive statistics to analyze data from the participant information and demographic questionnaires.

RESULTS

A total of 28 caregivers participated. Demographics are reported in Table 2. The age of the caregivers’ infants ranged from 1 to 6 months. Bed-sharing behaviors, including frequency, location, and breast-feeding, are reported in Table 3.

Review and coding of 3 transcripts yielded consistent themes across the 3 audiotaped sessions and were corroborated by notes from the fourth session. The themes can be organized by the questions that drove the study: 1) parents’ motivation to bed share, 2) parents’ beliefs about the risks of bed sharing, and 3) parents’ responses to advice about bed sharing.

Motivation to Bed Share

Parents reported that they bed share for the following 5 reasons: 1) better sleep for parent and child, 2) convenience, 3) tradition, 4) child’s safety, and 5) the emotional needs of parent and child. Each of these is discussed in more detail below.

Better Sleep

Parents overwhelmingly expressed the belief that both parent and baby sleep better when they shared a bed. The parents perceived that infants fell asleep with less difficulty and crying and had fewer episodes of waking during the night than when sleeping apart from the caregiver. One parent asserted of her infant, “She sleeps longer when she sleeps in the bed [with me].” Parents then correlated improved infant sleeping—longer durations and more peaceful sleeping—with their own ability to obtain restful sleep. As one parent declared, “I get a longer amount of sleep when she’s in the bed with me.”

Convenience

Parents repeatedly used the word *convenient* to describe bed sharing and explain their reasons for sleeping with their infant. They discussed the ease with which it allowed them to tend to the baby’s needs during the night. As one mother explained it, “If he’s crying, you don’t have to get out of the bed. You can go right over and see what’s wrong. If they wet, you go right over and feel.” Nursing mothers believed that bed sharing made breast-feeding convenient. One mother explained, “I’m breast-feeding

Table 2. Demographics and Characteristics of 28 Participating Parents

Characteristic	Value
Age (y)	
Mean	27.4
Range	17–50
Race, n (%)	
Black/African American	24 (86)
White	2 (7)
Missing	2 (7)
Ethnicity, n (%)	
Hispanic/Latino	4 (14)
Non-Hispanic/Latino	23 (82)
Missing	1 (4)
Gender, n (%)	
Female	26 (93)
Caretaker status, n (%)	
Single parent	14 (50)
Two parents	9 (32)
Parent and other adult	5 (18)
Education level, n (%)	
No high school	1 (4)
Some high school	4 (14)
High school graduate	20 (71)
College graduate	2 (7)
Graduate degree	1 (4)

and to roll over and just to do it without getting up, getting her, anything else.”

Tradition

Parents consistently identified a tradition of bed sharing with their own parents and with previous children as an explanation for their choice to bed share with their baby. One mother’s response to the question about the decision to share a bed was, “Well, I still sleep with my grandma.” Along those lines, they identified the habitual nature of the practice and the comfort in knowing that one’s ancestors did it this way as well. One parent asserted, “It’s like tradition to sleep with mother.”

Child’s Safety

Parents described bed sharing as necessary to protect their child from external threats. They reported that by being close, they can better monitor and guard their baby from harm. This is illustrated in the following quote by one mother: “You get to watch what they’re doing. Like if something is going to happen to them and you just watching them so they safe the whole night.” Parents identified

Table 3. Bed-sharing Behaviors

Characteristic	All Groups (N = 28)
Nights per week bed sharing all/part night	
Mean	6.5
Range	4–7
Bed sharing all night 7 nights a week, n (%)	20 (71)
Location, n (%)	
Bed	21 (75)
Bed and couch	5 (18)
Couch	1 (4)
Other	1 (4)
Breast-feeding, n (%)	3 (11)

a variety of potential threats—house fires, violent older siblings, and bugs crawling on the baby—from which they could protect the child by bed sharing.

Many parents expressed their belief that bed sharing is protective against SIDS because the parents would immediately know if the baby stopped breathing. Caregivers acknowledged they were not sure how they would know because they would be asleep, but they asserted a strong belief that they would be more likely to identify a lapse in breathing and would wake up if they were physically close to the baby. One person confirmed, “There’s always that thing, too, with the sudden infant death thing where...you want her by you so you can always be conscious and aware they’re right beside you until they can get out of that range, that danger zone, you know.”

Emotional Needs

Parents described bed sharing as addressing their own emotional and comfort needs as well as those of the infant. Parents described feelings of pleasure, closeness, comfort, and security when bed sharing. They discussed the enjoyment they experience from being with their babies during waking hours and described bed sharing as a continuation of that pleasure: “It’s your baby. You cherish it. And it feels good being beside your baby like that.” They described bed sharing as a bonding experience between caregiver and child. Caregivers referred to the “comfort” and “security” they personally feel when bed sharing. They sometimes attributed that sense of security to their ability to ascertain the baby’s safety while bed sharing. Parents directly acknowledged their own need for security, unrelated to confirming the baby’s safety. They referred to their own loneliness, which is assuaged by bed sharing. One parent remarked, “Sometimes I go get them to come in the bedroom. I don’t want to be in there by myself. I want them in there.”

Parents also reported they bed share with their infants in response to their children’s perceived needs. They interpreted their infant as having preferences and demands for physical and emotional closeness, and viewed bed sharing as satisfying these demands: “She feels safe when she’s in Mommy’s bed. She knows when she’s in the bed.” Parents believed crying indicated their infant’s desire for the comfort provided by bed sharing. Several parents described feeling helpless in resisting what they perceived as their infant’s strong-willed demand for bed sharing. One parent explained, “Whether I put her in my bed or not...she does get there.” Indeed, parents repeatedly anticipated a struggle to later transition their baby to solitary sleep. Anticipation of this difficulty did not outweigh the factors that led these parents to bed share.

Beliefs About the Risks of Bed Sharing

Although all focus group sessions included discussions about the risks of infant injury and/or suffocation with bed sharing, there was no consensus among parents. Parents expressed 2 opposing beliefs: first, feelings of ambivalence about engaging in bed sharing despite risks;

and second, insistence that bed sharing poses no risk for their particular child.

Among parents worried about the risks of bed sharing, the range of concerns included fears that blankets and pillows could smother the baby; that a parent, partner, or other child could roll over onto the baby (overlying); and the baby could fall out of the bed. In every focus group discussion, parents reported near-miss incidents of suffocation when they awoke just in time to prevent harm, as illustrated by the following quote: “Like when you sleep, even though you think you’re staying still...like the other day she was not necessarily smothering, but she was like 2 seconds away from being under the pillow.” Responding to questions about what they would advise others, these ambivalent parents asserted that despite the fact they themselves shared beds with their children, it is dangerous and they would not recommend it to others. One parent remarked, “I would recommend not to do it...because it really is a bad thing and it’s very, very dangerous.”

Despite acknowledging these risks and their fears, participants addressed their worries by taking multiple precautions. Parents thought they had reduced risks by arranging pillows and comforters carefully or by sleeping in a big bed. One parent remarked, “People roll on their babies and that’s the fear that I have because sometimes I can feel myself—well, I’m not going to—I could feel myself like getting close, but I have so much space.” Some parents ascribed their babies’ safety thus far to luck and pointed to the reasons described above for continuing bed sharing despite their fears. As one parent commented, “It’s comfortable, but it makes you worry.” Parents then accommodated to the tension between motivation to bed share and worry about its risks: “It’s up to you and if that’s what’s going to make getting through the night easier for you and your baby, then not to beat yourself up about it.”

Among participants who denied risk in bed sharing with their infants, the primary reason for this assertion was their certainty they would never roll over onto their child. These caregivers described themselves as “light sleepers,” confident that they would wake up if the child was near harm. One mother asserted, “I don’t see nothing wrong with her sleeping in the bed with me. I really don’t. I’m a light sleeper. I know she’s beside me. I’m not going to harm her.”

Response to Advice

Parents reported receiving advice from family, friends, and health care providers. They received advice for and against bed sharing. Some family members and friends had their own positive experiences with bed sharing and thus recommended it. Other family members and friends cautioned against it because of the practical consequences of “spoiling the baby,” never being able to leave the baby with a sitter, and the difficulty of transitioning the child to solitary sleep later.

Some participants did not recall receiving advice from a health care provider. For those who did, the reported health care advice was of 2 themes: first, do not bed share;

you may roll over and kill your baby; and second, if you do bed share, pay attention to other SIDS risk factors by avoiding extra pillows and covers and by putting the baby to sleep on his or her back.

Participants believed that clinicians have an obligation to recommend against bed sharing but reported that the clinician's advice against bed sharing generally did not influence parents' decisions. One participant explained how she would treat clinical advice: "I would take it in and listen, but it would go in one ear and it's going right out the other because I'm still going to sleep with my baby the way I sleep with her." However, parents expressed an interest in advice on strategies to increase the safety of bed sharing such as avoiding extra coverings and soft bedding. One mother reflected on the recommendation she received from her primary care provider: "I mean like the whole cover thing for me was like something I never thought of." In one group, a parent informed the group about this risk, and they agreed as a group that they would have appreciated receiving this advice from a health care provider.

DISCUSSION

This qualitative study explores primarily African American inner-city parents' motivation for bed sharing and their response to health care providers' advice not to bed share. We identified 5 motivating factors for bed sharing: better sleep, convenience, family tradition, child's safety, and fulfillment of caregiver's and infant's emotional needs. Caregivers admitted holding conflicting beliefs about the safety of bed sharing but were not significantly influenced by clinicians' advice to avoid bed sharing. These findings may have implications for how clinicians counsel parents.

Contrary to the evidence that bed sharing increases the risk of SIDS, many of our participants believed that bed sharing is protective. Additionally, according to parents, bed sharing protects against external threats (eg, fires, vermin, aggressive siblings) not considered in AAP guidelines.⁹ Indeed, for some parents, bed sharing may be less of a risk to child safety than other aspects of their home environments. Even parents who acknowledge the risk of overlaying trust that bed sharing confers other safety advantages, such as the ability to monitor breathing and to protect against external threats.

In addition to safety concerns, we found the beliefs that infants were more comfortable and slept better when bed sharing were powerful motivators for bed sharing among our study caregivers. This is inconsistent with research about sleep: studies comparing the sleep of bed sharing and solitary sleeping infants do not necessarily support better sleep in the former. Bed-sharing infants have more nighttime awakenings than solitary-sleeping infants. However, the percentage of the night spent awake does not differ between groups, suggesting longer awakenings in solitary-sleeping infants.²⁵ Additionally, bed sharing does not enhance parental sleep: mothers are more likely to experience transient arousals when bed sharing with an infant compared with sleeping separately from the

infants.²⁶ Perhaps parents' belief that both mother and infant sleep better when bed sharing is the result of less distress from infant awakenings accompanied by crying and/or decreased need for caregivers to get out of bed to respond to the infant.

The emotional needs of both caregiver and infant were also strong motivators for bed sharing. These factors are similar to those of studies of parents from other countries. Abel and colleagues' New Zealand study also described beliefs that continued physical closeness between mother and infant was an important method of communicating love, comfort, and connection.¹⁴ Parents from the United Kingdom described parental convenience and response to perceived infant needs as primary reasons for bed sharing.¹⁶ A study of 40 bed-sharing New Zealand families noted enjoyment, comfort, and reassurance for the mother among reasons for bed sharing.²⁷

For the caregivers in our study, clinicians' advice not to bed share was not a sufficiently meaningful motivator. Parental belief in the safety of bed sharing appeared to be based on their own experiences and the practices of their family members, including their parents and grandparents with whom they had slept as children. Other studies have suggested similar discrepancies between clinician advice and parental practice. Morgan and Johnson¹³ surveyed pediatric resident physicians and parents of their infant patients. Although most resident physicians reported advising parents against bed sharing, a third of parents reported bed sharing during the first 12 months of their infants' lives.

Even among caregivers concerned about bed-sharing risks, health care providers' advice to not bed share did not dissuade them. The theory of reasoned action posits that individual behavior is determined by the value and validity people place on their own personal attitudes and beliefs regarding a behavior versus those of other individuals (such as health care providers).¹⁷ Our results indicate that parents identified many benefits of bed sharing. Even parents concerned about bed-sharing risks described skepticism regarding the likelihood of infant injury or suffocation. Our findings are similar to a Canadian survey in which 72% of study participants reported bed sharing despite 89% acknowledging some risks.²⁸

Additionally, many of our participants reported interest in advice to lessen risks associated with bed sharing. This provides an opportunity to educate parents regarding other SIDS risk factors. Parents should know parental smoking is consistently a strong SIDS risk factor.^{5,6} Bed sharing should only occur on firm mattresses without soft bedding, comforters, and pillows.^{4,6,7,29,30} Infants should not bed share with other children or with any adult who is overly tired or sedated from alcohol, medications, or illicit substances.³⁰ Bed-sharing infants, like all infants, should be put to sleep on their backs because side and prone positions are independent risk factors for SIDS.^{29,31} Our study suggests parents would be receptive to increased education about these risk factors for SIDS. Additionally, we suggest providing parents with the alternative of sharing a room rather than a bed. Room sharing

provides proximity and closeness for intimacy and monitoring while, unlike bed sharing, decreasing risk for SIDS.^{30,32,33}

Our study has several limitations. This is a descriptive qualitative study that uses a select sample population—caregivers recruited from a single inner-city primary care clinic in Pittsburgh. Thus, the results cannot be generalized to all bed-sharing parents. Further studies are necessary to examine the prevalence of these beliefs in the larger population of caregivers who share beds with their infants. Our study also occurred the same year the 2005 AAP policy statement against bed sharing was released. Families' beliefs and attitudes regarding bed sharing may have changed since that time. A broader range of perspectives and attitudes may have emerged in a larger number of focus groups. However, no new themes had emerged by the fourth focus group, suggesting that 4 focus groups were sufficient.

Additionally, our study design and size did not allow us to make comparisons on the basis of participant characteristics such as race, gender, age, number of children, or breast-feeding practices. For example, we only had 2 men among our study participants. It would be interesting to obtain perspectives specifically from male partners of bed-sharing mothers to explore their unique concerns, beliefs, and attitudes.

Also, only 3 study participants were breast-feeding. The lower rates of breast-feeding in our study population could be because most participants were African American mothers, who report lower breast-feeding rates compared with white, Asian, and Hispanic mothers.³⁴ Additionally, although breast-feeding has been associated with bed sharing among white non-Hispanic and Asian mothers, it was not among black and Hispanic mothers.^{12,35} Studies that stratify participants by race and breast-feeding practices are needed to make comparisons across these populations.

An important contribution of this study is that it broadens the scope of understanding parents' decision to share a bed with their infants and the relative weights they attribute to benefits and risks in the decision-making process. Understanding parents' decisions augments the practice of family-centered care, which emphasizes the family's perspective in making decisions about their child's health care.³⁶ Although our participants' beliefs about these issues may not be representative of all bed-sharing parents, they suggest that parents may have a different perspective from what clinicians may assume. Discussions that engage parents on issues important to them may be more effective in encouraging safe sleeping practices.

The results of this study suggest that for the parents we interviewed, the benefits parents experience from sharing a bed with their infants outweighed their concerns and the warnings of others about risks associated with bed sharing. Although some parents may ignore advice not to bed share, most seemed willing to learn how to minimize bed-sharing risks. Counseling regarding bed sharing should include suggestions of room sharing and reducing bed-sharing risks.

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