Co-Sleeping with Her Baby: A Qualitive Study of Adaptive and Prescriptive Voices in Parenting Decision Making

Elizabeth A. Tran

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CO-SLEEPING WITH HER BABY:
A QUALITATIVE STUDY OF ADAPTIVE AND PRESCRIPTIVE VOICES
IN PARENTING DECISION MAKING

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University
In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Elizabeth A. Tran

August 2011
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ABSTRACT

CO-SLEEPING WITH HER BABY:
A QUALITATIVE STUDY OF ADAPTIVE AND PRESCRIPTIVE VOICES
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Elizabeth A. Tran

August 2011

Dissertation supervised by Eva Simms, Ph.D.

This project presents a qualitative study of how parents described the process of deciding to bed-share with their children. Particular emphasis was placed in understanding how those parents described relationships with advice sources. The Listening Guide feminist discourse analysis method was used to analyze interviews with five mothers who self-identified as having regularly slept with their babies to identify discourses with particular emphasis on references to self and authority. The context of this project is explained in detail with review of socio-political and scientific perspectives on decision-making and co-sleeping. Interview analysis resulted in the identification of two ways of engaging with information that were labeled as ‘Prescriptive’ and ‘Adaptive’ voices in parenting. The two voices of discourse are described in detail including their distinct modes of
temporality, values, agents of action, information processes, and use of conceptual terminology. Discussion of results addresses how co-sleeping mothers, in this project, all referenced frequent consideration of relationships with their children and their children’s’ perceived preferences and needs. Further discussion addresses when parents chose to build relationships with advice sources or withdraw from conversation.
ACKNOWLEDGEMENTS

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Thank you to my husband, CJ, who always believed in the strength and wisdom of my own voice. Even when I doubted my own potential, you helped me learn to believe again.
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1. LITERATURE REVIEW

Socio-Cultural Context: Plurality of Parenting Practices

After years of researching the socio-political intricacies of how parents decide where to place their infants to sleep, my own daily experience almost convinced me to abandon this project. Riding a local city bus, I noticed a large poster behind the driver where I usually found advertisements seeking pharmaceutical birth control trial participants or announcing changes in bus fare. On that day, the poster numbered how many infants died while sleeping with parents within the county in recent years and it stated that the only safe position for infant sleep is supine, alone, and in a crib. I found myself crushed for having been so foolish, spending years engaging in what I thought was a deeply personal and controversial issue of the interpersonal and political aspects of infant sleep placement, only to find all controversy halted by the power of a public health campaign. I suddenly wondered if any participants I might interview who practiced anything but the sleep placement method listed on that poster needed to be converted and to realize that no loving, reasonable parent could place his or her infant in greater risk of death for the sake of personal preference about sleeping locations.

I eventually remembered that many pediatricians and scientific researchers advocated alternative sleeping arrangements and large portions of the population have and would likely continue alternative sleeping arrangements despite the pleading of public campaigns. I remembered that a process of discussion and engagement with varying cultural traditions continues despite that poster which proclaimed a singular option. I wanted my research to catch sight of the powerful voices that request our
obedience with varying degrees of influence about the practical concern of infant sleep placement.

There are increasingly fewer unified conventions to guide and support parents who are left to figure out day to day parenting practices on their own with increasing numbers of options. For previous generations of parents or those in less materially affluent places around the world today, practical restrictions and common standards of the community limit[ed] the amount of options for childcare strategies (Cassidy, 2006). Within one culture, a majority of mothers may breastfeed infants until they reach at least a year of age because that is the only safe option without access to high quality formula or some of the other luxuries and ideologies which make bottle-feeding a realistic option (Cassidy, 2006). Many parents in mainstream American culture individually negotiate between conflicting values about whether or not to breastfeed, what kind of formula to buy, whether a mom should pump milk at work, when to introduce solids, how to deal with possible confusion for the baby between bottle and mother’s breast, or how to judge whether or not it is acceptable to breastfeed her child in a public setting away from home. Even once a mother decides that she wants to begin introducing solid foods, she might spend half an hour standing in the baby food aisle of the grocery store wondering if the generic baby food is just as nutritious as an organic brand that costs twice as much, and whether or not that financial tradeoff is worthwhile.

Parents in this situation have the responsibility to figure out what modes of parenting are best for them and their children with many contradicting opinions and ‘facts’ to choose from. Yates and Sclater (2000) describe the two-fold consequence of
living in a culture free form a larger organizing narrative that would manage its members.
“A recurrent theme in debates about the nature of contemporary culture is its ambivalent
caracter. On the one hand, there are new possibilities for self-expression, and on the
other, new risks to negotiate and a heightened potential for disappointment and confusion
in all spheres of life” (p. 135). Faced with countless decisions about how to raise
children, including serious issues such as nutrition, discipline, furniture, education, potty
training, medical illnesses and vaccinations, bedtime, etc., parents bear the great
responsibility of choosing what they hope may be the best for their families from the
sometimes endless options set before them. Researchers have tried to find reasons for
various parenting decisions. Anderson and Minke (2007) investigated how parents make
decisions regarding the education of their children. Fulmer (1997) tracked how parents
integrated external information and variability in information seeking patterns of parents
selecting child care agencies. Stephanie Knaak (2005) traced socio-historical influences
of breast-feeding choices.

Almost every aspect of child-rearing in this culture requires parents to sift through
competing claims, advice, and demands as they look for sources of guidance regarding
the many possibilities before them (Kelli Connell-Carrick, 2006). For some parents, that
sifting goes smoothly and for others, it does not. In other times or places, elders have
operated as authorities providing the answers to many of those questions, if there were
even enough confusion to warrant asking them. Today, advice from grandparents such as
rubbing bourbon on a teething baby’s gums, spanking an unruly child, or letting a restless
baby fall asleep on her stomach may seem questionable to contemporary parents. No
longer bound to the parenting styles of predecessors or contemporaries, parents must sort
through dispersed examples and ideologies in seeking guidance about how to make choices for their families. This means that parents may not only feel confused about parenting decisions, but also about who to turn to for help in making such decisions.

Returning to the mother trying to decide if she should spend extra money on organic baby food, we could imagine competing claims she may hear from childcare magazines, television commercials, internet websites, her pediatrician, and advice from family and friends. Some may vehemently claim that the certified organic food is a waste of money, that anything but certified organic baby food could permanently harm her child, or that she should stop worrying so much and simply choose based on her own preference because her child needs her to feel calm and confident instead of anxious and confused. Likely each advice source has some direct or indirect financial investment in particular outcome, increasing the scrutiny with which she should investigate their claims. The mother is left to sort through those claims and somehow find a compromise that she believes works well (or not so well) for her family.

Social Construction of Identity

*Individuals in a fragmented cultural context*

Some authors propose that the progression of modern individualism and postmodern plurality set up confusing and dissatisfying ways of engaging with daily life within fragmented and conflicting pluralistic cultural systems. When familial and local traditions for organizing daily habits break down or develop greater variance, individual choices become the primary sources of direction. Some individuals may feel that process
is managed more easily than it is for others. J. H. van den Berg (1961) proposes that people have more questions about daily living than in the past due to lost continuity in the process of passing down traditions generationally (p. 37). Breakdowns of strong local communities can make finding one’s place and way of living more difficult to establish. The clever, able, and perhaps lucky manage to uphold relationships and values that suit their lifestyles while also fitting in to their larger culture. As the responsibility of the individual, many find this task too intricate and confusing, such as parents who spend late nights researching conflicting methods on internet forums. Van den Berg proposes that many people suffer today because they could not make it through the obstacle course of a pluralistic value system. Robert Cushman (1995) also describes how the “dismantling of communities and traditions” (p. 161) increases the complexity and sense of emptiness felt by many individuals. His analysis continues to describe how individuals are encouraged to find meaning and satisfaction in seemingly choice based consumerism (p. 167).

Ken Gergen (2007) claims that contemporary individuals in this culture encounter “multiple and disparate potentials for being” due to inundations of disjointed information from non-local sources (p. 304). With his concepts of the “Saturated Self,” “populating the self,” and “multiphrenia,” Gergen describes the difficulties of living in a pluralistic, postmodern age. He links the “Saturated Self” directly to postmodernism when “all previous beliefs about the self are placed in jeopardy, and with them the patterns of action they sustain” (p. 303). Instead of believing that each person maintains a stable identity across time, he describes how the self becomes “populated” with competing voices and “Selves as possessors of real and identifiable characteristics—such as rationality, emotion, inspiration, and will—are dismantled” (p. 303). Gergen compares a
contemporary urban individual with someone in a small town one hundred years ago. The contemporary person probably encounters more people and images, along with their opinions and arguments, in the first two hours of the day as the small town’s person might have encountered in a whole month. This constant bombardment of differing voices and corresponding opportunities for differing values and actions can lead to what Gergen calls “multiphrenia” (p. 305). Daily encounters with new potentials for how to live may bring greater confusion and despair when people realize they cannot integrate all they desire into unified identities. For example, a parent may have to decide between following family tradition and heeding the advice of a physician. One may choose to do what feels personally right but feel ashamed of that decision in other circumstances. Making a decision about how to perform parenting tasks implies changing one’s status in relation to cultures, traditions, and authority sources. The practical tasks of parenting require more cognitive evaluation between dis-integrated possibilities instead of participation in organized sets of cultural traditions.

Van den Berg, Cushman, and Gergen wrote within the United States of America or Europe, so their claims would presumably generally apply to those populations. My own experiences lead me to believe that variance of racial identity may predict attitudes towards parenting advice, such as frequently seeking advice or feeling uninterested in any external advice, but little objective data is available to clarify that assumption. The lack of information about cultural context in how parents engage with advice sources reflects how formal scientific inquiry emphasizes understanding parenting behaviors but not attitudes or perspectives regarding those behaviors. Further, while Van den Berg, Cushman, and Gergen identifying particular difficulties regarding decision making in the
past 50 years, they fail to articulate significant cultural revolutions of previous ages that probably influenced practical decisions for the better. This may lead to an under-estimation of how people successfully adapted to cultural shifts in the past.

*Example From Popular Culture*

Charles Bruner (1987) contends that “Culture is constantly in process of being recreated and renegotiated by its members. In this view, culture is as much a forum for negotiating and re-negotiating meaning and for explicating action as it is a set of rules or specifications for actions (p. 123). A recent interaction on the television show, Oprah, between the television host, Oprah Winfrey, and a mother in her audience, provide a glimpse of this forum for negotiation in the realm of parenting.

This particular episode, entitled "Secret Lives of Moms" (2009), featured mothers sharing "mommy confessions" about actions they expected others to find somewhat embarrassing or even shameful. At the conclusion of the show, the host and audience spoke about tensions they felt regarding the different choices mothers made about working full time or staying home with their children. One mother asserted the importance of following one’s own path in choosing how to raise children and respecting parents despite their different choices:

We judge people because we're insecure of the choices we make. There's such grace for knowing that as women we make choices, we make choices, it's not about if we're a good mom or a bad mom. It's not about if, you know, what we're doing and why we're doing it, it's about the grace for knowing we make these choices and we, we have will, we have free will to make those choices and do what we want with them. And you know, but I think, the beauty of it all is that, taking motherhood as a whole, and saying, you know what, there's no right or wrong answer,
there's no right or wrong, there's no, I can't look at somebody and say, oh that's bad, because, maybe it's great for them.

Oprah interrupted the mother adding the condition, “There's no right or wrong answer if you're working in the best interest of your children, when you're working in the best interest of your children.” She added the sobering caveat to the mother’s individualistic appeal by placing limits in the interest of the children being cared for. In this dialogue, each woman spoke of concerns that make sense when living amidst multiple voices of authority and opinion. Neither established who knows or should determine what behaviors serve “the best interest of your children”. Instead, they voiced positions of caution about taking personal intuition or external constraints to extremes. *We have yet to find how individual parents experience and find themselves as participants within that conflict to see how the culture is re-negotiated and what living is like in that process.*

The Problem of How to Organize Sleeping Arrangements

*Options in Sleeping Arrangements*

While occasional families experience little conflict around bedtime, many parents worriedly struggle with the countless ways to organize their families’ sleeping arrangements (Crowell, Keener, Ginsburg & Thomas, 1987; Gaylor, Burnham, Goodlin-Jones, & Anders, 2005). What to do with family sleeping arrangements is a topic highly charged for debate – engaging questions of embodiment, intimacy, safety, sexuality, medical authority, emotional attachment, government intervention, parenting styles, furniture and accessory production, moral ideology, intuition, and financial resources. Richard Ferber, the well-known author of the parenting advice book, *Solve Your Child’s*
Sleep Problems (2006), said that “The practice of ‘co-sleeping,’ where the child sleeps in bed with his parents, is probably the single most controversial topic related to pediatric sleep” (p. 41). For this project, I have chosen to focus on how parents decide where to put their infants to sleep at night.

Some authors have tried to devise labels with which to categorize and label sleep placement practices but such terms are not universally applied (Ball, 2005). Moreover, application of static labels falsely assumes that families follow unified patterns of behavior that fall within limits of the terms. ‘Bed-sharing’ and ‘co-sleeping’ generally refer to the practice of adults and children sleeping together in one form or another, usually with caregivers and children sleeping in the same bed at night. Two parents might sleep in one bed with all of their children or a single working mother might bring her infant into bed with her for the night so that she can have more time to bond with and nurse her child. A couple might split up into two beds with a child in each or allow older children to regularly crawl into their bed in the middle of the night. Variations of sleep placements abound and families often modify sleep placement habits for varying factors ranging from daily preference to serious illness. Where to place infants to sleep usually changes across a family’s development and frequency of practices may adapt to changing circumstances. Attempting to identify families as ‘co-sleepers’ or ‘bed-sharers’ problematically oversimplifies how parents engage in dynamic processes of adaptation across time, changing placement hourly through the night or after several months of particular practices.

Co-sleeping is used to describe bed-sharing but can also refer to parents sleeping
with a child near the bed such as in a bassinet or sleeping with a child on a non-bed surface such as a couch. Ball (2002) defined bed-sharing as “if the infant slept in the parental bed with one or both parents (at the same time the parent(s) slept), for any portion of a night or nights for which nightly logs were recorded (p. 211). Ball subdivided more categories of bed-sharing such as “habitual bed-sharing”, “combination bed-sharing”, and “occasional bed-sharing” (p. 211). For this project, I use the terms co-sleeping and bed-sharing interchangeably because that is how the parents often used those words and there is no consistent formulation in any other literature set to warrant more specified usage. In this paper, the two terms refer to sleeping with a child on some sort of shared surface, usually a bed.

Surveys attempting to understand how many children consistently bed-share with parents estimate that bed-sharing rates of 25% for American parents (Gaylor, Burnham, Goodlin-Jones, & Anders, 2005) and 35.2% of parents in Oregon (Lahr, Rosenberg, & Lapidus, 2007). Lozoff, Wolf & Davis (1984) found co-sleeping rates of 35% of Caucasian families and 70% of African American families in Cleveland, Ohio. Factors for white families reporting co-sleeping included older age of children, lower parental education, less professional training, more reported family stress, “more ambivalent maternal attitude toward the child,” and disruptive sleep problems of the child(ren) (p. 1). No other factors were found as predictive for African American families in that study. Sleep logs and interviews gathered from mothers in Texas found 47.4% of babies bed-shared with parents at least once during the first month of sleep diaries. The researcher presumes that this number is lower than the actual prevalence because of cultural pressure to under-report bed-sharing. When mothers were asked of “ever bed-sharing” up
to 4 months of age, 70% of mothers reported bed-sharing (p. 212). Gaylor, Burnham, Goodlin-Jones & Anders (2005) conducted video observations of parents in California for 68 families for one year and found 25% of reported co-sleeping at all follow-up interviews and one-third of those parents reported this behavior as problematic.

Some parents actively choose to bed-share because they enjoy it while others do it as a response to a child’s sleeping problem (Gaylor, Burnham, Goodlin-Jones, & Anders, 2005). Some parents say that they welcome children into bed to quell behavioral problems or anxiety, whether the child’s or the parents’. In a culture that values well planned and consistent behavior, reactive bed-sharing is generally considered less healthy, with some evidence confirming this judgment due to effects on later sleep habits (Murkoff, Hathaway, & Eisnberg, 1996).

Bed-sharing as Culturally Deviant

Perhaps the easiest way to define bed-sharing might lie in its deviancy from the cultural standard of parents sleeping in one bed with children sleeping alone in other rooms. Using the phrase ‘bed-sharing’ itself is thoroughly culture-specific in its purpose as a label for something other than the norm. While we might assume that the phrase “bed-sharing” simply describes an objective phenomenon, the word’s existence and function are inextricably born of the meaningfulness as something deviant. It is a practice so seemingly different from something like standard or regular sleeping that it warrants development of its own term. There is no popular phrase for parents who put children to sleep in separate beds. In cultures where the practice we call bed-sharing is common, where adults and children sleep together without question, that phenomenon is simply
called ‘sleeping’.

Values about sleeping with infants and children vary throughout cultural circumstances. Interviewers who asked parents from Mayan culture if they would ever put a child to sleep alone heard responses of astonishment as the mothers described finding that question unreasonable to them (McKenna, 2000). A mother in Vietnam was shocked to hear that parents in the United States place their children to sleep in nurseries, telling the researchers that “babies are too valuable to be left in a room alone” (Merelli, 1992, p. 608). She presented a contrast to the common belief of parents in particular socio-economic circumstances who might assume children are safe in their own nurseries all alone. Hence we cannot validly say that some other cultures “bed-share” in the same way that we do because for them, sleeping with children is the norm and not the same kind of political stance which sets them apart from public standards as it does in this community. Lahr, Rosenberg, & Lapidus (2007, p. 1) found that mothers who they believe bed-share “because of cultural norms” are less likely to change their bed-sharing behavior when faced with campaigns discouraging it. As campaigns to decrease bed-sharing in the United States have not demonstrated dramatic change in practices, newer research has begun trying to understand cultural factors and reasons for maintaining the practice despite contrary advice. It seems researchers show interest or receive funding to understand values of parents when parents do not obey behavioral prescriptions of dominant cultural institutions.

*Solitary Infant Sleep is a New Norm*

Circumstances in the last century transformed the landscape of infant sleep (Ball,
Following the baby boom of World War II, bottle-feeding and solitary infant sleeping became the standard model for infant care in middle class families with growing concerns for infant autonomy and greater faith in scientific promises to exceed the benefits of mothers’ milk in chemically engineered formula (Cassidy, 2006). Formula takes longer to digest so formula-fed infants sleep more deeply through the night, making it easier to place babies in separate cribs with less frequent feedings (Ball, 2003). Increasing numbers of families could afford homes that had enough room for separate nurseries and furniture to equip them. A greater sense of physical security in middle-class and upper-class homes made it more reasonable to leave defenseless infants in separate rooms. Finally, changes in attitudes about the sexuality of parents have made the idea of children sleeping with parents seem awkward and even deviant. Patricia Donogue-Carey explains, “Sleep had come to mean sex, and concerns that bed-sharing might threaten marital intimacy took on a priority greater than the traditional wisdom of being close to one’s baby in the night” (2002, p. 2). Greater emphasis has been placed on the romantic and sexual relationship of parents and the act of sexual intercourse has become so closely linked to sleep that one can say “I slept with that person” to acknowledge an act of sexual intercourse.

Parents May Feel Conflicted About Sleeping Arrangements

Some parents have only heard of parents putting infants to sleep in cribs and might assume that cribs are the only reasonable place for babies to sleep. Other families may live in communities where children frequently bed share and feel leery of placing infants alone in cribs. In between those two preferences there remain countless
possibilities of options such as parents who bed-shared growing up but now believe that babies should always be placed in cribs, parents who do not know they can safely bring their babies into their beds and struggle to make solitary sleeping work, parents who were told they should not bring their children to bed with them but do so without telling friends or physicians, and parents who adamantly believe children should sleep with their parents but cannot get a good night’s sleep unless they place their babies in cribs. Families might also feel divided between partners. No doubt each partner could find lists of authorities to support each side. For example, a mother might cherish the moment she shares in bed with her newborn while the father resents having less time alone with his wife or one parent might believe children should feel free to crawl into bed during the night while the other adamantly expects children to stay in their own beds until morning. Individuals may even feel personally ambivalent about where children should sleep, such as a mother who lives in a dangerous neighborhood and feels afraid to let a baby sleep away from her but heard from her physician that bed-sharing is very dangerous or a mother who was once excited about the idea of bed-sharing but feels frustrated and overwhelmed by constant physical contact with her baby. Even more, children’s temperaments, health conditions, or other factors may frustrate parents in the foreclosure of promised choices which no longer remain viable options.

The Structure of the Bed-sharing Debate in Scientific and Popular Literature

As responsibility now mainly falls on individual parents sorting through various types of authorities, they must make judgments with a fine balance between personal preferences and what others tell them is good for their children. In communities where
there are multiple “goods,” or someone’s “good” is someone else’s “bad,” parents still have to act instead of waiting until experimental sciences or anthropology provide an impossibly definitive resolution. Even if the jury is still out, parents must decide where to put their child to sleep tonight. If or when science fails to provide a clear boundary or when guidelines feel inadequate, what happens?

I sorted the current literature on the issue of bed-sharing into four categories: articles in popular and scientific media that encourage bed-sharing and discourage solitary infant sleeping, articles in popular and scientific media that disapprove of bed-sharing and encourage solitary infant sleeping, studies that attempt to impartially answer specific questions about particular aspects of infant sleep position, and articles discussing this lack of consensus and how parents should reflectively sort through the data. Trying to figure out how to deal with the varying perspectives in this debate can feel dizzying. This precariousness highlights the difficulty of taking a liberal attitude in trying to understand and validate a plurality of opinions while maintaining standards within a community. Furthermore, that liberal attitude, the desire to incorporate many voices and traditions, is itself an opinion and judgment that often fails to recognize that it too forecloses some modes of experiencing the world.

*Advice Against Bed-sharing or in Favor of Solitary Infant Sleep*

Within the scientific literature, some studies begin with the assumption that bed-sharing is deviant. Ball (2003) says,

Data on what, for decades, were regarded as the ‘norms’ of infant sleep were ‘established’ in the United States and United Kingdom, when
breastfeeding rates were at their lowest and solitary sleeping arrangements for infants were the norm. Nonetheless, the data from such studies are still cited in current pediatric texts as the standard against which infant sleep development is measured. (p. 181)

Ball describes how proponents of bed-sharing as a safe sleeping option must defend its fittingness as another reasonable way for families to arrange their sleeping situations due to its deviance from the solitary sleeping norm. This stance means that the decision of whether or not to bed-share brings with it decisions about where one stands in relation to formal authorities. In 2002, the U.S. Consumer Product Safety Commission joined with the Juvenile Products Manufacturers Association to launch “a national safety campaign aimed at reducing deaths associated with placing babies in adult beds” (U.S. Consumer Product Safety Commission [CPSC & JPMA], p. 1). The press release states that at least 180 children died between the years of 1999-2001 while sleeping in adult beds. Even though that data is anecdotal—based on police investigation reports and death certificates with varying amounts of information about whether or not parents were intoxicated, what kind of bedding and furniture was used, whether or not parents smoked, and without comparison of children sleeping in cribs to compare infant mortality rates, the governmental commission found the evidence convincing enough to join with JPMA to “campaign” “to consumers at retail outlets nationwide” (p. 1). The campaign told parents to buy cribs or increase their infant’s chances of dying. These organizations demonstrated no reference to the existing empirical studies that have failed to demonstrate a significant risk in practicing safe bed-sharing practices as compared to placing infants in cribs. The parenting advice book published by the American Academy of Pediatrics (2004) fails to mention bed-sharing or co-sleeping in its text, neither in content about sleeping arrangements or in the index. Even though a large number of parents do it, their omission
is something like a denial of its viability at as defensible practice. Some parenting books offer methods to help parents who co-sleep transition into solitary sleeping situations, such as *Break the co-sleeping habit: how to set bedtime boundaries – and raise a secure, happy, and well-adjusted child* (Levine, 2009) and *A Parent's Guide to Getting Kids Out of the Family Bed: A 21-Day Program* (Shapiro, 2008).

*Studies in Support of Bed-sharing or Against Solitary Infant Sleep*

Even though some organizations have declared that bed-sharing is dangerous, several empirical studies have demonstrated that bed-sharing might actually be safer than placing infants in cribs. Richard & Mosko (2004) found that heart rates of infants sleeping in solitary conditions were lower and less stable than the heart rates of infants bed-sharing, both for infants who regularly bed-shared and those who regularly slept in cribs. Richard (1999) found that bed-sharing was associated with a higher mean auxiliary temperature than solitary crib sleeping, related to the increased “movement-associated arousals” that occur when bed-sharing that would protect infants from SIDS. Barone (2002) found that infants who slept close to their mothers tended to appear physically calmer with lower frequencies of spontaneous startles. Okami, Weisner, and Omstead (2002) studied emotional and cognitive consequences of bed-sharing in a longitudinal investigation of outcome correlates and found that bed-sharing was not associated with sleep problems, sexual pathology, or other negative factors at ages 6 and 18. Many parents believe that bed-sharing is actually safer than placing infants in cribs and turn to books advocating bed-sharing such as *The family bed* (Thevenin, 1987), *Sleeping with your baby: A parent’s guide to cosleeping* (McKenna, 2007), *Good nights: The happy
parent’s guide to the family bed (and a peaceful night’s sleep) (Goodavace & Gordon, 2002), and The Attachment Parenting Book : A Commonsense Guide to Understanding and Nurturing Your Baby (Sears, W. & Sears, M., 2001).

Lack of Consensus

A paper edited by Stein, M. (2001) demonstrates this conflict of information between the anti-bedsharing public information and scientific literature that supports bed-sharing with an innovative type of article. In Cosleeping (bedsharing) among infants and toddlers, Stein pieces together 3 expert opinions on two cases of infants who bed-shared with their parents. In this article, he writes about a case where one parent feels satisfied with a bed-sharing arrangement and another where a second parent feels ambivalent about the arrangement. Stein begins the article describing his own personal dilemma as a pediatrician. Initially assuming healthy infants should develop autonomy and self soothing skills through crib sleeping, he found that pro-bedsharing arguments from other professionals, in combination with discovering how many of his own patients bed-share, shook his sense of confidence in maintaining that perspective. He presented these two cases to three physicians and let them reply with their arguments on the matter. In this article, Dr. Calvin Colarusso argues that bed-sharing impedes proper development of autonomy and interferes with proper sexual development. Dr. James McKenna argues that co-sleeping works better when parents find it enjoyable but not when it becomes a reactive way of coping with sleep problems. Dr. Nancy Powers discusses co-sleeping as a natural way to integrate breastfeeding into the mother and child’s lifestyles and comments on how parents can maintain their own marital sexuality and provide a safe
sleeping environment while co-sleeping. In this article alone, the first consulting physician shares his concerns for child safety and development with a recommendation against bed-sharing with no cited evidence. Two other physicians share evidence that bed-sharing can facilitate healthy bonding and breastfeeding, and a fourth physician situates himself as somewhere in between, appreciating the arguments of both sides. For those parents who have conflicting or impoverished cultural traditions about sleeping arrangements, scientific evidence may initially seem like an ideal source of guidance. For now, this is one area where the scientific debate is still out. Moreover, science cannot determine which factors we value such as specific safety results, closeness with one’s baby, and influence on sexual behavior. If physicians specializing in this area disagree on their recommendations based on the same body of research, how much more might parents feel confused when adding in advice from popular media and other parents. If these four physicians cannot find consensus, this also conflicts with the univocal recommendations of the AAP and lack of alternative recommendations in their popular parenting advice book.

Choosing Who to Tell

The kinds of struggles that families could have around this issue are infinite. Each family has its own histories, traditions, communities, personalities and temperaments, material limitations/opportunities, types of relating and communicating, preferences, and role models that complicate or simplify decisions about where children should sleep. In a sense, those differences between families make an imposing and universal proclamation about how all children should sleep untenable. There are far too many different factors to
determine how a family experiences bedtime to make a unified requirement such as “all babies must sleep in cribs” or “all babies must sleep with their parents” realistic. As there are few studies that show either sleeping arrangement is necessarily harmful to children, neither empirically supporting solitary crib sleeping or family beds to such a degree that one or the other could be definitively indicated (and indicated for what), the issue becomes a matter of personal preferences and each family is left to negotiate what works best for them. Many physicians and parents become missionaries for one type of sleeping routine or another, trying to convince parents to bed-share or place their children in cribs for the sake of those children and the culture at large. Parents must discern whether or not such arrangements are publicly acceptable or discussable depending on their contexts and personalities.

Recommendations about Bedtime Decisions in Parenting Advice Books

Without communities that congruently parent their children according to the same widely accepted principles or clearly endorsed authorities who provide the assurance of definitive answers, parents face an onslaught of books, magazines, television shows, internet websites, advice from friends and families, and product commercials offering to provide guidance. These authors appeal to parental intuition but also order parents to make decisions in the light of reason, with their child’s life and general well-being on the line. This is quite a daunting task for many parents to accomplish.

Instructing Parents to Base Decisions on Personal Inclinations

A quick survey of popular parenting books demonstrates how some authors
encourage each family to sort through all of the different factors in their lives and somehow figure out what way of sleeping works best for them. Some voices in our culture value a plurality of choices while others promote authoritative stances. In his famous parenting book, Spock (2004) combines both of these in a single paragraph from his parenting book:

Experts often have strong opinions about this, pro and con. I think it is a matter of personal choice. There is no evidence that sleeping together—or not sleeping together—affects a baby’s physical or emotional health. So it makes sense to do what feels right and comfortable for you. (p. 59)

He first incorporates the voice of ‘experts’ and ‘evidence’ with the conclusion that they fail to indicate one particular option’s superiority. He then positions the voice promoting personal choice as ‘making sense’ because the other authorities do not suggest one particular stance. Sears, W., Sears, M., Sears, R. and Sears, J. (2005) encourage parents to highly regard personal intuition regarding sleep placement more or less above what others instruct them to do: “The only persons who can answer the question ‘Where should baby sleep?’ are mom and dad. Listen to what you and your baby and your inner voice are trying to tell you!” (p. 4). In his book, Ferber (2006) repeatedly confirms the importance of discerning one’s personal feelings about the issue by advising parents: “Before you make this decision, there are certain considerations you should take into account. The decision should be yours, made by the parent or parents, and based on your own personal philosophies, not on pressure from your child or from anyone else” (p. 43).

He leaves parents’ options open to what they discern by means of their personal research, experience, and intuition. He again emphasizes the importance of parents being true to themselves in deference to this culture’s valuing personal opinion. The lack of specific
guidance seems the price to pay for parents’ freedom to choose practices that feel true to who they are. All of these authors beseech parents to listen to their individual sense of direction with authoritative voices.

These authors further the unquestioned defense of each parent’s dignity to choose what they believe will best serve their families. They also assign a tremendous load of personal responsibility, particularly in this issue where some authorities claim that the wrong choice could lead to the death of one’s child (as in warnings from AAP and JPSC). If a parent has read that children usually sleep more deeply in their own cribs with further data suggesting that deep sleep may raise the likelihood of SIDS, that parent might assume that placing a baby to sleep in his or her own crib is less safe than in a family bed. That parent might then come across an article that describes how children have died from overlay and entrapment in parents’ beds, with the conclusion that infants should always be put to sleep in cribs. The wrong choice could result in a preventable tragedy seemingly at the fault of a parent’s decision.

While those writing childcare books recommend that parents choose which options feels most fitting to their parenting philosophies, they assume parents have relatively coherent and unified self concepts to base their decisions on. Gergen (2007) describes how more and more, individuals likely feel that all of the divergent influences in our culture cause personal difficulties. The jumbled and conflicting influences “pull us in myriad directions, inviting us to play such a variety of roles that the very concept of an “authentic self” with knowable characteristics recedes from view” (p. 302). Returning to our Oprah example, the basis for choices and their limitations remains unclear. We know
that parents have the imperative to make choices for their families and that they should do what is in the best interest of their children but we do not clearly understand what those mean to each family.

Imposing Limitations

Murkoff, Hathaway, and Eisinger, authors of the famous What to Expect in the First Year (1996), share information they organized about possible consequences of bed-sharing or crib sleeping. While they initially appeal to the personal authority of parents, they quickly add that parents should not let personal feelings in the middle of the night disrupt a logical plan based on data read in the daylight.

While there’s no shortage of theories and certainly no shortage of opinions on the issue, the decision of whether to have your baby join you in bed or sleep solo in her crib—like so many decisions you’ll make in your tenure as parents—is a very personal one. And it’s a choice best made when you’re wide awake (read: not at 2 A.M.), and with your eyes wide open to the following considerations. (p. 265)

These authors show less concern about where infants sleep than how parents make and implement those decisions. In another statement, Ferber (2006) similarly places qualifications on his encouragement of diversity and freedom of choice. In addition to establishing the parent’s judgment as authoritative, he also sets up an opportunity for judging certain sleeping arrangements as incorrect:

Whatever you want to do, whatever you feel comfortable doing, is the right thing to do, as long as it works. I do not presume to dictate parents’ child-rearing philosophies. As long as they don’t choose a path that I think will be harmful to their youngster, I will work with them according to their choice”. (p. 41)

Ferber adds the condition that he should believe that the path the parents choose is not
harmful to their children. Perhaps parent and child sleeping on a firm mattress is acceptable but it is not okay for them to sleep on a waterbed because the baby might suffocate or overheat in the night, no matter what the mother’s intuition tells her. Ferber’s authority by means of his position as a physician and his citation of empirical studies quickly establishes limits and boundaries for parental behavior, relative to his judgment as someone in a position of formal authority.

Research About Bed-sharing Families

*Demographic Surveys*

Many studies use surveys to find “factors” for bed-sharing. Iglowstein, Beatrice, Molinari, Largo, and Jenni (2006) investigated the sleep behavior of pre-term and full term infants, finding no difference in bed-sharing or breastfeeding behavior across 10 years. Lozoff, Abraham, and Davis, (1984) found that certain factors correlated degrees of stress, education, and professional skill with bed-sharing for Caucasian families. They found that those factors did not determine bed-sharing rates in African American families. Lahr, Rosenberg, and Lapidus, (2006) identified “risk factors” for bed-sharing such as annual income below $30,000 and race defined as Hispanic, black, or Asian Pacific Islander. Lindgren, Thompson, Haggblom, and Milerad, (1998) found that parents in Sweden who disregarded official recommendations about infant sleeping position were more likely to bed-share and disregard other professional infant care advice. Stein (1997) studied two cases of bed-sharing and noted that choices about childcare, such as where a baby should sleep, remain “heavily influenced by cultural norms and acceptance, as well as by practical demands.” McCoy et al. found that the ethnicity of parents, along with
breastfeeding, was the strongest factor in predicting bed-sharing (2004). It also found that instances of bed-sharing increased in households with an absent father. Breastfeeding occurrence or lack of space did not account for bed-sharing, as the majority of children who slept with parents reportedly had their own beds or sleeping places available.

Nelson, and Chan, (1996) surveyed families to understand what behaviors contribute to Hong Kong’s low SIDS rate and found 32% of children sleeping in a bed with parents and a very low rate (3%) of maternal smoking. These studies fail to help us catch site of the process by which parents live out these “factors” when making sleep placement decisions or if those “factors” are more accurate measures of who is willing to conceptualize or describe their behavior as co-sleeping than measures of who actually brings an infant into bed.

**Qualitative Research**

The majority of studies about the topic, whether for or against specific sleeping arrangements make arguments to hold up their positions by using data from quantitative or anthropological studies. From these studies, scientific scrutiny and expert opinions make generalized claims about behavior in family bedrooms and intimate experiences. Intuition and families’ traditions become valid only when congruent with empirical evidence and parents have to sort between authorities who may take their cues from different data. Ball, in his study “Reasons to bed-share: why parents sleep with their infants” (2002) asked parents why they bed-shared but limited the scope of his data to the content of their responses without investigating the source of their “reasons” or the process parents went through in deciding those reason felt significant. The research literature has yet to investigate how parents organized those reasons and how parents take
up the scientific data in that literature. Some researchers have given parents “voice” by asking them to list reasons for their behavior in surveys but none have asked them how they feel about all of the information that the scientific experts produce.

2. METHOD

Narrative Analysis

Despite the abundance of research articles about sleep placement and parental medical decision making, none have addressed the aspects of experience relating to parental identity and relationships with knowledge sources during that decision making. Instead of parenting according to one absolute set of standards, parents negotiate how various practices fit into their identity as parents. I would expect that some parents may have had more difficult experiences than others in that process of incorporating or rejecting practices. Listening to their experiences will help health care researchers and practitioners understand the effects of competing advice and what constitutes “good” or “bad” guidance. Parents also have suggestions for how health care providers might help other parents through the process of making early parenting decisions.

Charles Bruner describes the importance of understanding our relationships with information we engage with. He writes that “What is needed is a basis for discussing not simply the content of what is before one, but the possible stances one might take towards it” (Bruner, p. 129). Instead of previous studies only trying to understand what “content” is available to parents, more work is needed to identify what stances they take towards it. In narratives, we make references to our relationships with formal and informal authorities. We participate in discourses built upon values larger than our own
opinions. Looking for powerful social discourses in our stories can help us understand how authoritative voices “regulate” our social experiences (Woofit, 2005, p. 154). Woofit (2005) explains that analysis of discourses within texts can “illuminate the ideological supports for power relations” (p. 154). A narrative method provides opportunity for beginning to see how concepts discussed in academic discourse, such as ‘multiphrenia’ and pluralism, actually relate to experiences of people living outside of that academic realm. This works toward to develop “a voice more resonant with people’s lives” (Brown and Gilligan, 1992, p. 31). A narrative method can provide a fruitful meeting ground for theoretical cultural analysis and everyday lived experience.

In looking for a method that helps identify “ways of knowing and learning, identity transformations, and moral outlook [that] have seldom been examined by academic researchers” (Belenky, Clinchy, Goldberger & Tarule, 1997, p. 11), I found the “Listening Guide” method described by Gilligan, Spencer, Weiberg, and Bertsch, (2007). Instead of surveying factors of sleep placement as has been done before, the Listening Guide provides a structured method with which to investigate how parents recount having engaged in the interpersonal and political process of deciding where to place infants to sleep. It was specifically designed to investigate how individuals narrate their relationships to their cultural sources of knowledge and authority, including knowledge and authority that feels personally derived. Multiple reading stages also provide opportunity to identify literal voices within each story and implicit cultural values. Validity in identifying voices of influence is supported in how those larger cultural messages and values are found in other cultural artifacts (such as the values previously identified in the Oprah segment and parenting books). As this method
requires multiple listening steps for various kinds of ‘voices’ in narratives, it is particularly fitting to situations where some participants may have ambivalent feelings or feel concern about unspoken social rules. Multiple readings for these ‘voices’ provides a structure to individually articulate each voice.

The Listening Guide method provides a balance between requiring a disciplined set of procedures and remaining open to novel developments. The consistent reading structure it requires across samples increases objectivity while analyzing the interviews. Applying the same reading steps to each interview facilitates comparisons between samples for evaluating individual differences by comparing how the reading steps were applicable to each interview. This method also remains open-ended to additional possibilities for analyzing the data, a benefit in this project that was investigating a previously unstudied phenomenon. While I had some expectations of results before beginning the study, discussions with parents about this topic had taught me to expect surprises. For example, at a social event I listened to a mother describe her sleep placement decisions for her daughter. To me, it seemed that she knew exactly what she wanted for her family and that the experience went very well for her. I asked if there was anything she wished would have been different, expecting to hear that she was satisfied with the process of her sleep placement decision making. I was surprised as she quickly began listing things that she wished advice-givers would have done differently to support her. The Listening Guide method was particularly fitting to this project in how it invites innovation of the method to address experiences that include surprising information. I developed the Listening Guide beyond its initial delineations of voices within societal power structures which I will explain further in the next
Before beginning the research, I planned to actively integrate my own first-person voice into my writing when making decisions about how to interpret and relate data. Explicit description of my own perspective addresses two aspects of my research. The first is how my research is invariably influenced by my own perspective as within my own socio-historical milieu. The second reason for incorporation of my own voice is in use of my own voice as a research instrument, another way of addressing aspects of experience that include my own felt responses to interpersonal experiences. Despite this plan, I found it much more challenging to write in the first-person and incorporate my own personal responses. I found reading articles and dissertations by others who used the same method helpful by witnessing their own use of voice to see how I could fit my voice into this project. I needed to read examples because I have generally approach most research and academic tasks with the standard passive voice that assumes a universal tone, prevalent in formal education. I also found difficulty incorporating my own sense of voice in transitioning from working at my clinical position that required I use a passive and de-identified voice for 40 hours per week to then describing myself as an active researcher and interpreter of information in this project. I frequently turned to a dissertation completed with this method to help me catch on to my own self-referencing, first-person voice. By witnessing how other feminist researchers engaged with their own responses and voice, I mustered the courage and know-how to take on that task myself. Some use of my own voice is in explicit reference to my views but also in my presentation of information which inevitably includes my own socio-culturally situated...
perspective, values, and circumstances.

Procedures

Sample

I recruited participants from multiple types of parenting organizations, such as local community and midwife organizations. I contacted leaders of local parenting groups and asked the leaders to distribute emails or flyers asking for participants. In the emails and flyers I explained that I was interested in understanding how parents chose where to place infants to sleep. Participants could have multiple children at the time of the interview but had to have a child between 1 and 3 years of age and answer “yes” or otherwise affirmatively when I asked them if they regularly share a bed with their baby. I recruited both male and female participants but generally received responses from mothers. I also contacted a family that I interviewed for a small pilot study I conducted in 2006. I previously interviewed them about their sleep placement decisions for a class paper and asked them if they would like to participate in this study but they declined due to a recent loss in their family. I received about 50 emails and phone calls of interest in a few weeks. I interviewed five participants by meeting with those who responded to scheduling requests first.

Of note, when I was recruiting participants, I found some community and healthcare leaders who, in addition to discussing the logistics of recruiting participants, wanted to talk more about bed-sharing as a cultural issue. One leader, for example, said that she was not allowed to discuss bed-sharing due to her employment through a government-funded agency with a strict policy that condemned bed-sharing and threatened termination of employees who discussed the issue when referencing their
community positions. She described feeling unable to tell me what she really thought and felt for fear of retaliation from this government agency. She mentioned some resources that were of further help to me but I never learned the story she said that she wanted to share but felt she should not share due to possible consequences. Another community leader spoke freely in her support of bed-sharing but described how many nurses, social workers, and other community leaders are threatened with negative consequences when discussing the issue in public. I did not record those discussions as they were not a part of my formal research procedures but the general description of that atmosphere of fearing free discussion contributes to a holistic understanding of this issue. Those in formal employment and leadership positions relating to child-welfare often face more perilous consequences when discussing this issue than those who are not in those positions. One of the participants disclosed in her interview that she was particularly concerned about my efforts to preserve her confidentiality for this reason.

Interviews

I met with most of the participants in their homes and one requested to meet in a restaurant. When I first met each parent, I began by discussing the research process and consent form with her. I explained limits to confidentiality in the study and possible benefits and consequences of participating. I also discussed how they may leave the study at any time. I then explained that I was interested in understanding how people arrived at their sleeping arrangement for their infant. With my questioning, I tried to find a balance between guiding them to discuss specific aspects of their decision-making while leaving room for their version of their narrative, both in topic and in structure. I first asked more general questions broad enough to encourage a longer narrative in which they would have
more space to arrange plotlines instead of following the order of many shorter questions. I first asked them to describe their current sleeping arrangements and then describe how they decided where to place their infants to sleep, including how they interacted with advice sources and integrated personal intuition. I also asked for their reflections of what would have helped or supported them. I asked each parent all of the questions in the interview schedule although sometimes in different order depending on the conversational flow of the interview. I tried to phrase questions with holistic emphasis on circumstances and personal feelings of each mother, for example, phrasing a question as “what was going on for you when…” instead of only asking “why”. If she had more than one child, I asked her to describe the process for each child in the order she chose.

I quickly felt ill-prepared when faced with the question of how to manage my in-the-moment decisions to remain fairly neutral or to engage in discussion. I frequently found myself wanting to respond to participants’ statements by sharing my shock, outrage, or delight. After spending four years reading everything about this topic that I could get my hands on, it was incredible to finally find myself formally interviewing a bed-sharing parent while reminding myself to keep quiet! While feminist methods challenge the ideal of a ‘neutral’ interviewer gathering data with a false sense of objectivity, I felt called to honor each participant’s story as she told it, not as influenced by the whims of my own desire to converse. I now appreciate the richness fostered by method designs that build in context for such conversation. For this project, I erred on the side of neutral and generally only asked questions without making statement responses.

I transcribed audio-recordings of the interviews and spent several weeks reading
and re-reading each transcript. After spending so much time with the transcripts, I began to admire both the decisions of the participants and the organic integrity of their stories. I felt proud for having captured snapshots of their journeys as mothers trying to make the best of challenges. I also felt something like haunted by the dozens of parents who responded to my invitation to participate as I continued receiving phone calls and emails weeks after the last interview from parents asking to participate. What about their stories? What could we all have learned? What remarkable circumstances did they manage? How might they each problematize the single-voiced instructions against bed-sharing that oversimplify the issue? How would they each remind me that this project is even worthwhile and that this issue matters? These parents left voicemails and emails describing how they wanted to talk and share their stories. I have felt honored to participate in sharing these stories.

Interpreting the Data

To analyze this data, I began by using the multiple listening modes as defined in Brown and Gilligan's Listening Guide (1992). Those steps include listening for plot, listening for reference to self, listening for mention of contrapuntal voices, and listening for relationships with authorities and societal frameworks. They hold that listening to stories or reading texts with four questions in mind can “attune one’s ear to the harmonics of relationship” (p. 21). I read through transcripts of each interview dozens of times looking for different kind of ‘voice’. The separate readings helped me specifically identify each person's references to self and references to advice-givers in the context of each story. Descriptions of each step of the reading guide include:

Step 1: “Listening for the Plot” (Gilligan et al., 2003, p. 160).
Understanding the plot of someone's story is the first step from which to begin understanding each narrative, including explication of context and events. After reading for plot, I summarized the events each mom described in her story to understand the terrain for the following listening steps.

Step 2: “I Poems” (Gilligan et al., 2003, p. 162)

In the second step I read looking for literal reference to self using the pronoun “I”. I read through each interview marking each reference to self using a highlighter and then combining those highlighted texts to form “I Poems”. The process of constructing the poems helped me attune to how participants identified and described their own voices.

Step 3: “Listening for Contrapuntal Voices” (Gilligan et al., 2003, p. 164)

In this third step I read through each text looking for “signs of self-silencing or capitulation to debilitating cultural norms and values—times when a person buries her feelings and thoughts and manifests confusion, uncertainty, and dissociation, which are the marks of a psychological resistance” (Belenky et al. p. 30). After having carefully looked for reference to and assertion of one’s own voice in the second reading, I looked for instances when participants described concerns of other authoritative voices. Belenky et al. described using this step to uncover voices that “constrain the expression of feelings and thoughts, and consequently narrow relationships, carrying implicit or explicit threats of exclusion, violation, and at the extreme, violence” (p. 29) and “signs of political resistance, times when people struggle against abusive relationships and fight for relationships in which it is possible for them to disagree openly with others, to feel and speak a full range of emotions” (p. 30). Brown and Gilligan (1992) describe
the how feminist researchers can use this part of the data analysis to learn more about power dynamics within relationships:

As resisting listeners, therefore, we make an effort to distinguish when relationships are narrowed and distorted by gender stereotypes or used as opportunities for distancing, abuse, subordination, invalidation, or other forms of psychological violations, physical violence, and oppression, and when relationships are healthy, joyous, encouraging, freeing, and empowering. p. 29

Trying to observe repressive and resistant dynamics, I looked through each narrative to find what voices a participant was either submitting to or resisting. In the next section, Contrapuntal Voices in the Narratives, I will describe that process in detail.

Step 4: “Composing an Analysis” (Gilligan et al., 2003, p. 168).

The first three steps together provided a basic foundation from which to investigate participants' evaluations and relationships with the characters in their narratives (p. 168). Using evidence from each interview, this fourth step is where I described how each participant integrated the contrapuntal voices in each narrative (p. 169).

Contrapuntal Voices in the Narratives

Development of the Voices

I planned to follow the third step of the listening guide by identifying resistant and capitulating voices as spoken by the mothers within the interviews. The Listening Guide as described in the text, Women’s Ways of Knowing, instructs researchers to identify a voice of the participant that silences its’ self under pressures from oppressive authorities and another voice with which the participant resists such forces. In their study with adolescent girls, Meeting at the Crossroads, Brown and Gilligan took note of these opposing ways of relating to knowledge and authorities:
As the phrase “I don’t know” enters our interviews with the girls at this developmental juncture, we observe girls struggling over speaking and not speaking, knowing and not knowing, feeling and not feeling, and we see the makings of an inner division as girls come to a place where they feel they cannot say or feel or know what they have experienced—what they have felt and known. 1992, p. 4

For a topic ripe with disagreements between parents, physicians, political groups, and complex family dynamics, I believed that looking for two such voices regarding relationships with advice sources about bed-sharing would fit well. Indeed, I found self-silencing, uncertainty, and explicit resistance, but they were not situated as simply for or against oppressive structures. After spending several weeks with the transcripts, carrying them everywhere I went and marking them with many provisional ‘voices,’ I knew that I could not complete the third step of the reading guide strictly as it was written. Each time I tried, I quickly encountered complicating ways of speaking that did not fit into the dichotomy of self-capitulating or resistant voices. What I noticed was that the mothers felt confident enough to describe their experiences of knowing and not-knowing. They also described feeling respect or appreciation when other people seemed humble about what they claimed to know. Most participants felt frustrated by advice sources who did not join them in forthright discussion that included admitting to limitations of what one knew. In some situations, honesty about not-knowing was identified as a mark of personal strength and wisdom. The mothers took up many modes of relating to their difficulties and authorities but few fit into a clear pattern of resisting or submitting to some sort of external power. While making choices for one’s own family is situated as an interpersonal and political behavior, always in some relation to cultural norms and authoritative claims over that family, the majority of the mothers’ stories seemed organized by another set of values.
There were particular circumstances when pitting an oppressive versus a liberated voice seemed appropriate, such as how one of the participant’s mother in-law continually pressured her to change her co-sleeping behavior. Yet, even in cases when that application of the oppressive or resistant voices appeared to work, I still encountered muddied terrain when I did not know which sentences should be highlighted by an appropriate color of the oppressing or the resistant voice. For example, when the participant felt harassed by her mother in-law but then sought advice from nurses who also taught that bed-sharing was dangerous. She said that she valued the advice from the nurses and gladly listened to most of it except their advice against co-sleeping. It is impossible to identify if her advice seeking was an accurate reflection of her own liberated self-awareness as a parent recognizing she needed advice or due to an internalized oppressive cultural system that convinced her that others knew more about proper mothering than her, or both of those options. For the most part, it became much more difficult to determine who was an ‘authority’ than I first expected. While physicians, mother in-laws, or cultural norms appearing in personal doubts definitely possess authoritative status, the mothers often determined to what degree they listened to or respected those messages. Some chose to respect sources as authoritative or helpful without feeling oppressed, instead appreciating the advice. In a sense, they decided when and how to acknowledge authoritative sources, a seemingly liberated choice to choose one’s own authorities.

I found repetition of particular kinds of statements that complicated the dichotomy between oppressed and liberated voices. For example, mothers often identified that doing what they chose was not working out, such as when a participant
repeatedly said that finding a way to get her children to sleep in their own beds would help everyone get better sleep. Regarding when she brought up bed-sharing to her pediatrician knowing he would tell her to stop, she said “I think I, I wanted to hear him say it to make me do it that time.” She engaged an external authority who disagreed with her behavior with the goal of eliciting him to motivate her in the direction she said she wanted to go, of finding a way to get her children sleeping alone. When she described instigating a discussion so that her physician would prompt her to place her daughter alone in a crib to sleep, I had difficulty determining if that was an empowered choice or some sort of surrender to norms that felt alien and unwanted. For many of the complex relationships the mothers described, submitting and resisting felt like inapplicable and inadequate terms. The heuristic device of identifying some voice-ing as resistant and some as capitulating did not fit the structures with which the mothers organized their stories. Most of what the mothers described did not include defying or submitting to authorities or authoritative discourses. I seemed to catch sight of another kind of process that included prioritizing of values that guided further engagement with external advice sources and information. Although developers of this method propose the dichotomy of resistant and capitulating voices, feminist research also values adjusting research methods to the lived experiences of participants. In this case, that meant articulating new kinds of voices in relationship to authorities.

*Developing descriptions of discourses in the narratives*

Carol Gilligan et al. acknowledged that particular research projects may require definition of new voices that remain attentive to discussion of authority and resistance (2003). They write:
The development of these listening for contrapuntal voices is an iterative process. The researcher begins with an idea about a possible voice, creates an initial definition or description of this voice, listens for it, and then assesses whether the definition of this voice makes sense and whether it is illuminating some meaningful aspect of the text. (p. 168)

I recognized that I needed to define and describe new voices based on the narratives the participants shared with me. I looked at the complexities that ruled out the simple repressed and resistant voices for initial inspiration. Initially, I was struck by the sense of external influence as ubiquitous and how the mothers dealt with experiences that included many factors beyond their own choosing. While a resistant voice seemed to emphasize choosing, each participant described how parenting, almost by definition, is managing life with unending encounters of circumstances beyond what one chose. In this case, that includes a baby being born with a certain sleeping preference and other circumstances impacting sleep behaviors. Then there are individuals or collective groups of people who attempt to impact us, often experienced as externally oppressive, such as publicly funded campaigns against bed-sharing or physicians who pressure behavioral changes to what behavior they believe works best.

I first tried to re-conceptualize the oppressive versus resistant voices by identifying shifting voices that change depending on circumstances or a vague notion of mothers resisting and then choosing to learn from alternative voices. I pursued this to follow my sense of how some of the mothers defied and then later chose to learn from alternative voices but I could not discern any way to systematically track that shifting voice across time. The stories the participants told did not fit well into a dualistic system. They were generally not ideologically ‘for’ or ‘against’ particular concepts but instead ‘for’ what seemed best for their families at particular times and places. Staring blankly at the narratives, I felt the impending crisis of having data that would not fit my
method and wondered how or if this dilemma could resolve. I tried many different schemas for identifying consistent themes in relationships with no reliable formulation that seemed useful.

Feeling like I had no idea how to make the right connections, I turned to the transcripts with a more descriptive instead of categorical perspective. With that view I noticed that, seemingly more consistently than any other behavior, each mother shared an integrative focus on the present. I noted other qualities of how they approached their worlds including formal authorities, their children, and other circumstances. I began listing those similarities in the simplest aspects of their narratives, such as what seemed to matter to them and what they considered when describing their values and relationships. My list suddenly developed a unifying theme: that each mother spoke with a voice concerned about multiplicities including past, present, future and baby, mother, family. They were not speaking with chaotically shifting voices. Instead, they were listening to multiple kinds of concerns – that was the unifying quality of their voices. This voice was used in dialogue with another way of engaging with information, a much more static voice I will address later.

Instead of focusing on content such as ‘bed-sharing is good’ versus ‘bed-sharing is bad,’ or attitudes towards authority such as ‘authorities are trustworthy’ versus ‘authorities do not know,’ I saw that the stance of the mothers in the interviews was remarkably integrative of multiple values. I saw an integrative present-concerned voice, still interested in future, and balancing multiple priorities. I distinguished this from a static, future-focused proclamation-style of voice. Mothers occasionally spoke with that static voice but that was generally when describing the discourse of advice sources.
One of the participants mentioned the term ‘accidental parenting’ in her interview from a book called The Baby Whisperer. As she described it, the term referred to parents who did what felt right in the moment instead of implementing behavioral plans meant to instill habits for the future, such as sleeping alone. She explained that she found most other parents find the word implies negative judgment about failing to do what someone decided has long-term benefits by doing what is easier in the immediate moment. It seemed to be the an extreme approach of only focusing on what feels easiest in the moment instead of what would serve children best in the future.

While the term ‘accidental parenting’ addressed concern for the present, I was looking to describe a more comprehensive set of concerns that includes some consideration of the future, although as a lower priority when compared to the present. In contrast to ‘accidental parenting,’ ‘adaptive parenting’ seemed like a more appropriate term for describing the style of voice I heard from the mothers. I began writing a list of the qualities I found in each of the mother’s narratives and found adaptation seemed primary: integrating varying information and concerns, now-oriented, responsive, considering child’s choices and actions, trusting first-hand experience, switching physicians/advice sources to find good fit, asking for help when it felt necessary, and remaining aware of an information-filtering perspective.

I performed an internet search for the term ‘adaptive parenting’ to see if it was already in public use. I found many sites for parents of children with special needs, so the term has been used in reference to parenting for children who are somehow
categorized as outside the norm of physical or mental ability. That would seemingly require parents to look beyond norms or instructions for parenting children identified as non-‘special needs.’ I read the first article I found that used the term for parenting in general, not just parenting ‘special needs’ children. The article was written by a mother in her blog as an argument for her proposal for using the term “Adaptive Parenting” as “the New AP.” She referenced the term “Attachment Parenting” as the old “AP,” a style of parenting that emphasizes the importance of maintaining close relationship and proximity with one’s baby. The author felt alienated from an Attachment Parenting group after parents in internet forums criticized her own parenting choices for failing to uphold Attachment Parenting behavioral prescriptions. She wrote, “if Attachment Parenting came with ID cards, the AP Police would have revoked mine.” She continued,

To me AP now means Adaptive Parenting. I’m adapting how I raise my children, and in more ways than one. I adapt depending on what is best for that particular kid…I adapt depending on what is best for my own sanity, what is best for this family as a whole, and I leave room for further adapting depending on new research or ideas that I may not have thought of in the past. (Osborne)

Her description of this “Adaptive Parenting” resonated with what I was attempting to describe regarding the participants of this study. When trying to summarize the movement of this voice, the term seemed most apt as both flexible and consistent parenting across changing circumstances and a variety of sleeping arrangements. I felt excited to find a mother describing this term as arising from reflection of her own experience including frustration with non-flexible imposition of monolithic behavioral systems.
As I was writing qualities of the Adaptive voice, each aspect of it seemed to contrast what I began referring to as the ‘Prescriptive voice.’ The Prescriptive voice is future-focused, static, non-responsive, imposing, ideal-focused, speaks in generalizations, and aligns use of data to its own claims. When mentioning it, I capitalize ‘Prescriptive’ to identify it as a specific construct from this project. In specifying the dimensions of difference between the two voices, I initially identified nine areas of difference: temporal focus of concerns, priority of values, agent of action and intervention, styles of sources of knowledge, role of conceptual terminology, considered factors, values, certainty and universality, uniformity across time, and militancy or enforcement of beliefs. I noticed enough similar themes to begin clustering them into fewer dimensions for manageability when coding. I finally decided this model of five dimensions most succinctly represented the identified differences between the voices. Each theme overlaps somewhat with the others but the individual dimensions of difference are helpful for articulating each perspective.
## Dimensions of the Adaptive and Prescriptive voices

<table>
<thead>
<tr>
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<th>Prescriptive Voice</th>
<th>Adaptive Voice</th>
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<td><strong>Temporality</strong></td>
<td>a. Future oriented</td>
<td>a. Emphasizes present concerns</td>
</tr>
<tr>
<td></td>
<td>b. Presumes universality across time</td>
<td>b. Decides and re-evaluates in the process of living</td>
</tr>
<tr>
<td></td>
<td>c. References impersonal histories (empirical research)</td>
<td>c. Incorporates decisions into individual history</td>
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<tr>
<td><strong>Consider Factors/Values</strong></td>
<td>a. Survival rates nearly sole concern</td>
<td>c. Complex and varied concerns</td>
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<td>b. “Independence” of child as assumed value</td>
<td>d. Aesthetical values</td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td>a. Top-down, parents as main agent</td>
<td>a. Varied agents, recognizes children as holding influence in family behavior</td>
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<tr>
<td><strong>Role of Information</strong></td>
<td>a. Often fails to prove/validate claims</td>
<td>a. Looks to first-hand experience and advice from other parents</td>
</tr>
<tr>
<td></td>
<td>b. Critiques non-compliance</td>
<td>b. Changes advice sources if they conflict with values</td>
</tr>
<tr>
<td></td>
<td>c. Self-imposing with assumed universality</td>
<td>c. Self-limiting, aware of claim as from one’s own perspective</td>
</tr>
<tr>
<td><strong>Conceptualization &amp; Terminology</strong></td>
<td>a. Conceptually managed</td>
<td>a. Gradually conceptualized</td>
</tr>
</tbody>
</table>

*Table 3.1*

1. **Temporality:**

**ADAPTIVE:**
- Now oriented
- Deciding while in the process of living and organically evolved
- Referred to personal histories

**PRESCRIPTIVE**
- Future oriented
- Assumed universality across time
- Impersonal history

The Adaptive and Prescriptive voices differ in their discussion of temporality.

With the Adaptive voice, participants describe feeling drawn to behaviors within the web of experience present at the time of the behavior. Their priorities overall include concern
about the past, present, and future, but primarily focus on present experience. The Adaptive voice integrates decisions into the individual’s history, such as what they know of their children and personal experiences with their own families. The Prescriptive voice emphasizes an ideal for a certain kind of future event, such as trying to assure that a child is sleeping by himself at age 17 by altering behavior for that child as an infant. Concerns about the present become secondary to the future ideal. What matters most about behaviors ‘now’ is what it means for increasing the chances of a chosen event ‘later.’ The Prescriptive voice rarely refers to its place in socio-cultural history unless it is presenting its advice as an advancement to older, seemingly outdated information.

2. Considered Factors/Values:

ADAPTIVE:
- Complex concerns, it’s not just me, but ‘us’
- Aesthetical considerations such as perceived beauty

PRESCRIPTIVE
- Survival rates as nearly sole concern
- Independence (culturally assumed and non-reflective values)

This aspect of difference between the voices addresses the specific reasons considered in decision-making and what qualities count as important or valid concerns.

With the Adaptive voice, multiple factors influence decisions about what is best, ranging from practical concerns with furniture to aesthetic values such as whether a behavior feels “beautiful.” The preferences and well-being of the parent is usually more integrated, such as whether a sleeping arrangement helps a mom feel more rested, with an overall appreciation that a rested mother is probably more prepared to respond well to her child during the day. Another consistent value has been for a mother to respond quickly to her child’s needs so the child feels comforted and secure. The main concerns
of the Prescriptive voice are survival rates and imagined effects on future sleeping behaviors, primarily solo-sleeping as an older child or adult, often projected years or even decades into the future. Solo-sleeping is an assumed accomplishment in trying to prevent children from being too dependent on their parents, a constant concern for the Prescriptive voice. Coddling or “giving in” to crying children reinforces unhealthy interdependence. This voice does not value the aesthetic responses of parents and children about nighttime routines, such as those who enjoy cuddling.

3. Agent of Action/Intervention:

ADAPTIVE:
- Bottom up, children do hold influence in family behaviors

PRESCRIPTIVE
- Top-down, parent as all-powerful over family behaviors

This aspect of the two voices addresses who is regarded as the significant agent of action in behavioral changes within families. The Adaptive voice balances a strong consideration of the parent’s plans and preferences with the responses of the children and other people frequently involved in home life. While parents may make plans, children and other circumstances co-determine if and how those plans ever reach fruition. Each mother interviewed described influence from their children over how sleeping occurred, either through screaming, fidgety-ness, or other expressions of what the mothers perceived their children as wanting. While parents still decide how to manage their family situations, they actively acknowledge how they incorporate additional voices into their stories. With the Prescriptive voice, parents are generally considered the main authorities and agent of change within their homes. Parents should make plans and implement them without bending. Giving in to influences outside of their original plans is
conceptualized as a poor behavioral choice that will likely lead to problems later due to inconsistent administration of limitations.

4. Sources of Knowledge (Style of information use):

ADAPTIVE:
- First-hand experience and looking to other parents’ experiences
- Switching advice-sources to find fit with beliefs and goals
- Self-limiting
- Overriding alternatives, aware of own perspective

PRESCRIPTIVE
- Usually do not feel burden of proof
- Critiquing non-compliance
- Self-imposing, assumed universality
- Judgment up to legality

This aspect of difference between the two voices is how they incorporate and relate with information from varying kinds of sources. The Adaptive voice considers many sources with particular concern for local and personally derived or shared information. For example, a mother may read an internet site that features examples of how dozens of moms solved their sleep problems to find which advice fits the particular concerns of her family. This includes turning to knowledge acquired through multiple relationships, such as family or other parents met in parenting groups. They often remain consciously aware of their role as filtering through those many individual voices, particularly when those voices conflict. The participants also described how they understood that what worked for them may not work well for other families. Within the Adaptive voice, mothers described switching physicians or other professionals to find those who were willing to work collaboratively or in compromise with their particular practices and values. From the Prescriptive voice, what seem like
un-questioned medical traditions remain norms. Those who do not comply with those norms are critiqued as non-adherent and endangering their children. This voice speaks with assumed universality and turns to limited research that excludes experiences that fail to reinforce its claims. Many of its claims are scientifically clumsy and rely on just as much anecdotal data as opposing ideas but this voice otherwise maintains its precedence publicly and in its own opinion.

5. Role of Conceptual Terminology:

Adaptive:
- Gradually conceptualized

Prescriptive
- Conceptually driven

The voices differ in how conceptualization and terminology fit into the process of parenting. From the Adaptive voice, parents generally manage their families and conceptualize their behaviors if engaging in external discussion, such as with other parents or physicians. None of the mothers in this study said that they planned to sleep with their children until the moment each one pulled her baby into a bed with her. All describe something that I term the “moment of conceptualization” when they identified sleeping with their babies as a thing with a label. In a lived sense, none of the participants ‘decided to bed-share.’ Instead they each brought an infant into bed and fell asleep due to varying circumstances that made that behavior seem reasonable to them. Application of a label for the process is secondary to the primary experience of sleeping with one’s baby. The priority for the Adaptive voice remains what improves life as it is lived, not how to conceptually sort through and evaluate parenting terms. The labels of ‘bed-sharing’ or ‘co-sleeping’ are initially incidental, although they begin to place the parents in a socio-
cultural conversation of terms once the parents identify with them. In contrast, the
Prescriptive voice is conceptually driven as it starts from categorical understanding of
behavior instead of behaviors as they are lived relationally. Discussions about
“Ferberizing” and “Co-sleeping” explicitly and implicitly reference universalized
conceptualizations and categories identified for research and disseminating information
to mass markets. Because the Prescriptive voice does not value making effort to learn
much about all the varied factors parents take into account in their decisions, brief
conceptual terms become the only way to quickly reference a larger set of behaviors and
values the advice-giver recommends implementing. When conducting research, families
usually must identify as “bed-sharing” or not, rarely with any opportunity to identify
variance in amount of kinds of sleeping with their babies, reflecting a preference in most
formal research for conceptually-driven understanding of family behavior.

Informal Illustration

In my enthusiasm about the development of these voices as workable constructs
for this project, I visited my neighbor who bed-shared with her one-year old daughter in
her nursery for half of most nights. As we talked, her husband, a physician, sat down
next to her with his dinner of re-heated leftovers after a long day at the hospital. When I
described the Adaptive and Prescriptive voices and how they addressed bed-sharing,
she and her husband nudged each other, rolled their eyes, and laughed about their
resonance with the opposing descriptions. She felt aligned with the Adaptive voice and
immediately identified her husband and his physician friends as generally aligning with
the Prescriptive voice. She had often spoken about her flexible schedule with her
daughter, particularly the luxury of not having to maintain a strict agenda as she did not
need to wake up at a particular time for external employment. She described that as providing her the freedom to follow whatever schedule felt necessary to continue breastfeeding and enjoy sleeping with her daughter. She also felt frustrated with how some physician friends felt adamant about the correctness and universality of their methods even when they contradicted with advice from other physicians who felt just as convinced of their own beliefs. She gave the example of a dinner with two pediatricians who held divergent perspectives on what age to introduce babies to eggs to avoid development of allergic reactions, leaving her to conclude that neither one reliably knew what was definitively best in that situation. She shared a bed with her daughter in tempered non-compliance to her husband’s wishes for their daughter to sleep in her own crib. He seemed to still respect and honor her parenting but the tension between discourses appeared evident in our casual discussion.

3. NARRATIVE PRESENTATION AND ANALYSIS

According to the steps of the Listening Guide defined above, I first individually analyzed each participant’s narrative, listening for plot and reference to self. I began by writing descriptions of each interview and my summary of each story to provide the reader with enough background information to make sense of the direct quotations used in the further descriptions. When listening for a plot-voice, I selected each participant’s statements describing the practicalities of her story. I then grouped together each participant’s narrative using direct quotes from the interview into four categories: current sleeping arrangements, development of the current sleeping arrangements, how people responded to the sleeping arrangements, and plans for the future. Part of the plot includes the reasons participants chose what they did and so the next portion of each
summary are reasons for bed-sharing abstracted as direct quotes from the interviews. All reasons listed were those presented as ascribed to by the participants. For example, reasons stated as coming from a grandmother were not included. The initial plot summaries conclude with my written response to each interview. These responses include reflection on the interviews and the stories as an opportunity to take note of interpersonal and non-verbalized aspects of the interview experience. After each plot, I present direct quotes regarding how each participant described how she withdrew and shared her voice in particular circumstances. These two sections consist of first person descriptions of how a participant used and withdrew her voice depending on what she wanted, needed, and how she chose to relate with others.

Following the description of the Plot-voice, each analysis includes two ways of addressing the question of how each participant referred to herself. I first present an “I Poem” that was written using the participant’s first-person descriptions, presented in the order they were spoken. The poems are long but necessarily so, as each reflects complex changes in reference to self. These poems reflect some of my interpretation of each mother’s narrative in how I edited and formatted them. For example, I deleted repeated reference to some phrases such as “I think” for women who used that phrase much more than any other. I present these poems with the intention that they would be emotionally evocative to the journey of each participant in trying to understand how she refers to herself in relationship with others and as an agent of change in her family. Following this, I present text selected from the Prescriptive voice within each narrative. In each case, I simply identified each use of the Prescriptive voice in a narrative, abstracted them from the transcripts, and strung them together. Strikingly, this all adds
up to only a few sentences or paragraphs from each narrative. I did not do this for the Adaptive voice as the vast majority of each plot descriptions are from the Adaptive voice. I created this section as similar to the I-Poem as an emotionally evocative opportunity for noticing how one feels when looking at the situation from the perspective of the Prescriptive voice’s concerns and its ways of making sense of co-sleeping.

Following the first two steps of analysis, I coded each participant’s interview transcript using the 5-point description of the Adaptive and Prescriptive voices. For the first case of Marissa, I demonstrate that coding in detail (the entire coded narrative is in Appendix D). For the following four cases, I selected cogent examples instead of demonstrating a fully coded transcript for manageability of reading. The fourth step of analyzing the relationships of the voices included analysis completed within each description of the narratives, in the development of the 5-point description of the Adaptive and Prescriptive voices, and in the discussion section of this paper. Direct quotes from the Adaptive voice are identified in “Papyrus” Microsoft Word processing font and the Prescriptive voice in “Lucida Calligraphy.”

Marissa’s Story

The interview

Marissa is a thirty four year old married Caucasian mom with two children, a boy about three years old and a daughter who is about to turn one. Originally from England, she moved to the U.S. about five years ago for work. She worked full time as an office manager in finance until she had her first child. She returned to work part time until she
had her second child. She plans to return to work again in a few months. Marissa emailed me in response to an email distributed to her internet-based social club for moms. When I arrived for the interview, her son was at preschool and her daughter was quietly playing in the living room where we sat. Her adorable cat visited us on the couch for the second half of the interview.

*My summary of Marissa’s story*

The arrangement of sleeping spaces for Marissa’s family is almost always in flux. She usually begins the night alone in bed with her husband. In the early morning, her daughter wakes up to nurse and Marissa usually brings her into the bed for the feeding and they sleep for another hour or two. Marissa’s son also joins them in bed when he wakes up at night. She is trying to get him to stay in his bed until a night light with a timer changes color around 6 A.M., indicating that it is morning and he may leave his room and go to his mom but he has seemingly not yet caught on. Marissa and her two children regularly take their afternoon nap together in her bed. She states that she and her husband want their children out of the bed because sleeping together no longer improves sleep quality and they feel concerned about long term sleeping habits if the children do not learn to sleep through the night regularly on their own. Despite those stated intentions, Marissa and her husband still welcome their children into bed most mornings. She knowingly admits that they do not feel motivated to return the children to their beds because they will soon go travelling for a few weeks which she found usually disturbs any progress they made toward that solitary sleeping goal prior to travelling.

Marissa began bed-sharing with her son when he became too heavy to easily lift
in and out of a bassinet and feed while sitting up in a rocking chair. She said that she accidentally fell asleep with him in the bed and the ease of keeping him next to her quickly led to a nightly bed-sharing habit. She began bringing him into bed with her for naps when she was pregnant with her daughter. She brought her daughter in bed with her to nurse but her daughter quickly slept alone in a crib without much difficulty.

Marissa seemed genuinely ambivalent about bed-sharing, trying many tactics to help her son, in particular, adapt to sleeping through the night on his own and then describing how helpful bed-sharing was when her children were younger. She occasionally mentioned how she felt bed-sharing was a nice opportunity for improved restful sleep and comfort for her children but those comments seem overshadowed by her current mission to sleep through the night without the daily tug of little hands at 5A.M. Feeding this motivation may be her son’s growing size and proclivity to ‘pinch’ her throughout the night.

The responses of others to Marissa’s bed-sharing were mixed. Marissa said that she tended to “waffle” and change her own position on the matter. As she listened to other mothers at her club, she realized that other families slept together. She also lives next to a family who bed-shares with grade-school aged children. While she initially defied her physician and parenting books that recommended solitary sleeping arrangements, she later turned to them for advice and motivation to follow through with a routine to get her son to sleep on his own through the night. Marissa also explained that her husband generally felt concerned about bed-sharing because of the bad sleeping habits it might instill. He has not followed through with adequate follow up as is necessary for the various solitary sleeping instilling protocols.
Below are plot highlights from Marissa’s narrative that explain her current sleeping arrangement at the time of interview, how that arrangement developed, how she and others responded to that, and her plans for future arrangements.

Marissa’s story in her words:

Current sleeping arrangements

We’ve basically gotten tired of sharing our bed with children...for the last month Emily’s been going to bed in her crib in the evening...and actually sleeping through. But she wakes up around 5:30. So at 5:30 I bring her into the bed, feed her, and then if I’m lucky she’ll fall asleep again....until 7:30 when we pretty much all get up. And then my son...he naps in my bed in the daytime when he’s home with me, I have to fall asleep with him...if I’m lucky she’ll sleep at the same time...because if he wakes up he needs, he needs me there....At bedtime, though, he goes to bed in his own bed which takes a while because he’s been used to having a crutch, I guess. And now we, we’re trying to force him, we’ve got this night light that changes colors and when it turns off you can get up basically. So supposedly, when it turns off he can then come in to our room but we try to put him back. So normally anywhere after 6 he normally wakes up and then he comes in for the final hour of snooze as well. So we have an hour of four in a bed [laugh], but it’s better than half the night or a full night which we were on a while ago...we’re slowly getting out of it...He wakes up and he just goes to our room and he has a gate on his door but he’s like, got some issues with that, [laugh], so he’ll just [laugh], if we shut the gate he’ll just scream and wake her up so we leave it open.

How she decided

He hated his bassinet...and he wouldn’t sleep...and then I guess in those sleep deprived first few weeks of having a child I, I used to fall asleep feeding him and I’d wake up and he would sort of, I’d wake up in a panic because he had sort of fallen off my lap or, well, the bumpy pillow. And then one night I think I was so tired, I just put him down next to me and the next thing I knew, we were waking up in the morning and it was like, oh, that was easy...When he was big enough to feed him lying down like sort of side by side then sleep just came so much easier. He’d wake up every two to three hours to feed but I wouldn’t have to move. And then we sort of, it just became a habit.

When I was pregnant with her I was so tired that we just got up, one day said, oh, I, I just needed to nap. So I just said “why don’t you come and nap in mommy’s bed?” and that just happened and then happened again and then it continued to happen until after she was born and then she’d nap in the bed with us...it became the family nap, the family nap bed...She actually slept in our room for the first three months and slept
quite well...I thought, she’s getting three meals a day, she’s probably not hungry, so I just put her to bed one night in her room and left her for five minutes and then went back and then left her for another five minutes but she fell asleep within the second five minutes. So that was quite easy to sleep train her and then she slept through the night and that’s been how that’s continued.

We were actually trying not to do it. I’d say to my husband “if you wake up and find the baby lying next to you, you get up and put her back to bed” and of course, I think he was even, he was like, “oh well, she’s asleep.”

Evaluations of the process

I joined the mom’s club after a few months and certainly more people out there did it so I was like, okay, I guess this is fairly common [laugh]...why hide the fact. Not that I was hiding it but I sort of thought, is this not what I should be doing as a parent kind of thing...I don’t know whether I’d say they influenced us but they certainly made us think we’re not the only people doing this so let’s not worry about it so much but um, I guess really the only people involved in the process was my husband and I.

I don’t think before children I even thought about the concept of sleeping with them...so we did the usual, well I say the usual, what most people do. You know, we kitted out the nursery with the crib...and when she, he is too big he’ll move to the crib and everyone will, it’ll all be great and normal and it never crossed my mind that, you know, we’d have our baby in the bed. My husband’s always joking, you know we’re going to have 17 year olds in our bed...we just want our bed back basically [laugh]...We know that the children need to be able to fall asleep themselves, I guess so when they wake up in the middle of the night they can put themselves back to sleep...I know we need to do that...Once they get to an age where they should feel, where they don’t need to wake up for milk, then I’d say, from my experience that, that, that would be a good time to stop and looking back, for my son, we should have stopped there and he’d be a better sleeper now, maybe he’d be able to sleep on, on his own.

I know my children and in the moment, if the only way for them to feel safe and sleep, if it’s to do it the way we’re doing then fine, you know. I’m not going to leave if my son doesn’t, is scared of the dark and doesn’t want to lay in him room alone...I wouldn’t sort of leave him there screaming and fretting even if the doctor said you probably should.

Plans for the future

I’d say at nine months maybe we tried to do the Ferber method, the crying, you know where you put them in the crib and leave them...but we kept going back and forth...it was just the only way to keep sleep. When we travel he always generally sleeps with us because he’s always been a
bad sleeper...Now we’re at a stage where we need to be more strict when we travel because that generally messes everything up...If he wakes up we put him back, if he tries to come back, we put him back again...because by which point she’s normally in our bed when he wakes up.

My ideal now is, is sleeping alone, mainly to get some sleep...when they’re both newborn...they need that love and nurturing or whatever and they like to stay close. I’ve got nothing against having them in the bed early till they get bigger because then it’s just not restful for anybody.

Marissa’s reasons for bed-sharing abstracted from her narrative in her words:

- He hated his bassinet...He wouldn’t sleep.
- I guess in those sleep deprived first few weeks of having a child I, I used to fall asleep feeding him.
- I think I was so tired I just put him down next to me.
- It makes nursing much easier.
- Well the point in doing this is so we sleep better...If I was really tired I thought, let’s just bring him into the bed at bedtime, it’s easier.
- I wouldn’t have to move.
- It just became a habit.
- Just knowing the comfort of hearing a heartbeat or whatever, they, you know, say about a newborn. And my son would always sleep better with, you know, knowing that he was next to us.
- It just happened.
- I used to feed him in a rocking chair but I was getting so tired sitting in the rocking chair that it just got to the stage where I’d lean into the bassinet without having to get out of bed, grab him, feed him, sort of slump to one side and that would be it for the next three hours.
- Just ease of it...we were actually trying not to do it.
- I just needed to nap so I just said, “why don’t you come and nap in mommy’s bed” and that just happened and then happened again and then continued to happen.

Marissa describing when she used her voice:

Marissa described how she discussed her bed-sharing openly with other parents and provided advice to other parents who did it. She provided supportive information and did not describe trying to change anyone’s plans or perspectives. She also used the term ‘waffling’ in reference to her willingness to discuss her own parenting,
presumably referring to a judgment that her narrative about it is disorganized or not adequately precise.

I think I just waffle a lot [laughing], um, I don't, I mean, I'm always, if I meet other parents I'm always happy to, I think what I meant was I'm always happy to openly discuss my parenting whether it's sleeping, toilet training, anything like that...Another friend of mine had said, “oh the baby only sleeps in our bed.” And I was like, “oh yeah, oh yeah, that happened with us” and it, I was, I think, with Evan I was almost, not embarrassed by it but it was like, if people would say “where does he sleep, is he sleeping through the night?” I’d be like, “well, you know, actually he sleeps in our bed.” And most people we knew were like, “oh my baby sleeps through the night and isn’t she wonderful” and, so I was always, um. Yeah and now I think, so I think it was just talking to other people that made me think oh, well we’re doing something different, maybe this isn’t the norm and when I started, when I spoke to more and more people, uh, and then I think then I joined the mom’s club after a few months and certainly more people out there who did it.

We’ve had friends that have had babies and they say, “oh, he only wants to sleep between us” and instead of saying “God no don’t do it, you’ll regret it in two years time,” I’ve just said, “exactly the same with us. I suggest you sleep with, without pillows and pull your sheets further down the bed.” One of my friends said that’s a genius idea because she was worried about smothering him. I said “push him up, you sleep lower down.”

Marissa describing how she withdrew her voice:

Marissa described withdrawing her voice from conversation with two people, her pediatrician and her mother. While she did not say this explicitly, it seems that neither of those sources provided much helpful advice about sleeping arrangements.

After the sort of initial conversation with the pediatrician about putting Evan to bed, I never mentioned sleeping to him again until I had her... [My mother] knew we were doing it but never, I think the only time we talked about sleeping she was like, “oh you all slept great at like six weeks” and that was sort of the extent of our, uh...we never really talked about the sleeping together.

My response to the interview

Immediately as Marissa began telling her story, I felt grateful that she offered a
refreshingly different experience than the two participants I had interviewed earlier who clearly preferred bed-sharing over placing their babies in cribs. Marissa felt ambivalent about bed-sharing and shared her many contradicting ideas in the discussion. It seemed as if neither of her arguments about why her family should or should not bed-share felt particularly convincing to her. She spent large portions of the interview focusing on how bed-sharing influenced sleep, such as getting more sleep with the children in bed or keeping the children out of bed to improve their future sleep habits. She emphasized how her children need to learn to sleep alone but that seemed secondary to what helped her family sleep at 5A.M. Occasionally, Marissa made striking comments about staying with her children at night for their comfort such as how she would not adhere to physician orders to leave her son crying if she felt that her son needed comfort. Those comments felt peripheral to her running argument about present and future sleep quality and I was not quite sure how they fit together. Perhaps my confusion about her values reflects her own questions of priorities. She kept calling her son a “bad sleeper” but then said she would comfort him over adhering to a behavioral plan to manage that very same poor solitary sleeping. Though Marissa sought advice from books, her interview felt primarily focused on the condition of her and her children with minimal reference to outsiders. The concerns driving her conflict about bed-sharing felt internally maintained and as if others had minimal genuine influence. She also described a learning process about when and where to discuss bed-sharing or withhold her story to avoid unwanted criticism. She also described herself as taking leadership in supporting other parents who bed-share with advice from her own experience.

*Marissa ‘I Poem’*
If I’m lucky…I have to…If I’m lucky
I guess, I guess, I don’t know, I guess
I’d wake up
I think I was so tired

I knew, I think, I think
I wouldn’t have to move
I can’t really remember
I was really tired
I was so tired
If I was, you know, wide awake

What was I going to say?
I’d say
I just thought
I guess, I guess, I guess
I could sleep
I’d wake

I think I just waffle
I meet other
I’m always happy
I think, I meant
I’m always happy to
I belong
I met
I know, I know
I don’t think before children I even thought about
I guess, I guess I’d, I say
I don’t think I even planned it
I was getting so tired

I started reading
I bought
I think
I don’t know
I was like, okay
I think
Then I transitioned
I’d say to my husband
I think, I’m not sure, I can’t really remember
I guess, I guess talking about it
So I, I, another friend of mine had said
I was like, oh yeah, I was, I think, I was
When I started
I spoke to more

I joined
Not that I was hiding
I sort of thought
I should be
The parents I knew
I guess reading
I started reading
I’d always favor the argument
I’d read
I’d sort of
I’d tell my husband
I deal with
I was so tired
I just, I, I just needed to nap

I don’t mind
I guess
I’m not going to want
I dread
Now I’m, I could have been, I realize now
I try
I don’t know, I guess
I just, I need to worry about now
I should
I’m sure
I mean, I mean, I don’t know
I felt agreeing with what he was saying, I guess
I sort of acknowledged
I know we need to
I didn’t feel bad or wrong
I think I probably felt
I’m the mother
I’m the children
I deal
I know
I’m not going to leave
I’ll lay with him
I wouldn’t
I think, I mean
I value
I don’t agree
I don’t follow the, the rules
I hear
I never mentioned
Until I had her.
I think I just wanted to be told by someone in authority
I don’t know…I don’t know if I can
I would say, I’d say no
I think I, I wish
I guess I’m 50/50
…I think it’s great when they’re little
I hope I answered your questions, maybe I [laugh] waffled a bit.

My response to Marissa’s I Poem

In developing Marissa’s poem, I was struck by the ‘waffling.’ We spoke by
telephone the night before our interview and Marissa said that she wondered how much
time the interview would take because she could say so much about the issue and her
experiences. When I asked her in the interview about that feeling of having so much to say, she said that she felt her presentation of her experiences usually included time-consuming “waffling,” perhaps as in contrast to a concise, unified message, as if that might have been what I was looking for from her. This also felt particularly striking as Marissa works successfully in a supervisory executive position where, I assume, phrases like “I guess” and “I don’t know” might detract from an image of credibility.

Although the I-Poem is meant for the reader to note an emotional response, Marissa also repeated many themes I want to highlight. She frequently refers to modifying her position such as leaning and transitioning, perhaps reflecting a flexible integration of external circumstances. She also refers to not knowing and guessing, maintaining openness to the notion that she is wrong or perhaps someone else has ideas for how she could improve. She frequently refers to “thinking,” so much so that I deleted many examples of “thinking” because that it would have made the poem much longer. She often positions her perspective as its own, prefacing her statements with “I think” to elucidate how she is the person arriving at the conclusion. She refers to reading, buying, and acknowledging external ideas with plenty of “should”s. She does a lot of guessing and a fair amount of mentioning that she “don’t know.” She seeks out advice and then defies the authority of that advice-giver. She wants her physician to reinforce what she should change now to improve her children’s futures but she wants to reject that advice when it does not feel right for her children right now. She frequently mentions her need for a good night’s sleep. Her poem includes many worries perhaps without a unified vision.

Marissa’s story told from the prescriptive voice:
We’re going to have 17 year olds in our bed if we’re not careful. We know people who still sleep with their 5 year olds and we don’t, we don’t want that to happen. We want, I guess for their independence as well but then to be able to stay in bed and sleep. My sister’s first child was perfect so, you know, did everything right...He’ll move to the crib and everyone will, it’ll all be great and normal...Is that not what I should be doing as a parent...The parents I knew all had perfect sleeping babies that all went in their own room and slept until 7 o’clock in the morning.

You’ve got to change that...You’ve got to cry her out, put her in bed and leave her, she doesn’t need to feed at 3 o’clock...he needs to learn to be...they need to learn to fall asleep on their own just to help them be good sleepers even in their adult life...I’m sure it will continue to get worse...We know that’s where we need to be, you know, we know that the children need to be able to fall asleep themselves, I guess so when they wake up in the middle of the night they can put themselves back to sleep...If it’s medically necessary...follow the rules...you need to do the Dr. Ferber, the crying it out...you need to bring Ferber into the house. The pick-up put-down, so you pick them up as soon as they cry, soon as they stop you, the second they stop you put them back in the crib...it had examples and how many minutes to leave them.

He’s always been more worried about what’s going to happen when they’re older...do it up until six to eight months...that would be a good time to stop and, looking back for my son, we should have stopped there and he’d be a better sleeper now, maybe he’d be able to sleep on, on his own.

Adaptive and Prescriptive Voices in Marissa’s Story

I. Temporality
Concerned about the present

Marissa’s references to the temporality within her narrative generally reflect concerns consistent with the Adaptive voice although she frequently mentioned a lingering worry regarding a future-oriented concern of the Prescriptive voice. While bringing her babies to bed with her seemed best at certain times, Marissa, her husband, and others remained worried about how the bed-sharing habit might detrimentally affect future sleep habits of her children.

She said, “having two young kids is like, I just, I need to worry about now, not worry about what might happen in the future even though I should because I’m sure it will continue to get worse [laugh]... I sort of acknowledged and agreed, yes, we, I know we need to do that but I still did it in my own time.” She generally reported responding to the needs of her family in the moment they happened instead of making a finalized decision about sleeping and maintaining a consistent routine aligned with that decision. This would have been the case if her concern about future problems with sleeping habits outweighed her concerns about her family’s comfort in the present and so she might have placed both babies in cribs without responding to any cries to follow the plan parenting guides recommended as something like a guarantee that her children would learn to sleep alone peacefully. Instead, Marissa usually did what felt right in the moment she did it.

Deciding in the midst of living

Marissa frequently described how she made decisions about where her children would sleep in the midst of changing circumstances, considering options based on what was happening around her and what would help that moment go most smoothly. For
example, she did not explicitly plan to begin regularly sleeping with her son but instead noticed that it became a habit retrospectively:

One night I think I was so tired I just put him down next to me and the next thing I knew we were waking up in the morning and it was like, oh that was easy. And then we sort of, it just became a habit.

For Marissa, “bed-sharing” was not a concept she studied and chose with an intellectualized decision making process and then implemented consistently across time. Instead, she remained aware of her general parenting values such as wanting to breastfeed and wanting to sleep and did what felt immediately right or helpful in concordance with those goals. In this particular case, that behavior was to keep her son next to her after feeding instead of the complex rocking chair to crib routine she originally tried.

When Marissa described how she dealt with her physician’s recommendation that she undertake a training process to adjust her son to sleeping alone in his own room, she acknowledged that the idea had merit but it did not feel appropriate for her family at that particular time. While she felt concerned that the children would have sleeping problems in their future years as a consequence of decisions to bed-share at this time, that problem felt further away and less concerning than her current concerns. The Prescriptive voice emphasizes how parents should first decide what behaviors they want from their children in the future, often projected years or even decades beyond an infant’s actual age, and how that should guide current behavior. The Prescriptive voice presumes that parents should expect from their children what they want in the future, such as a child sleeping alone now to increase sleeping alone in the future, without much consideration of how a different or complementary behavior now may actually serve solo-sleeping in later years.
We want him to have healthy sleep habits so, um, as well as you know my husband’s always joking, you know we’re going to have 17 year olds in our bed if we’re not careful...That’s kind of a future worry in the back of my mind.

Marissa’s Adaptive voice clearly considers those “healthy sleep habit” concerns with a greater preference for immediate issues.

A non-completed process

When I asked Marissa if she felt her sleep placement decisions were completed or part of an ongoing process, she described how she expected many more changes in their sleeping arrangements due to upcoming changes in their circumstances. She felt aware of having to tailor her family’s arrangements to what possibilities and preferences may change in the future.

We’re slowly getting out of it...It’s still part of a process...I have a feeling that when we go on vacation in a couple of weeks we’re going to have our son in the room with us. But maybe that wouldn’t happen but I think it’s gonna be an ongoing process because we do travel a lot and that generally, when we get things back to normal, or, well, when we get things in a good place where everybody’s in their own room, everybody’s getting, you know, a reasonable amount of sleep, we go away and then it just all starts again. Um so it’s definitely, definitely a process.

Marissa expected that changes would continue as her family and their conditions continue evolving so she did not assume a unified behavioral system would continue as planned. Her response here was something akin to, I plan to not make plans based on previous experiences of seeing circumstances and, therefore plans, change.

Within her own history

Another difference in how both voices present temporality within narratives is
how the Adaptive voice situates choices as a part of Marissa’s history while the Prescriptive voice generally ignores personal history with a guise of objective universality across time. Marissa said, “I’m all for, when I was a kid I’d wake up from a nightmare, you know age eight and I’d go sleep with my mom and she’d be fine with it, I’m sure it was only like once a month or something but I can remember doing that at various ages.” Marissa, like most mothers in the interviews, referred to her own personal history of sleeping together with her own parents. In contrast, at no point in the interviews and rarely within research is the socio-cultural history of solitary infant sleep presented. When the Prescriptive voice describes parenting routines, it rarely indicates the history of values and traditions in those routines, instead presenting the material as somewhat universal and a-historical without explanation of cultural-historical influences unless describing its practices as advancements. Marissa referred to her own history of bed-sharing with her family when identifying both its benign nature as not preventing her from developing healthy adult sleep and in the recognition of value about parents welcoming children who want comfort during the night. “Bed-sharing” was not an a-historical parenting technique equally considered among others for her. It was part of her history and her story of what it means to comfort her children.

II. Considered factors/values

With the Adaptive voice, Marissa described how she considered many different factors when making choices about sleep placement including factors that the Prescriptive voice regards as undeserving of consideration. While the Prescriptive voice is mainly concerned with independence of children from their parents and survival of infants from smothering by their parents, the Adaptive voice considers many other
Complex and multiple concerns

Marissa provided many examples of complex concerns she considered when arranging her family’s sleeping placements. For example, she needed a room where her international guests could sleep when visiting so she kept her daughter’s crib in her own bedroom to keep a guest room available. Marissa thought through multiple implications of behavioral plans before implementing them. She mentioned that her husband often voiced concern about how co-sleeping with their babies could negatively affect their children’s future sleeping skills. As a concern of the Prescriptive voice, Marissa countered his concern and the assumed implication that bed-sharing would exacerbate those difficulties with consideration of what changes felt realistic at that time. She said:

He obviously parents the children but at the end of the day I think I make it known that I will have the final say. So I think he sort of knows that now so I think he would leave it to me to make a decision. Like he might have a bright idea which I might agree with but I’ll be the one to follow through with whatever change in any parenting, whether it’s sleep or whatever.

While she could have simply agreed to the style of sleep arrangement her husband wanted of somehow making the children sleep in solitary beds, part of Marissa’s decision making included thinking through who would actually follow through with consistently returning the tip-toeing or crying children to their beds at all hours of the night. Knowing her husband’s history of neglecting to follow up on such plans and taking into account her perceived value of a good night’s sleep, Marissa decided against her husband’s occasional recommendations by thinking through the many factors that
would determine the plan’s success or relative failure.

To list the factors Marissa mentioned considering regarding sleep placement, she thought about sleep quality of each family member, practical availability of space, comforting for her children, impact on future sleep habits and the ‘grown-ups’ having their own bed back, expected impact of upcoming travels, and the personalities and behavioral histories of her children. The Adaptive voice remains aware of its values and incorporates those concerns into behavior decisions. One of the most frequently mentioned themes in Marissa’s interview was how bed-sharing helped her and her children get more sleep, particularly when breastfeeding. Although she never said something as clear as ‘a well-slept mom is a good mom,’ her frequent mentioning of needing sleep seemed to imply that value. She initially nursed her son, Evan, in a rocking chair sitting upright as recommended by the AAP but then tried feeding him while lying down and quickly realized that felt much easier. She said “it's mainly to do with, | think it makes nursing much easier | think...When she woke up, um, I'd say 80 percent of the time | kept her in the bed again because | was so tired and it was easier that way.”

Marissa described some concerns about safety and the future sleeping skills of her children. She mentioned some of these humorously, as if she were demonstrating that she took factors about safety and future sleeping skills of her children into account while sounding less concerned about those factors than the previously mentioned values about sleeping and comfort. I labeled these as Prescriptive as she quickly identified reasons why these goals are secondary to her other concerns for her children, such as
comforting her son if he is sick. She said,

They need to learn to fall asleep on their own just to help them be good sleepers... take safety precautions, don't sleep with the baby if you're like really, really drunk, [laughing], and silly stuff like that... I guess for their independence to be able to stay in bed and sleep... we know that the children need to be able to fall asleep themselves, I guess so when they wake up in the middle of the night they can put themselves back to sleep.

She refers to these concerns as “silly” and sounds unconvinced of their significance to her. I believe preventing smothering is probably a top priority to Marissa and if she really listed what she considers in sleeping arrangements, it would be at the top as little else matters if something harms or kills her child. Her calling it silly seems to refer to the way those concerns are normally addressed as somehow disproportionate or unrealistic to her.

Aesthetic values

Marissa also described aesthetic qualities of sleeping together that she valued, such as comforting her children at night:

When she was younger it was a comfort for her, she would sleep better with one of us... I guess just knowing the comfort of hearing a heartbeat or whatever, they, you know say about a newborn. My son would always sleep better with, you know, knowing that he was next to us... If my son doesn’t, is scared of the dark and doesn’t want to lie in his room on his own, for example, I’ll lay with him until he falls asleep... I think the reason we’ve done it, well I guess is sort of two-fold: everybody slept better but because the kids have felt more comfortable, you know and I obviously want my children to be comfortable.
As she referred to the benefits of comforting her children as reasons for keeping them with her while she slept, she measured the value of advice from others according to that same aesthetic preference to comfort her children with her presence. For example, although she found value in her physician’s argument that she train her daughter to sleep solitary in a crib, she valued certain ways of parenting that did not fit the method he suggested which was to “Ferberize:”

I’d actually bought, recently bought another book because I didn’t want to Ferber because she was, you know, little, delicate, female, I don’t know, I was like, I don’t want to put her to bed crying, I didn’t think she’d be able to cope with it because she used to hate being put in her crib...trying to find ways to do it without leaving them to cry...When they’re both newborn, they were both, they need that love and nurturing or whatever and they like to stay close...The reasons that, that made it happen and made it continue were, you know the kids, both babies being, well, where they wanted to be and being happy and everybody getting rest.

Marissa used her values as something like a measuring stick with which to evaluate external advice. Unless someone convinced her that particular advice furthered her goals for her children to feel safe and comforted, she did not implement that advice.

Just as Marissa considered many factors in deciding to sleep with her children, she referred to many of those same factors again when deciding to try transitioning her children to their own beds. The Adaptive voice is not married to a particular behavior plan but instead focused on integrating multiple values to find a workable solution. Marissa decided that bed-sharing had become less helpful in regards to improving sleep
as both children became fidgety and restless in an adult bed. Considering this change in
her children, she began wanting to transition to an arrangement where each child would
sleep through the night in his and her own room. Describing the need for the transition,
she said:

We've basically gotten tired of sharing our bed with children...actually
being able to get some sleep ourselves because my son is sort of
constantly like, he does this little pinching thing but it's like for comfort
for him, he's not pinching maliciously, and then if he stops pinching you
he starts stroking and it gets, as you can imagine at 3 o clock in the
morning, sometimes it's pretty irritating...From three to six months of
age I'd say she wouldn't even, it got to the point where she wasn't
settling any better with me there hugging her and, you know, having all
night access to milk kind of thing so I just thought, well the point in doing
this is so we sleep better and it just wasn't happening even for her, so it
just, so that's when we made the change.

III. Agent of action/intervention

Marissa frequently described her children as co-determining their own sleeping
arrangements. The fleshed out sleeping arrangements almost entirely depended on
whether or not her children went along with them. Here she discusses her dependence
on how they behaved at various times:

I'm lucky she'll sleep at the same time but if not she'll play on the floor
and then I'll, you know, because if he wakes up he needs, he needs me
there basically...So normally anywhere after six he normally wakes up
and then he comes in for the final hour of snooze...he hated his
bassinet...and he just hated sleeping in there and he wouldn't sleep... he
didn't want to fall, he wouldn't fall asleep on his own...Um, so, hopefully
it will continue, [laughing], hopefully she'll be a bit more independent
than our son's been.
She described herself as hoping she’ll be “lucky” about her children’s behaviors going along with what she would like. She described her children’s needs, preferences, and behaviors as definitely influencing what happened. Ultimately, she cannot make her children fall asleep and she describes feeling keenly aware of how there is only so much a parent can do to keep a child in a particular bed.

While she described more complex needs and preferences of her children listed above, Marissa also gave an example of how her son, too young to talk, simply did not seem a good fit for one of her initial behavior plans. When Marissa initially began bringing her son to bed with her, she purchased a device to keep him in a position the manufacturer of that product advertised as safer than sleeping flat in a bed. It was a sort of pillow meant to prevent him from being rolled on or suffocating. Her son did not adjust well to the device so she had to change her plans again.

I bought, I think it’s called a snuggle nest, you can buy this little thing you put...that you put between the pillows but it’s on a wedge and he kept slipping down so he hated that. So I was like, okay, that was a waste of 60 dollars...

Something as simple as the shape of her baby’s body may have impacted whether or not she could follow through with the “snuggle nest” plan. The Adaptive voice speaks as acutely aware of how, often, parents make plans while babies disregard those plans. As Marissa later began trying to help her son adjust to sleeping alone for most of the night in his own room, she also ran into the dilemma of how, as he was big enough to crawl out of a crib, there is little she could do to physically restrain him to his own
room when he desired to crawl into her grown-up bed. Even when she tried restraining him with a gate, he began screaming which woke up both his parents and their daughter. His desire to join them in bed played a significant role in how the family carried out early morning arrangements. While Marissa could decide how to respond be either ignoring his screaming or removing the baby gate, he still co-determined the mood of many mornings to come.

He wakes up and he just comes to our room and he has a gate on his door but he’s like, got some issues with that, [laugh,] so he’ll just, [laugh], if we shut the gate he’ll just scream and wake her up so we leave it open.

While Marissa’s son had behaviors that increased his chances of sleeping in bed with his mom, her daughter’s behavior initiated Marissa’s choice to move her to her own crib. It seems that even if Marissa wanted her daughter to continue sleeping with her, her daughter did not want to or could not get a good night’s sleep with that arrangement.

That was at the stage where, as I mentioned earlier, where she was still sleeping in our bed but she wasn’t sleeping any better, she’d just stir all night. Um, and I thought if she’s going to stir all night she might as well stir somewhere else...she did so well I mean it wasn’t like with my son it was a horrible transition we had to, I think I left him crying 45 minutes for, for a week. But she was much easier, so.

Marissa gave abundant examples of how her children co-determined where they slept at night or at least co-determined how Marissa’s plans worked out in the flesh. She did not give as many first-hand examples of making a decision regarding a sleeping outcome and applying it without letting her children sway her resolve, the way the
Prescriptive voice assumes parents should implement changes. She mentioned feeling that she should parent that way, such as how other parents told her that “Ferberizing” regardless of how often her children would cry and protest might ultimately be best for her family. The Prescriptive voice might likely assume that she greatly under-estimated her influence over her children and their responses. For example, perhaps inviting her son into bed with her in the first few months set up his resistant behavior of trying to sleep more closely to her. That advice implies that parents can most effectively implement behavioral routines before children develop capacities to resist or show disagreement by walking. If she eventually does decide that “Ferberizing” will be best for her family, her children will still hold particular influence over how they will respond to that transition and how well her family will sleep for those days, weeks, months, or longer.

III. Engaging with information

Filtering information with her values

Even though Marissa explained how she wanted her children to transition to sleeping each alone in their own beds, she reported still following the routine of welcoming them into bed with her because it was easier such as when her son frequently walked into her bedroom at 5AM for cuddles. When Marissa wanted encouragement or an added source of motivation to follow through with solitary sleeping practices for her daughter, she purposefully mentioned bed-sharing to her physician knowing his likely judgmental response based on how he responded in the past. As she predicted, he told her to “Ferberize,” referring to the method of placing children to sleep in their own cribs without reinforcing their crying by responding to it.
Regarding that interaction, she said:

I think because parents all know the term I think so he said, I think he said “you need to bring Ferber into the house” and I did because I knew, I did, I think I was almost, I think I, I wanted to hear him say it to make me do it that time…I think I just wanted to be told by somebody in authority.

Despite eliciting the response she believed would help her go ahead with establishing a solitary sleeping routine for her children, Marissa still felt undecided about the issue. Even after her physician admonished her for failing to “Ferberize” until then, she still decided that it still did not feel right for her family at that time and she has yet to implement the “Ferber” method. She reported going home from that appointment motivated to read books about helping babies adjust to solitary sleep placements. When I asked her why she did not purchase a Ferber book, she said that she wanted “a gentler approach” for her daughter. She found a book with another method that she referred to as the “pick-up put-down” through internet searching and talking with her sister. She reported taking ideas from over a dozen parenting books because no single book prescribed solutions that she believed would work for her son. Marissa actively chose and filtered her encounters with some information sources. She engaged with her physician almost as if using rules in a game to get the response she thought she wanted. She searched through books, internet sites, and suggestions from others holding them up to the measuring stick of multiple factors (previously delineated in section II) she valued for her family.

Aware of her perspective

When describing how she sorted through information sources with a preference
for arguments favoring her sleeping arrangements, Marissa acknowledged her own perspective. From the Adaptive voice, she remained aware of and acknowledged that and how she filtered exposure and use of some information sources. For example, she explained her bias in discussions with her husband. She said:

> Every time I started reading articles I’d always favor the argument that said co-sleeping is the best, you know I’d read things against it and I’d sort of, I’d tell my husband and be like, oh but this guy says that it’s much better to do that because it’s, I’d always start favoring anybody that said co-sleeping is fine or in fact co-sleeping is the best thing to do for your child.

She clearly described how she favored information sources that validated her own behaviors, perhaps also feeling partial to those sources because they referred to values similar to her own. Speaking from the Adaptive voice, Marissa consciously reflected on that process of filtering through her own biases. The Prescriptive voice rarely admits to any bias as it attempts to prevent universalized information free from what it considers the stain of perspective.

Beyond favoring arguments that correlated with her own, Marissa acknowledged that she edited advice that did not fit what behaviorally occurred in her home or what matched the values she wanted to tailor her choices to. She spoke about how she processed the recommendation of her physician to “Ferberize.”

> Um, I’d say I felt agreeing with what he was saying but at the same time wasn’t going to rush home and do it that night. It was like yeah we know that’s where we need to be, Um, but yeah, I sort of acknowledged and agreed, yes, we, I know we need to do that but I still did it in my own time...I didn’t feel bad or wrong or, um, I think I probably felt more along
the lines of well I’m the mother, I’m the children, I deal, you know, it’s, you know, it’s kind, it’s up to me. I know my children and in the moment if the only way for them to feel safe and sleep, if it’s to do it the way we’re doing then fine, you know, I’m not going to leave...even if that was the case I wouldn’t sort of leave him there screaming and fretting even if the doctor said you probably should. I think there’s a sort of limit, [laugh/sigh]. But uh yeah I mean I value the doctor’s opinion on pretty much everything but if at the same time I don’t agree, if it’s not medically necessary I don’t, follow the, the rules... like, yeah, I hear what you’re saying and then, but at the moment it’s not going to work for us.

Information from advice sources was only as valuable as it was applicable to her family’s circumstances, her values about her parenting, and her judgments or whether or not that advice fits the preferences of her children. With an Adaptive voice, Marissa clearly states the situated nature of her filtering perspective. Both the Adaptive and Prescriptive voices filter information but the Adaptive voice more openly reflects on its own bias. She qualified this bias with the notion that she would follow her physician’s advice if it was “medically necessary” without explanation of what constitutes “medically necessary.” Perhaps that qualification brings to light how her physician claims authority over concepts outside of his medical domain and she reserves the right to override his advice in those areas.

Aware of her sources

Marissa also described how she found various information sources, mostly through discussion with her sister and internet searches. When her physician recommended a particular parenting method, she searched for books that described alternative practices meant to achieve the same goal, as the method he prescribed did
not feel right to her. She said:

So I, I bought another book which is the Baby Whisperer which had more like a gentler approach to doing it. And then with my son I’ve got, I got about 15 different sleeping books so I was like, but uh, the Baby Whisperer approach was, and it’s said if you’re thinking of Ferberizing, it said read this first. So I read it and did it for the first few nights, so I did some Googling.

She described selecting which information felt helpful from multiple sources instead of following any unified sets of advice. When asked to evaluate the more than dozen books she read, she said,

I think they were great because I took ideas from each of them when I skimmed through them again with [my sister]. I actually sent some of them to my sister so she had to sort of read some back to me over the phone as well. But just all different sleep theories of how to get your baby to sleep gently without leaving them.

Marissa managed the multiplicity of advice by sifting through which felt gentle and effective for her family and found sources through intimate and internet communities.

Knowing what “feels right”

While I began this project expecting to find reference to how mothers made decisions with intuition informing them, use of the actual word ‘intuition’ occurred rarely, not appearing in Marissa’s interview at all. She did refer to a sense of authority in what “feels right” to her and when I asked her if she had advice for other parents, she said:

I guess, you know if it, if it feels right for your family and if it’s working,
then great… You know if you aren’t comfortable with it, I think if you’re not, then maybe it’s a sign that you shouldn’t be doing it… there’s so many debates out there about whether it’s good or bad or safe or unsafe, I mean, I don’t know, I don’t even know where I’m getting at with this. Um, I guess I’m 50/50 and obviously talking in personal experience.

Marissa described how she believes sleep placement deciding should take into account what the parent is comfortable with as a significant factor. While some parents and other advice sources claim their own perspectives are best and should be universalized, Marissa admitted that she is still “50/50,” not even convinced which methods are best for her family in the short term or in the long run. Note that her advice was not to follow a specific behavioral practice about sleeping but instead how to discern what “feels right for your family.”

Learning and sharing in community

While Marissa repeatedly describing turning to what felt right for her family, she still appreciated learning that other mothers came to conclusions or behaved similarly to her. Here she stated how she wondered if “this is not what I should be doing” and she felt reassured by finding other moms like her in a club and in her neighborhood:

I joined the mom’s club after a few months and certainly more people out there who did it so I was like, okay, I guess this is fairly common, [laugh], um, you know it, you know, is nothing, why hide the fact. Not that I was hiding it but I sort of thought, is this not what I should be doing as a parent kind of thing… speaking to them and, because we’re very close, we share a driveway… I don’t know whether I’d say they influenced us but they certainly made us think we’re not the only people doing this so let’s not worry about it so much…
Facing spoken and unspoken norms

Marissa and others use the Prescriptive voice when referring to an assumed normality of solitary infant sleep placement and an ideal of infants sleeping quietly through the night in their own cribs. Marissa judged her family’s own situation as inferior to that standard when saying, "my sister’s first child was perfect so, you know, did everything right, [laugh/sigh]...So I think it was just talking to other people that made me think oh, well we’re doing something different, maybe this isn’t the norm.” She initially believed that she was going to more or less follow the norms which she calls “the usual.”

So we did the usual, well I say the usual, what most people do, you know we kitted out the nursery with the crib and you know all the whatever else you need, the changing table. Uh, my sister gave us a bassinet, um, so I was like okay great we’ll have this by the bed and when she, he is too big he’ll move to the crib and everyone will, it’ll all be great and normal and it never crossed my mind that, you know, we’d have our baby in the bed.

The Prescriptive voice simply assumes that its directions are the norm and ideal without much discussion about applicability or individual adaptation. Likewise, Marissa quickly learned that bed-sharing was not an acceptable option to even discuss with her physician, as any mention of it was quickly met with her physician’s warning against it without a discussion of why she was doing it or what particular benefits it was bringing.
her family at that time. The first time she mentioned it, “he was just like, you’ve got to change that, like very anti- um, yeah, very anti-bed-sharing...you’ve got to cry her out, put her in bed and leave her, she doesn’t need to feed at three o clock, so yeah my experience with doctors has been, So yeah, doctors were, I’d say not on board with it.”

IV. Integrating conceptual terminology

Experience based decisions

Of all the themes in Marissa’s interviews, one of the most transparent is how the bed-sharing practices preceded conceptualization of the behavior. Recalling the middle-of-the-night circumstances when bed-sharing first happened, she said:

I used to feed him in a rocking chair but I was getting so tired sitting in the rocking chair that it just got to the stage where I’d lean into the bassinet without having to get out of bed, grab him, feed him, sort of slump to one side and that would be it for the next three hours, um, it was never sort of thought process like maybe I’ll let him sleep in the bed.

Naming after doing

While some parents presumably reflect on which style of sleep placement they want to impose on their children, Marissa assumed she was going to follow what she later identified as normative sleeping practices with a bassinet and then crib. When the arrangement with the bassinet began to feel impractical, she adapted to what helped her and her son sleep better. She explicitly described how she later began recognizing her
new behaviors as conceptually different from the norm:

| don't think before children | even thought about the concept of sleeping with them... | It just happened and then happened again and then kept happening and we obviously at some stage we realized, oh, we're co-sleeping, and then | started reading about it.

Marissa also described how she re-conceptualized the afternoon naps with her children. She first stayed with her son to help him sleep, fell asleep herself, and eventually welcomed her daughter to share the naps too. She labeled her bed “the family nap bed” following the behavior that preceded that naming and conceptualizing. She said, “and then it kind of became the family nap, the family nap bed.” Marissa also identified the term “co-sleeping” after the behavior already became habit.

Nicole’s Story

Interview

Nicole is a twenty-seven year old Caucasian female who lives with her husband and one year old son. I arrived at her home at the same time as her best friend, Jenna, who was still in her work uniform from a fast food restaurant. Nicole invited me into a small, warm living room with two sofas and a chair. She explained that her husband would watch her son, Nicholas, while we talked. Nicholas ended up staying with us in the living room for most of the interview captivated by a children’s television show with the volume muted. Three robust cats moved on and off our laps. Jenna sat a few feet away from Nicole and me on another couch, watching the interview. Nicole explained that her extended family lived about two hours away so she mainly depended on her husband and Jenna for support raising her son. Nicole’s husband popped in and out in between taking phone calls. He seemed eager to participate but needed to attend
to some other task. He spoke with me casually after the interview about, more or less, the same concerns Nicole voiced. He specifically asked about the possible impact of the interview and my research since he wanted other people to know more about bed-sharing.

*My description of Nicole’s story*

Nicole described multiple sleeping arrangements with her baby. She said that she usually sleeps with him wherever he falls asleep such as together on the couch, in a car-seat that she sometimes takes into the bedroom or with her on the couch next to him in his playpen. When he wakes up at night, she takes him onto the couch to nurse and finish sleeping for the night. She said that she wakes up whenever he moves but he still fell off the bed or couch a few times. She purchased a bed-rail for the couch to prevent that in the future. She said the back of the couch helps her feel physically supported when breastfeeding.

When I asked Nicole how she experienced deciding where to put him to sleep, she first referred to her own history as a child by describing how she slept with her grandparents until age four. When she had her son, she liked being with him as much as possible, saying, “it just seemed so natural to have him by me all the time.” Nicole said that even the first time she let him sleep while he was laying on her in the hospital bed, she knew that was considered deviant by medical staff. She said, “I knew they told me I wasn’t supposed to.” She continued sleeping with him close to her when they came home from the hospital. Nicole quickly began describing when she felt pressured by her grandmother and mother in-law to stop sleeping with her son. She also described how she decided “I can’t tell people that I co-sleep generally because the backlash is, it’s
insane.” She said that the warnings from others unsettled her confidence in co-sleeping so that she felt more anxiety about it and tried using a bassinet instead.

Nicole said that she wished others would accept her decision to cosleep and show support or at least stop criticizing her for it. She stated her reasons for bed-sharing and excitedly discussed how her discovery of the Drs. Sears’ parenting book provided scientific support of co-sleeping as a safe practice. Nicole said that she began researching general information about childbirth when she became pregnant because she felt nervous about the birthing procedures and she wanted to become a better parent than her parents were to her. She said that her own internet research convinced her to breastfeed. She also paid to attend classes at the hospital with her husband about childbirth and parenting. She said that she generally liked the classes and learned helpful information from them.

Nicole’s story in her words:

Current sleeping arrangements

_We sleep wherever the baby falls asleep...if we’re gonna be awake he’ll fall asleep on the couch and instead of moving him I’ll just sleep on the couch with him or sometimes we’ll have to drive him in the car and he’ll be in his car seat so we put him in his play pen until he wakes up then he moves to the couch and I nurse him there...very rarely I’ll take him upstairs into the bed but we just got a bedrail so I think we’re going to start doing that more so we’ll all sleep together in the bed so I can nurse him._

How she decided

_When I was little I did sleep with my grandparents...so that’s something I was accustomed to but...when I had my baby, he, it just seemed so natural to have him by me all the time...he didn’t like to be put back in the bassinet._

_In the hospital I’d have him laying with me, I know they told me I wasn’t supposed to but um, you know, I would stay awake just to have, because he was asleep on me and I didn’t want to put him back._

Evaluations of the process
My mother, my grandmother, my mother-in-law, have all been, you know, trying to instill in me that he’s gonna die if I sleep with him… I feel like she tries to brainwash us because she, she will tell us something fifty times and then she’ll keep saying it the same exact way she said it before but it’s almost like where she wants to annoy us to the point where we give in and we’re like, fine, you know, so then I get upset about it, and then I am just blunt and tell her to stop. And then of course, she says that I’m a horrible person because I broke down and couldn’t, for the, you know, fifty millionth time be nice and tell her, no, really this is what we’re doing…I’m telling you Dr. Sears, he, he’s the only reason that I can with my mother-in-law tell her that it’s okay because he’s a doctor.

For a long while I was really nervous about still sleeping with him, I mean, it’s not like um, it’s not like the things that my family or friends say, it’s not like it doesn’t faze me… It made me more stressed… so the less that I deal with that, the more confident I am… I can only handle so much of her trying to be against me before I try to please her… Whenever I try to do what she says, it’s not right, so I end up doing the opposite anyway… I tried to keep him in the bassinet… I feel bad about trying to force that on him because he wasn’t happy about it. I just don’t see any reason why your baby shouldn’t be close to you.

I wish people would be more supportive because I really feel that this is, this is an essential part of his development because he feels secure and he feels like he is taken care of and well taken care of which means there is more room for him to learn because he isn’t crying all the time.

I had very terrible parents, my mother is the most selfish person and my father has been in prison my whole life so… I want to be the parent that I didn’t have. So I try to work off of that but because I’m so aware of my parenting, of how it’s affecting him, that’s I guess why I don’t appreciate people giving me advice and trying to force it down my throat because, do they really think I haven’t researched all this stuff to figure out what would be best for our family?

I was still nervous about having him… I knew what I needed to do, I knew what he needed, and I felt confident. There were plenty of times, though, where I got nervous where I was like, is this right, you know, is it supposed to be like this, and I would call the hospital or I’d call the doctor to ask questions. I’m not afraid to ask questions, I’d rather ask a question than do something wrong.

Plans for the future

Eventually, like I said, he’s going to sleep on his own because he’s got to, I mean, he’s got to transition to be independent when he sleeps, he’s not going to have me forever to sleep with, I want to sleep with my husband alone… when he’s little and he needs me like he does, I don’t see any problem with it and neither does my husband.
Nicole’s reasons for bed-sharing abstracted from her narrative in her words:

- When I, when I had my baby, he, it just seemed so natural to have him by me all the time.
- [Regarding history of bed-sharing with grandparents], so that’s something I was accustomed to.
- I didn’t want to put him back.
- It’s just easier for me nursing him, if he wakes up, I don’t have to like, get up.
- While he’s nursing in the middle of the night, because it’s easier for me and, you know, it’s convenient for him, and he feels like he gets taken care of right away.
- This is an essential part of his development because he feels secure and he feels like he is taken care of and well taken care of which means there is more room for him to learn because he isn’t crying all the time.
- He didn’t like to be put back in the bassinet.
- I know now, you know, that he, that he would prefer to be with me…my baby personally wanted to be close to me.

Nicole describing how she withdrew her voice

Nicole described avoiding discussion of her bed-sharing with others to avoid “backlash” or people telling her that bed-sharing is wrong. She does not value conversations with advice sources if they only seem to provide general information that does not feel specifically applicable to her family.

I can’t tell people that I co-sleep generally because the backlash is, it’s insane… I’m not gonna argue with [medical professionals], I usually just smile and nod because, I mean, there’s no reason to get into a discussion with someone who thinks that because they read something in a textbook that they know what they’re talking about, some of them don’t even have kids, so they don’t know, you know, um, but it’s like. I really feel like they’re doing off of statistics and it, you know without knowing the proper amount of people who actually, you know, share beds with their baby, which I’m sure they don’t because people are afraid of telling people because of, like I said the backlash that they get. Then I don’t know how you could properly discern the real statistics of how many people or how many babies have died and how many babies haven’t.

E: When you’re saying, you said I can’t tell people, can you please say a little more about where that can’t is, you know, that you can’t tell?

It’s more like, it’s more like, um, I can, I mean I know I can, it’s just, I don’t want to deal with, I don’t want to deal with them going off on me
about it or judging me because I sleep with my baby. I mean, people judge people for the stupidest things… I feel like I have to be careful what I say, otherwise an otherwise a pleasant situation may be turned into a lynch mob, you know, but, um, no. I know I mean I don’t mind talking about what I do or, especially if somebody seems open to it, you know and they don’t seem like they’re going to, you know, be totally opinionated and try to make me believe what they believe, then I’m fine. But if I, you know if I can just avoid, you know, if I can be pleasant with someone and avoid confrontation about it, then I try to.

Nicole describing when she used her voice

Nicole described using her voice engaging in conversation about bed-sharing when she refers to “Dr. Sears” as evidentiary support to the validity of her own claims and when she is with friends who she feels understand enough to avoid arguing with her.

I’m telling you, Dr. Sears, he, he’s the only reason that I can with my mother-in-law tell her that it’s okay because he’s a doctor…I know I mean I don’t mind talking about what I do or, especially if somebody seems open to it, you know and they don’t seem like they’re doing to, you know, be totally opinionated and try to make me believe what they believe, then I’m fine…Um, I have very few friends, very few, and the friends that I do have, none of them seem to, it doesn’t seem to bother them, they don’t care.

My response to the interview

I immediately wished I could have found a way to incorporate Nicole’s husband into the interview. As I left, his eagerness to discuss the issue with me made leaving much more difficult but I needed to get started on the long interstate drive home. Given Nicole’s frequent mentioning of his mother and reference to increased tensions between Nicole and her husband, I wanted to understand his perspective on the matter.

Nicole presented a story with many struggles that ran deeper than just decisions about where she placed her son to sleep. She sought out guidance that she felt she
needed because of her own history with inadequate parents but she also felt that some sources of guidance offered bad advice. Sometimes she gave in to pressure from her mother-in-law to change her practices and sometimes she defied books and physicians whose advice did not feel right to her.

Nicole’s ‘I Poem’

I’ll just sleep
I nurse him
I’ll take him
I think
I can

I mean…I mean…I mean…I’m…I’m…I want to make sure

I was little
I did…I would…I was
When I, when I had my baby
    I’d have him
    I know
    I wasn’t supposed to
    I would
    I didn’t want to
    I got this book
    I tried

I really feel
I actually
    …that he’s gonna die if I sleep with him
I mean, I know
I’m pretty sure
I mean, I’m sure
    I found out they died because…
I can’t roll over on him
I mean
I can’t tell people
I co-sleep
I’m not going to change just because
I shouldn’t
I mean…I mean… I mean?
I definitely
…input that I’ve gotten
I’m telling you
I can
I mean
I’m not like that
I mean

I had very terrible parents
I don’t want him to be messed up, I want him to be complete and whole and I want him to feel loved
I want to be the parent that I didn’t have
I’m so aware of my parenting
I was looking up, I was looking up…I was looking up…I did a lot of research…I did some more research
I was still nervous…I wanted to make sure that I was fully equipped
I knew what I needed to do, I knew what he needed, and I felt confident
I got nervous where I…I would call…I’d call

I didn’t do any research on that
If I had I would have found
It’s hard…I don’t understand
I had the baby and I started reading
I was already doing…I was doing
I trust what he says

My response to Nicole’s I Poem

Nicole’s I-Poem was the first I constructed. I was excited to see how it really seemed to reflect the larger themes of her story, including her values and difficult
relationships with others. Her concern for her son’s well-being and efforts to learn as much as she could to best take care of him are clearly evident. It appears that self-reflection and researching, including reading and listening, have been part of how Nicole explains trying to find what is in the best interest of her son.

Nicole’s story told with the Prescriptive voice

He’s gonna die if I sleep with him…there are risks with SIDS…if it’s not, you know, stamped and pre-approved by a doctor than you shouldn’t do it…I shouldn’t be doing this…we had to get rid of our cats because if they smell the milk on the baby’s milk they would smother him to death in the middle of the night…we had to put a, a net on the outside of the baby’s crib to keep the cats out…absolutely do not do that because that’s another thing that could fall on the baby…I needed to give him formula…something was gonna happen to him…don’t sleep with your baby…You’re supposed to let him cry, it’s good for their lungs.

[About co-sleeping devices] babies can be pushed up against it and they can suffocate...

Adaptive and Prescriptive Voices in Nicole’s Narrative

I. Temporality

Nicole generally spoke in ways consistent with the Adaptive voice in describing her parenting. She mentioned ways that advice sources were both helpful and contributed to her distress when using the Prescriptive voice. Regarding temporality, she generally focused on increasing pleasant bonding experiences with her son in the present. Although she described wanting the arrangements to eventually change, she did not see those
present and future goals as mutually exclusive. She described feeling mainly concerned about the present quality of sleep in her family and wanted him to transition to sleeping alone but did not believe that sleeping with him as a baby would cause any additional problems with a future transition. In that way, she both decided to sleep with her son but saw that as part of a non-completed process that will evolve has her son and her family changes:

Well, he’s eventually, like I said he’s going to sleep on his own because...he’s got to transition to be independent when he sleeps, he’s not going to have me forever to sleep with, I want to sleep with my husband alone, and that’s really how it’s going to be. But for right now, when he’s little and he needs me like he does, I don’t see any problem with it and neither does my husband.

She also described bed-sharing as part of her own history because she slept with her grandparents. She received Prescriptive advice from her mother-in-law and her pediatrician about how bed-sharing while her son was young would set him up for difficulties sleeping alone at later ages but she chose to focus on the present moment instead of focusing on that imagined future.

II. Considered factors/values

Nicole described complex concerns integrating her values of wanting to maintain closeness with her son, quickly and consistently responding to his needs and continuing breastfeeding at least through his first year. She wanted to respond to his needs without him having to panic or cry. For example, she said: “It’s just easier for me nursing him...he doesn’t even have to cry...he makes fussy noises and that’s it. When he cries
it’s because he’s in pain and he always gets taken care of before he cries.” She was proud of how her son seemed to trust her consistent presence and responsiveness. Nicole attributed bed-sharing for helping him develop a more generalized sense of security:

[It just seemed so natural to have him by me all the time...] I would stay awake just to have, because he was asleep on me and I didn’t want to put him back...he’s by me all the time...he’s cuddly, he’s sweet...he is such a well adjusted baby, he doesn’t have a fear of strangers...it seems like he’s a more confident baby. And then a lot of the people who have babies who don’t co-sleep and don’t nurse, their babies are crazy, they scream all the time, they don’t listen, they don’t have that bond.

She called bed-sharing “an essential part of his development because he feels secure and he feels like he is taken care of and well taken care of which means there is more room for him to learn because he isn’t crying all the time.” She described having heard many arguments against her bed-sharing decisions from the Prescriptive voice. For example, her mother told her that “you’re supposed to let him cry, it’s good for their lungs.” Nicole addressed other concerns from the Prescriptive voice such as the possibility of rolling over onto and smothering her son but she did not believe feel that threat applied to her due to her close bond with her son and taking certain recommended steps from her research to bed-share more safely.

III. Agent of intervention

Nicole defined her values of wanting to sleep close to her son and found that was
easiest when simply sleeping where he fell asleep. She said, “we sleep wherever the baby falls asleep” such as letting him sleep in his car-seat brought into the house if he fell asleep on a trip or staying on the large sofa in the living room. She reported that “he didn’t like to be put in a bassinet” as why she did not follow through with her initial plan to place him to sleep in a bassinet. She said:

| I know now that he, that he would prefer to be with me. I think it personally should be about the baby, if he wanted to sleep in his crib and he did, then fine, but my baby personally wanted to be close to me. I just don’t see any reason why your baby shouldn’t be close to you. |

IV. Engaging with information

Nicole described how she was deeply committed to being a better parent to her son than her parents were to her. With her father incarcerated during her childhood and her mother making poor decisions, she wanted some external guidance about parenting to avoid her mother’s mistakes. She researched information on the internet and in books to help ensure she made good decisions for her son. She purchased classes at a hospital led by nurses about general parenting information and attended all of them with her husband. Interestingly, she reported appreciating and following just about all of their recommendations at the parenting classes except regarding sleep placement. She respected and felt grateful for their knowledge and opinions except when they told her to place her son in a crib to sleep. Regarding bed-sharing, she turned to books and websites mostly by Drs. Sears, Sears, Sears, & Sears because they advocated bed-sharing. She began a few statements with “Dr. Sears says…” to reinforce her own perspective.
Nicole was aware of her own values and clearly identified how she picked-and-chose advice sources by filtering them through her values. She also depended on knowing what felt right to her. When she asked how she dealt with external advice when it conflicted with her own choices, she said “I don’t feel that that’s the best thing for him so that’s not what I’m doing.” She repeatedly described many experiences when family, particularly her mother-in-law, tried to convince her to stop bed-sharing. She said that she stopped talking to most people including her family and her physician about sleeping behaviors because she felt “backlash” for failing to follow the solitary sleeping behaviors they wanted her to do. She did report that their warnings and naggings wore her down and she sometimes followed their advice against her own sense of what “felt right.”

Nicole questioned the authority of some advice sources when their recommendations did not feel right to her, conflicted with her values, or seemed inapplicable to her specific family. She described what sounded like the way the Prescriptive voice emphasizes the value of authorities who generally claim to use scientific information to provide universally superior information regarding safety and health of children. She challenged that saying,

Some people feel like if it’s not stamped and pre-approved by a doctor that you shouldn’t do it and I’m not like that, I mean doctors are great but I don’t feel like they have the very last say in child rearing.

Nicole reported disengaging with advice sources when she expected them to simply argue against bed-sharing, particularly since those care providers did not seem to
understand her and her family’s perspective:

It’s just the doctors before we had him, you know, in general every doctor I’ve spoken with has told us to not sleep with your baby, and I mean, I’m not gonna argue with them, I usually just smile and nod because, I mean, there’s no reason to get into a discussion with someone who thinks that because they read something in a textbook that they know what they’re talking about. Some of them don’t even have kids, so they don’t know, you know, um, but it’s like, I really feel like they’re going off of statistics and it, you know without knowing the proper amount of people who actually, you know, share beds with their baby, which I’m sure they don’t because people are afraid of tell people because of, like I said the backlash that they get. Then I don’t know how you could properly discern the real statistics of how many people or how many babies have died and how many babies haven’t.

She further questioned the statistics used to justify arguments that bed-sharing is more likely to result in infant death than solitary crib sleeping. She said that she imagined many parents would not tell researchers that they bed-share due to social norms against bed-sharing and that probably made scientific studies about bed-sharing safety inaccurate and unhelpful. She described how she thought medical authorities did not have access to actual stories of parents and so their conclusions were flawed by what Nicole saw as their unwillingness or inability to successfully listen to parents.

When I asked Nicole how her experience could have been improved, she described two things. The first was that she wished she would have known more about breastfeeding and jaundice because she encountered a situation involving those issues in the hospital without access to the internet or her books to find information to support her argument when a nurse insisted that her baby needed formula. The second idea for
improvement was “if there was more support,” but she quickly retracted that idea as impossible because each baby, mother, and situation is unique and so there is no universal set of values with which to “support” decisions.

Well, in the hospital, the nurses tried to force, well just one nurse, really, tried to force formula on my baby because he had jaundice and told me that it would help get rid of his jaundice, well I didn’t know my baby was going to have jaundice, I didn’t do any research on that, and if I had I would have found out that breast milk is actually better for jaundice because it makes them go to the bathroom more but I didn’t know that and so she told me something that wasn’t true to get me to do what she wanted and so I was really upset about that because I didn’t want him having any formula at all. It didn’t end up affecting anything, he went back to nursing just fine, but still that bothered me. I think that if there was more support, I think that’s probably the only way that could have made the experience any better, would be support.

Nicole wanted support for implementing what she felt was right and she wanted medical professionals to align to those ideas that she felt were supported by her own research. She then addressed how she imagined such support as impossible because it would require that advice sources individualize that support.

I mean it’s hard, at, that would be so hard to do, I don’t understand how that could even be possible because so many people are so different and not every situation is right for every person, I mean this baby, this situation is perfect for but the next baby we have, it may not be. You know, every baby’s different too, so it’s just, I don’t even think that that’s a possibility, really, but that, if you were going by perfection standards, that would be the only thing that I could think of that could make it better.

The notion of medical professionals taking the time to find what seems “right” for each
parent and baby feels unrealistic to Nicole.

V. **Integrating conceptual terminology: Experience based, naming after doing**

Nicole began bed-sharing after her son’s birth in the hospital when she wanted to stay with him as much as possible. She initially tried to stay awake with him on her chest but quickly began feeling more comfortable falling asleep with him in bed with her. She also found that he appeared upset when she placed him in his bassinet. She only later learned the terms “bed-sharing” and “co-sleeping” through her research after already having figured out that she liked keeping him in bed with her. Moreover, she reported feeling happy when her physician eventually stopped trying to convince her to stop bed-sharing which Nicole believed was because he saw that her son appeared healthy and happy.

*Rachel’s Story*

*Interview*

I arrived at Rachel’s apartment on a hot summer evening. Her husband originally offered to participate but he suddenly needed to take their son, Ben, to Ben’s grandmother’s house. It would have been really great to hear his perspective, particularly after Rachel had so much to say about his mother! I met Ben as his dad collected their things for their journey and he was a sweet, quiet young man. My interview with Rachel was my first so I was very nervous. It felt like an intense experience to visit the home of a family I did not otherwise know and ask about some of their most precious and intimate moments. Luckily, Rachel had plenty to say about the matter and actively shared her story with heartfelt and detailed responses to my
questions.

*My summary of Rachel’s story*

Rachel is a Caucasian 28 year old mom who slept together in a bed with her husband and her son, Ben, from his birth. She said that even though she had a crib set up for him before he was born, she rarely touched it and kept Ben with her instead. She found that he stayed most calm when touching her. When he was diagnosed with diabetes and underwent hospitalization, she felt it was important to provide him with the comfort of sleeping with her, even in the hospital. Rachel recently began transitioning Ben to his own bed as he nears three years old because there is not enough room for him in their bed. She said that he is slowly moving to a room immediately next to hers. She often sleeps half the night in her bed and half with him in his bed. While her husband’s mother disagreed with the bed-sharing, Rachel had support from her lactation consultant and mothers in La Leche League, an organization that supports breastfeeding.

*Rachel’s story in her words*

Current sleeping arrangements

*The current arrangement is a musical beds type deal, [laugh]. When we moved back here which was in April, we lived in a house previously, um, he was strictly in our bed because his room was upstairs and I didn’t feel comfortable leaving him up there, he’s, he’s diabetic. He was diagnosed with neonatal diabetes at 20 days of age so, but he was sleeping in our bed before that. Um, but since we moved here he’s had his own bed since the rooms are so close to each other. I was trying to transition him to his own bed, just a twin bed and he did really well with that he actually, within a couple of weeks started sleeping through the night for the first time in his life here so that was really exciting for me [laugh]. But now I know of, he goes back and forth so I go back and forth between the beds, you know my husband in the master bedroom and then Ben in his room, and I just go in there whenever he needs me, sometimes I sleep with him the rest of the night, sometimes I go back to my own bed.*
How she decided

My reason for doing it is all my own...when I grew up, I’m one of four children and my parents always welcomed us into the bed whenever we needed.

When he was a newborn in a bassinet next to our bed and he just, he wouldn’t sleep longer than an hour [laugh/sigh] by himself, so I just, from the beginning, from the first couple days that he was home I would place him on my chest so I wouldn’t roll on him. I was always afraid to roll over on him when he was that tiny so I’d place him on my chest to sleep and he would sleep for hours at a time and so it was an instant fix and we all got sleep...I did whatever it took to keep him asleep and, and that was to hold him whether it was, you know walking around holding him while he was sleeping, sitting on the couch, or sleeping with him at night, but as long as he was touching me he would stay asleep for longer, so I did what I had to do, it wasn’t, I didn’t force it upon him, he forced it upon me [laugh].

You know I didn’t really think about it before. I was really insistent to my husband to make sure the crib was set up before Ben was born, I was really concerned with having that there and I never used it...When he wakes up he’s usually frantic even as an infant if I wasn’t nearby, if he couldn’t see or hear or touch me he would just freak out...it was just the most natural thing for me to do...I had a lot of problems breastfeeding in the beginning. Ben had problems latching and, and I got a referral for a lactation consultation through a La Leche League leader in the area and she came to our house when Ben was seven days old and she just invited me to the group.

Evaluations of the process

It was just my mother in-law and, there are a couple of friends who kind of thought it was weird but they weren’t, you know, negative about it, they just kind of didn’t understand it.

At the time I think it was just, that’s what our culture is, you set up for the baby registry and the crib is like the number one thing you’re supposed to register for so you do but, you know, um, you don’t know what parenting is going to be like until you do it.

My son was diagnosed with diabetes at twenty days and we were very fortunate to have such supportive doctors of breastfeeding and of sleep sharing because the four days we spent in the hospital, I didn’t leave the, the whole time. My husband, I think, left to get some things only for a couple of hours but all three of us slept on a little pull out trundle bed and nobody in the hospital ever said a word to us about it, they just, you know, for them it seemed like it was pretty normal too. It was something that they probably see a lot of in that pediatric unit...You know whether he was sick or not, he was always close to me, I was always holding him and so I don’t think it was really a decision I think it was just something I did without
thinking…I don’t think I was thinking, I think it was just a reflex.

I like to study things, medical things, I, I, every time my son gets sick I’m researching and stuff like that. I’m very interested in things like that, so, when she says something that makes sense in my head and from whatever medical, I mean, I’m not, you know I don’t have any degrees in medicine or anything but I know, I know my stuff when it comes to that so when it’s aligned with that, I just, it just, the light goes on. I think it’s a lot of instinct, for sure.

Plans for the future

It’s definitely a process. You know, I felt like coming here, we have a queen size bed and it’s crowded, the bigger he got the more it was, so that was really my only reason for trying to get him into his own bed, it’s just so I would have more space at night. Coming here, back to the condo…I thought coming here would be an exciting transition, you know you get this cool new room, a cool new bed, we made up with big exciting thing for him with new sheets and he was really excited about it, he got pretty ramped up about it and um, and so um, and he was very excited to sleep in his own bed for a while but he still, any time he wakes up, he wants to have me close, so.

Rachel’s reasons for bed-sharing abstracted from her narrative in her words

- My reason for doing it is all my own.
- His room was upstairs and I didn’t feel comfortable leaving him up there, he’s, he’s diabetic.
- My parents always welcomed me into the bed whenever we needed.
- He wouldn’t sleep longer than an hour by himself...he would sleep for hours at a time and so it was an instant fix and we all got sleep, um, so that was really the reason we did it, it worked, and that was the only thing that worked. Um, and I liked being close to him.
- I did whatever it took to keep him asleep and, and that was to hold him...as long as he was touching me he would stay asleep for longer.
- He forced it upon me, so it was just, the best thing for him and for me to be able to get sleep too.
- It would make it easier to breastfeed through the night because you don’t have to get up.
- He’s usually frantic, even as an infant, if I wasn’t nearby, if he couldn’t see or hear or touch me he would just freak out.
- It was just the most natural thing for me to do.
- [Regarding the hospital crib] I knew he wasn’t going to sleep on that, and scream, he was in a strange place, it’s cold and they have those metal bars that look like a cage…I never wanted him to be in that thing.
• Whether he was sick or not, he was always close to me, he was always close to me, I was always holding him and so I don’t think it really was a decision I think it was just something I did without thinking.
• I don’t think I was thinking, I think it was just a reflex.

Voicing her story

Rachel began mothering with a quieter voice about her bed-sharing habits. She explained how she observed peoples’ reactions before deciding whether or not to discuss bed-sharing with them to avoid undue conflict. As she began discussing it more freely with moms in her La Leche League group, she felt more confident talking about the matter in other places, such as in front of her disapproving mother in-law. She now describes herself as an “advocate” for bed-sharing as her story empowers other mothers to choose bed-sharing if it feels right for them.

Rachel describing how she withdrew her voice

It’s not as normal as it is in other cultures so, there is, there is some negative stigma there and you learn to only talk about it with certain people, to hide it from others….I knew before my son was even born that [my mother in-law] would be kind of an issue as far as that would go. So I would kind of avoid the topic around her.

E: Was there some sort of process you had for testing out who was okay to talk to about it and who wasn’t?

I think I would usually avoid [talking about bed-sharing] until I knew if, you know, if somebody else would, would start to talk about it and then I could sense that, that person wasn’t supportive of it, I would just keep quiet and avoid the topic.

E: So any medical workers, doctors, nurses who haven’t been supportive?

Mmm, I don’t think so, I never discussed it with them really [laugh/sigh].

Rachel describing when she used her voice

Umm, you know the breastfeeding support group that I went to, there were a lot of moms there who also did the bed-sharing so, it was, it was a normal topic of conversation, about that, who did it and who, how long they did it, and who they would um, receive a little flack from and usually it was, a parent, a grandparent of the child, within that group. So I
was always comfortable talking with them. My lactation consultant, of course was very supportive...if it came up, I would participate. And as he got older, I think I got a little bit more confident in what we were doing, because, you know I had more friends who did it and just in my, in my network a lot more people are talking about it so I think I grew more comfortable with it, um, over time and then I felt a little more comfortable speaking about it in front of other people and even now my mother-in-law, now I don’t even mind taking about it in front of her. It took two years to get to that point to be comfortable in that, to say it in front of her, now I don’t mind her knowing.

E: How does that work with her now?

I think that now she’s the one who just keeps her mouth shut [laughing]...Yeah, yeah, she doesn’t like to rock the boat so if we talk about it, my sister-in-law and I talk about it a lot. They, they bed-share a little bit here and there. Her kids mostly sleep in their own beds but they sometimes come into their parents’ bed so we talk about it when we’re over at the grandparents’ house, and my mother-in-law will just sit there very quiet and not [laugh] talk about it at all.

[I have], I don’t know how I want to say this, um, maybe a persuasive attitude towards people to do it because I know, um, that it is normal and it’s sweet and it helps babies sleep and develop and they need to be touched a lot. People don’t understand how much babies need to be touched and held and so you can do that in your sleep. And that it can be very safe and I think, I think that I’ve probably put other, other moms at ease with my stories and opinions on it too. So I think that I’m just a, an advocate for it, in my own network.

I have, I have a friend in mind who would occasionally bed-share but it was both or her, both her in-laws and her parents frowned upon it quite a bit and so, she would confess to me that she would sometimes do it, you know after she heard that I did it she would confess to me that she sometimes did and that she enjoyed it as well, so, I know that at least with her, that um I think I made her feel more comfortable about it, knowing, just her knowing that I also did it.

My response to the interview

One of the most compelling images in Rachel’s story is of her young family nestled together in a hospital room on a trundle bed because she knew that was the right action for them at that time. Rachel had the appearance of a physically strong woman, particularly in her confident posture. She clearly fought for her son through frightening
circumstances, strengthening and clarifying her own perspective. She identified herself as having a leader’s mission, wanting to free others to do what they feel is best for their families, particularly bed-sharing. I envision her walking through some sort of overwhelming chaos of doctors telling her what to do while she holds her baby with her head high. Rachel is supported through a legacy of strong women: her mother, her breastfeeding coach, countless mothers in La Leche League from her childhood and from today. It is as if those women blazed a trail for her to feel free to mother her son as she knows he should be mothered, like they also wrapped their arms around him as he slept peacefully in that hospital bed and in his family’s bed.

Rachel’s ‘I Poem’

I didn’t feel comfortable
I was trying
I kind of
I go back and forth
I just go
Sometimes I
Sometimes I
I, uh

I grew up
I slept
I shared
I think
I grew
I was
I, I don’t
I make on my own
I usually
I just
I would
I wouldn’t

I was always afraid

So I’d

I liked

I think, I’m trying

I’m sure

I just

I knew

So I

I’m sure

I just don’t

If I ever had doubts

I would

I wouldn’t say

I consider

I’m not sure

I don’t

So I did

So I did what I had to do

I didn’t force it

So I

I think

I think I would

I knew if

I could sense

I would just keep quiet

I would participate

I think I got

I had more friends

I think I grew

I felt a little more

I don’t even mind

I don’t mind her knowing.

I felt comfortable…I would hear him

I fell asleep with him…I fell asleep with him…I go in there with him
I, I feel because I do it and because I grew up that way
I think I made her feel more comfortable...knowing that I also did it.

My response to Rachel’s I Poem

I felt drawn to highlight words in ‘bold’ for their energy and strength. I felt haunted by the words in italics, seasoning her story with pangs of vulnerability. Her strength rose from her struggling. She actively engaged with private and social challenges while finding direction from sensing what felt right for her and her son. She relied on her own sense of knowing when deciding where to place her son to sleep and when deciding how to protect their secret from others. She offers that knowledge to other parents charismatically but still situated in the wisdom she developed through her relationships with others.

Rachel’s story from the Prescriptive voice

You set up for the baby registry and the crib is like the number one thing you’re supposed to register for...Formula was better than breast milk...Insulin is the way they’ve always done things...You know I don’t have any degrees in medicine or anything.

The most accepted thing in our culture is obviously cribs...a crib is the safest thing...it can be dangerous...The campaign, the Back to Sleep campaign...back to sleep in their own bed...so that’s what people think is the right thing to do when it’s advertised all over the world, or the U.S...When you are pregnant you’re bombarded with every crib manufacturer known to man...your selection is based on style or convenience or whatever but everyone assumes you’re gonna have a crib and you’re gonna use it...It’s in every baby magazine, when you come home from your first prenatal visit you get a packet of information...but it’s everywhere. And it’s in all the baby registries, when you go to ‘Babies R Us’ and you
do your registry it's at the top of the list of things you’re supposed to register for so.

Adaptive and Prescriptive Voices in Rachel’s Narrative

I. Temporality

Rachel described feeling focused on the quality of present experiences without extensive planning for how her son would sleep in the future. She also described how she decided to bed-share in the moment it occurred without prior planning. She called it “an instant fix and... the only thing that worked” at helping everyone sleep. She prioritized his comfort in the present moment and based decisions on what was most helpful generally at that moment. She also considered her son’s sleeping arrangements as flexible, appreciating multiple ways he could sleep depending on circumstances and how he felt. For example, she wanted him to transition to his own bedroom but she still joined him in his bed and welcomed him back into her bed when he seemed to want that. Instead of implementing a consistent, specific sleeping behavior across time, she continually adapted to her son’s changing preferences as he grew more used to sleeping alone.

Rachel did not consider her bed-sharing decision-making complete but instead expected more adaptations in the future. She also identified how bed-sharing fit into her own history of sleeping with her family as a child. She said, “my parents always welcomed us into the bed whenever we needed and I slept with, um, my brother for a while, he was two years older when we were very young. My sister and I shared a bed so we were always with somebody so I think it's just, just how | grew up and that's
II. Considered factors/values

Rachel’s aesthetic values about comforting her son influenced where she placed him to sleep. When her son was admitted as an inpatient in the hospital, she felt the hospital bassinet provided when her son was admitted as an inpatient was “prison like” with metal bars and nothing soft. She acknowledged that made sense in terms of germ sterility in a hospital setting but that is not where she wanted her son sleeping. She contrasted that to bringing him into her bed which she said was “so sweet and natural.” She balanced multiple values and priorities, the most important being her son’s comfort, breastfeeding, and her sleeping adequately. She said, “me being rested and my son being rested and happy was the most important” and “it helps babies sleep and develop and they need to be touched a lot, people don’t understand how much babies need to be touched and held.”

III. Agent of action/intervention

Rachel definitely considered her son as co-determining where he slept at night. She described how he cried when placed in a bassinet as a newborn and how he stopped crying when touching her. She said, “he wouldn’t sleep longer than an hour by himself...he forced it upon me.” She responded to his cries by keeping him near her. She also adjusted her sleep as he began transitioning to his new bed in his own bedroom.
She said, “I just go in there whenever he needs me.” She makes sense of bed-sharing as responding to her son’s wants and needs.

IV. Engaging with information

Rachel believed her bed-sharing has been counter to assumed norms for sleeping although she initially followed those norms herself. She said, “Everyone assumes you’re gonna have a crib and you’re gonna use it...in every baby magazine.” She purchased a crib and vaguely expected to use it. She attributed that decision to how cribs were incorporated as a key item to purchase in commercial publications about registering for her baby shower. She followed the norm of preparing a crib for her son’s nursery but later considered the purchase a waste of money. She even re-evaluated the norm of expecting to use a crib as possibly harmful. She said:

The most accepted thing in our culture is obviously cribs. You know, it makes my stomach churn every time there’s a recall, though, because people assume, in the US people assume that a crib is the safest thing but it isn’t always, I mean babies die from cribs malfunctioning...if the numbers had been adjusted to, you know, account for mothers drinking or smoking or obesity or whatnot that bed-sharing is actually safer.

Rachel’s decision-making both about what to do and who to take advice from included integration of scientific literacy and awareness of her own instinctive responses. For example, the physicians who originally diagnosed and treated her son found a novel medication that could treat his diabetes without multiple injections per day. Rachel eventually quit her job to take care of her son which precipitated a change in health insurance. This required her to find another pediatrician who was willing to
learn about and oversee administration of that new kind of treatment. She integrated her instinct and her own research to decide which physicians could best help her son. She explained:

I don’t know how to say this, but, I’m, I’m very, I like to study things, medical things, I, I, every time my son gets sick I’m researching and stuff like that, I’m very interested in things like that, so, when she says something that makes sense in my head and from whatever medical, I mean I’m not, you know I don’t have any degrees in medicine or anything but I know, I know my stuff when it comes to that so when it’s aligned with that, I just, it just, the light goes on. I think it’s a lot of instinct, for sure.

Rachel felt strongly about her plan to breastfeed before her son was born. When she later learned about her son’s diabetes, she grew more active in studying scientific information herself and choosing physicians by whether or not they would discuss her perspective or if their practices felt concordant with what she found in research and what felt right to her. She explained:

I refused to go to a doctor that doesn’t, that I don’t see eye to eye with...I’m not going to continue to go to somebody that I don’t agree with because I fight very well with medical personnel...I just have to try them out. Go to an appointment and talk about it and if they don’t want to talk about it, on to the next one.

She would only turn to a physician who was willing to talk about her concerns, presumably meaning a discussion instead of just a prescription. In her search for a physician who would work with her to help her treat her son with the newer protocol, she found other physicians who “wouldn’t discuss it at all at their appointments so we
just never went back.” She did not say that she left physicians for lack of knowledge about the new procedure. Instead, she left when they were unwilling to talk about options outside of their regular modes of operation. She filtered information and advice sources according to her values and remained aware of her filtering as it happened.

V. Integrating conceptual terminology

Rachel primarily described bed-sharing as something she decided to do as a reflexive response to her son instead of something she evaluated conceptually before implementing. She said: “whether he was sick or not, he was always close to me, I was always holding him and so I don’t think it really was a decision, I think it was just something I did without thinking…I don’t think was thinking, I think it was just a reflex.” Thus, she did not conceptually decide to bed-share. She definitely thought about it, completed further research about the topic, and reflected on how bed-sharing fit into her larger values and goals for her son, but that all followed her initial response to her son that she described as “a reflex.” She further explained how making plans for one’s child before that child is born is of limited usefulness because all those plans may change. She said, “you don’t know what parenting is going to be like until you do it, you know, some kids, I have a friend whose kid will absolutely not sleep in their bed.”

When asked if she had any advice for parents, she said:

Just be open to anything, I mean, you have no idea what each kid is going to be like, you don’t know where they are going to want to sleep,
how they are going to want to eat, how long it’s going to take, um, you know, you don’t know what their sensitivities are to things, it’s, you just have to be really open minded because anything could happen and even if it’s not something, like bed-sharing that is culturally mainstream, there are people out there, you can find support no matter where you are.

Rachel emphasized openness to one’s child and that child’s preferences, along with consideration of changing circumstances in deciding what works.

Corinne’s Story

Interview

Corinne met me at a restaurant near her neighborhood because she did not want to meet with me in her own home. Before the interview, I felt concerned about how the loud music and diminished privacy within the restaurant would negatively affect the interview experience, particularly if Corinne felt the music was distracting or if she felt nervous about openly sharing her story with other diners nearby. Unfortunately, a restaurant was the only public meeting place I could locate in a radius of a few miles to her home. I arrived early to seek out the most private place available and to brief the waiter on my hopes for privacy during the interview. I was pleasantly surprised when Corinne arrived and quickly began sharing her story while seemingly unfazed by the presence of people around us. She said that she did not feel concerned about the other diners in the restaurant. After the interview, I saw how such a bold attitude informed Corinne’s own parenting experiences.

My summary of Corinne’s story

Corinne is 35 years old, African American, and has two sons who are six months and two years old. She “stays home” while her husband works outside the home. Her
six month old baby regularly sleeps with her and her husband in bed and her older son sleeps in his own bed. When her first son was born, she placed him in a bassinet next to her bed that her own mother gave her. Corinne moved him to a small play pen when he grew too big for the bassinet. She described how she knew what was best for her children’s sleeping routines by knowing them and herself well. She rarely sought advice from others since advice that is not specified to her own family was usually not useful or needed. She became a leader in a breastfeeding support group. Corinne seldom encountered resistance to her practice of bed-sharing because she rarely told others about it.

Corinne’s story in her words:

Current arrangements

My youngest sleeps with us in bed.

How she decided

[Her first son] didn’t need anything at night because he was fine so we just transitioned him...to his own bedroom and that was that. The younger one just never stopped nursing so, he was in the bassinet for probably a few months and then when he got too heavy to just keep picking up out of the bassinet four or five times a night I just said, he’s just gonna sleep in the bed with us because it was easier, he was too heavy...he just slept in the bed and he’s been there ever since...The only thing I can honestly say I planned on doing when I had children was breastfeeding. So I knew that but the rest of it I just figured we’ll see.

Evaluations of the process

I’m not a person who would ask for advice or needs anyone to give input. I know my children and I know how I want to do things and I do it...I wanted to see what other people were doing...like-minded type people. And I started going to breastfeeding support group meetings.

It’s just natural, it just felt right. And that’s pretty much how I make all my parenting decisions. Based on how I feel, what feels right or what feels wrong and if something doesn’t just instinctively feel right, if I have to question myself or try to convince myself then that means it’s not right for me...I know my children inside and out, upside down, sideways,
backwards and forwards…it’s more important for me to figure out who they are and what they need.

It’s not natural to let a baby who needs, is still very needy, cry it out in a room by themselves when they have no idea what’s going on. They’re simply responding to an instinctual biological need at that point still and for, and to just ignore that, I think there’s something wrong with that.

Plans for the future
E: “Any sense of where things are gonna go with that or what might change?”

No, and I don’t worry about it.
E: “Do you ever worry about it?”

Nope, I don’t worry about things, I just deal with what I’m given at the moment and then I’ll see what happens.

Corinne’s reasons for bed-sharing abstracted from her narrative in her words
- The younger one just never stopped nursing so…it was easier, he was too heavy.
- It just feels right to me to do it the way I do it.
- It’s not natural to let a baby who needs, is still very needy, cry it out in a room by themselves when they have no idea what’s going on. They’re simply responding to an instinctual biological need at that point still and for, and to just ignore that, I think there’s something wrong with that.

Voicing her story

Corinne’s moments of self-silencing seem wrapped up in how she feels about the beliefs of others around her. For example, she explained that she does not want to listen to advice from other people who do not know the specific circumstances of her children and her family. She identified the only time when she asked her pediatrician for advice as when she asked whether or not it was critical for her to begin feeding her son solids. She spoke up when she felt she needed to but otherwise protected her family’s story from people she was not sure would respect it.

Corinne describing how she withdrew her voice

They would ask, if they asked, I would say he sleeps with us or they sleep wherever and I’m not a person who would ask for advice or needs
anyone to give input…The doctor, you know when you go the doctor’s appointments, how are they sleeping, where do they sleep? In bed, with us, or whatever, you know. I’m not one to necessarily volunteer a lot of information. If they ask, uh, how night time is, it’s fine. Because I, I really don’t. I’m really not interested in a lot of people’s opinions and advice so I give people information on a need to know basis. If I have questions or if I needed advice I would ask someone who was um, like minded, I wouldn’t just ask, because I know there are a lot of people who don’t feel like you should, you know there’s that whole campaign where you shouldn’t sleep with your children and all of that and I don’t agree with that. I think that that’s uh, a mindset that comes from uh, not somewhere very healthy so I’m not interested in their opinions or advice about it.

I’ve been interviewed by people before and they changed things around to suit their needs, and so I’m gonna be careful about what I say and I’m gonna say it the way that I think is best for me to say it because I don’t even know you, you wrote this [consent form] up and signed it and everything, you could still go and spin it however you might feel is best.

Corinne describing when she used her voice

I’m a breastfeeding support group leader…I enjoy it, meetings, take phone calls from moms, pregnant moms, moms who are breastfeeding, anyone who wants information about nursing, breastfeeding at any stage, weaning…I guess they thought I was good with other moms or just in general with um, my comments and empathy and, you know just kind of relating to people and, so I mean they just kind of, you know how I deal with my children, you know that’s a big part of it, parenting. Um, so I honestly, when I first started going to the meetings I didn’t know that they um, paid that close attention. Now as a leader I understand why, you know, um, but when, after they ask, you know when they say “we’ve noticed this and that and how you do this and say this.” I thought, well that’s interesting so that’s why they asked.

My support group really stresses giving information as opposed to answers or advice. You know I can say, ‘well this worked for my family,’ you know, and uh maybe ask another mom, ‘what worked for your family, I know you did something a little different, what worked for you,’ you know, so it’s more recognized and every family is different and trying to give them enough information to make a choice about what works for their family because there’s no answers.

I think that my personality is so strong that people don’t know how to take it, you know so I, I have to kind of water it down sometimes, I have to be careful because I’m very, my first instinct is to say something to people like, well why would you do that, you know better than that but you know, I, you can’t always do that. Some people you can do that with and some people, most people you can’t….so I do a lot more listening than anything because um, and then you decide what approach to take with people. So, but I, yeah, sometimes it’s uh, not easy.
Our goal is to help mothers breastfeed, not to tell them where to put their babies to sleep, not to tell them what foods to eat, even though we can encourage healthy lifestyles, and you know, positive mothering through certain means. You can’t say, ‘well this is the only way my support group does it’ and then, you know, you don’t do that.

My response to the interview

I felt intimidated by Corinne’s strong presence and succinct explanations. She initially gave very short responses without detailed information. In the beginning I was concerned that she would not verbalize enough to help me understand her story. As the interview progressed, she mentioned “censoring” herself, leading to a discussion about how she decided what to share with others about her parenting. She also disclosed that she previously felt maliciously misrepresented about her participation in her breastfeeding support group which she responded to by becoming more closed off when discussing parenting issues. At the end of the interview, I realized that my feeling nervous probably led me to end the session earlier than with the other mothers once all of the interview schedule questions were answered. When I thanked her for her participation and ended the meeting, she asked if it had been a full hour (the estimated length of the interview described during recruitment) because it did not feel that long to her. It felt like an hour to me but I was shocked when I went home to review the recording and transcript to find that I ended the interview after only 35 minutes. I feel saddened looking at the transcript and seeing only a few more minutes of discussion followed when she shared that piece of her story with me. Perhaps she was preparing to share more sensitive or nuanced aspects of her experience. This piece of the interview with Corinne highlights the precarious dance of entering into discussion about one’s decisions and personal experiences when the partner has not yet earned one’s trust.
Corinne’s ‘I Poem’

I mean I’m not really good at talking about myself
I have two boys
I stay at home

I’m not a person who would ask for advice

I know my children
I know how I want
I do it
I’m not one to
I, I really don’t, I’m really not interested in a lot of people’s opinions
I give
If I have questions…If I needed advice…I would ask
I wouldn’t just ask, because I know
I don’t agree
I’m not interested in their opinion

I just think…I think that we…I, I think

It just feels right to me to do it the way I do it so that’s how I do it
I never looked up anything, I never researched
I’m not interested…I think…I’m not interested
Other than what I ask her
I’m sure
I know
I don’t understand people who don’t know
I don’t know I just have seen it
I mean I don’t know how you don’t know
I’m a breastfeeding support group leader
I had my sons and I go
I’ve always, I’ve been active
I was…I wasn’t comfortable
I wanted
Like I said
I started going
I’ve always known
I don’t see how people don’t know
I’ve just always known
So I, when I needed them I looked it up and I started going
I was interested so
I actually
I just had never thought about it
I enjoy it
I enjoy it
I’m leading
I don’t judge
I do have issues with…I have issues with that
Well, I don’t
I think there’s something wrong with that
Thank goodness I haven’t had to
I definitely don’t know how I would
I don’t agree

I, I think that my personality is so strong
I have to kind of water it down sometimes, I have to be careful
I’m gonna be honest
I’m gonna be careful about what I say and I’m gonna say it the way that I think is best for me
I know my children.

My response to Corinne’s I Poem

I highlighted certain phrases in bold because I was struck by power of those statements. Corinne describes and seems to experience herself as strong in regards to decisions about her children. She seems to feel that “know”ing her children and knowing what she wants are the prime indicators of what is best for her family. She referred to advice from others as generally unwanted and not useful. Even so, she feels she “have to be careful,” the “have to” indicating an external imperative to temper what
her communication to avoid offending others. As further explained in her interview, she feels that pressure as a group leader instructed by that group’s policy to support mothers in breastfeeding without training in other areas, such as bed-sharing, that could turn away a parent from the group and fail to support her breastfeeding. That sense of having to “water it down” might refer to efforts to develop a collaborative teaching style but she remains aware of it and has agreed to take that upon herself. She also described having felt her words were misquoted by a previous interviewer which brought undisclosed negative consequences.

Corinne’s story told from the Prescriptive voice

You shouldn’t sleep with your children…it makes them, uh, less dependent or they’re gonna, you know, be needy if we keep them too close too often…he needs to be in a, a co-sleeper or something at least not in the same bed…all the research says if, never sleep with a child if you’re under the influence…you shouldn’t sleep with your baby seeing that you use drugs or alcohol, you shouldn’t be impaired and sleep with a child.

Adaptive and Prescriptive Voices in Corinne’s Story

I. Temporality

Corinne described generally focusing on present parenting concerns instead of focusing on future outcomes. She definitely described caring about future goals but seemed to expect that focusing on current concerns would best serve her sons’ futures. She said, “I don’t worry about things, I just deal with what I’m given at the moment and then I’ll see what happens.” She also described how sleeping arrangements in her home
were not permanently decided but instead would remain flexible to the needs of her family. She facilitated her children sleeping where they seemed to feel comforted instead of developing a behavioral plan for solo-sleeping.

II. Considered factors/values

Corinne believed that parents and their advice sources usually vastly over-emphasize the importance of children becoming as independent as possible from early ages. She said,

I just think that it’s ridiculous. I think that we, you know, here in our culture we’re so um, set on separating ourselves from our children because we seem to think that it makes them, uh, less dependent or they’re gonna, you know be needy if we keep them too close too often and, I, I think it’s ridiculous so um, it just feels right to me to do it the way I do it so that’s how I do it.

Corinne chose to respond to what her children seemed to need and want without worrying about their becoming too dependent.

III. Agent of action/intervention

To Corinne, the needs and preferences of her children were clearly primary in her decision-making. She presumed that her children each had a need to be close and comforted and she felt obliged to respond to that need.

Well, I don't think, it's not natural to let a baby who needs, is still very needy cry it out in a room by themselves when they have no idea what’s going on. They’re simply responding to an instinctual biological need at that point still and for, and to just ignore that, I think there’s something wrong with that... I don’t agree with the whole crying it out thing.
She further explained the importance of responding to their needs. She tried to listen to her children and believed in following what “felt right:”

The only thing I can tell people is to know your children. Advocate for what’s best for your children. If you think sleeping with your child is the best thing for your child, sleep with your child... I mean that’s the only thing. That’s my only advice for parents, learn who your children are, know what they need, learn who they are and you know what they need and give them what they need. That’s, that’s the only thing I could suggest.

IV. Engaging with information

Corinne decided what was best for her family by knowing her children and acting on what “felt right.”

It’s just natural, it just felt right. And that’s pretty much how I make all my parenting decisions. Based on how I feel, what feels right or what feels wrong and if something doesn’t just instinctively feel right, if I have to question myself or try to convince myself then that means it’s not right for me.

Corinne knew there were people who disagreed with her parenting style in informal opinions and formal anti-bed-sharing campaigns. When I asked her about how she responded to those, she described how she focused on what she felt was right for her children regardless of other opinions. She rarely asked for advice even from her pediatrician because she did not think external sources had much information that could help her beyond what she found from her own sense of what was right and knowing her children. She said:
I’m really not interested in a lot of people’s opinions and advice so I give people information on a need to know basis. If I have questions or if I needed advice I would ask someone who was, um, like minded. I wouldn’t just ask because I know there are a lot of people who don’t feel like you should, you know there’s that whole campaign where you shouldn’t sleep with your children and all of that and I don’t agree with that. I think that that’s uh, a mindset that comes from uh, not somewhere very healthy so I’m not interested in their opinion or advice about it....I never looked up anything, I never research anything. I’m not interested in what any entity out there or anybody says or thinks.

The only time Corinne recalled asking another person for information was when she decided against starting her first son eating solids when he was six months old. She had repeatedly heard that babies needed solids by six months and she wanted to know more about exclusively breastfeeding so she joined the breastfeeding support group. She specifically chose that community because of their shared values. She said, “I wanted to see what other people were doing, you know like I said, like-minded people.”

Corinne described how she has tried to operate as a community leader. Her breastfeeding support group chose her to join their leadership based on how she successfully manages responsibilities of parenting her own children. She has felt the leadership position is challenging because she holds particularly strong beliefs about certain parenting practices, such as how mothers should not leave babies to cry indefinitely in their cribs at night. She limits her own sharing of her passionate beliefs about particular issues for two reasons. The first reason is that her support groups explicitly defined their policy as supporting whatever safe practices help mothers breastfeed to avoid diversion from that mission over debates of non-breastfeeding
focused concerns. She also acknowledged that parents usually do not receive such strong messages well. She said:

> You know what sometimes I, I think that my personality is strong so that people don’t know how to take it, you know so I, I have to kind of water it down sometimes. I have to be careful because I am very, my first instinct is to say something to people like, well why would you do that, you know better than that but you know, I, you can’t always do that. Some people you can do that with and some people, most people you can’t. So, I um, I do a lot more listening than anything because um, and then decide what approach to take with people. So, but I, yeah, sometimes it’s uh, not easy.

Corinne has taken quite a bit of concern to consider where parents come from when tailoring her approach to counseling them. This is a particularly unique feature to the Adaptive voice, as Prescriptive advice distributes the same information to different people in the same way, regardless of what seems to fit best. That lack of listening and tailoring both information and mode of discussion is one of Corinne’s main complaints about many advice-giving processes in parenting. She said:

> I think the problem with advice sources is that they give answers instead of true information. Because if, if you ask me a question and I give you an answer about how to do something and that doesn’t work, then what next? And, I think that what they need to do is teach parents how to read their children or, you know, encourage that parents get to know their children and feel their children and that’s really the way you know your children.

V. Integrating conceptual terminology

In the interview, Corinne only used the terms bed-sharing and co-sleeping when
I used them in my questions, never referring to them on her own when discussing sleeping. In that sense, the terms only seemed to apply when retroactively used to describe a process that actually occurred without conceptualizing of them. She went on to say that there are “no answers” about parenting:

A lot of questions in parenting don’t have an answer because it’s so individual because my kids aren’t like anybody else’s kids and I’m not like another mother and my husband isn’t like another, you know. Everything is very individual so it’s really difficult to get answers or advice, you know. My support group really stresses giving information as opposed to answers or advice. I can say this worked for your family, I know you did something a little different, what worked for you, you know? So it’s more recognized and every family is different and trying to give them enough information to make a choice about what works for their family because there’s no answers.

Corinne described how the realm of “answers” offers inapplicable advice to her family because “everything is very individual.” “Answers” seem to prescribe universal recommendations instead of integrating into what feels right for her family.

Ayanna’s Story

I knew Ayanna from working together at a previous clinical site where she is employed as an administrator. When we first met, we found our way to the topic of bed-sharing during casual conversation. I left that clinical site but called her when I began recruiting participants. She said that she wanted to participate but it took us a few months to find a mutual time and location that worked. The interview was the first time I visited her home.

The interview
Ayanna is a 24 year old single Hispanic mom with one daughter who is 18 months old. When I arrived at her apartment for the interview, I met her daughter for the first time. Ayanna’s sister, a few years younger than her, sat at the computer with headphones over her ears. Ayanna explained that she welcomed her sister to live with her after a recent geographic move. Her sister waved ‘hi’ and then went back to her mission online. Ayanna mentioned that we could only meet for an hour because her sister needed a ride to work and did not have her own car. Ayanna’s apartment has two bedrooms so she gave the first bedroom to her sister and made the other bedroom the nursery for her daughter. Ayanna pushed her own bed up against the corner in the living room.

*My summary of Ayanna’s story*

Ayanna lived in Puerto Rico until she was ten years old and then moved to Texas with her family. She became pregnant with her daughter midway through college. After finishing her degree, she moved to Ohio to live closer to family. Ayanna initially placed her daughter to sleep in a crib in her own nursery. As her daughter became hungry every hour or two, Ayanna found the late night and early morning ventures in and out of the nursery exhausting and unsustainable. She soon began keeping her daughter in bed with her instead of journeying to and from the nursery and found that arrangement worked well. When her daughter was three months old, her family began warning her that her daughter would develop bad sleep habits unless she began sleeping alone. By then Ayanna had moved to a smaller home and placed her daughter in the crib next to her bed. At one year of age, Ayanna’s daughter began crying and screaming in the crib every night until Ayanna brought her back into bed. After six months of struggling
through this arrangement, Ayanna tried placing the crib in another room and found that her daughter slept through the night without problems once she was out of sight. At the time of the interview, she still brought her daughter into bed with her once a week for cuddling and said that she knew that might cause sleeping problems in the future.

Below are plot highlights from Ayanna’s narrative, explaining her current sleeping arrangement at time of interview, how that arrangement developed, how she and others responded to that, and her plans for future arrangements.

Ayanna’s story in her own words:

Current sleeping arrangements

Now she has her own room and we’ve done that for a while now; but I mean I’m not gonna lie and say she doesn’t sometimes come into my bed [laugh]... At about 18 months, I don’t know what changed but she started staying in her crib and she, she still is actually in a crib, I have to convert it into a toddler bed just because I’m afraid of her trying to get out of it.

How she decided

When she was first born I was breastfeeding and it was very difficult to be going in and out of the crib so she slept with me until she was about three months old... because it was easier for me to breastfeed that way... Everyone started telling me that it was about time that she went into her own crib because you don’t want her to be dependent on sleeping with me all the time so at three months I put her in her crib and she didn’t really have any issues. I didn’t have any problems with her sleeping until she was about a year old.

Then she didn’t want to sleep in the crib for nothing in the world. For, from like 12 months to 18 months I had a hard time, she wouldn’t go to bed at a regular time, I’d have to fight her for maybe an hour or two for her to actually get in her crib and she’d actually, I’d have to pull her out and she’d have to sleep with me in my bed, fall asleep there, and then I’d transfer her over to her crib and it was terrible, every single night. My pediatrician...told me that if she’s fine or she’s fed, if she’s not wet, then you can let her cry it out and I just felt like that was cruel because she, he said she’d forget about it but she would sit there and cry for 20, 30 minutes if you let her...I tried that for a little bit but I just couldn’t bear it.

The issue I had between 12 and 18 months was I lived in a one bedroom...I can’t be in the same room as her which is what was
happening before I had my bed in the same room with her and so she could see me and she’d be in her crib and she could see me. So as soon as I did that, as soon as I moved here I was like, I don’t care I’m going to sleep out here [in the living room], um, yeah she has her own room and that resolved the issue.

Evaluations of the process

A lot of people advised me against it, that’s just the culture here I think that they want to make the child independent as soon as possible because you don’t want them developing a habit later and you don’t want them being in your bed...but I knew, I mean in other cultures it’s very common. [My mom] told me that it would be okay to do it at first, that’s why I did it for the first three months so she told me it was okay to do it for the first few months and because she was fresh out of the womb and in shock and needed comfort and all that. So I just went along with it until I felt like she was, she felt comfortable and basically, like being alive outside of the womb and once I felt that she, she was fine being there then I put her in the crib.

I know that certain experts do have kids but there’s a lot of them that don’t have kids and I had this one pediatrician, I left her, she was really young, not that there’s something wrong with that but she didn’t have any kids and it was all, it seemed like all very textbook advice and I didn’t like that so I switched and I would rather go with the advice of a mom that has like two or three kids than somebody who’s been studying development of children. I realize with experience that the more like, at first I didn’t know what I was doing at all so I’d go to my pediatrician for absolutely everything, every question, everything, but the more experience I got the more I realized that a lot of things I could just figure out on my own.

Her father was very against it, he said I was going to create problems but I don’t think the co-sleeping itself is what caused the problem later on. I just think it was the fact that she didn’t have her own space, we were in the same room...I listened to what they said but in the end I just did what I felt was better for me and the baby and it was just um, more comfortable. I got to sleep more, she seemed happier so I did it...I think I made the right decision for us and it’s a good bonding, it’s, it’s a good bonding experience, that’s why I do it once, once in a while because I like having her in my bed and we cuddle, it’s cute [laugh].

Plans for the future

So you just bring them into your bed and sleep and I’m still guilty of it once in a while but I made a room that, now we have a rule like we’ll sleep together one night a week...it’s just like a way to spend some time together.

Ayanna’s reasons for bed-sharing abstracted from her narrative in her words
• It was easier to breastfeed that way.
• It was just a matter of convenience and just because I wanted to be close to her.
• She was fresh out of the womb and in shock and needed comfort.
• It creates a confidence in the child and, and the baby learns like when you, when they cry that you’re there for them instead of letting them cry it out.
• I tried [letting her cry it out] for a little bit but I just couldn’t bear it.
• I think it’s important for them…to know that they can come to you if they need to.
• It’s so much easier than like sitting there and going like, sleepless nights by like two or three months.
• It’s just like a way to spend some time together.
• I had to breastfeed every hour, every hour and a half… and just having to wake up every, every two hours minimum, it was just rough coming in and out, going… it just wasn’t working.
• I’d bring her into my bed because it was the easiest way to breastfeed was laying down and I’d just start to fall asleep.
• It’s a good bonding experience…I like having her in my bed and we cuddle, it’s cute.

Voicing her story

Ayanna mentioned asking others questions and listening to their responses more than any other kind of communication. She was open about describing her difficulties to others in hopes that they might have a helpful suggestion. She actively sought professional therapy to help her find more solutions for difficulties with her daughter. While she mentioned reading messages in “internet cafes,” she did not post responses or formally join the discussions in those communities.

Ayanna withdrawing her voice

While this did not make it into the transcript, one dramatic shift in Ayanna’s voice happened when she began describing how she feels spanking is useful in certain circumstances but she knows many people find it unacceptable or consider it to be child abuse. As she spoke, she slowed her pace and used a quieter tone of voice. That
lowered tone of voice was the closest example I found of Ayanna communicating anything about withdrawing her voice from discussion with others.

*Ayanna describing when she used her voice*

The doctor, I told him that I was having trouble, this was when she younger. I said, the fact that I was talking to him about breastfeeding and it was just more convenient to have her in the bed with me, and he said that he would advise for me to make a habit of putting her in her crib...I ask my pediatrician questions, I ask my mom...She has a speech therapist that comes by once a week and I, I speak to her about disciplinary issues...I naturally ask a lot of questions. Or I realized that I needed help with it so I just started asking all, like first, like all the moms that I knew and then my pediatrician and also her therapist, we actually, I sought therapy for various reasons for her disciplinary issues...I just asked whoever I knew if they had a kid I would ask them and I just asked my pediatrician any questions that I have.

*My response to the interview*

Ayanna’s interview beautifully complicated the overall direction of the data I collected. She simultaneously was pro-bed-sharing and pro-solitary-sleep with her same child. She felt discouraged by professionals who criticized her for bed-sharing and then repeated some of their claims as her own, such as how she may have instilled bad sleeping habits in her daughter, only to later claim again that she made the right decisions for her family. When trying to locate a clear oppressive or resistant voice in her narrative, I felt completely incapable of determining which was which, similar to the problem I found with Marissa’s narrative. Staring at an unmarked transcript without much clarity about where to highlight in yellow or in pink, I embraced the challenge to find new voices that transcended such a dichotomous distinction. Ayanna’s experience was both complicated and simple. Through her story, she helped me appreciate the nuance of differences between the voices in her story.
Ayanna’s ‘I Poem’

I’m originally
    I had her
I was in college…I graduated
    I thought it would be good for the baby
    Here I am

I mean I’m not gonna lie
I was breastfeeding
I don’t think I put her in the crib…I put her in her crib
I didn’t have any problems with her

I had a hard time…I’d have to fight…I’d have to pull
I don’t know what changed
I have to
    I’m afraid

I had a lot of people telling me
I knew, I mean
So I didn’t
    I wanted to be close to her I was, I was putting her in the bed with me but I knew that I had to stop that

Yes, the doctor, I told him that I was
I was talking

I take everything with a grain of salt
I listen…And I read…And I do research…And I also ask my mom
    And I didn’t really see anything wrong with it
    I just did what I wanted

That’s why I…I just went along
    Until I felt
I didn’t really listen
    I ultimately make all the decisions
I read a lot... I ask my pediatrician... I ask my mom
I basically go a lot with instinct and what my mom says

I think... I don’t know
I just felt like that was cruel
I tried... I just couldn’t

I always look
I know that certain experts... I had this one pediatrician, I left her
  I didn’t like that
I switched
I would rather

The issue I... I lived in
  I was like, I can’t, I can’t
I had my bed... I moved
  I don’t care I’m going to

I prefer
I think
I gave
I separated us... I tried... I tried... I tried
I realized
I think
I’m a single mom

I’m not really sure... I’m not really sure
  I think I had a, I don’t know, a unique case

I don’t think it’s a bad thing
I think you have to make the distinction
I wasn’t getting any sleep... I wasn’t getting any sleep
I know a lot of Americans don’t feel this way
I would never go to the extreme
I know that it creates problems later
I’ll try not to do it... I have to go to work... I never get any sleep
  The more experience I got, the more I realized that a lot of things I could just
figure out on my own

When I was pregnant I went and I got a bunch of books
If I believed what they believed I wouldn’t have done it

They said that I was the problem

He said I was going to create problems

I just did what I felt was better for me and the baby

I think I made the right decision for us.

My response to Ayanna’s ‘I Poem’

I was struck by how Ayanna’s poem so clearly reflects the struggles of her story. It begins with her and her baby, taking note of where she stands. She began parenting asking her mother, her pediatrician, books, and internet forums for answers about what she should do. She struggled with handling her daughter’s sleeping and obviously cared about what felt best for her daughter and what would help everyone get some sleep so she could stay awake at her full-time job. Then she noticed what she felt and what she learned from her own experiences which was that she could know and decide what was right for her and her daughter. She still struggled with her daughter but she had a sense that she could find her own way through it. She described the message that she caused problems by initially letting her daughter sleep with her and, in the interview, seemed convinced that was the case. While she accepted that claim made by her pediatrician that her daughter’s sleep difficulties were Ayanna’s fault, she also knows and feels that she made the right decision.

Ayanna’s story told from the Prescriptive voice

You don’t want her to be dependent on sleeping with me all the time... make the child independent as soon as possible because you don’t want them
developing a habit later and you don’t want them being in your bed… co-sleeping is dangerous because you could like, roll over on the baby and all that stuff….but I knew that I had to stop that because she was developing bad habits... make a habit of putting her in her crib because she would develop a bad habit... it would be okay to do it at first... it would be a bad habit later and she’d want to be coming into our bed...

It’s more about an individualistic culture and independence and like, a kid needs to have his own room, your kid needs to sleep in his crib... if she’s fine or she’s fed, if she’s not wet then you can let her cry it out... she’d forget about it... put them in time out one minute for every year so she’d be in time out for two minutes.

I know that it creates a problem later on because they want to come into your bed all the time... it’s not safe... you might roll over on your baby and suffocate them, God forbid...

Obviously she needs to go to the doctor and they know more than I do about medical stuff... so I’d go to my pediatrician for absolutely everything, every question, everything... I just needed them to give me the prescription because I can’t get it... I would never neglect that, I would never not go... to see if something she’s doing or something that’s happening to her is out of the normal, you know... I wouldn’t say okay, she didn’t go to the doctor so I’m not gonna go. I was the problem... I was going to create a problem... I listened to what they said.

Adaptive and Prescriptive Voices in Ayanna’s Story

I. Temporality

Ayanna described feeling mostly concerned about enjoying the present moment with her daughter although she frequently wondered if past bed-sharing contributed to her
daughter’s resistance to sleeping alone. At the time of the interview, she seemed to feel generally satisfied with the arrangement of her daughter sleeping alone in her own room while Ayanna slept in a bed in the living room. She said they slept together about once a week now for enjoying “cuddle” time. She also connected her sleeping practices with her daughter to her own history of sleeping with her sister and mother in Puerto Rico. She shared that information after the interview was completed and cited it as evidence that it was a benign behavior.

Ayanna described concerns from The Prescriptive voice in her narrative that emphasized future negative consequences for enjoying bed-sharing with her daughter. She said that she had heard parents should “make the child independent as soon as possible because you don’t want them developing a habit later.” Ayanna identified that belief as more common in the United States. While she valued the idea of her daughter’s future independence, she also described how it conflicted with her own sense and cultural belief that young babies need a comforting mother with them at night:

“It was okay to do it for the first few months and because she was fresh out of the womb and in shock and needed comfort and all that so I just went along with it until I felt like she was, she felt comfortable and basically, like being alive outside of the womb and once I felt that she, she was fine there then I put her in the crib.

Ayanna saw newborns as needing the comforting of a close parent more than they needed to be secluded in a crib as others told her to do. She saw the needs of her daughter as changing across time. She also described how her original plans for sleeping
arrangements did not work out as she thought they would. Instead, she had to adapt to the changing situation:

We decided she was going to go to her crib. I mean we had everything set up for her but once I was actually in the moment and I realized how hard it was. I had to breastfeeding every hour, every hour and a half, she was sometimes like twenty minutes at a time. And just having to wake up every, every two hours minimum, it was just rough coming in and out, going. She had her own room and I had my own room and I'd be going across the house, going to her room, picking her up, breastfeeding, putting her back, every like hour and a half, it just wasn't working.

Instead of maintaining her original plan, Ayanna adapted and brought her daughter into bed with her instead of staying up most of the night walking in between rooms and feeding her daughter sitting up and awake in the nursery.

II. Complex concerns

Ayanna considered complex and multiple values when deciding where she wanted her daughter to sleep. She frequently mentioned concerns of physicians and family about her daughter becoming independent. She sometimes challenged the belief as contrasting with her cultural background that encouraged mothers to sleep with their babies to provide comfort. At other times, she repeated the concern for her daughter to be able to sleep independently as her own concern. She summarized what her physician told her about how she could leave her daughter alone in a crib to cry. Ayanna described her own beliefs that contrasted his advice:

All that, it’s different in Puerto Rico, it's more like, um, I don’t know, what the term for it but it’s like, it’s more of like, as a whole, a familial type thing. It doesn’t matter, they think it’s actually good for the child if
you put it in your bed because it creates a confidence in the child and, and the baby learns like when you, when they cry that you’re there for them instead of letting them cry it out, that’s what my pediatrician told me to do. He told me that if she’s fine or she’s fed, if she’s not wet then you can let her cry it out and I just felt like that was cruel because she, he said she’d forget about it but she would sit there and cry 20, 30 minutes if you let her.

Ayanna eventually wanted her daughter to sleep in her own bed so Ayanna could sleep through the night but not to bestow some sort of ideal independence on her daughter’s character. As Ayanna is a single mother who works full-time, she described wanting to make the most of time together with her daughter, which sleeping together has done for her. She said that she tries to limit bringing her daughter in her bed to weekends because she does not need an efficient night’s sleep on weekends like she needs during the workweek. Instead, weekends were when she could settle for the lower efficiency of sleep with a daughter who wakes her to snuggle.

When I asked Ayanna if warnings about the dangers of bed-sharing affected her, she explained how she felt concern for her daughter’s safety but it seemed that their practice was safe because of how her body responded to her daughter:

Yeah when I was sleeping with her when she was little, now she’s big but when she was little there’s that problem where people think you might like roll over on your baby and suffocate them, God forbid. But I was, I wouldn’t move at all, like I’d wake up in exactly the same position that I’d go to sleep in. And she didn’t move that much either.

Ayanna seemed to feel those warnings to other parents about bed-sharing did not apply to her due to evidence from her own experiences of waking up safely with her daughter.
III. Agent of action/intervention

Ayanna keenly felt her daughter’s will when her daughter wanted to sleep with her. She described having to “fight her” for her to sleep in her crib. While Ayanna wanted her daughter to sleep in her crib at certain times, her daughter did not go along with all of the plans. Even though she eventually ended up sleeping in the crib alone, her responses definitely impacted how Ayanna’s evenings progressed:

Then she didn't want to sleep in her crib for nothing in the world. For, from like 12 months to 18 months I had a hard time, she wouldn't go to bed at a regular time, I'd have to fight her for maybe an hour or two for her to actually get in her crib and she'd actually, I'd have to pull her out and she'd have to sleep with me in my bed, fall asleep there, and then I'd transfer her over to her crib and it was terrible.

When Ayanna decided she wanted her adult bed to herself so she could get enough sleep before work, her daughter had a different perspective that surely influenced the progression of their evenings for about six months. Ayanna eventually found a practice that seemed to work when she realized it was her daughter’s ability to visually see Ayanna that seemed to keep her daughter screaming for her. Ayanna took note and moved her bed to a separate room.

IV. Engaging with information

Ayanna turned to “instinct,” her research in books and on the internet, and discussions with her mother and medical professionals to decide how to parent. She turned to many different information sources but remained aware of filtering through them through her own perspective. She said, “Well I, I just go with, first of all I read a
lot, like I read a lot, I ask my pediatrician questions, I ask my mom, I basically go a lot with instinct and what my mom says.” Ayanna also described how she generally valued advice from other moms above advice from specialists. She frequently turned to internet forums for parents although she did not write in them herself. Instead, she read through questions and comments of other parents to inform her perspective. She said, “I used that website or other like, other resources for moms, moms that go out there and ask questions and, I think a lot of it is bet, it’s better to get advice from experienced moms than experts because experts, they can only talk about generalizations.” Ayanna explained how she initially turned to her pediatrician with frequent parenting questions but she eventually relied more on her own perspective and the conversations of other moms she observed online. At that point, she minimally turned to the pediatrician for medical care but she did not seem to respect relying on a physician for guidance beyond that. She said:

*Obviously she needs to go to the doctor and they know more than I do about medical stuff...so I'd go to my pediatrician for absolutely everything, every question, everything...I just needed them to give me the prescription because I can't get it... I would never neglect that, I would never not go... to see if something she's doing or something that's happening to her is out of the normal, you know... I wouldn't say okay, she didn't go to the doctor so I'm not gonna go.*

When I asked Ayanna if she believed there was any way advice sources could have improved her early decision-making about sleeping arrangements, she said, “I'm not
really sure. I’m not really sure if they would have been able to help me because I think I had a, I don’t know, a unique case.” She seemed to believe that medical advice sources are not particularly adept at working with a “unique case” which she identified as. Perhaps she saw mainstream advice sources as only working well with families who seemed to be non-unique.

V. Integrating conceptual terminology

Ayanna explained that she used the term “co-sleep” for bringing her daughter in bed with her but only in reference to the behavior when considered conceptually, such as with a physician or in a book. She said, “I mean I know that’s the technical term for it but I never said let’s co-sleep.” When I asked her where she picked up that term, she said, “Probably at the doctor’s and reading articles, that’s what they called it. And there were a lot of articles against it but I think that’s just because of where we live.”

Reflections on the Relationships of Many Voices

A project about deciding where to place a baby to sleep turned into a project of listening to mothers describing their relationships with their children. They brought me along to enter into a world where relationships and tactile responses precede or temper conceptualized terminology and strategies; a world where mothers remain keenly aware of the interdependence of each family member and how changing behaviors of one changes the home for everyone else; a world where information from advice sources is sought to support a pleasant and fulfilling familial culture. The participants in this study welcomed me into that space and I saw and felt how it contrasted a world of techniques,
statistical estimations of survival and a preoccupation to create children who quietly accept nightly isolation from their parents. These mothers decided that most of the advice they received about sleep placement, solicited or not, from external and formal sources felt unhelpful, inapplicable, or irrelevant to their goals. Helpful advice sources presented information that seemed useful, realistic, and aligned with the goals of the mothers.

Each participant’s story contributes unique aspects of the decision making process and shares similar application of the Adaptive and Prescriptive voice constructs. The reasons for co-sleeping were mostly described from the Adaptive voice, although not entirely. Reasons against co-sleeping were mostly described in the Prescriptive voice, often as reactions from others the mothers were describing without agreeing with. For example, when Ayanna described others telling her that “a kid needs to have his own room, your kid needs to sleep in his crib.” The portion of each plot that tells the story from the Prescriptive voice often feels alien from the real concerns of each family. Perhaps the messages from the Prescriptive voice sound alienated because, almost by definition, they have not been digested as something that feels immediately applicable to each family’s current situation.

Most parents described setting up a nursery as it seemed like the normal, logical way to prepare for a baby’s arrival. This may reflect how solitary infant sleeping is a sort of unquestioned cultural norm, additionally supported by the juvenile product industry. Each woman spoke with varying degrees of confidence in her decisions and some identified regrets for how they believe they might be in better situations now if they had made different choices months ago. In these particular narratives regarding the
decision to bed-share, the stories as told from the Prescriptive voice included warnings about negative future outcomes such as over-dependent children who lack self-soothing skills and have bad habits of wanting to be close to their family at night. They also include instructions that tell parents to stop responding to the perceived wants or cries of their babies. Often each mother’s responses or desires, such as to be close to one’s baby while sleeping, was identified as dangerous or bad in some way. The literal advice of the Prescriptive voice would likely differ across experiences of different parents. For example, if I had interviewed mothers who left Attachment Parenting groups when they decided solitary infant sleeping was essential to their families working well, the Prescriptive voice in those stories might generally argue for bed-sharing.

In beginning to identify what provides structure to the Adaptive voice as differentiated from arbitrary or “accidental parenting,” I believe Corinne’s distinction between “answers” and “true information” is helpful. It seems that, for her, answers are information about how to implement a specific technique but fall short if that technique does not prove helpful for a family’s specific circumstances. She identifies the more useful term of “true information” as knowing how to “read their children” and gain a stronger sense of what one’s children want, are comfortable with, or what is best for them through mindful relationship with them. She seems to be providing a prioritizing of relationally-situated knowing as a skill that requires practice and development. Nicole’s critique of traditional advice from the Prescriptive voice identifies the problem of what Corinne refers to as “answers” being unhelpful because they still must be integrated into each unique baby’s circumstances and needs:
So many people are so different and not every situation is right for every person, I mean this baby, this situation is perfect for but the next baby we have, it may not be. You know, every baby’s different too.

Regarding what the mothers wanted from advice sources in general, it seems the mothers valued a broad scope of information sources. *When I asked each mom how she decided where to place her infant to sleep, none gave responses like, “I read through all of the data and decided what was least likely to result in death or over-dependency later in my child’s life.” Instead, they told stories lush with details of relationships, responses from others, and discernment of internal senses of what felt right.* Moreover, there was hardly a unified decision to bed-share in these narratives, instead narratives of evolving family circumstances and preferences with expectations for continued change in the future. Understanding the decision-making of these mothers requires looking at the processes that occurred within practical and relational structures. Any explanations of the choices to bed-share in these families that removes the voices of the babies the mothers responded to, the particular arrangements each family faced, and the personal discernment of each mother renders those explanations fictions, far from the experiences actually occurring.

4. DISCUSSION

Revisiting Why Talking About Bed-sharing Still Matters

Looking back at my original experience encountering a sign on the city bus that brought me to question if this discussion about bed-sharing holds much value, I have found continued assurance that it does concern many parents and warrants investigation. That poster explaining that all parents should place infants to solitary
sleep in cribs did not signify the end of the conversation like I imagined it might. Indeed, I learned more about how that conversation has gone underground or into a world where some of those talking about bed-sharing have become silent in some public arenas while sharing their stories in others. In trying to find participants, I found some community leaders wanted to share more with me than just permission to distribute my research flyer. Particularly those from central Ohio identified legal and policy-level enforcement of solitary infant sleep. One breastfeeding consultant, for example, said that she could not distribute my flyer at her facility even though she wanted to because of ramifications on her employment. In a hushed tone she told me, “You know we really aren’t supposed to talk about bed-sharing unless we’re telling people not to do it.” Others warned me of what a “hot” issue it was and how it might be difficult to find an organization, particularly if it received county funding, that would risk any semblance of supporting bed-sharing for fear of losing employment or more. Through careful changes in tone of voice and choice phrasing of words, they communicated disagreement and resistance to those unilateral policies. To hear an adult woman say “I’m really not allowed to talk about that” in an informal conversation on her personal telephone definitely re-energized my desire to provide a forum for women who disagree with a particular way of parenting or educating parents to voice their stories.

Parenting as Technique

After working with the participants and their narratives, I found a surprising answer to one of my original guiding questions about how parents can know and decide what is best for their children and how advice sources can be of most use in that
process. I found a voice of parenting with knowledge of the parents’ own needs and values informing choices determined through connection with their children. Returning to the mother who spoke up in that Oprah episode saying “There is no right or wrong answer,” she seemed to refer to particular kinds of answers put forth from prescriptive voices. In this project, each participant heard others claim to know what was in the best interest of her child. Each mother had mixed responses to those offers from the Prescriptive voice. From the Prescriptive voice, we can solve the problem of poor parenting by asking or requiring parents to conform to sets of conceptually organized behaviors to accomplish some sort of end, such as increased short term survival rates or reduction of some sort of malady. My own question about how parents find what is right or wrong now appears to have been a search for how such universalized guidelines are managed, far from what my participants turned to when making decisions based on deeply personal and particular concerns. Indeed some policies that operate like universal guidelines provide essential management of behaviors on the periphery of acceptability, such as defining neglect and maintaining medical standards of professional care. Those legalistic kinds of limits became a bit clearer in this project and clearly influence many aspects of parenting decision making. The participants in this project articulated other ways of finding and defining “right or wrong” in what I identified as the Adaptive voice.

My way of approaching the problem emphasized conceptual boundaries. The discussion about what was “best” and “right” in a universal sense was what I brought to this project, not what the mothers described. They described trying to sleep safely and pleasantly with multitudes of moving pieces in their homes. The earlier mentioned
terms ‘postmodern plurality’ and ‘modern individualism’ are conceptual ways of describing cultural phenomena. While perhaps useful in some settings such as academic papers, their limitations as concepts are due to how they represent generalized observations. Indeed, the terms transform our lived experiences as we encounter and use them, but they can seem deceptive in their usefulness for helping us understanding lived experiences. Dare I admit that I became somewhat lost in framing parenting conceptually, and in that process, missed the boat altogether by looking for a conceptual solution to the problem. Thanks to the participants who rarely mentioned the terminology from academic articles I steeped in for years prior to the interviews. Fortunately, a feminist research method helped me overcome

I found many other authors, scientific and political, who discussed bed-sharing problems conceptually and with assumptions of general universality. As traditional frameworks for maintaining values and behaviors among parents have broken down, I found three kinds of sources attempting to address the need for some sort of guidance. This way of managing plurality follows the western tradition of addressing loss of traditional structures with seemingly objective data sources from scientific pursuits and an inundation of commercially-driven media. The Prescriptive voice’s framework is unrealistic as it has not been organized by collective parents but instead conceptually driven promoting medical model values of prediction, planning, and non-interdependence with results of scattered studies jumbled together. Boundaries come into question when parents look for instruction or face persecution for behaviors labeled as problematic. None of these sources of guidance seem to adequately address questions of values, meaning, and relationships. The mothers described tiring of those
two sources of information and instead some turned regularly to community groups and internet forums. They were looking for something beyond disjointed behavioral tidbits and product recommendations.

In my original research proposal, I identified conflicting arguments within a pluralist culture and proposed that they would feel dizzying to parents trying to organize all of the information. What I went on to find was that while some participants did describe finding conflicting advice, that problem seemed peripheral to their main concerns. They were less concerned with who was right or best in an objective, universalized sense. Instead, their primary concerns were what practices were best for their children at that time given their multiple values and circumstances. Some moms argued their cases as superior to their physicians’ advice by questioning the mode of research about bed-sharing or by describing aspects of bed-sharing that scientific studies failed to address, such as ease of response to their babies. Marissa identified how bed-sharing worked for her but seemed genuinely neutral about its usefulness for others. Each mom identified how she could imagine circumstances where multiple ways of sleeping might serve families well at different times.

Organic Integrity of Knowing Self and Children in the Adaptive Voice

This project led to results I had not foreseen prior to the interviews. Instead of messy and confused responses to plurality such as ‘multiphrenia,’ I found mothers whose approaches to the plural perspectives had an organic structure, a sort of organizing backbone that required a closer and more detailed look for me to notice. Their solutions were not solved by a simple intuitive versus scientific information
dichotomy. Instead, they drew upon more sophisticated systems of values and relationships. I suspect that many advice givers rarely look to, notice, or respect the integrity of those organizing systems and instead mistake them for something like “accidental parenting.”

Marissa mentioned the concept called “accidental parenting” from a book (which I have not read), “The Baby Whisperer.” For this project, I refer to the term as she described it as meaningful to her, not necessarily as the author intended. Marissa said, “In the baby whisperer book she calls it accidental parenting and a lot of people have reviewed the book and feel patronized by the way, by the way she calls it accidental parenting but I think it’s actually a pretty good term because we didn’t plan to do it either time, it did happen by accident.” As Marissa described the concept of ‘accidental parenting,’ she sets it up as in opposition to a rationally planned way of parenting that is generally not swayed by changing circumstances or the preferences of the children. She believes that her son’s resistance to solitary sleep is due to her failure to implement solitary sleeping immediately after he finished nursing around seven months. Instead, she did what felt best in those late-night moments and sees her as now paying the price for giving in to his crying and the easiness of co-sleeping.

When I asked Marissa if she felt the term ‘accidental parenting’ was patronizing, she said, “No. That’s when I read the reviews I thought I was going to read the book and get angry but I didn’t I was like, there was some things I didn’t agree with but I actually thought the term accidental parenting, from, from our perspective was actually quite apt because it did happen by accident twice, [laugh].” Marissa questioned her early parenting choices and practices, such as welcoming her son to bed for sleep,
comfort, and ease of breastfeeding. This concept of ‘accidental parenting’ encouraged her to consider those early decisions as something like irresponsible failures of will to enforce a more strict pre-decided sleeping system of some sort with a dichotomy of planned versus accidental decisions. I would propose the Adaptive voice takes values and future goals into account although prioritizing them differently than some sort of completely planned parenting. There seems to be a difference between Adaptive and ‘Accidental parenting,’ although they both might seem equally deviant to a Prescriptive voice. The Prescriptive voice seems to judge anything failing to follow socially sanctioned pre-planned behaviors as accidental. The Adaptive voice offers understanding for how parents can indeed adapt to the changing needs of their families with serious consideration of values and planning of a more flexible type.

Looking for Conversation: The Mothers’ Advice, What They Wanted and How They Withdrew

In my introduction, I suggested that this project could help care providers understand how some parents believe they could have been supported through certain modes of advice provision. Even though parenting books, pamphlets, and advice from physicians are prolific, the scientific and care-providing institutions developing them have yet to produce a research based or even experience-based understanding of how parents decide whether or not to utilize those information sources. Understanding that might help clarify how to develop more helpful supportive materials for parents. I asked each mother if she had any advice for other parents and if there is any way she believes her own sleep decision making process could have been improved. I found that the mothers generally filtered external information into their familial value systems. Those
looking for specific answers sought out the kind of answers they wanted and those who
did not want input generally ignored advice. Certainly the information milieu of each
mother had reciprocal impacts on her experiences and judgments of her own behavior
but without the behavioral conversions those advice sources probably hoped for. I also
found myself struck by a lingering question of if we, as a larger community, really want
mothers to change their behaviors to meet the recommendations of medical pamphlets
and few-minute interventions with care providers who barely know the children the
advice is meant for.

*Developing voice*

When Sears et al. (2006, p. 20) encourage parents to listen to their inner voices for
guidance, they presumes parents feel connection to an “inner voice” and that the voice
speaks wisely. Ferber encouraged parents to base their decisions “on your own personal
philosophies” (p. 43), seemingly presuming that parents have developed wise “personal
philosophies.” Neither text says much more about what those terms mean or how to
develop those faculties. I was struck by similarities in what I saw as positive qualities of
these mothers in approaching the co-sleeping issue with an Adaptive parenting voice to
how Carl Rogers began defining a set of values he hoped science would serve. In his
book, Becoming a Person, Rogers identifies how those using science as a tool should
become more explicit in what end they seek from it. He initially describes a scenario
where approved behaviors would be reinforced toward a behavioral utopian ideal, such
as in B.F. Skinner’s treatise, *Walden Two*. Rogers identifies three major problems with
that proposal: the first as the problem of which behaviors would be identified as ideal,
the second as the sacrifice of individual freedom to rigid communal control, and the
third as the problem of living life for results instead of finding meaning and value in the process of living. To address these problems inherent to strict behaviorism, Rogers proposes the ideal of “a self-actualizing process…by which the individual creatively adapts to a new and changing world” (p. 395). He argues why we should value freedom to adapt to ever evolving problems over rigid implementation of techniques. Most real-life situations involve many unique factors that universalized behavioral techniques inevitably fail to address. Rogers holds that awareness of one’s values and “effectiveness of adaptation” with “an increase in self-responsibility and self-direction” are ultimately more helpful than behavioral prescriptions because they serve as a compass for meaningful continued growth and problem-solving (p. 398). He also values them as good human endeavors in their own right. Rogers specifies how looking to values and developing effective adaptation skills creates meaningful order instead of choices made on a whim: “who is open to his experience, and self-directing, is harmonious, not chaotic, ingenious rather than random” (p. 398). This appears to reflect the contrast identified in this project between Adaptive and Accidental responses to challenges.

*Developing parents’ sense of Adaptive voice*

Taking some direction from the work of Rogers, perhaps developing an Adaptive voice requires gaining a sense of one’s own preferences, values, and an understanding of what significance those values hold in one’s family that could be called an ‘inner voice’ or ‘personal philosoph[y].’ In addition to understanding one’s own values in general, for this to turn out well in parenting, this almost certainly requires a benevolent, empathic, and wise relationship with one’s child. One of the most significant values I identified in this project was how the participants felt connected to
and aware of how their children were feeling. While we may assume that sensitivity and accurate empathy develop naturally, some parents have identified difficulty feeling that they know what they or their children want (Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1997; 1986). Some folks who developed this sense of connection to their children may assume that this happens naturally and without explicit efforts at development from individuals and their communities, but the Women’s Ways of Knowing project identified women who did not feel a sense of connection or confidence in their own sense of knowing, intuition, or the ability to know what their children wanted. Women in the ‘Silent” stage of knowing frequently turned to those they viewed as authoritative to tell them what their children needed. This may indeed by an acceptable option for some parents, but it at least identifies how a sense of knowing one’s own feelings about information and what one’s own child wants and needs does not develop automatically. This becomes a problem when those decision-making advice sources are not available or trustworthy. Also, as Rogers pointed out, failure to develop that working compass guided by one’s own values leaves one dependent on behavioral techniques and those people who prescribe those techniques. Ultimately, we are all vulnerable to being misled intentionally or by ignorance of respected advice sources in our communities, but those without a sense of “what’s right” for one’s own self and children face particular vulnerabilities. It seems to me that what seems most critical to good parenting includes accurate empathy when connecting to one’s child and developing a strong sense of what is best for one’s family, including making good use of external information sources. Unfortunately, I believe that those two facets of parenting seem minimally addressed in the public realm of parenting.
information. Women’s Ways of Knowing identifies how long and difficulty is the journey to discovering and developing one’s own sense of voice.

Women’s Ways of Knowing: Constructed Knowing and the Adaptive voice

Returning to a major research project completed using the voice listening-method, Women’s Ways of Knowing described stages of epistemological development in women. The original authors intended to address mainstream psychology’s failure to include women in research of epistemological development. Mary Belenky, Blythe Clinchy, Nancy Goldberger, and Jill Tarulet interviewed women from varying socio-economic groups and identified stages of development for modes of engaging with knowledge and relationships. They articulated five stages and named them, in order of development: Silence, Received Knowledge, Subjective Knowledge, Procedural Knowledge, and Constructed Knowledge. The constructed stage of knowing described women who “find a place for reason and intuition and expertise of others” (p. 133) while “integrating objective and subjective knowing” (p. 134).

The researchers described women in the constructed stage of knowing, explaining that “they experience themselves as investigators and search for truths that cut across the interests and biases that lie within a single disciplinary system,” (p. 140). This seems parallel to how the mothers in this project integrated information from diverse kinds of information sources, trying to understand the meaning and significance of communications from sources as experientially varied from a cooing infant to a behavioral prescription from a physician. Those identified as constructed know-ers also understand the significance of relationships as deeply important to learning, in addition
to sensing one’s own inner direction. The authors wrote, “there is a capacity at the position of constructive knowledge to attend to another person and feel related to that person in spite of what may be enormous differences…the ability to imagine and be sensitive to the interior life of others (p. 143).” Women in this stage of ‘constructed knowing’ value the process of listening to others, even when they disagree. These seem to be women who developed psychological skills for thriving, even interpersonally, within pluralistic information systems. They lose respect for sources that claim authoritative status but that fail to respect relationships. Belenky et al. (1997) found that women in this stage felt “experts must reveal an appreciation for complexity and a sense of humility about their knowledge” to earn the respect of “constructive” know-ers (p. 139).

I state my own position as valuing this stage of knowing. As Belenky et al. (1997) found, many people do not reach this stage and instead remain more obedient to behavioral prescriptions or feel less interested in listening to many different voices. Such ways of knowing may better fit particular personalities and cultural settings. The participants in this study all seem to fit into this constructed knowing, likely self-selected because they all chose to identify as falling outside of larger cultural norms and they responded to my solicitations to share their stories. I do not imagine I would have heard from mothers in the silent stages who did not feel empowered to use their own voices to share their stories nor those in a received knowing stage who likely went along with traditions of where other people recommended their baby sleep. Constructed knowing seems to reflect one possible mode for how mothers integrate information from self, baby, and the rest of the world.
Belenky et al. (1997) describe how women can feel empowered to develop their own voices and build relationships that value mutual respect and discussion. These researchers generally refer to sources of guidance in this task as “teachers” because this research was completed for the field of formal education. They describe a model of understanding an instructor as a “midwife-teacher” who supports students in developing their own voices instead of only learning to repeat information (p. 217). They suggest a teacher “assist students in giving birth to their own ideas, in making their own tacit knowing.” One way of facilitating this is to share access to the information the teachers uses and for that teacher to discuss encountering the information instead of merely presenting it. “Instead of the teacher thinking about the object privately and talking about it publicly so that students may store it, both teacher and students engage in the process of thinking and they talk out what they are thinking in a public dialogue (p. 219).”

Prescriptive at its Best

To first quickly review the main qualities of the Prescriptive voice, it focuses on future results and quantitatively measurable values such as mortality rates, it emphasizes the role of parents as practitioners consistently applying thought-through plans, it considers its scientific information to have universal value for guiding most people, and it leads discussions with conceptual planning and reified use of constructed terminology. Many aspects of the Prescriptive voice reflect goals of quantitative science in trying to predict and therefore control outcomes for variables across time with application of universalized instructions organized with conceptual planning. Asking how the Prescriptive voice can best serve parents and their children is akin to the
question of what role quantitative natural science plays in the development of a parent as a parent. As quantitative science is a tool that can be used in different ways and that transforms communications and relationships, I want to take a closer look at what it can provide at its best and what harms we might avoid. As a tool, we must decide what we want to accomplish with it, such as increased survival rates of infants. The problem grows more difficult if we want to develop parents who are more connected to the needs and wants of their children as that involves additional values. Perhaps recommendations about how to develop parents who integrate multiple kinds of information to meet changing circumstances in their families in accordance with the Adaptive voice may even require certain strengths of the Prescriptive voice.

Our values inform and are reciprocally informed by our utilization of natural science. The scientific method itself filters our engagement with the world by only accepting measurable qualities identified in experiences across individuals and time, gathering information from as many sources as possible to provide as much universally applicable information as we can. In its structure, it implies the values identified above. The scientific method also requires us to decide what counts as good, ideal, or the goal of learning. This provides direction and meaning to the process of trying to understand, predict, and control particular experiences. The Prescriptive voice, if it wants to turn to science for any sort of beneficial public effect, should include understanding of what is beneficial. This project has already reviewed those values in the second aspect of each voice (values). The first goal for research and dissemination of information in this larger cultural environment is definitively infant safety in measured mortality rates for deaths during infant sleep. None of the other goals would matter if infants were not alive. A
second goal might be something like infant health, but scientists must carefully consider how they would identify and measure such a phenomenon. The participants described advice sources concerned primarily about the future non-dependence of children in needing excessive comfort at night due to having failed to learn self-soothing by having to face the upsetting experience of crying alone (incongruously, a claim not demonstrated in the scientific literature).

Straightforward Science

In her interview, Corinne identified that the organization she previously worked for as a social worker likely would have said that mothers should not bring babies into bed with them. Corinne said that policy would have made some sense given that most of the mothers she worked with had risk factors against safe co-sleeping, such as drug use and cigarette smoking. Sometimes dissemination of such policies, as in accordance with the Prescriptive voice, seems to make practical sense. While working on this project, I frequently found parents breaking such rules about infant sleeping. As I have become particularly familiar with sleep safety studies, I have found several behavioral rules that I think make sense given what researchers have found. Some of those rules would include making sure a baby’s crib is devoid of any objects other than the clothed baby, always placing a baby to sleep on his or her back, and keeping the nursery free from any trace of cigarette smoke, even from parental clothing. When I saw a baby laying on its side in a Pampers commercial and then heard a mother explaining to her father how her daughter finally sleeps through the night when they keep a blanket in her crib, I cringed at the thought of disobeying the pronouncements of the AAP and arguments from research about safe sleep. This occurred so frequently that it brought
me to question the utility of such recommendations. Distribution of such materials seem
to make sense under a logic that says babies will be safer when all or most parents
follow these rules, so we must convince more parents to follow them. Brochures and
advice seem to presume that those methods influence parents but, at least in this study, I
found that parents face many different pamphlets and advice sources, often with
conflicting information, and they adapt advice to what feels right for their families. In
the participants’ stories, the Prescriptive voice was largely spoken by physicians and
some family. Most mothers described how consultations with their physicians were
largely ineffective in improving sleep satisfaction. All five mothers described willfully
disregarding the advice of their physicians because it failed to adequately speak to their
values and concerns. Instead, as Ayanna and Nicole mentioned, it sounded more like
their care providers were reading from textbooks with impractical and therefore
unusable advice. I would not have thought that keeping a crib empty except for the
clothed baby was impractical advice, but for the mother I overheard talking to her
father, it was.

The structures that maintain use of the Prescriptive voice as it generally was
found in this project include problematic attitudes toward use of scientific information
such as failure to actually read details of studies and evaluating their efficacy. Those
described as using this voice seemed to form perspectives through personal or
anecdotal data and then filtering further information through that filter without being
aware of the filter. As a personal example, my friend, who is a physician, told me that
she thinks parents should never sleep with their children in the same bed because she
once saw a suffocated baby in an emergency room that had reportedly been killed while
sleeping with a parent (she was not privy to any other details). While I have never been in that position myself and imagine it would indeed form a lasting impact on my own perspective about bed-sharing, this physician was admitting that she was basing her decision on witnessing one unique and ambiguous experience instead of turning to the peer-reviewed scientific data that generally sustains the authoritative stance of the Prescriptive voice. We do not actually know the conditions of that baby's death, such as if the parents had been using drugs or were gravely overweight, two factors that increase risk of death by smothering. The issue with this case is how she is universalizing a behavioral prescription based on a form of information that is formally inadequate for that purpose.

_How the Prescriptive Voice has Fallen Short...the Discussion Ends_

As participants presented many reasons for choosing actions that differed from what their pediatricians recommended, this study highlighted meaningful reasons for non-adherence to medical advice. These women each described feeling disconnected from advice sources of some kind. In every case, each woman felt that advice from her physician was irrelevant or even wrong for her family. She turned to her own sense of what felt right and other family or community for support. All of these women were non-adherent to physician advice about an issue that some claim could lead to early death for their babies, hardly a small detail. They each presented many kinds of evidence and arguments supporting their decisions. They critiqued advice sources as falling short when they failed to consider the mother’s values and concerns for her family. When advice sources seemed unhelpful, the parents frequently withdrew from conversation without significantly changing their parenting behaviors. To reiterate, the
parents did not change their behaviors to please the physicians; they simply stopped talking to their physicians about it.

Both explicitly and more generally throughout their narratives, the mothers wanted and sought after discussions with their advice sources. All responded honestly to initial queries about their bed-sharing behaviors from pediatricians and some actively sought sleeping advice until they all decided to avoid conflict by staying quiet about it in appointments. The parents generally lost the respect for their pediatricians for discussing sleep behavior. Advice was considered useful if it was applicable and supportive of a mother’s goals for her family. They by and large respected providers who seemed to show interest in their ideals, value their individualized family needs, and provide useful advice. For example, the physicians who encouraged Rachel to seek out a pediatrician who would try a new treatment for her son’s diabetes and her lactation consultant who helped her learn a comfortable position to hold her son to breastfeed more comfortably.

Ayanna, Nicole, and Corinne discussed how they came to believe that most advice sources could not provide useful advice because they provide general information which does not help “unique” people. Ayanna seemed to consider her case as especially unique while Corinne and Nicole described feeling that every case has unique concerns. None felt that universal advice could adequately address their needs. When I asked Ayanna if she thought advice sources could have done anything differently to help her, she said “I’m not really sure. I’m not really sure if they would have been able to help me because I think I had a, I don’t know, a unique case.” Presumably from identifying herself as unable to be helped by those care providers, she
implies it was her “unique” story that set her apart from the kind of parents who advice sources can actually help, as if the advice is meant for parents in non-unique situations or for styles of parenting that she considers more socially acceptable. Perhaps she meant that advice sources are meant to help parents who have never broken her cited cultural norms of placing babies in cribs, who have four-bedroom homes, or who did not want the comfort of cuddling with their children at night. This experience of feeling the medical sources failed to seem helpful or connect to the mothers who identified their values as outside of mainstream cultural norms led to the end of conversation as those mothers withdrew from discussion with those sources.

Each of the mothers described why they withdrew from conversations. Generally, they remained quiet in situations where they sensed that the other person would not be responsive, genuinely listen, or if they knew saying certain things would spur what felt like useless instructions to change behavior based on what the advice source wanted to happen. In contrast, the mothers described speaking up among other parents and advice sources that seemed to respect their values and their ways of managing parenting. Nicole explicitly suggested this withdrawing from conversation as a weakness of scientific research regarding co-sleeping because she believes enough parents would lie or withhold information from researchers to skew the data. She was arguing that even the research about sleep placement is out of touch with actual parents and what really happens at night because parents have learned to filter their discussions with representatives of the medical community to what seems most socially acceptable. She identified how an unwillingness to really listen to those outside of a conceptualized behavioral norm damages the credibility of the scientific community’s understanding of
sleep behavior.

The parents acknowledged that some advice sources maintained authority and expertise in specific areas but also narrowed the scope of that authority. For example, Ayanna described trying to figure out most problems on her own except for particular medical problems if they require a prescription for medication. Ayanna maintained some respect for her physician’s authority, mainly for writing prescriptions, because she cannot legally do that herself. For Ayanna, writing prescriptions was a way of identifying where to draw a line of the physician’s territory. Otherwise, she considered him more or less irrelevant to her own decision-making. She originally asked her pediatrician and her daughter’s speech therapist many parenting questions but she eventually withdrew her respect and discussion based on her negative experiences interacting with them. While I doubt that pediatricians or other advice sources want their advice to feel inapplicable to parents except for those more narrowly defined regions, there may be mixed degrees of concern for issues outside of something like purely medical content, if such a category could be delineated.

**Shared decision making**

I recently shadowed medical trainees during a didactic about utilizing Motivational Interviewing for medical patients who were interested in smoking cessation therapies. Although clearly anecdotal, the experience helped me understand more about in-office consultations. I shadowed two care providers, one a medical student who had training in Motivational Interviewing. She seemed to appreciate the emphasis that counseling method placed on encouraging the patient to do most of the
talking and meeting that person where he wanted to begin taking steps to change instead of trying to get him to simply conform to her recommendations. She seemed to understand that her goal in the consultation was to bring about the patient’s own motivation and adaptation of general recommendations to fit his own lifestyle, values, and goals. I also shadowed a different primary care resident for a consultation with a patient who arrived at the appointment highly motivated to quit smoking. The physician looked very nervous during the initial instructions for the consultations when the preceptor explained the counseling method. The only question he asked was about dosages of smoking cessation of prescription products. He eagerly grabbed the educational-handouts I slid toward him so he could share them with the patient. He was sweating and breathing tight, appearing quite nervous. He awkwardly laughed that he normally never does such consultations because they are too time consuming and cannot fit into the 20 minute appointments. I sat through 30 minutes of him treating the patient’s smoking as a disease that had to be figured out through endless queries about the minutiae of the patient’s smoking. That was followed by descriptions of all the problems continued smoking would cause, ranging from a miserable death to erectile dysfunction. The patient, initially quite chatty and enthusiastic about quitting, sat silently and told the doctor he was probably not ready to quit. The physician deferred to me at that point, looking for some way to get back on track. I followed my training in Motivational Interviewing to asking the patient more about his own goals while emphasizing his strengths to build confidence in his ability to actually quit. The patient appeared much more motivated again and identified how he believed a smoking cessation group would best meet his needs. At that point, I deferred again to the
physician who carried through the referral to that support group.

I was deeply impacted by this experience, particularly with the primary care physician. I truly believe that the physician wanted improved consultation skills and he felt inadequately prepared for such conversations. He seemed to genuinely care about the patient’s health but felt frustrated that the person in front of him could not be fixed in the way of a physical malfunction. I also saw that the effective portions of that consultation took all of five minutes and the other twenty five were the physician grappling for points of connection to the patient’s concern. It seemed that the problem was not that he only gets 20 minutes, but that even an hour would probably not have been enough time to provide an effective, life-changing consultation given his current state of clinical training and lack of skill for harnessing a patient’s agency to make positive decisions and behavioral progress. I appreciate this example of a clinical encounter gone awry because the physician appeared to feel unequipped for handling this interpersonal situation despite his good intentions. Ayanna’s description of narrowing the scope of her pediatrician’s expertise to writing prescriptions for medication echoes this physician’s difficulties with the non-prescription-writing components of this interaction. I described this example identify how it is over-simplifying the matter to say that those who are described as using the Prescriptive voice are some sort of deliberately oppressive or uninterested providers who pressure parents with behavioral prescriptions. The physician in this didactic I witnessed was struggling to connect with the patient’s own reasons for engaging in smoking cessation not for lack of effort, but seemingly more difficulty related to lack of training in consultation skills.
Corinne mentioned how she imagined that, if she were still working with parents who regularly used illegal drugs, she would recommend they place their babies in cribs or bassinets to sleep more safely. In that case, she would speak from the Prescriptive voice using generalized information from safety studies about sleeping with babies that demonstrate increased danger after periods of illegal drug use. Perhaps scheduling and other administrative factors impact how available physicians generally find time to research the actual data instead of relying on hearsay and unfounded generalizations. Professional organizations also seem to play a role in managing how the forums they organize make information available. While I previously mentioned a general proclamation from the AAP that bed-sharing is dangerous and should be avoided by parents, a later document seems much more fitting with what I have identified as ideals for the Prescriptive voice in increasing its helpfulness to parents, such as sharing specific and contextualized information and discussing degrees of possibilities to foster more flexible responses instead of all-or-nothing statements about sleeping positions.

*Improving utility of the Prescriptive voice*

I found this information by visiting the AAPs website and looking for recent updates to its position on bed-sharing. I found a new policy statement where the American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome provides detailed information in an article of several pages collecting and presenting summaries of data regarding infant sleep safety (2005). Instead of over-generalizing information in a brief paragraph, this document takes several pages to begin addressing complex sleep issues. They use accurate but simple language so that those with varying degrees of scientific training could make sense of the information. Instead of making
over-arching statements about particular sleeping positions, the authors specifically addressed specific components of behaviors they found as increasing risk of SIDS. Some limitations of this piece may include its sole focus on survival rates without addressing other values in sleep placement decisions beyond SIDS. Even so, the detailed presentation of information seems to facilitate a realistic conversation about sleeping practices. The values delineated in my description of the Prescriptive voice are demonstrated in the article, but in a seemingly more helpful way than in their previous press release against bed-sharing that was only a few sentences. They even present some data on the impact of sleeping arrangements across time, such as how side-sleeping is statistically much less likely to cause a problem if an infant sleeps on its side regularly and that patterns of how side-sleeping greatly increases risk of SIDS only seem to apply to infants who have rarely slept in other positions. They describe how trying to convince a mother whose baby has regularly side-slept that it must sleep on its back has much less of a scientific foundation than trying to prevent a mother from changing to side-sleeping.

This kind of detailed information, with clear reflection on the limitation of current research, seems more likely to facilitate useful discussions between providers and parents. For example, if numerous studies have clearly demonstrated that placing a baby to sleep near parents who smoke cigarettes increases that baby’s risk for SIDS, the advice source could identify evidence for that claim as strong to the parent. If a parent asks if bringing an infant into bed is safe, the advice source could describe what kind of information is known regarding that issue. For example, identifying known risk factors that increase danger (such as narcotic drug use) and describing the formal research as
having mixed results. Advice sources might take up the challenge to consider one’s willingness to bracket certain values. For example, a value of supporting infant survival might be essential for a physician while a preference to sleep alone could be bracketed when working with parents of other preferences in that area. If an advice source had a particular perspective based on anecdotal information, such as having seen a baby suffocated in a parents’ bed, she could carefully consider how that experience may contribute to sharing biased information as possible generalization to other babies remain unclear in the scientific literature. In this project, the mothers demonstrated awareness of their own values and effective and empathic relationships with their children. The mothers also found ways to maintain decisions aligned with those values through varying challenges and changing circumstances. That task seems clearly beyond the scope of what a pediatrician might develop with a parent in a quick consultation but there are few others institutions, beyond the medical, where professionals are well situated to facilitate such development in parents. Establishing relationships with community resources to provide referrals or hiring social workers, nurses, or psychologists to provide services for parents seeking additional support seem practical ways to begin addressing the issue.

Some popular parenting books identify the need for parents to develop their own ‘parenting philosophy’ or to identify a sense of what feels right to one’s family to decide how to filter and implement advice. This seems akin to the researchers in the Women’s Ways of Knowing Project identified development of a “constructive” way of knowing with which women learn to integrate their own values with other kinds of information, including scientific research. Both of these works include imperatives to
support people in doing more than just listening to what authorities tell them to do or simply doing what feels right. More recent research in the medical community has utilized the term “Shared decision making,” referring to an ideal process where people from the medical community can work with consumers of medical information to develop more satisfying decisions that engage consumers of medical information as active agents within decision-making for their cases. A recent study listed concerns of African American mothers, cite that those concerns need to be addressed in public safety campaigns about infant sleep placement (Joyner, B., Oden, R., Ajao, T. & Moon, R. (2010).). This piece recommends tailoring information to parents and considering and valuing factors of their decisions.

Parental Development Taken for Granted

In treating the act of parenting as a conglomeration of parenting techniques learned from accumulated workbook pages or parenting classes, the Prescriptive voice fails to grapple with the question of what being a parent means and how identity as a parent develops beyond what behaviors to implement. I imagine that many advice sources stick to that prescriptive stance assuming that most parents know how to adapt and form loving relationships with their newborns, taking that process for granted. During my own personal employment experience of working with adolescents in a court adjudicated population, staff frequently tried to find adequate ways to address the needs of young parents who often had complex relationships with their babies. For those of us who knew these young men and women well, it seemed clear that the question of what it means to become a parent and how to situate a bearable identity within that condition was a daunting developmental task which did not always work out
The Harlem Children’s Home developed a parenting education program that conveys some factual information about what seem to be good parenting practices. It fosters a connection between parents and children and develops the parents’ own sense of knowing what how to make sound judgments. One mother who graduated from that program described how she previously had difficulty understanding what her baby was feeling and how or why her baby might want her to interact less aggressively.

I would hear people talk about how you shouldn’t yell or scream at children, let alone hit them, and I’d think to myself, they’re just being too sensitive—a beating worked for me, it taught me a lesson. Then at Baby College they explained some things to us: why it might be better to call a time out than to yell at a child, what bad effects can result from hitting a child. They didn’t preach, they just talked about the facts and let us think and talk it out ourselves. (Barnes, 2002, p. 7)

This mother described how the program encouraged participants to discuss their opinions of the information presented. Instead of only telling these parents what to do, the Parent University program shares information and works with parents to develop their own sense of what is right or best for their families. As this mother said, “they didn’t preach” techniques and behaviors. Instead, they provided information and maintained guiding relationships that encouraged parents to discuss their own perspectives and how they felt that information applied to their own families. They fostered discussion instead of squelching it with clear and shared discussion of “facts” and opportunity for parents to come to their own decisions.

I originally identified competing claims and demands in a pluralistic culture as my problem of question when looking at the decision-making process. The participants seemed to simply address those as part of parenting. Even if every parent in the country...
believed in bed-sharing, she might still encounter a baby who has contrary plans. I do not think I would have encountered the inherent adaptations required in parenting, an ultimately interpersonal task, from an academic discussion. Instead, it seemed I found the issue of judgment and how sound judgment is formed. Reflecting on Bruner’s original contention that meaning and behavioral norms are “re-negotiated” through public discussion, the pressures to withdraw from public discussion described by the participants take on further reach than leading to individual parents feeling alienated. As many parents have withdrawn from that process of renegotiation in many venues for public discussion, that process of negotiating terms seems much more likely to feature a skewed perspective.

On a Feminist Method

Attending systematically to the voices of women beyond academic settings is a first step in bringing about a more egalitarian re-negotiation of cultural structures. If we look closely enough at everyday discussion of practical issues, we find useful emergent ways of understanding power dynamics within relationships. For example, this project demonstrated how women withdrew their voices from discussions with those who did not seem to understand their way of reasoning (Adaptive) and who expected the women to simply listen without a more authentic discussion process (Prescriptive). Due to this process of withdrawing from discussion, those speaking from the Prescriptive voice are likely to continue hearing only their own reasoning or that of others who think like them, an self-enclosed system of validation. Enclosed within each voice are values about ideal mothers. For the Prescriptive voice, it seems that mothers who listen to and follow the guidance of formally recognized authorities, typically physicians, who agree to follow
their values (independence in the future) and application of recommended behaviors (solitary infant crib sleeping) are valued as ideal.

Developing the detailed degree of understanding regarding how the mothers interviewed in this project experienced their decision-making about sleep placement would not have been possible without a method open to finding new ways of understanding parenting. My iterative identification of the parenting voices only occurred after a moment of crisis when I found initial attempts to group values or behaviors thematically, leading me to look at the structure of those processes instead of solely focusing on the content. Scales to develop quantification of preference for Adaptive or Prescriptive parenting discourses would probably include endorsement of several statements taken from the breakdown of specific details of each voice described earlier.

Further studies and innovations

If I were in a position to make improvements on this original project, I would make only a few changes. Interviewing more participants and from a greater variety of circumstances would definitely provide greater clarification of these issues. Additional variations such as interviewing fathers and couples would further elucidate additional family dynamics regarding this concern. A preliminary screening prior to accepting interviewing parents could provide greater assurance of such diversity by screening for parenting practices, ethnicity, income level, geographic region, and so on. While I found myself wishing the interviews had lasted longer due to my further interest in details of their stories, asking many more questions would likely lead to unwieldy
protocols due to length. There certainly remains a need to gather stories from community leaders regarding this issue, as I found many spontaneously begin sharing their stories with me during the recruitment process. Their interactions within government and medical structures would assuredly provide further explanation as to how the Prescriptive voice maintains its formal authority in many situations. Undoubtedly, interviews, focus groups, and participant-action research with physicians and common advice sources would serve significant informational and transformative needs.

Another issue yet to be tackled by this project includes understanding what larger sets of values and challenges lead to the formation and persistent use of the Adaptive and Prescriptive voices. Moreover, any critique of the Prescriptive voice from someone absorbed in the academic field of psychology, namely this researcher, strikes with the irony due to psychology’s socio-political role of trying to explain, predict, and control human experience, even if in qualitative guise. Parents still turn to me at social gatherings with questions of whether or not their children are normal or healthy even if one’s six year old son enjoys wearing his mommy’s dresses or when one’s four year old daughter screams for hours at a time. Outside of whether or not I am in an appropriate position to quell their anxieties or offer advice, these incidents unveil the doubts we feel about decisions and the problems we face. While pluralistic cultural systems surely exacerbate some forms of confusion or not-knowing, these basic questions about being ‘ok’ or ‘healthy,’ whatever that means, seem more fundamental to engaging in lives that we value as precious and that we sometimes face as frighteningly vulnerable.

With its stakes so high, parenting seems a particularly fitting realm of human
experiencing for catching sight of how we respond to the astonishing realization of absolute inter-dependence with other vulnerable creatures. I am struck by the similarities between qualities of the Prescriptive voice as akin to financial life and disability insurance. The refined practices of prediction, calculation, and confirmation of future security probably help millions of parents sleep more soundly at night with confidence in how those sturdy structures help their families ward off potential adversity. For all of the critiques I offered regarding the Prescriptive voice, its apparent widespread appeal indicates that it addresses larger concerns in some helpful way. Perhaps our desire to believe in its universal and over-simplified claims bolsters its convincing aura of security. The participants in this project described embracing or at least acknowledging many unknowns within parenting. I return to Gergen’s claim that individuals face the problem of increasingly “multiple and disparate potentials for being” and wonder how others will choose to live with that challenge (2007, p. 304).
References


Did you share regularly share a bed with your infant?

If so, please consider participating in the first formal study of your story!

A study of parents’ experiences when deciding where to place infants to sleep is being conducted at Duquesne University. If you choose to participate, identifying information will remain confidential.

 Seeking participants who meet these guidelines:
  o Regularly shared a bed with your infant.
  o Currently have a child between 1 and 3 years old.
  o Male and female participants welcomed.

If you are interested in participating, please contact Elizabeth Tran at trane@duq.edu or 412-913-3142.
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: A qualitative investigation of the interpersonal negotiation of infant sleep placement decisions.

INVESTIGATOR: Elizabeth Tran
Duquesne University Psychology Department
600 Forbes Avenue
Pittsburgh, PA, 15282
412-913-3142

ADVISOR: Eva Simms, Ph.D.
Duquesne University Psychology Department
600 Forbes Avenue
Pittsburgh, PA, 15282
412-396-6522

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in clinical psychology at Duquesne University

PURPOSE: You are being asked to participate in a research project that seeks to investigate how parents relate with advice sources when deciding where to place infants to sleep. You will be asked to allow me, Elizabeth Tran, to interview you. The interview will last approximately one to two hours. I will audio record and transcribe the interviews.

These are the only requests that will be made of you.

RISKS AND BENEFITS: Participation in this study is not likely cause risks greater than those encountered in everyday life. A possible benefit of participation is the opportunity the interview will provide for reflecting on your parenting
experiences.

**COMPENSATION:** Participants will not receive monetary rewards for participation. However, participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:** Specific names and locations of your family and third parties that you may mention during the interview will be disguised in the transcriptions. Any additional identifying material of the participant and anyone the participant talks about will also be deleted or disguised in the transcriptions. The disguised transcriptions will be shared with others and may appear in the written research study. Consent forms and original audio-tapes will be stored in a locked file in the researcher's home. All identifying materials will be destroyed at the completion of the research.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Elizabeth Tran at 412-913-3142, Dr. Eva Simms at 412-396-6522, and Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board 412-396-6326).

________________________________________  __________________
Participant's Signature                   Date

________________________________________  __________________
Researcher's Signature                   Date
APPENDIX C: INTERVIEW SCHEDULE

Semi-structured interview guide

The initial interview question will be broad enough to encourage a longer narrative in which they will have more space to arrange plotlines instead of following the order of many shorter questions. I will ask them about their how they decided where to place their infants to sleep, including how they interacted with advice sources and integrated personal intuition and what their evaluations of their experiences were regarding what would have helped or supported them. To discourage parents from simply listing why they made the decisions they made, I will specify my concern for understanding the holistic experience enveloping those choices. For example, phrasing a question as “what was going on for you when...” instead of only asking “why”. If they have more than one child, I will ask them to describe the process for each child in the order they choose. Belenky et al. (1997) recommend asking further questions that explicitly draw out first person responses from participants, such as asking “Is the way you describe yourself now different from the way you would have described yourself in the past?” (p. 31). (From method section of proposal)

Approximate interview questions in order:

1. Please describe your past and current sleeping arrangements with your infant in detail.

2. With my project, I am trying to understand how you experienced the process of deciding where to place your infant to sleep. Please describe what was going on for you during that process, including how relationships with other people and advice sources were involved.

3. Do you have any other comments about the involvement of others in this process for you?

4. Do you feel that your sleep placement decisions are complete or will the process of making sleep placement decisions continue?

5. Looking back, how do you feel about the decision making process? For example, are there things you wish would have been different? Is there anything you wish others would have done differently?

6. Do you have any advice that you believe would be helpful to other parents?
APPENDIX D: MARISSA’S CODED INTERVIEW TRANSCRIPT

Notes for this coded narrative:
This narrative was coded in detail according to the color demarcations used in the previous explication of the voices of the method section for this project. Prescriptive voice statements are marked with underlining and all colored text without underlining is represents the Adaptive voice. Lines marked with an “E:” indicate a question or statement of the interviewer.

[Explanation of study and consent agreement]
E: How old is she again?
8 months
E: And do you have any other children?
Yeah I have a son who’s three in September, he’s in preschool, it wouldn’t be calm with him here [laugh].
E: So can you tell me first a bit about yourself, kind of the basics, where you’re from?
I’m from England and my husband is too, we moved to the states about 8 years ago. We spent four years in California. We’ve been here since three years. I guess our son was born just after we moved here to Ohio and I used to be a manager and I’ve actually going back to work in a few weeks to help out, mainly with research as well, so, [laugh]. What else? I don’t know. I’ve been, well, I guess, I’ve been switching between staying home and working part time ever since, well since my son was one really so. Umm. What else? That’s it really, [laugh]
E: And what does your husband do?
He runs an electronics company.
E: Can I ask how old you are?
33
E: 33?
So, and my husband’s 34
E: So how old were you then when you had your son, 30, 31?
I was 30 just, it was like two weeks before my 31st birthday
E: Can I ask what brought you to the United States?
My husband’s work
E: Was that a big transition?
It was but we were sort of young and well I say single, we were together but, umm, so it was kind of easy, we weren’t, apart from leaving friends and family behind it was, you know, not, not too difficult. It was probably more difficulty moving from California to here, not that we had kids by then but uh, I don’t know I guess, we were probably still
quite immature where we moved to San Francisco and then we got kind of settled and you know were getting, I don’t know what I’m trying to say, [laugh]. But we transitioned easily I should say that. I wouldn’t want to do the move now with two kids though [laugh].

E: It would be very different

Yeah

E: So getting to the sleeping arrangements, can you describe the sleeping arrangements maybe that you have now and then what you’ve done in the past too?

Yeah, now because we’ve basically gotten tired of sharing our bed with children, um, we recently got pretty tough because, um, so I’d say about, for the last month she’s been going to bed in her crib in the evening, um, and actually sleeping through. But she wakes up around 5.30 so at 5.30 I bring her into the bed, feed her, and then if I’m lucky she’ll fall asleep again but, um, so she basically comes into our bed around 5.30 until say 7.30 when we pretty much all get up and then my son, um, he used to always, would, well obviously we’re talking about now, he, he naps in my bed in the daytime when he’s home with me, I have to fall asleep with him. Um, if I’m lucky she’ll sleep at the same time but if not she’ll play on the floor and then I’ll, you know, because if he wakes up he needs, he needs me there basically. um At bedtime though he goes to bed in his own bed which takes a while because he’s been used to, you know, having a crutch I guess. And now we, we’re trying to force him, we’ve got like this night light that changes colors and when it turns off you can get up basically so supposedly when it turns off he can then come in to our room but we try to put him back. So normally anywhere after 6 he normally wakes up and then he comes in for the final hour of snooze as well so that’s where we’re at now, so we have an hour of four in a bed, [laugh], but it’s better than half the night or a full night which we were on a while ago. Um, so, we’re slowly getting out of it

E: What you didn’t like about four in the bed?

Um, well actually being able to get some sleep ourselves because my son is sort of constantly like, he does this little pinching thing but it’s like for comfort for him he’s not pinching maliciously and then if he stops pinching you he starts stroking and it gets as you can imagine at 3 o clock in the morning sometimes it’s pretty irritating, [laugh], and then also you know we want him to have healthy sleep habits so, um, as well as you know my husband’s always joking, you know we’re going to have 17 year olds in our bed if we’re not careful. We know people who still sleep with their 5 year olds and we don’t, we don’t want that to happen we want, I guess for their independence as well but then to be able to stay in bed and sleep. Um, and there’s just no space, laugh, we have got a cal king bed so it’s very wide, I don’t know how, um, but, but yeah, we just want our bed back basically, [laugh].

E: And what about the beginnings, maybe it would be easier to say from your son first because he came first?

Um, with him it started, he hated his bassinet, we had a little rocking bassinet next to the bed and he just hated sleeping in there and he wouldn’t sleep umm and then I guess in those sleep deprived first few weeks of having a child I, I used to fall asleep feeding him and I’d wake up and he would sort of, I’d wake up in a panic because he had sort
of fallen off my lap or, well, the bumpy pillow and then one night I think I was so tired I just put him down next to me and the next thing I knew we were waking up in the morning and it was like, oh that was easy and then when he got bigger, it’s mainly to do with I think it makes nursing much easier I think. When he was big enough to feed him lying down like sort of side by side then sleeping just came so much easier he’d wake up every two to three hours to feed but I wouldn’t have to move. Um. And then we sort of, it just became a habit and then that probably lasted from when he was very young you know a few weeks old until, [sigh], I can’t really remember exactly I’d say probably younger than a year, um, I’d say nine months maybe we tried to do the Ferber method, the crying, you know when you put them in the crib and leave them, basically [laugh/sigh]. Um, but we kept going back and forth like he’d sleep in his crib, um, if he’d wake up at two or three instead of trying to rock him, spending an hour in his room ,we’d just bring him back into the bed so we were always pretty, it was just the only way to keep sleep was just to bring him in um but we’d sort of go in circles there’d be times if I was really tired I thought let’s just bring him into the bed at bedtime it’s easier but now he’s almost three and when we travel he always generally sleeps with us because he’s always been a bad sleeper but now you know he’s almost three and we just got back from a trip and he was used to sleeping, we actually put a twin bed next to our bed so he was in a separate bed but he could still hold onto one of us and then when we got back from that trip it was just, you know he didn’t want to fall, he wouldn’t fall asleep on his own which he’d been doing fine so, um, well now with him we’re at a stage where we need to be more strict when we travel because that generally messes everything up and we’re back to square one, um, and, yeah, so he’s sleeping in his own bed now. If he wakes up we put him back, if he tries to come back we put him back again, um, if it’s almost getting up time we’re like, okay, you can come in but no pinching, [laugh]. Um, because by which point she’s normally, because she wakes up at 5.30 she’s normally in our bed when he wakes up, um, I don’t know, which, but.

E: How did things start out with her?

Um, she was a pretty good sleeper at first, she would sleep, she actually slept in our room for the first three months and slept quite well, um, she’d fall asleep in the bed with us, I’d normally lie her down and then transfer her to the crib which was in our room near the bed, um. And she’d sleep for about five or six hours. When she woke up, um, I’d say 80 percent of the time I kept her in the bed again because I was so tired and it was easier that way. Sometimes if I was, you know, wide awake from getting up, like make the effort to put her back. Um, and then at 3 months we moved her into her room. Where I would do exactly the same thing she’d still fall asleep in my room, in my bed with us but whenever she woke up in the middle of the night I’d bring her in. and that was up until about six weeks ago. So, six and a half months. When I think she was just waking up out of habit. Because she’d started solids and I thought she’s getting three meals a day, she’s probably not hungry so I just put her to bed one night in her room and left her for five minutes and then went back and then left her for another five minutes but she fell asleep within the second five minutes so that was quite easy to sleep train her and then she slept through the night and that’s been how, that’s continued.

Um, so, hopefully it will continue, [laughing], hopefully she’ll be a bit more independent than our son’s been but um, I mean when she was, she definitely slept

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better when she was in our, when her crib was in our room, um but she was also younger then. But um, what was I going to say, oh yeah even when she was sleeping with us, sort of from three to six months of age I’d say she wouldn’t even, it got to the point where she wasn’t settling any better with me there hugging her and you know having all night access to milk kind of thing so I just thought well the point in doing this is so we sleep better and it just wasn’t happening even for her so it just so that’s when we made the change.

E: And sleep better, is there a way you could say what that means for her?

Well I guess just when she was younger it was a comfort for her, she would sleep better with one of us so she, you know if even, you know she’d fall asleep I guess when she was small enough to fall asleep on my chest or on my husband’s chest or whatever, um, I guess just knowing the comfort of hearing a heartbeat or whatever, they, you know say about a newborn. Um. And my son would always sleep better with, you know knowing that he was next to us but then it just got the stage where she was in our bed and still wide awake. Which the whole point in having her in our bed was so I could sleep so you know in theory she’d sleep so I could sleep but then she wasn’t sleeping. I think we were keeping, you know I’d move and she’d wake up, she’d move and I’d wake up so. Kind of defeated the objective of sleeping with us so.

E: Last night I know we spoke quickly on the phone and you were saying something about how you could talk for hours about it and I’m wondering what it was that you were feeling like?

[Laugh], no, no I think I just waffle a lot, laughing, um, I don’t, I mean, I’m always, if I meet other parents I’m always happy to, I think what I meant was I’m always happy to openly discuss my parenting whether it’s sleeping, toilet training, anything like that. Um

E: Do you have any places where you are able to do that? Any outlets that you regularly meet with or anything like that?

Yeah, I mean well I belong to a sort of play group, mom’s group. I don’t actually do a lot with them. Um, but I have a group of friends who have, well, I met them, they have kids similar age to Evan, to my son, and um, most people I know here are, I know through having kids so it’s generally, even when we go out as adults we generally it around the dinner table talking about, [laugh], is the baby sleeping through the night yet? ‘No’. it’s generally.

E: So with my project, I’m trying to understand how you experienced deciding where to place them to sleep and so if you could describe more what was going on for you in that process even before your first child was born, you know there’s decision making about whether or not to buy a crib or how you ended up with a bassinet or what you planned, maybe if you could say something about what was going on for you at that time?

I don’t think before children I even thought about the concept of sleeping with them. We didn’t, but, well, okay I guess apart from my sister and maybe a couple of people, my sister’s first child was perfect so, you know, did everything right, [laugh/sigh]. I guess I’d never spoken to anybody about putting your children to bed and so we did the usual, well I say the usual, what most people do, you know we kitted out the nursery with the crib and you know all the whatever else you need the changing table. Uh, my
sister gave us a bassinet, um, so I was like okay great we’ll have this by the bed and when she, he is too big he’ll move to the crib and everyone will, it’ll all be great and normal and it never crossed my mind that, you know, we’d have our baby in the bed. And then I don’t think I even planned it when it happened, it just happened. And I think that’s what a lot of, a lot of people have said, because I used to feed him in a rocking chair but I was getting so tired sitting in the rocking chair that it just got to the stage where I’d lean into the bassinet without having to get out of bed, grab him, feed him, sort of slump to one side and that would be it for the next three hours, um, it was never sort of thought process like maybe I’ll let him sleep in the bed. It just happened and then happened again and then kept happening and we obviously at some stage we realized, oh, we’re cosleeping, and then I started reading about it and I bought, I think it’s called a snuggle nest, you can buy this little thing you put, I don’t know if you know what they are, that you put between the pillows but it’s on a wedge and he kept slipping down so he hated that so I was like, okay that was a waste of 60 dollars. Um, and then we ended up having to do things like my husband likes to sleep with two pillows it’s like no we have a baby in the bed you’re only allowed one pillow, it was to be flat, and you have to have the sheet, like, we have to put, you know you have to put Evan really high up the bed pull the sheets really low down the bed because of the smother and all that but up and then when I became pregnant the second time all along we said we’re going to be strict, no, the baby’s not coming in the bed, he or she we didn’t know. Um. Which is why we put, well we didn’t have a, we’ve only got their bedrooms so we had to keep her nursery as a guest room for a while so we were putting her crib in our room anyway. It was like from day one she’s gonna go in the crib which didn’t happen, I think it was too big for her. So she’d sleep and like we had a bassinet stroller, so she used to sleep, we had that up in our bedroom for a while and then I transitioned her to the crib and we kept saying she’s not going to sleep in the bed she’s not going to sleep in the bed and then after a couple of months the same thing happened [laugh], just the ease of it again, didn’t plan it. We were actually trying not to do it, I’d say to my husband if you wake up and find the baby lying next to you, you get up and put her back to bed and of course, I think he was even, he was like, well oh, she’s asleep.

E: When you picked up that term cosleeping, any sense of what was going on, it sounds almost like your realized one day what was happening. Can you say more about that transition period where you identified as cosleeping?

Um, I’m not sure I can really remember, um. I guess, I guess talking about it so, I, I, another friend of mine had said, oh the baby only sleeps in our bed and I was like, oh yeah, oh yeah, that happened with us and it, I was, I think, with Evan I was almost, not embarrassed by it but it was like, if people would say where does he sleep, is he sleeping through the night I’d be like, well, you know actually he sleeps in our bed and most people we knew were like, oh my baby sleeps through the night and isn’t she wonderful and, so I was always, um. Yeah and now I think. So I think it was just talking to other people that made me think oh, well we’re doing something different, maybe this isn’t the norm and when I started, when I spoke to more and more people, um, and then I think then I joined the mom’s club after a few months and certainly more people out there who did it so I was like, okay, I guess this is fairly common, [laugh], um, you know it, you know, is nothing, why hide the fact. Not that I was hiding it but I
sort of thought, is this not what I should be doing as a parent kind of thing.

E: Any sense of where you picked that up from?

Um, just because the parents I knew all had perfect sleeping babies that all went in their own room and slept until 7 o’clock in the morning. Um, and then I guess reading, of course every time I started reading articles I’d always favor the argument that said cosleeping is the best, you know I’d read things against it and I’d sort of, I’d tell my husband and be like, oh but this guy says that it’s much better to do that because it’s, I’d always start favoring anybody that said cosleeping is fine or in fact cosleeping is the best thing to do for your child. And. But.

E: Any sense of how other people were involved including physicians, nurses, medical personnel?

Our pediatrician, um, I think I mentioned it once that we were, that he was not, that Evan wasn’t going to bed in his own bed and he was just like, you’ve got to change that, like very anti- um, yeah, very anti-bed-sharing and even with both kids I’ve said oh she still wakes up in the night he’s like, you’ve got to cry her out, put her in bed and leave her she doesn’t need to feed at three o clock, so yeah my experience with doctors has been, you know, obviously. And he sort of said, you know, you know, he needs to learn to be, I say he because it was my son the first time, you know they need to learn to fall asleep on their own just to help them be good sleepers even in their adult life. So yeah, doctors were, I’d say not on board with it.

And then my husband, I think both times is always sort of pushing, you know getting them out of our bed. But then at the same time, you know when he’s the one that has to get up early to go to work. You know, he’s, he was never gonna be the one to go and put them back into bed. You know he’d say I don’t want them in the bed but then when my son would wake up at 3 after Lucia was born it sort of happened that I deal with her if he wakes up you deal with him so of course if Evan woke up his dealing with him would be picking him up and putting him in our bed so that’s not really dealing with it, is it. [laugh]. You know trying to change, change the sleeping pattern in the house. And I think because we just did that for so long he got used to waking up, you know as a toddler as opposed to not being a baby anymore, um, after she was born. He got so used to it that is why we’re still having a problem now that he’s almost 3 and then when I was pregnant with her I was so tired. That we just got up, I just one day said oh, I, I just needed to nap so I just said why don’t you come and nap in mommy’s bed and that just happened and then happened again and then continued to happen until after she was born and then she’d nap in the bed with us. I’ve got like a rail on the side. Um, which we took off his bed and put on our bed for, for her. Um, and then it kind of became the family nap, the family nap bed. And still now, if she falls asleep at the same time as him which is not that often we all still get into bed together at nap time.

E: Is that something you like? Or something you don’t like? Or how do you feel about that?

I don’t mind it, I’m worried about what’s going to happen when, um, I guess, as she gets to a year and I get, I don’t know normally when they transition to one nap a day, if her nap time, well there’s going to be a point where I’m not going to want to spend three hours in my bedroom basically helping him stay asleep but I dread the day that he
stops napping so if staying up there at the moment helps him stay asleep then it’s great but at the same time, now I’m like, that’s three hours of my day that I could have been doing something else. So, I realize now that having let him nap in my bed for, probably been over a year now, um, and when I try to put him in his bed he will wake up, you know after an hour or so. And that’s it whereas in my bed he’ll sleep three hours so sort of now it’s easy and convenient but um, I don’t know when he stopped transitioning away from napping. Like a lot of people with their toddlers do quiet time instead of napping which would be him playing in his room for a couple of hours I guess on his own but he’s not used to being in his room at naptime because he’s always in my room so. Um. That’s kind of a future worry in the back of my mind but at the same time, having two young kids is like, I just, I need to worry about now, not worry about what might happen in the future even though I should because I’m sure it will continue to get worse [laugh].

E: When you say you’re sure it will get worse?

No I mean, his, the sleeping, well, the night time is getting better, I mean, he’s learning to stay in his bed now until, well, until his nightlight changes color but you know the napping thing is not ideal, it’s okay, it’s not doing anybody any harm, everybody’s getting rest, um, but I don’t know where I’m going with this.

E: When you mentioned that experience with the doctor when he said you need to be placing your son in his own bed, any sense of what you were feeling during that interaction with him?

Um, I’d say I felt agreeing with what he was saying but at the same time wasn’t going to rush home and do it that night. It was like yeah we know that’s where we need to be, you know we know that the children need to be able to fall asleep themselves. I guess so when they wake up in the middle of the night they can put themselves back to sleep which she can do now but my son still can’t do, he wakes up and he just comes to our room and he has a gate on his door but he’s like, got some issues with that, laugh, so he’ll just, [laugh], if we shut the gate he’ll just scream and wake her up so we leave it open. Um, but yeah, I sort of acknowledged and agreed, yes, we, I know we need to do that but I still did it in my own time.

E: Any sense of how you were feeling about yourself as a parent, as a mom as he’s telling you this and it’s something that you’re not doing?

Um, I didn’t feel bad or wrong or, um, I think I probably felt more along the lines of well I’m the mother, I’m the children, I deal, you know, it’s, you know, it’s kind, it’s up to me I know my children and in the moment if the only way for them to feel safe and sleep if it’s to do it the way we’re doing then fine, you know, I’m not going to leave, you know, if my son doesn’t, is scared of the dark and doesn’t want to lie in his room on his own, for example, I’ll lay with him until he falls asleep which we don’t do he does fall asleep on his own but even if that was the case I wouldn’t sort of leave him there screaming and fretting even if the doctor said you probably should. I think there’s a sort of limit, [laugh/sigh], but uh yeah I mean I value the doctor’s opinion on pretty much everything but if at the same time I don’t agree, if it’s medically necessary I don’t, follow the, the rules, but something like that I’m like, yeah, you know, I hear what you’re saying and then, but at the moment it’s not going to work for us, [laughing], so. I think, I think after the sort of initial conversation with the pediatrician
about putting Evan to bed I never mentioned sleeping to him again until I had her and then it came up again and he said you need to do the Dr. Ferber, the crying it out.

E: Did he specifically say the Ferber method?

Yeah.

I think because parents all know the term I think so he said, I think he said you need to bring Ferber into the house and I did because I knew I did, I think I was almost, I think I, I wanted to hear him say it to make me do it that time.

E: And when you say you brought it up and then you’re saying, in bringing it up maybe you almost wanted to hear that, can you say something about what was going on at that time?

That was at the stage where, as I mentioned earlier, where she was still sleeping in our bed but she wasn’t sleeping any better she’d just stir all night. Um, and I thought if she’s going to stir all night she might as well stir somewhere else.

Yeah, I mean, I thought I knew we had to make sure, she was fairly underweight when she had her four month checkup so I didn’t really, I was like me maybe she should still feed every couple of hours at night even though she’s sick. So, and by which point you know I was so sleep deprived after having not slept for almost three years [laugh] after the first one was born, I think I just wanted to be told by somebody in authority, well, you know what I mean. By somebody that yeah, she’s ready, she’s big enough, she weighs enough, she can be, she did so well I mean it wasn’t like with my son it was a horrible transition we had to, I think I left him crying 45 minutes for, for a week. But she was much easier, so.

E: Did you go home and buy a Ferber book and, is that what happened, what happened after that?

I didn’t buy a Ferber book, um, I, but I did Google Ferbering, Ferberizing I believe the terms is. I’d actually bought, recently bought another book because I didn’t want to Ferber because she was, you know, little, delicate, female, I don’t know, I was like, I don’t want to put her to bed crying I didn’t think she’d be able to cope with it because she used to hate being put in her crib so I, I bought another book which is the baby whisperer which had more like a gentler approach to doing it and then with my son I’ve got, I got about 15 different sleeping books so I was like, but uh, the baby whisperer approach was, and it’s said if you’re thinking of Ferberizing it said read this first so I read it and did it for the first few nights which is basically instead of leaving them, it’s called the pick-up put-down, so you pick them up as soon as they cry, soon as they stop you, the second they stop you put them back in the crib so I was there for like an hour doing this I thought you know I can’t do this I’m just going to try the Ferber thing, [laughing], and it worked so, yeah, but I did come home and, even though I knew the whole thing but it had examples and how many minutes to leave them and, so I did some Googling, I spoke to my sister because her second child was the same thing, she was sleeping in my sister’s bed but it got to the point where she wasn’t even happy sleeping with her, she’d cry all night in bed with my sister and her husband and she, and she got uh, I think 12 months. I think what happened is my sister had fallen asleep and she was so tired one morning and the baby went to reach a cup of water on the bedside table over the bar and the water and fell over the bar and then she was just like
this has to change, this is obviously not safe for anybody, um, so I’d spoken to her and asked her how she dealt with the transition and she said they, you know, I believe it was 5 minutes and then go comfort her then 10 minutes then 15 minutes. And then 15 every time you know do it over 15 so I used her theory. Because a lot of, I think, I think Ferber might say you just leave them to cry until they fall asleep which I think may be a bit harsh. So yeah so I did sort of a combination of Googling and speaking to my sister.

E: How did you end up with those other 15 sleep books that you just mentioned?

That was my son because nothing every worked so I bought so many parenting books for him. I should probably sell them. I think they were great because I took ideas from each of them when I skimmed through them again with her. I actually sent some of them to my sister so she had to sort of read some back to me over the phone as well. But just all different sleep theories of how to get your baby to sleep gently without leaving them and, but um, yeah.

E: Any sense of how you picked those books, was there any reasoning behind it or?

Um, I think the books I bought would have been, I guess, well, related to sleeping which is what we’re talking about. But then trying to find ways to do it without leaving them to cry, um, and just, you know based on reviews and reading snippets online of them is how I chose them. But in the end, the leaving them to cry has worked, [laughing], both of them anyway, so

E: But it sounds like that was something that you wished had worked out, the not leaving to cry

Yeah, and I think everybody, that I know that has done it, that has left their kids to cry have not wanted to do it, or some people I think just did it like my sister who, you know is similar she sort of didn’t want to do it and when she did it, she was like, oh my god that’s the best thing, that’s the best thing, the best parenting decision I ever made. Because it’s really hard to do even if it’s, even you know only five minutes crying because to a baby it’s a lifetime of crying so, um,

E: Any reactions, you mentioned your sister, any other family members who had input or comments or influence on you?

Um, not really I mean, my mom never really, I don’t know she’s pretty good at sort of, I don’t know she’s very good at letting you get on with things your own way so she you know sort of said maybe you shouldn’t be doing that, um, but she never really commented on it. She knew we were doing it but never I think the only time we talked about sleeping she was like, oh you all slept great at like six weeks and that was sort of the extent of our, uh,. My mother in law, we never really talked about the sleeping together, she’d give me examples like my husband’s sister. Apparently my husband was a great sleeper as well but his sister, so my sister in law obviously, his mom gave me an example that she would never sleep she had to put a mattress on the floor of Ashley, that was my sister in law of when she was a baby in a crib she had to sleep on a mattress in the floor with her hand in the rails so Ashley would fall asleep and I think actually what she said was back then it was just, not less, not the dumb thing but maybe not even something you’d think about. They didn’t think about oh we’ll bring the baby in the bed it was like, oh god I’ve got to go sleep on the floor in the nursery. So, I guess.
E: Any other sense of how others have been involved in this process for you?
E: Involved or not involved?

Umm, umm, I guess a part, hmm, our neighbors have two kids, five and two, well almost. And they, they basically all sleep together and it’s not at the stage where the dad goes into the five year old boy when he wakes up at night and the mom goes to other two year old girl. They’re trying to change that now so I think when we got, when we started sleeping to Evan we talked to them about it and because they were doing it we were like, oh maybe it’s okay. They do it so we were just saying as long as when we’re not doing it when he’s two or three.

Um, I wouldn’t want to be in their situation because they just don’t, you know, they’re generally, they might as well just have one bedroom or something, [laugh], because they’re all generally but uh, I think sort of speaking to them and, because we’re very close, we share a driveway, you know we all, literally just, well my son walks into their house whenever he feels like it, it was like, well that’s what they do it can’t be that bad they function the next day and they’re normal people. I don’t know whether I’d say they influenced us but they certainly made us think we’re not the only people doing this so let’s not worry about it so much but um, I guess really the only people involved in the process was my husband and I, I mean.

E: And any, I know you said we quite a bit so, any other sense of him and what this process has been like for him? Deciding where to put them to sleep?

I mean he has always been, I guess verbally tough, they need, they have to go in their own room, um, but at two o clock in the morning when you’re half asleep, you know, he’s very easy to buckle, more so than me. Um, but I think he’s, you know, he’s, he’s always been more worried about what’s going to happen when they’re older, we don’t want the kids in the bed when they’re, you know when they’re, I don’t know where they’re not babies anymore, I don’t know what age he has in mind. And at the same time he wants to be able to sleep next to his wife, [laugh], without two kids in the middle. But, he generally, he generally, he obviously parents the children but at the end of the day I think I make it known that I will have the final say so I think he sort of knows that now so I think he would leave it to me to make a decision like he might, you know have a bright idea which, you know I might agree with but I’ll be the one to, you know, follow through with whatever change in, you know any parenting, whether it’s sleep or whatever.

E: So do you feel like your bed-sharing, or just even sleep placement decisions are kind of complete or do you feel like it’s still part of a process?

I think it’s still part of a process. Whenever we travel I think it’s gonna, we’re going away in a couple of weeks and we’ll see what happens to her because she’s only just started sleeping in her own room. Whenever we traveled when it was just my son, we traveled a few times with her as well, we’ve ended up getting hotel rooms with two doubles or whatever and it’s been like boy bed girl bed and the crib just taking up space but I’m hoping moving forward with her that she’ll, you know transitioning to, um, but I’m hoping she’ll be easier but I have a feeling that when we go on vacation in a couple of weeks we’re going to have our son in the room with us. But maybe that wouldn’t happen but I think it’s gonna be an ongoing process because we do travel a lot and that
generally, when we get things back to normal, or, well, when we get things in a good place where everybody’s in their own room, everybody’s getting, you know, a reasonable amount of sleep, we go away and then it just all starts again. Um so it’s definitely, definitely a process.

E: Earlier I heard you call sleeping together like a crutch, any sense of maybe where you picked up that term or?

Um. Either it just came out of my mouth or it might have been something the baby whisperer says, [laughing]. Um, yeah I mean, it, there, well, for my son still, he would sleep better I’d say quicker and longer if he had one of us whether he was in our bed or whether we were in his bed. Um, so I guess in that way but he can do it without us just not as well. But I’m not aware of where the term came from.

E: I’m wondering if it meant the ideal is, you know sleeping alone and the crutch is not as good or, sort of wondering if it meant anything like that for you?

Yeah, um, I’m not sure, I’m not really sure, [I don’t, laugh], sorry.

Yeah. Um, I mean my ideal now is, is sleeping alone, mainly to get some sleep. Um, when they’re very little I think it’s, um, I don’t know I mean when they’re both newborn, they were both, they need that love and nurturing or whatever and they like to stay close so I, you know I, we’re not planning on having more children but if we did again I wouldn’t, well, I don’t know if I can say that, but, I’ve got nothing against having them in the bed early till they get a bit bigger because then it’s just not restful for anybody. I think the reason we’ve done it, well I guess is sort of two fold everybody slept better but because the kids have felt more comfortable, you know and I obviously want my children to be comfortable.

E: Any sense of, we talked a bit about it, but any other sense of how you feel looking back at that decision making process and anything you would have done differently?

Would I do anything different? Um, I would say, I’d say no because when she was born, we said we would do it all differently and we didn’t, we ended up, I think because it was easier, or this is something that, in a lot of people, in the baby whisperer book she calls it accidental parenting and a lot of people have reviewed the book and feel patronized by the way, by the way she calls it accidental parenting but I think it’s actually a pretty good term because we didn’t plan to do it either time, it did happen by accident, but uh, you know the reasons that, that made it happen and made it continue were, you know the kids, both babies being, well where they wanted to be and being happy and everybody getting rest. I don’t know if, I think, looking back, maybe, I mean she’s still young but now she’s in a good place, sleeping, but, maybe with my son, we could have been a bit stricter as he got older. Like certainly from, um, just because we’re still battling to keep her in bed now.

E: Do you feel that term is patronizing, accidental parenting?

No. that’s when I read the reviews I thought I was going to read the book and get angry but I didn’t I was like, there was some things I didn’t agree with but I actually thought the term accidental parenting, from, from our perspective was actually quite apt because it did happen by accident twice, [laugh]. Um. But. I don’t know I mean it worked for us, I’ve got nothing against it. We’ve had friends that have had babies and they say, oh, he only want to sleep between us and instead of saying ‘god no don’t do it you’ll regret
it in two years time’ I’ve just said, exactly the same with us. I suggest you sleep with, without pillows and pull your sheets further bed. One of my friends said ‘that’s a genius idea’ because she was worried about smothering him. I said ‘push him up, you sleep lower down’.

E: Any other resources that you did turn to?
Um, a lot of internet research and reading just, not necessarily, well to get ideas but also to see what other people were sort of doing and saying about it, um, and, that’s it really.

Any advice you feel, you’ve given some already, but any other advice you think would be helpful who are starting that process on their own?
Um, I guess, you know if it, if it feels right for your family and if it’s working, then great. I think a lot of people worry about doing it. You know if you, and aren’t comfortable with it I think if you’re not then maybe it’s a sign that you shouldn’t be doing it. Um, but uh, but we were comfortable with it up to a point but when we got to that point we changed it. Um, but, and then you get this a lot from reading but, you know obviously the safety features like, because sometimes my husband takes sleeping pills if he’s got, you know, tough, you know work stress or whatever and I’m like you can’t take a sleeping pill with the baby lying next to you in case, not that I ever sleep deep enough, I’d probably know if he was to roll but obviously take safety precautions, don’t sleep with the baby if you’re like really, really drunk, [laughing], and silly stuff like that, but I think if it feels right and it works and everybody’s happen then, you know. Then definitely, but from just, just from our experience it’s like, stop it before the kid gets too used to it, I’d say after, when they’re old enough to sleep through the night on their own which I guess is 6, 7 months, I think that’s the time to stop doing it. Which is what we’ve done with her but what we didn’t do with my son which I think I wish we had been strict. But I’m all for, when I was a kid I’d wake up from a nightmare, you know age 8 and I’d go sleep with my mom and she’d be fine with it, I’m sure it was only like once a month or something but I can remember doing that at various ages and, you know and if they’re sick obviously we’re not going to say you can’t come in mommy’s bed [laugh].

E: Anything else you wish others would have done differently that would have been more helpful for you?
What do you mean, others?
E: Medical, or friends, or?
Um, I used to jokingly blame my mother in law for Evan wanting to sleep with us because they came to visit when he was newborn and she would never put him down. Um. Like I’d be sort of napping and recovering from having the baby, laugh, and I was like, when he falls asleep put him in the bassinet and I’d come down and she’d still be holding it and then when they left I’d say this is your mom’s fault that this happened because she just held him for two weeks. Obviously, that, I don’t really hold that true, [laugh]. Um, I don’t think anybody else was involved enough to really have helped or hindered. Um, so I can’t really say.

E: Yeah, anything else about this process for you, looking at the big picture?
Um, I don’t know really, I mean it’s, there’s so many debates out there about whether
it’s good or bad or safe or unsafe, I mean, I don’t know, I don’t even know where I’m getting at with this. Um, I guess I’m 50/50 and obviously talking in personal experience. I think it’s great when they’re little, if that’s how everybody in the house gets some sleep, but having experienced it twice around and still struggling with the first one I’d say, do it up until six to eight months and then if it makes it easier but once they get to an age where they should feel, where they don’t need to wake up for milk, then I’d say, from my experience, that, that, that would be a good time to stop and looking back for my son we should have stopped there and he’d be a better sleeper now, maybe he’d be able to sleep on, on his own.

E: So you said you’re a recruiter, can I ask more about that? What kind of recruiting?

I do all sorts. Um, I guess mainly finance because I’ve worked, I worked for a couple of different companies since moving here, mainly finance stuff, which, finance and accounting is like, I just sort of fell into recruiting those people, it’s not something that I, [laugh], know much about but, um, that’s what I was doing. But then I started not enjoying it, just like the sales-y side of business, I’m not really a sales person. I liked the, I liked the interviewing side and the sort of relationship management side so I switched to being an office manager for the recruiting company so I could still help out with, you know, some of the stuff when if needed but I didn’t I actually ended up trying to recruit people to be recruiters for our company, um, which was okay because it was just, you know I guess finding people and interviewing them and, sort of, um, so I guess that’s what I’ll be doing when I go back, but.

E: Any sense of what the transition from working to part time or being at home?

Um, well I did it when my son was one. Went back two days a week so I’m doing that just two days a week. Um, what I will be doing. And, I mean it was tough then, and even in daycare he always got sick so I generally spent one day a week at work because there was always something wrong and I think because he was my first child, although I was probably even a bit more worried about him being at daycare and my mind wasn’t really on it, whereas now I’m sort of, I don’t know I think I was more desperate to get away with him because he was quite hard work, she’s much easier but I think now, I think it’ll be easier this time because I’ve done it before, I know that they’re okay. Um, and actually want to get some adult brain cells back. Well, and he’s at preschool now, which she’s had, she’s not had a full year.

But, after sort of, I’m not sure, I’m hoping the transition will be easier than when I went back to work after having Evan because, as much as I love my children I’m ready to, [laugh], have some adult conversation as well.

I hope I answered your questions, maybe I [laugh] waffled a bit. Trying to think back to my son when we slept more, it hard to remember which is crazy because it’s only been two and a half years, it’s hard to pinpoint what we did, how long we did it for.